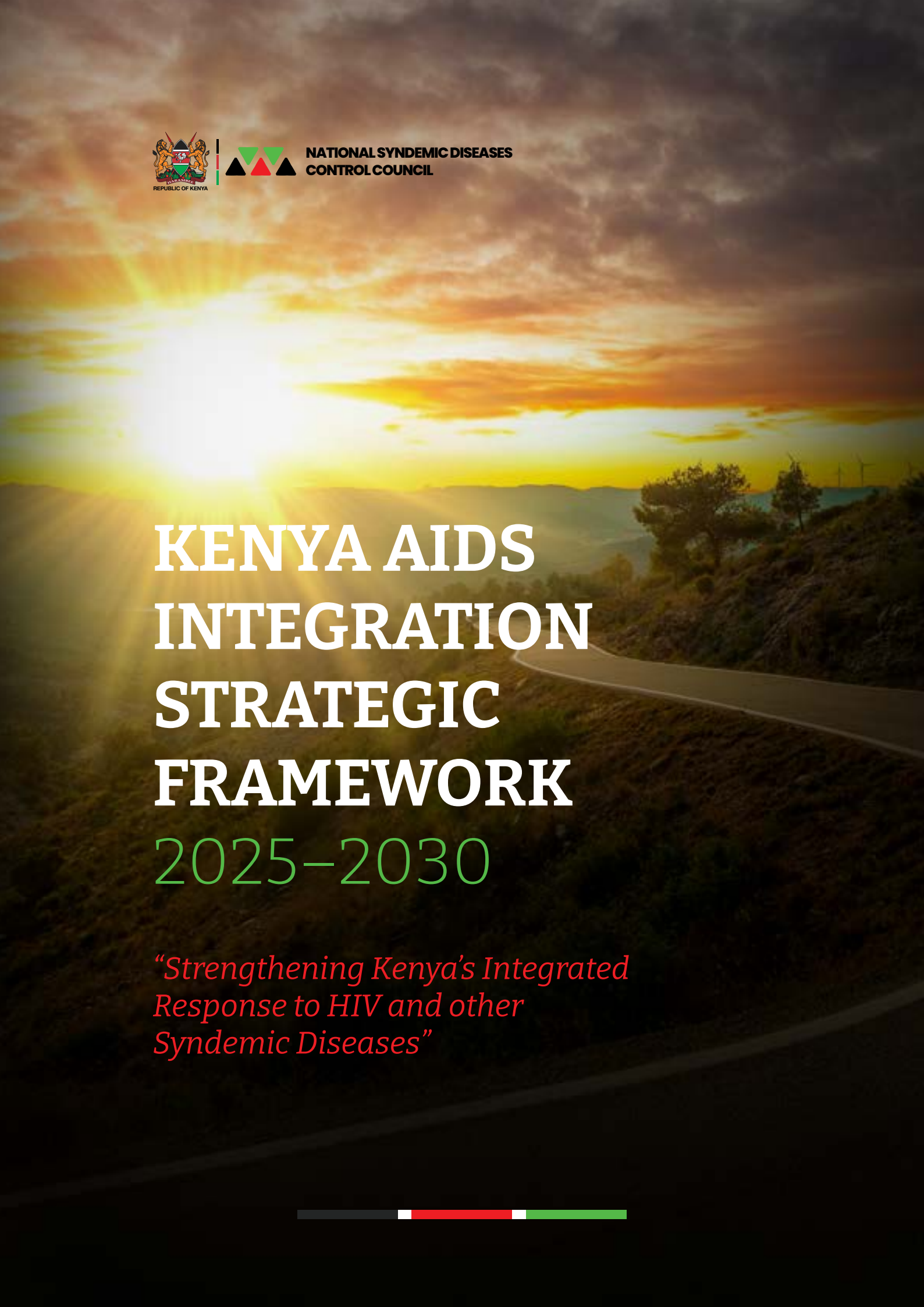

KENYA AIDS INTEGRATION STRATEGIC FRAMEWORK 2025–2030

"Strengthening Kenya's Integrated Response to HIV and other Syndemic Diseases"

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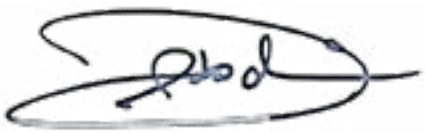
Foreword

Kenya's HIV response reflects decades of resilience, innovation, and progress, with significant reductions in new infections, expanded access to treatment, and improved survival. Yet HIV exists within a syndemic context, interconnected with tuberculosis, malaria, sexually transmitted infections, and the rising burden of noncommunicable diseases. These overlapping conditions intensify vulnerabilities, strain health systems, and jeopardise hard-won gains, underscoring the need for an integrated and sustainable approach.

The Kenya AIDS Integration Strategic Framework 2025–2030 succeeds Kenya AIDS Strategic Framework II and provides the strategic platform for embedding HIV within the broader health agenda. It consolidates lessons from past frameworks, responds to emerging national and global dynamics, and aligns with the World Health Organization's health system building blocks: service delivery; health workforce; health information systems; medical products, vaccines and technologies; health system financing; and leadership and governance. The framework adopts a Programme Science approach that integrates scientific evidence into programme design, implementation, and evaluation to ensure interventions are driven by science, context-specific, adaptive and results-oriented.

Kenya's success in integrating noncommunicable disease and mental health care into primary health care shows that integration is a proven pathway. KAISF builds on this experience, extending integration to HIV and other syndemic conditions to secure sustainability and enhance impact. By leveraging investments in surveillance, supply chains, monitoring, and community systems, KAISF promotes integrated service delivery, reduces duplication, and prioritises equity. It emphasises domestic resource mobilisation, innovation, and evidence-driven programming, while reinforcing Universal Health Coverage and strengthening frontline service delivery.

More than a health strategy, KAISF is a blueprint for resilience, equity, and sustainability. It safeguards HIV gains, accelerates integration, and positions Kenya's health system to meet the syndemic challenges of today and to build a healthier, more productive nation in line with the Constitution and Vision 2030.



Hon. Aden Duale, E.G.H.
Cabinet Secretary Ministry of Health

Preface

The Kenya AIDS Integration Strategic Framework 2025–2030 represents a critical step in charting the future of our national health agenda. It underscores Kenya's determination to preserve the gains made in the HIV response, while addressing the broader health challenges that demand integrated, resilient, and sustainable solutions.

This framework provides clear direction for aligning HIV programming with national health priorities and Universal Health Coverage reforms. It emphasises the importance of domestic resource mobilisation, innovation, and county ownership as essential for a sustainable response. Equally, it recognises the role of communities, civil society, and development partners in ensuring that the response remains inclusive and equitable. KAISF calls on all actors, including government institutions, counties, partners, and communities, to work together to deliver on its vision. It provides not only a roadmap for safeguarding the progress made in combating HIV, but also a platform for strengthening Kenya's entire health system.

I reaffirm the Council's commitment to ensuring the full implementation of KAISF and to mobilising collective action around its objectives. With continued collaboration and shared responsibility, Kenya can sustain its gains, accelerate integration, and realise the goal of ending AIDS as a public health threat by 2030.

Hon. Ahmed Ibrahim Abass,
Chairperson of the National Syndemic Diseases Control Council (NSDCC),

Acknowledgements

The National Syndemic Diseases Control Council extends its deepest appreciation to its staff, partners, and stakeholders for their invaluable contributions to the development of the Kenya AIDS Integration Strategic Framework KAISF 2025–2030. This process was made possible through the support and collaboration of the National and County Governments of Kenya, government ministries, departments and agencies, as well as numerous partners and stakeholders.

We are especially grateful for the technical input provided throughout the development and review process, and for the active engagement of networks of people living with HIV, civil society organisations, and community representatives, including key populations, adolescents and young people, persons with disabilities, women's organisations, and representatives of older people. Their lived experiences and perspectives have greatly enriched this framework.

We also recognise with gratitude the dedication, expertise, and guidance of the Core Review Team, whose leadership was instrumental in shaping the process.

The National Syndemic Diseases Control Council reaffirms its commitment to continued collaboration with all partners and stakeholders in advancing the national agenda of ending AIDS as a public health threat by 2030, while strengthening Kenya's health systems to address syndemic diseases in an integrated and sustainable way.

Douglas O. Bosire
Ag. Chief Executive Officer of the National Syndemic Diseases Control Council (NSDCC),

Abbreviations

ABYM	Adolescent Boys and Young Men
ADR	Adverse Drug Reaction
AGYW	Adolescent Girls and Young Women
AHD	Advanced HIV Disease
AI	Artificial Intelligence
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
AOP	Annual Operational Plan
ASAL	Arid and Semi-Arid Lands
ART	Antiretroviral Therapy
ARV	Antiretroviral
AYP	Adolescents and Young People
BP	Blood Pressure
CDH	County Director of Health
CHP	Community Health Promoter
CIHIS	Comprehensive Integrated Health Information System
CISC	County Integration Steering Committee
CKD	Chronic Kidney Disease
CMV	Cytomegalovirus
COP	County Operational Plan
CPD	Continuous Professional Development
CSO	Civil Society Organisation
CVD	Cardiovascular Disease
DFID	Department for International Development
DHA	Digital Health Agency
DHIS	District Health Information Systems
DRM	Domestic Resource Mobilisation
ECCF	Emergency, Chronic, and Critical Illness Fund
EMR	Electronic Medical Records
EMTCT	Elimination of Mother-To-Child Transmission
ETR	End Term Review
FCDO	Foreign, Commonwealth & Development Office
FSW	Female Sex Worker
GBV	Gender-Based Violence
HAND	HIV-Associated Neurocognitive Disorder
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HCW	Health Care Worker
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HPT	Health Products and Technologies
HPV	Human Papillomavirus
HRH	Human Resources for Health
HRHIS	Human Resource for Health Information System
HSV	Genital Herpes
ICT	Information and Communication Technology
IDP	Internally Displaced Persons
JAPR	Joint Program Annual Review
KAISF	Kenya AIDS Integrated Strategic Framework

KASF	Kenya AIDS Strategic Framework
KEMSA	Kenya Medical Supplies Authority
KHIS	Kenya Health Information System
KNASA	Kenya National AIDS Spending Assessment
KP	Key Population
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MNCH	Maternal, Newborn, and Child Health
MoH	Ministry of Health
MOU	Memorandum of Understanding
MSM	Men Who Have Sex with Men
MTCT	Mother-To-Child Transmission
MTEF	Medium-Term Expenditure Framework
NCD	Noncommunicable Disease
NHA	National Health Accounts
NHIF	National Hospital Insurance Fund
NSDCC	National Syndemic Diseases Control Council
NTD	Neglected Tropical Disease
NUPI	National Unique Personal Identifier
OI	Opportunistic Infection
OJT	On-the-Job Training
OPD	Outpatient Department or Organisation of Persons with Disabilities
PCP	Pneumocystis Pneumonia
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PESTEL	Political, Economic, Social, Technological, Environmental, and Legal
PETS	Public Expenditure Tracking Survey
PHC	Primary Health Care
PHCF	Primary Health Care Fund
PLHIV	People Living with HIV
PPP	Public Private Partnership
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
PWD	Persons with Disabilities
PWID	People Who Inject Drugs
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
RRI	Rapid Results Initiative
SHA	Social Health Authority
SHIF	Social Health Insurance Fund
SGBV	Sexual and Gender-Based Violence
SOP	Standard Operating Procedure
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
SWOT	Strengths, Weaknesses, Opportunities, and Threats
TB	Tuberculosis
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV and AIDS
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WISN	Workload Indicator Staffing Needs
WLHIV	Women Living with HIV

Glossary

1. **Health system building blocks are the six essential components that form the foundation of a strong health system, as defined by** the World Health Organization (WHO). These blocks are service delivery; health workforce; health information systems; medical products, vaccines and technologies; health system financing; and leadership and governance.
2. **Integration pillars in this framework are adopted from the six WHO health system building blocks and customised to the Kenyan context.**
3. **HIV health service delivery terms**

Advanced HIV disease (AHD)
As per WHO, AHD is defined as:

Adults, adolescents, and children ≥5 years: CD4 <200 cells/mm^3 or WHO Stage 3/4 clinical presentation

Children <5 years: Automatically classified as AHD due to rapid disease progression risk

Integration

Integration in health refers to the intentional design and delivery of services so that prevention, screening, diagnosis, treatment, and care for multiple conditions are provided within a single, coordinated platform. It moves beyond vertical, disease-specific programmes toward person-centred, holistic care that addresses the full range of health needs. In the context of HIV, integration ensures that every clinic, community, or hospital encounter becomes an opportunity to address HIV alongside related conditions such as tuberculosis, malaria, and noncommunicable diseases.

Opportunistic Infections (OIs)

Diseases caused by organisms that typically do not affect immunocompetent individuals, but exploit weakened immunity in people living with HIV, cancer patients, or transplant recipients.

Sexually Transmitted Infections (STIs)

Infections transmitted through sexual contact or, less commonly, via childbirth or blood. Examples include syphilis, gonorrhoea, chlamydia, trichomoniasis, HSV-2, HPV, and HIV.

Reportable STIs

Reportable STIs are those that, by law or national surveillance policy, must be notified to public health authorities when diagnosed. These diseases are included on notifiable disease lists because of their public health importance, especially regarding transmission risk, outbreak potential, treatment availability, and potential for severe complications.

The following table provides a list of reportable STIs in Kenya due to their strategic public health importance:

STI	Reason for notification
HIV	Lifelong infection with major public health impact; national surveillance essential
Syphilis	Easily transmitted and can cause congenital syphilis if untreated
Gonorrhoea	High prevalence, antimicrobial resistance concerns
Chlamydia	Common and often asymptomatic, but causes serious reproductive complications
Hepatitis B	Sexually transmissible and causes chronic liver disease
Hepatitis C	Less commonly sexually transmitted but reportable due to public health risk
Chancroid	Rare, but included in syndromic management surveillance
Genital Herpes (HSV)	Not always reportable individually, but monitored through syndromic approaches
HPV-related conditions	Cervical cancer screening and HPV vaccination

HIV-Related Comorbidities

Medical conditions occurring alongside HIV due to immune suppression, aging, or ART. They include infectious, non-infectious, and chronic diseases impacting quality of life.

Category	Description	Examples
Opportunistic infections	Infections due to immunosuppression	TB, PCP, CMV, Candidiasis, Cryptococcal meningitis
Co-infections	Common infections exacerbating HIV	HBV, HCV, Malaria, HPV, Syphilis
HIV-associated Malignancies	Cancers more frequently/severe in PLHIV	Kaposi's Sarcoma, Lymphoma, Cervical Cancer
Noncommunicable diseases (NCDs)	Chronic conditions linked to aging or ART	CVD, Hypertension, Diabetes, CKD
Neurocognitive & mental health	HIV brain effects, ART toxicity, stress	HAND, Depression, Anxiety, Substance Use
Metabolic & bone disorders	ART-related or immune-related changes	Dyslipidaemia, Insulin resistance, Osteoporosis

Populations of focus

Populations of focus refer to groups that experience heightened vulnerability, increased HIV burden, or limited access to services due to biological, behavioural, structural, or social factors.

Group	Definition	Examples
Key populations	High-risk behaviour + social/legal barriers	FSWs, MSM, PWID, transgender people
Vulnerable populations	High-risk contexts or professions	Fisherfolk, prisoners, truckers, discordant couples
Populations with heightened risk	Groups facing a combination of biological, behavioral, and structural factors that significantly increase their susceptibility to HIV acquisition and/or poor health outcomes, beyond the level of the general population.	Adolescent Girls and Young Women (AGYW), Adolescent Boys and Young Men (ABYM), Persons with Disabilities (PWDs), orphans and vulnerable children, the elderly, and people with specific comorbidities (e.g., advanced HIV disease, TB).
Priority populations	Face sociocultural/geographic service barriers	AGYW, ABYM, PWDs, IDP, migrants, elderly PLHIV

4. Health Products and Technologies (HPT) terms

- **End-to-end supply chain systems:** Seamless flow of commodities from procurement to patient delivery, including forecasting, warehousing, and reporting
- **Real-time LMIS visibility:** Instant access to commodity data across levels to prevent stockouts or overstocks
- **Buffer stocks:** Pre-positioned strategic HPT reserves of 9 months at the national-level stores and 3 months at facility to protect against disruptions
- **Last-mile delivery systems:** Mechanisms to reach the most remote facilities and communities
- **Stockouts:** Periods when essential commodities are unavailable at the point of care
- **Integration into national budgets:** Shifting HIV commodities into government-funded essential medicines lists
- **Local manufacturing capacity:** Domestic production of ARVs, test kits, and other HIV commodities
- **Multi-disease diagnostic platforms:** Shared lab infrastructure for HIV, TB, and other diseases
- **Pharmacovigilance and quality assurance:** Systems to monitor drug safety, side effects, and product quality
- **Interoperable LMIS linked to KHIS2:** Integrated data systems enabling decision-making and accountability

5. **Human Resources for Health terms**

- **Task shifting:** Rational delegation of tasks to optimize human resource use
- **Task sharing:** Collaborative distribution of responsibilities across cadres
- **Cross training:** Expanding provider competencies across multiple health areas
- **Integrated training plan:** Consolidated capacity-building across service areas and cadres
- **Workforce adaptability:** Capacity of health workers to adjust to evolving needs and technologies

6. **Health Information System terms**

Data: Health information generated by the system, including patient records, service delivery, surveillance, and registries. In KAISF, data is treated as a national asset and must be real-time, standardised, and interoperable.

7. **Health System Financing terms**

- **National Health Accounts (NHA):** Used to monitor and track total health expenditures, showing where money comes from and where it goes within the health sector.
- **Kenya National AIDS Spending Assessment (KNASA):** Tool for understanding resource allocation in Kenya's HIV response.
- **Public Expenditure Tracking Survey (PETS):** Conducted to improve public financial management, accountability, and service delivery.
- **Domestic resources:** Funds for health generated within a country's own economy, rather than relying on international aid or donor support.
- **Universal Health Coverage (UHC):** A global goal where all people can access necessary health services without financial hardship.
- **Social Health Authority (SHA):** State Corporation of the Government of Kenya that is responsible for the provision and management of public health insurance.
- **Social Health Insurance Fund (SHIF):** one of the specific funds managed by the SHA, focusing on providing social health insurance coverage, covers level 4 & 5 hospital including subcounty and county referral hospitals.
- **Primary Health Care Fund (PHCF):** a component of Kenya's SHA, established by the Primary Health Care Act to finance primary healthcare services at the community and lowest level of healthcare facilities.
- **Emergency, Chronic, and Critical Illness Fund (ECCF):** a fund managed by the SHA in Kenya to cover substantial costs for chronic and critical conditions, particularly after the benefits under SHIF are depleted.

8. **Programme Science**

An applied approach that systematically integrates scientific evidence into the design, implementation, and evaluation of public health programmes to enhance their effectiveness, efficiency, and impact. It seeks to bridge the gap between research and practice by using data and learning from real-world implementation to continuously refine programme strategies, optimize resource allocation, and improve health outcomes. Programme Science operates across three interrelated domains: Strategic planning – using epidemiological and behavioural data to guide priority setting and resource allocation; Programme implementation – applying operations and behavioural science to design and deliver interventions that are context-specific and effective; Programme evaluation and management – generating and using evidence from implementation to improve future programming and research through effective coordination and management.[1]

[1] Blanchard, J. F., & Aral, S. O. 2011. Program Science: an initiative to improve the planning, implementation and evaluation of HIV/sexually transmitted infection prevention programmes. Sex Transm Infect, 87(1), 2-3. https://doi.org/10.1136/sti.2010.047555

Executive Summary

Building on the legacy of the Kenya AIDS Strategic Framework II (KASF II), the new Kenya AIDS Integration Strategic Framework (KAISF) 2025–2030 represents a pivotal evolution in our national health agenda. This framework is conceived to strategically transition Kenya's HIV response from its historical reliance on vertical, donor-driven programmes towards a fully integrated, sustainable, and domestically financed model. This shift is deliberately aligned with the nation's transformative health sector reforms, most notably the ambitious drive for Universal Health Coverage (UHC) under the new Social Health Authority (SHA), ensuring the HIV response is a core and resilient component of Kenya's broader health system.

Progress amidst Disruption

Kenya's HIV journey is marked by remarkable progress, with new infections falling by 80% and AIDS-related deaths declining by 64% since 2013. We have scaled up treatment to over 1.2 million people, achieving 87% coverage and 79% viral suppression, and have dramatically reduced mother-to-child transmission to 9.3%. Despite these gains, significant challenges threaten this progress. Persistent gaps include low paediatric viral suppression at 66% against the target of 95%, geographic inequities, and enduring stigma. Furthermore, the health system now contends with a complex syndemic burden, where HIV intersects with Tuberculosis, mental health conditions, and noncommunicable diseases. These challenges, set against a backdrop of donor dependency and fragmented systems, are precisely why a new, integrated approach is essential.

Integration as a Reformative Health Agenda

Integration is a central pillar of Kenya's health sector reforms, guiding the transformation of service delivery, governance, and financing toward greater efficiency, equity, and sustainability. It builds on the lessons of the HIV response to strengthen the entire health system through coordinated, people centred, and data informed approaches that address multiple health needs within a unified framework.

In the Kenyan context, integration refers to the intentional design and delivery of health services so that prevention, diagnosis, treatment, and care for HIV and related syndemic conditions are provided through a single, coordinated, and people centred platform. This approach enhances efficiency, optimizes resources, and strengthens the resilience of the health system. It also responds to the need to reduce donor dependency while aligning with national health financing reforms. The integrated model promotes joint coordination across sectors, fostering greater effectiveness, accountability, and sustainability in achieving improved health outcomes for all Kenyans.

Vision, Goal, and Strategic Objectives

Vision: A Kenya free of new infections, preventable deaths, and stigma from HIV and other syndemic diseases.

Goal: An integrated and sustainable response to HIV and syndemic diseases that advances Universal Health Coverage in Kenya.

Strategy (by 2030):

- Reduce new HIV infections to less than **1000 new HIV infections in adults (>15 years)** and to less than 2**00 in children (0–14 years) by 2030.**
- Reduction of syphilis at ANC to less than **1% by 2030.**
- Reduce AIDS-related deaths by **50% by 2030.**
- Lower HIV-related stigma, discrimination, and other human rights violations to below **10% by 2030.**
- **Achieve 100% domestic financing** of the HIV response by 2030.
- **Achieve 100% integration of the HIV programme** into Kenya's broader health system in 47 counties by 2030.

Strategic Framework: Pillars, Priorities, and Approaches

The Kenya AIDS Integrated Strategic Framework (KAISF) 2025–2030 is anchored on six interlinked pillars that operationalise Kenya's vision for an integrated, sustainable, and efficient health system. Each pillar corresponds to a core component of the World Health Organization's health system building blocks and outlines strategic approaches to advance equity, resilience, and accountability in service delivery. Collectively, these pillars provide a coherent roadmap for implementation, guiding investments, strengthening systems, and ensuring that the HIV response contributes meaningfully to universal health coverage and the broader agenda of national health transformation. The six pillars, described below, define the foundation upon which Kenya's integrated HIV response will be built and sustained.

Service Delivery: To deliver sustainable, patient-centred care through integrated models. This includes redesigning client flow to effectively and efficiently take care of HIV, TB, NCDs, and mental health; strengthening primary health care and community-based outreach; and ensuring continuity of care for all, especially key and vulnerable populations.

Health Products and Technologies: To unify supply chains and ensure uninterrupted access to essential commodities. Key interventions include integrating HIV commodities into national and county procurement systems, scaling up multi-disease diagnostic platforms, strengthening pharmacovigilance, and promoting local manufacturing of drugs and supplies.

Health System Financing: To secure sustainable financing and reduce donor dependency. The strategy focuses on increasing domestic resource allocation, mainstreaming HIV services into the Social Health Authority (SHA) benefit packages, diversifying funding sources, and improving the efficiency and accountability of resource utilisation.

Human Resources for Health: To build a competent and motivated. This involves revising training curricula for integrated care, implementing task-shifting policies, strengthening workforce planning, and institutionalising continuous professional development and supportive supervision.

Health Information Systems: To build a competent, motivated, and more equitable workforce. This involves revising training curricula for integrated care, implementing task-shifting policies, strengthening workforce planning, and institutionalising continuous professional development and supportive supervision.

Leadership and Governance: To steer the integration agenda with accountability and inclusivity. This pillar establishes multisectoral coordination structures at national and county levels, promotes policy harmonisation, institutionalises community engagement, and fosters evidence-informed leadership.

Policy Directions and Strategic Priorities

The successful implementation of the KAISF hinges on a decentralised and collaborative model. The national framework will guide the development of context-specific County Operational Plans (COPs), ensuring local ownership and alignment with devolved functions. This process will be driven by the active participation of all key stakeholders—including national and county governments, communities, civil society, and development partners—within clear accountability frameworks and established multisectoral coordination structures to ensure coordinated action and shared results.

Measuring Results and Sustaining Impact

Monitoring, evaluation, and learning are central to achieving the objectives of the Kenya AIDS Integrated Strategic Framework (KAISF) 2025–2030. A robust system for Monitoring, Evaluation, Research, and Learning will enable continuous assessment of progress, identification of gaps, and generation of evidence to guide adaptive programming and policy decisions. Through integrated data systems, harmonised indicators, and real-time feedback loops, the framework will strengthen accountability across national and county levels while enhancing coordination and efficiency among programmes. It will also embed Programme Science to support data-driven learning and adaptive management, ensuring that lessons from implementation inform ongoing improvements in service delivery. Periodic reviews, including the Joint Annual Programme Reviews (JAPR) and a mid-term evaluation, will provide opportunities to assess performance, refine strategies, and sustain impact across the broader health system.

Way Forward and Commitments for Action

The KAISF is more than a strategy; it is a testament to Kenya's leadership and a covenant for the health of its people. Its success demands a collective, whole-of-society effort. We issue a call to action to all national and county government entities, development partners, civil society, the private sector, and every community to unite in this decisive decade of integration. By working together, we will not only end AIDS as a public health threat but also build a stronger, more resilient, and equitable health system for generations to come.

Building on the legacy of the Kenya AIDS Strategic Framework II (KASF II), the new Kenya AIDS Integration Strategic Framework (KAISF) 2025–2030 represents a pivotal evolution in our national health agenda.


HIV –
HIV –
HIV +

Section 1. A Strategic Framework for Ending AIDS as a Public Health Threat in Kenya

1.1 Context

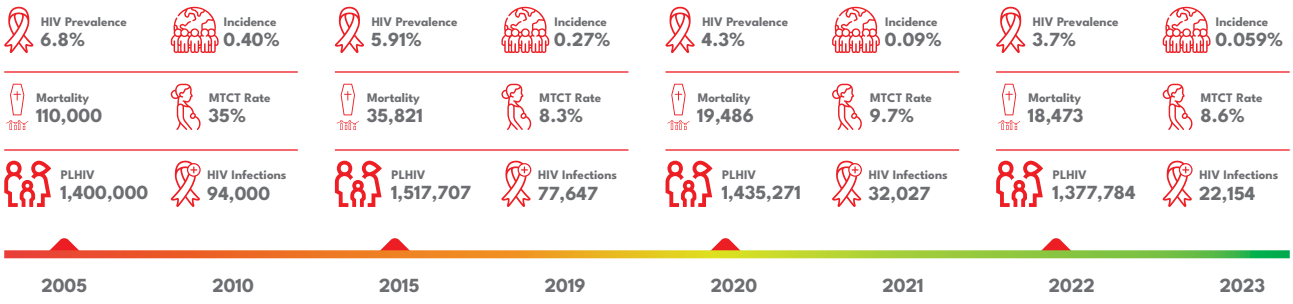
Kenya's HIV response has been characterised by resilience and transformation. From the first recorded case in 1984, the epidemic escalated into a national crisis, with infections surpassing one million by the mid-1990s and mortality peaking at 140,000 in 2002. In 1987, Kenya established national programmes to confront the epidemic, and in 1999 President Daniel Arap Moi declared HIV a national disaster. This turning point elevated HIV to a national priority and prompted the creation of mechanisms to coordinate and intensify the response.

Meanwhile, the global response was gaining momentum, with unprecedented political will, international funding, and new global health initiatives that reshaped how countries like Kenya accessed resources and expertise. These investments enabled Kenya to expand prevention, care, and treatment, contributing to remarkable gains.

AIDS-related deaths have fallen by 64% since 2013, while new infections have declined by 80% (Figure 1), reflecting the impact of expanded antiretroviral therapy and prevention programmes. By 2024, over 1.2 million people were on treatment (87%) and virally suppressed (79%). Mother-to-child transmission has also dropped from 14% in 2013 to 9.3% in 2024, averting over 133,000 paediatric infections.

Even so, major gaps persist, with viral suppression among children at only 66% and ANC coverage below targets. National HIV prevalence stands at 3.0%—higher among women (4%) than men (2%)—with 1.3 million people living with HIV, including nearly 62,798 children. Kenya's predominantly young population, with 59% under the age of 24, remains disproportionately affected, particularly adolescent girls and young women. Adolescents and young people accounted for 41% of adult new infections in 2024. Key populations in Kenya continue to experience disproportionately high HIV prevalence compared to the general population: 27.5% among female sex workers (FSWs), 19.1% among men who have sex with men (MSM), 9.2% among people who inject drugs (PWID), and 22% among transgender people (TG).

Figure 1. Kenya's Progress in HIV Control, 2005–2023



Source: NSDCC, Kenya HIV Estimates Reports

Kenya's syndemic context compounds these challenges. Tuberculosis remains the leading opportunistic infection among people living with HIV, with over 97,000 TB cases reported in 2023 and a 25% positivity rate among people living with HIV. Malaria remains endemic in several regions, complicating outcomes, while sexually transmitted infections continue to fuel HIV transmission, with rising antimicrobial resistance a growing concern. At the same time, noncommunicable diseases such as hypertension, diabetes, cervical cancer, and mental health disorders are increasingly prevalent as life expectancy improves for people living with HIV. Stigma, discrimination, violence, gender norms, criminalisation, and inequitable access to services continue to heighten

the vulnerability of Kenyans to these intersecting (i.e., syndemic) health conditions, undermining access to prevention, treatment, and care services.

1.2 Lessons from KASF II: Progress, Gaps, and Priorities for KAISF

The End-Term Review of Kenya AIDS Strategic Framework II (KASF II) identified progress but also critical gaps that must inform the next phase of Kenya's HIV and syndemic response.

Donor transition and service disruptions: Temporary funding freezes, including the suspension of U.S. assistance, disrupted services and exposed the fragility of donor-dependent supply chains, health workforce, service delivery platforms, and health information systems. This underscores the urgency of sustainable domestic financing and contingency planning.

Geographic inequities: While counties such as Siaya and Kisumu recorded significant reductions in new HIV infections, others—particularly in ASAL and marginalised regions like Mandera, Wajir, and Samburu—saw reversals, requiring county-specific strategies rather than uniform national approaches. Epidemic appraisals revealed distinct epidemic typologies across counties, underscoring the need for typology-specific population prioritisation and tailored intervention planning to ensure more effective and context-responsive HIV responses.

Supply chain fragility: Erratic access to HIV test kits, condoms, PrEP, and viral load reagents continues to interrupt prevention and treatment services.

Emerging syndemic burdens: Shifting patterns of STIs and hepatitis highlight weak surveillance and the limited integration of these conditions into HIV platforms. For instance, hepatitis C prevalence in Tana River rose from 3.3% to 10.8%.

Stigma and exclusion: Persistent barriers such as stigma, discrimination, gender inequality, criminalisation, and inequitable access continue to impede the utilisation of essential health services for adolescents, young people, and key and prioritised populations.

Collectively, these lessons reveal the fragility of gains made under KASF II and highlight the need for a more resilient, inclusive, integrated, and county-responsive approach under KAISF 2025–2030.

Data fragmentation: Expansion of EMRs and digital tools improved reporting in some counties, but weak interoperability and poor ICT infrastructure, particularly in ASAL areas, hinder consistent evidence-based programming. In addition, the use of data to inform decision-making and drive programme improvement remains limited, constraining the ability to optimise interventions, prioritise sub-populations, and allocate resources effectively.

Population-specific service gaps: Paediatric ART coverage remains low at 75%; mother-to-child transmission rates worsened in counties such as Tana River, Kwale, and Kilifi; and men continue to present late with advanced HIV, driving preventable morbidity and mortality. Effective programme coverage gap analyses further indicated significant gaps in both prevention and treatment services among key populations, as well as within programmes targeting adolescents and young people.

1.3 Cross-cutting challenges and emerging opportunities for an integrated national response

Kenya's syndemic response faces significant cross-cutting challenges: heavy donor dependence, with most commodities financed externally; a fragmented funding architecture; and parallel information systems with weak interoperability and limited domestic data sovereignty.

Kenya's health sector is undergoing major reforms to advance Universal Health Coverage (UHC), providing an opportunity for the HIV response to be fully aligned with health financing reforms under the Social Health Authority (SHA). A cornerstone of this integration will be the finalisation and implementation of an Essential Package for HIV Services that will be provided through the Social Health Insurance scheme.

Key cross-cutting challenges include:

Commodity Security: Currently, over 80% of HIV commodities are funded externally, creating structural vulnerabilities and dependency. Integration of all health commodities into national quantification, procurement, distribution, and monitoring platforms will strengthen supply chain resilience, and reduce dependency on donor-driven parallel systems.

Health Financing: A key barrier in domestic financing of HIV is the lack of standardised and routinely available data on the actual costs of delivering the essential package of HIV services across the country. In the absence of such data, budgets are formulated from imprecise and unreliable estimates.

Human Resources for Health: Kenya's health workforce is largely unprepared to meet the complex and evolving demands of HIV services, including emerging prevention and treatment approaches. HIV-specific content is inadequately integrated into pre-service training curricula, leaving many health care workers ill-equipped to deliver HIV prevention or treatment services effectively—particularly to key and priority populations. In-service training is rarely competency-based or aligned with integrated service delivery models.

Sovereignty of Data Systems: For years, PEPFAR has supported the establishment of different disease-specific data systems that have helped scale up HIV programmes but also reinforce vertical programming. These siloed systems have impeded the generation of timely, actionable insights for the broader health system, as health care workers often lack the capacity to integrate, interpret, and apply data across programmes.

Despite these challenges, opportunities exist through UHC and SHA reforms that can drive sustainable financing and the expansion of digital innovations, such as interoperable Emirs, artificial intelligence driven epidemic modelling, and real-time forecasting. The establishment of the Digital Health Agency (DHA) and rollout of the Comprehensive Integrated Health Information System (CIHIS) present a unique opportunity to unify Kenya's health information ecosystem under a sovereign, government-owned platform.

A comprehensive PESTEL/SWOT analysis was conducted to systematically assess the enabling environment for the integrated HIV response. This analysis, presented in Table 1, evaluates the Political, Economic, Social, Technological, Environmental, and Legal (PESTEL) landscape, cross-referenced with Kenya's internal Strengths and Weaknesses and external Opportunities and Threats (SWOT). The findings crystallise the foundational context for this strategic framework, illustrating how systemic enablers can be leveraged

to mitigate critical vulnerabilities, including donor dependency and fragmented systems. The strategic priorities and interventions outlined in subsequent chapters of the KAISF are a direct response to the evidence synthesised in this analysis, providing a validated pathway to a resilient and sustainable health system.

Table 1: PESTEL/SWOT Analysis

Dimension	Strengths / Opportunities	Weaknesses / Threats
Political	Strong government commitment through Vision 2030, UHC agenda, and devolved governance structures.	Heavy dependence on external funding exposes the system to international policy shocks (e.g., US stop work orders, shifting donor priorities). Coordination challenges across national and county levels.
Economic	Innovative financing mechanisms emerging: health bonds, earmarked taxes, PPPs, blended finance. Efficiency gains possible through integration of vertical programmes.	Fiscal space constraints and rising national debt limit domestic resource mobilisation. Tools to forecast resource requirements for health services are needed.
Social	Youthful demographic offers long-term dividend. Growing youth engagement, civil society advocacy, and community-led monitoring strengthen accountability and equity.	Persistent HIV literacy gaps, stigma, gender-based violence, and social and gender inequality undermine service uptake and outcomes.
Technological	Establishment of DHA, rollout of CIHIS, integration of EMRs with national data warehouses. Opportunities in AI analytics, mobile health, and digital adherence tools.	Digital divide, data protection risks, and cybersecurity vulnerabilities could undermine adoption and trust.
Environmental / Legal	Progressive legal frameworks (constitutional health rights, data protection law) and human rights commitments create an enabling environment. Policies supporting interventions with criminalised and marginalised populations facilitate programming.	Climate shocks, urbanisation, and population mobility increase vulnerabilities. Enforcement gaps and competing political priorities risk slowing progress. Criminalisation of certain populations and age-related consent laws limit equitable programme and service access.

1.3.1 Shifting Dynamics in Kenya's Syndemic Response

The rising burden of noncommunicable diseases among people living with HIV reflects the success of antiretroviral therapy in extending life, but also creates a dual challenge of managing hypertension, diabetes, cancers, and mental health alongside infectious diseases. This syndemic interaction strains health systems and calls for integrated models of care. Increased regional mobility, migration, and displacement are heightening demand for cross-border health services, yet migrants, refugees, and mobile populations often face barriers of documentation, stigma, and continuity of care, requiring stronger regional cooperation, data-sharing, and portable health records. At the same time, drug-resistant HIV strains, multidrug-resistant tuberculosis, and antimicrobial-resistant sexually transmitted infections are eroding treatment effectiveness, driving up costs, and threatening control efforts, underscoring the urgency of strengthened surveillance and new treatment regimens. Finally, the rapid adoption of digital health innovations—from artificial intelligence and predictive analytics to telemedicine and community-based digital tools—presents opportunities to modernise health delivery, though equity, data governance, and community trust remain critical to sustainable impact.

Emerging Patterns of Localised Incidence and Syndemic Clustering

From the Kenya HIV estimates 2024, data shows that new HIV infections are increasingly emerging in counties that historically had low incidence, including Mandera, Wajir, Marsabit, and other ASAL regions. This shift suggests a changing epidemic profile, where outbreaks are no longer confined to the traditional high-burden lake region and urban counties. Importantly, there is growing evidence in sub-Saharan Africa that HIV, TB, malaria, and other syndemic conditions cluster geographically, often affecting the same counties and even the same households. These co-occurring burdens are driven by shared social determinants—poverty, mobility, food insecurity, and weak health infrastructure—underscoring the need for place-based, multisectoral strategies rather than one-size-fits-all approaches.

The Household as a Critical Unit for Syndemic Service Delivery

Given the overlapping risk factors and disease burdens within families, the household is increasingly recognised as a critical unit for service delivery. A syndemic, household-centred approach, where HIV, TB, malaria, reproductive health, nutrition, mental health, and NCD services are provided together, can improve efficiencies, reduce missed opportunities, and strengthen continuity of care for vulnerable populations.

Protecting Equity gains in the Transition to Integration

While Kenya has made major progress in reducing disparities through targeted HIV interventions such as focusing on key populations, adolescents, high-burden counties, and high-transmission networks, there is a risk that blanket integration could dilute these gains. Integration must therefore be strategically sequenced and designed to preserve equity, ensuring that high-risk populations continue to receive differentiated, targeted, and adequately resourced services within broader integrated platforms.

Integration in the Kenyan Context

Integration in Kenya's health context represents a health systems reform agenda aimed at enhancing efficiency, expanding equitable access, reducing fragmentation, and improving responsiveness to the interconnected realities of people's health and wellbeing. It entails the coordinated design and delivery of health services across diseases, sectors, and levels of care to ensure comprehensive and people-centred service provision.

Integration aligns policies, systems, and resources to deliver prevention, treatment, and care for conditions such as HIV and other sexually transmitted infections, sexual and reproductive health, tuberculosis, malaria, noncommunicable diseases, and mental health, within a unified continuum of care. It strengthens service delivery through shared infrastructure, harmonised health products and technologies, sustainable financing mechanisms, competent and well-distributed human resources, interoperable health information systems, and inclusive leadership and governance structures that promote accountability and multisectoral collaboration.

In operational terms, integration enables individuals to access multiple services within a single platform, such as receiving HIV testing alongside NCD screening or reproductive health services or SGBV services, supported by consolidated data systems, coordinated planning, and unified supply chains. It can be implemented through various modalities, including service co-location, one-stop differentiated care models, facility and community-based platforms, and the alignment of parallel programmatic architectures.

Regardless of the implementation modality, the strategic intention remains consistent: optimize resource use, reduce inefficiencies and service redundancies, enhance client experience, and improve health outcomes through comprehensive, person-centred care that addresses coexisting conditions and intersecting determinants of health. Applying a Programme Science approach is essential to ensure programmes remain adaptive and responsive to gaps identified through data, evidence, and community insights—engaging affected populations in research and dialogue to co-create programmatic and policy solutions that drive population-level outcomes and impact as envisioned by this KAISF.

1.4 The Rationale for Integration

Overlapping epidemics strain an already stretched health system, while shifts in external financing underscore the urgency for stronger domestic ownership, efficiency, and sustainability. Kenya stands at a pivotal moment: transitioning from vertical, donor-dependent programming to integrated, people-centred, and sustainable services is no longer optional, it is essential. This shift is critical to safeguarding hard-won gains, strengthening health systems, advancing UHC, and accelerating progress toward ending AIDS as a public health threat by 2030. Recognising the complexity of this transition, Kenya will apply a Programme Science approach to ensure the HIV response remains evidence-driven, adaptive, and iterative. This will, enable timely course corrections and support achievement of the goals in the KIASF.

1.4.1 Leveraging the HIV Response to Drive Health Integration and Sustainability

Extending lessons and infrastructure from HIV to other priority diseases and integrating the syndemic diseases response into the broader health system offers an opportunity to reduce fragmentation, optimize resources, and strengthen the overall health system. The Kenya AIDS Integration Strategic Framework 2025–2030 (KAISF) has been developed to guide this transition.

This framework seeks to

- Promote a cohesive multisectoral approach for disease prevention and control.
- Enhance domestic resource mobilisation to reduce donor dependency and strengthen fiscal sustainability.
- Strengthen preparedness, responsiveness, and resilience of national and county health systems; and
- Institutionalise a programme science approach for data-driven and evidence-based decision-making and adaptive programming at all levels of implementation.

The examples in Table 2 highlight different approaches.

1.5 Integration precedents

1.5.1 Examples of integration in Kenya

Kenya has piloted and scaled several models of service integration to address HIV and comorbidities such as diabetes, hypertension, and other chronic conditions.

Table 2. Models of health service integration in Kenya

Facility & county	Model	PLHIV workload	Viral suppression	Staffing	Key features
Lumumba Sub- County Hospital, Kisumu (Level IV)	Chronic Care Centre Model	6,435	97%	108 staff (15 clinicians, 41 nurses)	One-stop clinic for HIV, diabetes, and hypertension; integrated EMR and pharmacy; continuity for clients with comorbidities.
Tenwek Mission Hospital, Bomet	Chronic Care Centre Model (longest running)	1,879	98%	1,819 staff (44 clinicians, 307 nurses)	All chronic conditions managed in one clinic; TaifaCare EMR across departments; shared inventory system for pharmacy.
Nakuru Provincial General Hospital, Nakuru (Level V)	Mixed Model (Chronic Care + OPD)	7,255	98%	783 staff (71 clinicians, 423 nurses)	Dual track: chronic care clinic for HIV/NCD co-morbidities + OPD for general HIV care; centralised pharmacy and harmonised data systems.
Nkubu Mission Hospital, Meru	All-Inclusive OPD Model	2,827	95%	219 staff (18 clinicians, 108 nurses)	HIV and NCD clients seen in OPD by the same clinicians; single pharmacy counter with private booths; multiple EMR platforms (TaifaCare, DREAM, hospital EMR).

Strengthening primary health care through integrated mental health and chronic disease care

Kenya has made notable progress in embedding mental health and noncommunicable disease services within primary health care. Through Universal Health Coverage reforms, counties have expanded screening for diabetes and hypertension, introduced community health promoters, and established outpatient mental health services. National policy instruments such as the Kenya Mental Health Policy (2015–2030) and the Mental Health Action Plan (2021–2025) reinforce this direction, providing a strong policy and institutional foundation for integration. In Kenya, transitioning technical assistance and site-level support to county governments reduced technical assistance costs by 70%, halved patient treatment interruptions, and expanded treatment coverage five-fold, from 20,000 to over 100,000

people. These experiences highlight how country-led integration can sustain gains, optimize resources, and deliver impact at scale.

Financial integration in Kenya's health sector: Transitioning toward sustainability

Effective health financing underpins equitable access, service continuity, and progress toward Universal Health Coverage. While early investments accelerated disease-specific scale-up, they also fostered parallel systems with limited interoperability and precarious viability. Recent donor funding disruptions have revealed the vulnerabilities of externally dependent models, reinforcing the urgency of domestic resource mobilisation and integrated county-led financing.

Kenya's financing landscape has evolved from vertically funded and donor-driven programmes, particularly for HIV, TB, and malaria, to more integrated and sustainable models.

Since 2010, Kenya has progressively adopted integration pilots and health systems strengthening approaches, with the post-2015 Sustainable Development Goal agenda accelerating efforts toward Universal Health Coverage, social health insurance reform, and devolved budgeting. Kenya's journey underscores the critical need to institutionalise financial integration by aligning HIV and syndemic disease responses with broader national health financing reforms grounded in equity, efficiency, and resilience.

1.5.2 International lessons on integration

Global evidence shows that integration improves both efficiency and outcomes. In Zambia, shifting HIV service delivery support from U.S. partners to provincial governments increased treatment coverage and viral suppression by 31% while cutting support costs by 44% per person[2].

In 2015, Cuba was the first country to be validated by WHO for eliminating mother-to-child transmission of HIV and syphilis by embedding universal testing, prompt ART, and follow-up within primary, antenatal, and maternity services. The EMTCT validation process demonstrated that using shared criteria and conducting joint audits for HIV and syphilis within maternal, newborn, and child health services enhanced coordination between programmes and strengthened quality assurance within routine health systems. The United Nations Development Programme documented Cuba's experience, showing that by leveraging existing service delivery platforms, supply chains, laboratories, and information systems rather than creating parallel structures, the country improved efficiency and long-term sustainability.

In the African region, South Africa's success in integrating HIV services into the wider health system offers a strong model of systemic reform and resilience. Through initiatives such as nurse-initiated and managed ART using task sharing, HIV care was decentralised to primary health care facilities, expanding treatment access while optimizing available human resources. The country also set up Central Chronic Medicine Dispensing and Distribution programmes that streamlined medicine access for people living with HIV and those with common NCDs, while the Integrated Chronic Disease Management (ICDM) institutionalised joint management of HIV, TB, and NCDs through shared clinical workflows, supply chains, and quality standards. Integration of MTCT services within maternal and child health platforms reduced early mother-to-child transmission to below 1% by 2017, demonstrating the power of embedding HIV into routine care. Together, these reforms transformed South Africa's HIV response into a cornerstone of health system strengthening, enhancing access, efficiency, and sustainability across the continuum of care.

In Kenya, transitioning technical assistance and site-level support to county governments led to a 70% reduction in technical assistance costs, halved patient treatment interruptions, and expanded treatment coverage fivefold, from 20,000 to over 100,000 people. These results demonstrate how country-led integration can sustain programme gains, optimize available resources, and achieve impact at scale.

Integration of HIV services within maternal and child health settings also improved prevention of mother-to-child transmission outcomes. Models that provided same-day HIV testing and antiretroviral therapy initiation during antenatal care increased ART uptake and enhanced infant HIV-free survival. Similarly, integrating family planning into HIV clinics promoted contraceptive use and dual protection. Postnatal "mother–baby pair" clinics that combined maternal ART, infant testing, and immunization strengthened retention and follow-up.

Task sharing among nurses and community health workers preserved the quality of care while expanding

access, and community-based models successfully reached underserved populations. These outcomes were supported by strong supervision systems, investments in the health workforce, consistent commodity supply, and active community participation.

MDGs Era 2000–2015: Vertical scale-up & donor-driven expansion

Key features:

- PEPFAR launched (2003) Unprecedented ARV rollout and HIV care scale-up across Kenya.
- Global Fund (from 2002) Parallel support to HIV, TB, and malaria vertical programmes.
- DFID/FCDO & bilateral donors Direct HIV/AIDS and health systems investment (2000–2020).
- World Bank System strengthening via SWAp (Sector-Wide Approach) and grants.
- UNAIDS Strategic guidance, global advocacy, technical oversight.

Implications:

- Rapid gains in HIV service access and outcomes
- Heavy donor reliance and siloed programme structures.

Transition Period 2010–2015: Integration experiments & warning signs

Key features:

- Integration pilots (HIV-TB, HIV-MCH) initiated in selected counties.
- Donor shift toward Health Systems Strengthening (HSS/RSSH).
- Stop Work Orders (SWOs) issued by PEPFAR highlighted fragility and overdependence.

Implications:

- Early signs of fatigue in vertical programming.
- Integration efforts lacked systemic anchorage.

SDGs Era 2015 Onwards: Sustainability and systems focus

Key features:

- Donor pivot to UHC-aligned platforms (NHIF reforms, SHA).
- Global Fund introduces sustainability and transition planning.
- DFID/FCDO winds down direct HIV investments (exit by ~2020).
- Joint health sector reviews and RSSH grants emphasise integration.

Implications:

- Move toward pooled financing and broader system investments.
- Pressure on Kenya to domesticate health financing and stewardship.

Post-COVID 2020s: Domestic financing, integration, and system resilience

Key features:

- Heightened focus on domestic resource mobilisation (DRM).
- Push for HIV–PHC integration, local manufacturing, and EMR harmonization.
- PEPFAR & Global Fund remain critical, but stress transition planning.
- 2025: US Stop Work Order (SWO) reawakens concern over funding gaps.

Implications:

- Strong imperative to embed HIV within primary healthcare.
- DRM, public financing reforms, and policy alignment now urgent.
- Renewed appreciation for multi-sectoral accountability and ownership.

Emerging lessons

- Kenya must institutionalize integration across health system building blocks.
- Donor transitions must be matched with DRM, legal frameworks, and county buy-in.
- Resilience requires coordination—not just co-financing—across stakeholders.

Section 2. Vision, Goal, Objectives, and Guiding Principles of KAISF 2025–2030

2.1 Vision

A Kenya free of new infections, preventable deaths, and stigma from HIV and other syndemic diseases.

2.2 Goal

An integrated and sustainable response to HIV and syndemic diseases that advances Universal Health Coverage in Kenya.

2.3 Strategic objectives and impact results

- Reduce new HIV infections to less than 1000 new HIV infections in adults (>15 years) and to less than 200 in children (0–14 years) by 2030.
- Reduction of syphilis at ANC to less than 1% by 2030.
- Reduce AIDS-related deaths by 50% by 2030.
- Lower HIV-related stigma, discrimination, and other human rights violations to below 10% by 2030.
- Achieve 100% domestic financing of the HIV response by 2030.
- Achieve 100% integration of the HIV programme into Kenya's broader health system in 47 counties by 2030.

2.4 Guiding principles of KAISF 2025–2030

This framework is anchored in the following principles:

Human rights, justice, and equity in access to HIV and syndemic disease serv ices, in line with the Constitution of Kenya (2010).

Inclusive participation of all stakeholders at national and county levels.

Evidence-informed action using data and strategic information to guide planning, prioritisation, and investment.

Universal access to quality, integrated prevention, treatment, care, and support, with a commitment to leave no one behind.

People-centred service delivery that places individuals and communities at the heart of planning and decision-making.

Multisectoral partnership and accountability to ensure coordinated, collective responsibility and shared results.

Responsiveness to emergencies by building resilient health systems capable of withstanding shocks.

2.5 Global, regional, and national commitments

The KAISF 2025–2030 is anchored in Kenya's constitutional right to health and aligns with national priorities, including the Kenya Health Policy (2014–2030), Vision 2030, and the Universal Health Coverage agenda. It advances the Operational Plan for Enhancing Country Readiness to Sustain a Resilient HIV Response Beyond 2030, the Kenya HIV Prevention Revolution Road Map: Count Down to 2030, the National Multisectoral HIV Prevention Acceleration Plan 2023–2030, and the Commitment Plan to End the 'Triple Threat': A Whole of Nation Approach 2023–2030. Regionally and globally, this framework aligns with the Sustainable Development Goals, the UNAIDS Fast-Track Targets, and the World Health Organization's Global Health Sector Strategies on HIV, Viral Hepatitis, and Sexually Transmitted Infections for 2022–2030.

Section 3. Using the Health System Building Blocks to Guide Integration

3.1 Advancing HIV integration through health system pillars

The development of the KAISF Integration Pillars was adopted from the World Health Organization's health system building blocks, which have long provided an analytical framework for health systems strengthening. The pillars serve as a structure for Kenya's integrated response to HIV, related diseases, and emerging health threats. Each pillar was analysed to assess capacities, identify gaps, and define strategic priorities. In doing so, the KAISF moves beyond disease-specific interventions to reinforce the underlying systems and enablers that are critical for prevention, treatment, surveillance, and long-term sustainability of syndemic disease responses at both national and county levels. The focus and considerations of each pillar is described in Table 3.

The Programme Science approach

The Programme Science approach is a framework that integrates scientific methods and evidence directly into the planning, implementation, and evaluation of public health programmes to improve their effectiveness and impact. It bridges the traditional gap between science and practice by ensuring that programmes are continuously informed and refined through data, learning, and community engagement. Using the Programme Science approach within KAISF provides a structured pathway to strengthen the effectiveness, adaptability, and sustainability of the HIV response. Programme Science enables programmes to evolve based on real-time evidence and community feedback. It promotes collaboration among researchers, policymakers, implementers, and affected communities to co-create solutions that address identified gaps and improve outcomes. Within the national HIV framework, this approach ensures that prevention, treatment, and care efforts are not only evidence-informed but also adaptive to changing epidemiological patterns and resource landscapes, accelerating progress toward national targets.

Table 3. The focus and considerations of KAISF Integration Pillars

Pillars	Focus	Key considerations
Service Delivery Systems	• Focuses on the availability, accessibility, quality, and integration of prevention, diagnostic, treatment, and care services for syndemic diseases. • Prioritises people-centred approaches that ensure services are responsive to client needs, reduce stigma, and promote differentiated service delivery models. • Prioritises identifying who is being missed by programmes and working collaboratively with affected communities to design strategies that close coverage gaps and reduce inequities.	• Integration of services across diseases (e.g., HIV/TB co-management) • Decentralised and community-led service delivery • Innovations such as digital health, mobile outreach, pharmacy-based services, and self-care. • Continuous consultation, research and feedback with affected community to understand their changing needs, priorities and access barriers

Pillars	Focus	Key considerations
Health Products and Technologies	• Ensures the availability and equitable distribution of essential health commodities necessary for syndemic disease control based on evidence and prioritisation. • Strengthens procurement and supply chain management systems to minimise stock outs and wastage. • Addresses barriers to accessing and utilising health products and technologies, particularly for key and priority populations, to ensure equitable access and uptake.	• Forecasting and quantification of syndemic commodities • Adoption of new technologies (e.g., point-of-care diagnostics, injectable PrEP) • Supply chain resilience and local manufacturing opportunities • Feedback mechanism is established to meaningfully engage affected communities in the design and delivery of health products, ensuring their perspectives inform continuous improvement, equity, and accountability
Health System Financing	• Addresses how the HIV response will be sustainably funded, focusing on reducing reliance on external funding and increasing domestic resource mobilisation. • Uses data and evidence to guide the prioritisation and allocation of resources towards interventions with greatest impact. • Advocates for strategic purchasing, efficient use of resources, and financial protection for vulnerable populations.	• Costing of Essential Package of Services • Forecast resource requirement and budget allocation and tracking at national and county levels • Mainstream HIV services into SHA • Innovative financing mechanisms (e.g., social contracting, leverage on infrastructure funds, bonds etc.) • Cost-effectiveness and sustainability planning
Human Resources for Health	• Strengthens the health workforce to effectively deliver integrated HIV disease services. • Focuses on training, retention, task-shifting, and expanding community health worker programmes. • Uses data and evidence to align workforce capacity, skills, and deployment with programme priorities (addressing gaps) and emerging needs.	• Capacity-building for multisectoral teams, including strengthening pre-service training • Addressing health worker shortages and distribution • Supportive supervision, mentorship, and career development • Strengthening capacity of health care workers to use routine data for planning and decision-making
Health Information Systems	• Enhances the collection, analysis, and use of quality data to guide decision-making at all levels. • Integrates HIV disease data into national health information systems (such as KHIS). • Embed research in programmes to understand and address the programme coverage gaps.	• Disease surveillance and routine reporting across programmes and populations • Use of data for coverage gap analysis, planning, resource allocation, and performance monitoring • Real-time data innovations and data visualisation like dashboards that simplify data access and utilisation • Capacity-building across cadres on data analysis and use

Pillars	Focus	Key considerations
Leadership and Governance	• Strengthens leadership, coordination, policy development, and accountability mechanisms across sectors and stakeholders. • Promotes community engagement, multisectoral collaboration, and rights-based approaches. • Promote the utilisation of data and evidence by leadership in decision-making and governance.	• Establishment and strengthening of multisectoral committees and technical committees • Policy alignment with national and county evidence-based priorities • Accountability frameworks for results and financial transparency • Development of progressive policies and laws to address barriers to access and utilisation of health services

3.2 Integration Pillars

3.2.1 Service delivery systems

Goal: To deliver sustainable patient-centred, gender-responsive care through contextually adapted, evidence-based integration approaches, advancing UHC's equity objectives.

Background

Service delivery is a core pillar of the health system, ensuring equitable, timely, and efficient access to people-centred care. It underpins the prevention, diagnosis, treatment, and care of HIV and related disease conditions through responsive, client-focused approaches that reduce stigma and improve outcomes. Key service delivery gaps include low health literacy, limited diagnostic access, delayed identification, weak service integration, and insufficient outreach to key and vulnerable populations, exacerbated by criminalisation, violence, and other cultural and gender inequality related barriers. Strategic priorities include strengthening public education, expanding integrated services and community outreach, leveraging innovations for early detection, and scaling inclusive, patient-centred models, continuously assessing and addressing coverage gap. Key challenges include low public awareness, stigma (notably 68% access barriers for key populations as per the RRI, 2025), access to services, delayed diagnostics, treatment and the intersecting "triple threat" of teenage pregnancies, HIV, and gender-based violence.

Rationale

Kenya's health system has made significant strides in expanding access to HIV and related services, yet persistent challenges in quality, equity, and continuity of care underscore the need to re-engineer service delivery. Multiple recent assessments, including the End-Term Review (ETR), Rapid Results Initiative (RRI), and Joint Annual Programme Reviews (JAPR), have exposed key weaknesses in how services are delivered across counties and platforms. These include fragmented vertical programming, underutilised primary health care (PHC) infrastructure, inequitable access for key and vulnerable populations, and overburdened health workers with limited capacity to provide integrated, people-centred care.

Additionally, service disruptions following shifts in donor funding (e.g., the 2025 PEPFAR Stop Work Order) revealed deep vulnerabilities in programme sustainability and continuity, particularly in high-burden counties and for high priority groups such as key populations. These challenges are compounded by geographical disparities, where some arid, semi-arid, and urban informal settlements remain underserved despite high HIV and syndemic disease burden.

To address this, KAISF anchors its strategy on transforming service delivery models, moving beyond siloed interventions to ensure that HIV, TB, STIs, NCDs, mental health, and reproductive health services are co-delivered through strengthened PHC systems and other models. This is in alignment with Kenya's commitments to Universal Health Coverage (UHC) under the Social Health Authority (SHA) and the Kenya Health Policy, which call for integrated, equitable, and efficient service provision across the life course.

Moreover, integration of HIV services into PHC and other

platforms, including community health, will improve early detection, continuity of care, and retention, especially for adolescents, key populations, and men who are often underserved. Differentiated service delivery (DSD) models, task-shifting, digital health tools, and public-private partnerships offer untapped potential to scale access while optimising resources.

The importance of identifying populations who are being missed or underserved by existing programmes and collaborating closely with affected communities to understand the underlying barriers to access and engagement is critical. By using data, community insights, and participatory approaches, programmes can design and implement targeted strategies that close coverage gaps, reduce inequities, and ensure that no population is left behind.

Ultimately, service delivery is where integration is operationalised, and where individuals interact with the health system. Prioritising service delivery integration is essential for achieving the KAISF goal of a unified, resilient, and people-centred response to HIV and related syndemic diseases. Table 4 presents the integrated strategic focus areas, key interventions, and expected results for integrated service delivery, adapted for the Kenyan context and HIV-syndemic integration agenda.

Table 4. Summary integration plan for HIV service delivery

Focus area	Description	Interventions	Comprehensive integration approach	Expected results
Comprehensive, integrated service delivery	Delivering person-centred, continuous, and coordinated care across the life course, linking HIV and syndemic disease services with PHC platforms.	Alignment with PHC and UHC Person-centred approaches	Institutionalize differentiated service delivery models (DSD). Integrate HIV and related disease services within PHC. Align service packages with disease burden and county typologies. Ensure delivery across life and disease course; from prevention to palliative care.	Enhanced patient outcomes and continuity of care
Service efficiency and optimization	Implementing national quality frameworks, service charters, and accountability tools to improve the effectiveness, safety, and responsiveness of health services.	Rationalization of services Service cohesion Quality of services	Eliminate duplication through service mapping and task redistribution. Consolidate fragmented delivery points through integrated clinics Scale up quality improvement (QI) collaboratives. Conduct integrated regular service quality audits. Harmonise and standardize guidelines and SOPs for integrated services.	Reduction in adverse health events and preventable morbidity
Continuity and coordination of care	Strengthening bidirectional referral networks and tracking mechanisms to ensure clients receive continuous, appropriate care across levels and sectors.	Seamless care pathways, client retention, and tracking transition of care	Harmonize referral protocols across programmes, and between community, PHC, and tertiary levels. Establish and implement harmonized referral tools. Map and strengthen facility-community linkages. Integrate transition protocols for priority populations (e.g., key and vulnerable populations, elderly, children and young people).	Increased retention in care and timely access to services
Service Readiness	Ensure adequate physical infrastructure, essential equipment, and supplies to deliver quality services at all levels of care.	Facility and equipment optimization	Optimize facility infrastructure to meet minimum service standards. Implement workload-based staffing norms. Prioritize investments based on service delivery gaps.	Improved physical readiness and supply chain reliability

Focus area	Description	Interventions	Comprehensive integration approach	Expected results
Equity and Accessibility	Promote equitable access across geographic and demographic groups, especially underserved populations like key and priority populations.	Geographical and social equity Population level equity Integration with community platforms Client-centred innovations	Design services that are culturally appropriate and language accessible. Develop tailored models for persons with physical, intellectual, or psychosocial disabilities, including home-based care, peer-supported adherence groups, flexible scheduling, and extended consultation times. Embed simple disability screening tools within client intake forms to identify and address special needs during clinical encounters and strengthen inclusive service planning. Develop differentiated models of care for children with disabilities as a special group with unique needs. Embed HIV and syndemic disease services into existing PHC structures and community units. Scale community-led service delivery models. Map underserved regions and high-burden populations to inform targeted service delivery planning. Expand coverage through mobile clinics, outreach programmes, and community health posts in hard-to-reach areas. Target youth, key and vulnerable populations, adolescents and young people, persons with disabilities, and marginalized communities with harmonized services. Expand community-based models and outreach mechanisms. Co-design services with communities to enhance uptake and trust. Provide harmonized materials in local languages and format. Incorporate screening for assistive device needs and the provision of essential aids, including hearing devices, low-vision tools, and medication organizers with reminders within chronic care and adherence support services.	Strengthened equity and sustainability in service delivery
Resilience and preparedness	Embed resilience and emergency preparedness into service delivery through climate-smart infrastructure and continuity planning.	Service continuity during shocks Emergency preparedness Service provision flexibility	Integrate emergency preparedness and climate resilience into health planning. Embed resilience planning in facility and service design. Establish harmonized continuity plans and surge capacity protocols. Build flexible, modular integrated service delivery models. Embed HIV and syndemic response in public health emergency planning. Mandate the revision of minimum service delivery requirements to ensure accessible health facility infrastructure, including ramps, widened doors, accessible toilets, and low-height service counters.	Enhanced system resilience to shocks and emergencies Improved service readiness and reach Greater continuity of care during crises More equitable and climate-resilient health service access Equity in access for all populations

Focus area	Description	Interventions	Comprehensive integration approach	Expected results
Human rights-driven and responsive service delivery	Implement multisectoral, inclusive anti-stigma initiatives that foster enabling environments for service uptake and retention for HIV and related diseases.	Address intersecting stigmas across health conditions. Institutionalize accountability mechanisms for stigma reduction.	Develop comprehensive anti-stigma programmes addressing discrimination based on HIV status alongside stigma related to TB, mental health, and other chronic diseases.	Reduced stigma index
	Strengthen GBV prevention and response mechanisms within health and community systems with survivor-centred care.	Integrate GBV services within routine health platforms. Strengthen multi-sectoral coordination and referral systems.	Integrate GBV risk assessment and response into multiple service points (maternal health, OPDs). Establish referral pathways to integrated support services.	Increased access coverage for the provision of integrated GBV services.
Understanding programme coverage gaps	Prioritize identification of who is being missed by programmes and design strategies that close coverage gaps.	Conduct programme coverage gaps analysis across programmes, geographies and populations. Use the analysis to collaborate with affect communities to design strategies to address the coverage gaps through adaptive programming.	Use routine and surveillance data to understand who is being left out. Conduct the analysis by age, geography, subpopulation, and programme where applicable. Use existing spaces like technical working group, health workers meeting, programme meetings to share the analysis and engage with affected communities to develop strategies to address the coverage gaps. Monitor implementation of planned actions and strategies to assess change.	High coverage of priority populations and reduction in inequity of programme coverage.

Outcomes

- **Expanded access to integrated, people-centred services** that address HIV and syndemic conditions within a unified, primary health care platform.
- **Improved efficiency and service quality** through harmonised delivery models, optimised resource use, and reduced fragmentation.
- **Strengthened continuity and coordination of care,** ensuring seamless linkage across prevention, treatment, and support services.
- **Enhanced equity and accessibility,** particularly for key and vulnerable populations, through targeted outreach and decentralised service delivery.
- **Increased system resilience and preparedness** to sustain service delivery during health emergencies, funding disruptions, or other shocks.
- **Enhanced efficiency** in identifying programme coverage gaps across geographies and populations, and in designing and implementing targeted strategies to close those gaps

3.2.2 Health products and technologies

Goal: To unify supply chain systems, enhance pharmacovigilance and quality assurance, integrate innovative solutions such as AI-enabled and multi-disease diagnostic platforms, increase access to new products and technologies, and promote local manufacturing.

Background

Kenya's ability to sustain essential commodities for HIV and other syndemic diseases hinges on a resilient, integrated supply chain. Currently, over 80% of HIV commodities are funded externally, and many remain excluded from national and county budgets and essential medicines lists, creating structural vulnerabilities and limiting local ownership. National quantification estimates project annual HIV health products and technologies (HPT) needs to exceed KES 150 billion (USD 1.2 billion) over the next strategic period (FY 2025/26 to FY 2029/30). Without urgent reforms to embed these commodities in public financing and planning frameworks, progress in treatment continuity, viral suppression, and epidemic control remains at risk.

Beyond financial sustainability, integration of HIV HPT within broader health systems supports efficiency, equity, and resilience. Kenya's HIV supply chain is among the most advanced in the health sector and serves as a platform for cross-programmatic integration with syndemic diseases such as TB, malaria, STIs, and emerging noncommunicable diseases. However, challenges persist, particularly fragmented procurement systems, weak pharmacovigilance, and limited diagnostics coverage at lower levels of care, largely due to siloed commodity management and infrastructure gaps.

Rationale

The Kenya AIDS Integrated Strategic Framework 2025–2030 calls for a coherent, nationally owned HPT delivery system that ensures 100% commodity availability and aligns with ongoing reforms such as UHC and the Social Health Authority (SHA). Integration of HPT into national quantification, procurement, distribution, and monitoring platforms will

- Strengthen supply chain resilience by leveraging pooled procurement and multi-disease platforms.
- Reduce dependency on donor-driven parallel systems.
- Support local manufacturing of essential commodities (e.G., ARVs, condoms, diagnostics).
- Enhance commodity security and equitable access, especially for vulnerable and key populations; and
- Improve service delivery efficiency by streamlining logistics across HIV, TB, malaria, and NCD programmes.

This integrated approach also facilitates data-driven forecasting and accountability while optimising infrastructure use across all levels of care.

The framework also prioritises the identification and removal of barriers that limit access to and utilisation of essential health products and technologies particularly among key and priority populations. These barriers may include stigma and discrimination in service delivery, inadequate supply chain management, limited availability of differentiated products, regulatory delays, or affordability challenges.

A structured feedback mechanism will be critical to meaningfully engage affected communities in the design, delivery, and monitoring of health products and technologies. Through regular consultation forums, participatory reviews, and user experience assessments, the perspectives of affected communities will directly inform product selection, distribution strategies, and quality improvement processes.

Table 5 outlines the integrated strategic focus areas, key interventions, and expected outcomes for strengthening access to HIV-related health products and technologies under KAISF 2025–2030.

Table 5. Summary integration plan for health products and technologies

Focus area	Description	Interventions	Comprehensive integrated approach	Expected results
Commodity security	To ensure uninterrupted availability of essential HIV and related disease commodities by integrating them into national and county essential medicines lists, budgets, and establishing robust buffer stock systems.	Integrate HIV and related diseases commodities into national and county essential medicines lists, budgets, and procurement through joint forecasting, quantification, and pooled purchasing.	Mainstream commodities for HIV and related diseases into the Kenya Essential Medicines List (KEML) and county essential lists and include them in the annual budgeting and procurement cycles of the general health system managed by KEMSA and county governments.	Reduced frequency and duration of ARV, PrEP, OI medicine, and HIV and related diseases test kit stock-outs
		Establish county-level buffer stocks.	Integrate buffer stocks for key HIV and related diseases commodities into the existing national and county buffer stock management system for essential medicines, ensuring a unified approach to emergency security for all health priorities.	≥ 3-month buffer stock available in all counties
Supply chain systems	To create a unified, efficient, and visible end-to-end supply chain by integrating logistics management, forecasting, procurement, and last-mile delivery for all health commodities.	Institutionalise integrated end-to-end LMIS with real time visibility for all HPT.	Fully integrate HIV and related diseases commodity data points and reporting into the national electronic Logistics Management Information System (eLMIS) used for all essential health commodities, ensuring a single source of truth for supply chain visibility.	≥ 90% of facilities reporting through interoperable LMIS for all HPT
		Implement unified forecasting and pooled procurement for HIV and related diseases and comorbidities HPT.	Mainstream the forecasting and quantification for HIV and related diseases commodities into the general health commodities forecasting and supply planning exercises conducted by the Ministry of Health and KEMSA, leveraging the system's pooled procurement mechanisms.	Reduced procurement costs through economies of scale
		Strengthen last-mile delivery such as use of drones.	Utilise and scale the national last-mile delivery solutions (e.g., drone networks, integrated distribution routes) for the routine supply of all essential commodities, including those for HIV and related diseases, rather than creating parallel systems.	Faster resupply turnaround (≤7-day rural–urban gap) with reduced reliance on emergency borrowing and redistribution
		Integrate innovative HPT dispensing models for HIV and related diseases and comorbidities.	Promote the "One-Stop Shop" model within public health facilities where pharmacy dispensing units provide all chronic disease medications (for HIV and related diseases, hypertension, diabetes, etc.) simultaneously, integrated into standard pharmacy operations. Define and institutionalize the role of community and faith-based organizations in last-mile distribution of commodities, logistics support, and adherence monitoring within the national supply chain strategy.	Reduced average waiting time at facility dispensing points by 50%

Focus area	Description	Interventions	Comprehensive integrated approach	Expected results
Diagnostics & new technologies	To expand access to and optimize the use of multi-disease diagnostic platforms and innovative health products for integrated testing, prevention, and care.	Scale up multi-disease diagnostic platforms.	Prioritise the procurement and deployment of multi-disease testing platforms (e.g., GeneXpert, multi-analyte machines) for the general laboratory network to efficiently test for HIV and related diseases from a single sample.	Reduced turnaround time for VL/EID & CD4 results
		Expand access to EID, VL, CD4, drug resistance reagents.		
		Integrate HIV and related diseases testing with TB/ malaria/NCD screening.	Mandate the use of integrated diagnostic algorithms and combined testing services at all primary care levels as part of the standard patient intake and assessment protocol.	Increased coverage of integrated HIV and related diseases testing and comorbidity testing
		Leverage innovative health products and technologies to improve HIV and related diseases/AIDS prevention, testing, and care.	Mainstream ADR reporting for HIV and related disease medicines into the national pharmacovigilance system coordinated by the Pharmacy and Poisons Board, using the same reporting channels as for all other medicines.	Expanded access to HIV and related diseases prevention, testing, and treatment HPT
Pharmacovigilance & quality assurance	To strengthen integrated systems for monitoring drug safety, reporting adverse reactions, and ensuring the quality of all health products, building trust and safeguarding patient health.	Strengthen adverse drug reaction (ADR) reporting systems with feedback loop to the providers and recipients of care.	Include HIV and related disease medicines in the national post-market surveillance and quality control sampling plan for all medicines conducted by the regulatory authority.	Increased ADR reporting compliance
		Enforce QA for ARVs, PrEP, and OI medicines.	Ensure the national pharmacovigilance database is interoperable with KHIS and the eLMIS, creating a unified dashboard for monitoring product safety and supply chain health across the entire health system.	Regular batch testing and post-market surveillance in place
		Integrate national pharmacovigilance dashboards with KHIS & LMIS for safety monitoring and supply chain decision-making.	Include commodities for HIV and related diseases as priority products in the national strategy for local production of pharmaceuticals and health products, offering the same incentives and support as for other essential medicines.	Real-time pharmacovigilance data integrated with KHIS and LMIS, improving visibility of ADR trends and product safety across facilities
Local manufacturing	To promote domestic production of essential HIV commodities through public-private partnerships, technology transfer, and fiscal incentives to enhance supply security and economic sustainability.	Promote local manufacturing of ARVs, PrEP, condoms, diagnostics, MAT products via PPPs, tech transfer, and fiscal incentives.	Integrate capacity-building support for local manufacturers of HIV and related diseases commodities into the broader national programme supporting WHO prequalification for all essential medicines and diagnostics.	≥ 50% of HIV and related diseases & comorbidities HPT locally produced by 2030
		Capacity build for WHO prequalification/GMP compliance.		
		Incentivise PPP investments.		

Focus area	Description	Interventions	Comprehensive integrated approach	Expected results
Addressing barriers	To address barriers to accessing and utilising health products and technologies especially among marginalised populations	Understand the barriers and reasons behind the coverage gaps related to new products and technologies. Devise strategies to remove the barriers to improve coverage. Establish space and processes to seek structured feedback from affected communities.	Ensure coverage gap analysis is conducted for new products and technologies like Lencapavir and affected communities are involved on a regular basis through existing or new forums to understand the barriers and develop solutions to address the barriers. Ensure that commodities are procured and distributed in accessible formats, including Braille, large print, easy-read, and audio versions, to meet the needs of persons with disabilities.	Barriers to access and utilisation of new products and technologies are understood and affected communities are involved in devising and implementing solutions to address the barriers

Outcomes

By 2030, implementation of these interventions should deliver the following:

Universal commodity availability for HIV and related diseases.

Integrated and efficient supply chain: Streamlined, coordinated procurement and distribution systems that minimise duplication, reduce costs, and optimise logistics.

Improved quality and trust: Pharmacovigilance and quality assurance mechanisms to ensure safe, effective, and trusted health products for HIV and related diseases.

Expanded access and uptake: At least 90% of clients enrolled in integrated dispensing models to enhance access, continuity of care, and treatment outcomes.

Sustainable and locally anchored supply: Donor dependency reduced by embedding commodities for HIV and related diseases in national and county budgets, promoting local manufacturing, and securing long-term cost efficiencies.

Health systems effectively identify and address barriers resulting in coverage gaps related to new HIV products and technologies through inclusive, community-informed planning and feedback mechanisms.

3.2.3 Health system financing

Goal: To secure sustainable, integrated, evidence-driven, and HIV-responsive financing within Kenya's UHC framework, reducing donor dependence while safeguarding essential HIV priorities and strengthening health system resilience.

Background

Kenya's HIV response continues to face significant financing challenges. Over 60% of programme costs have historically been funded by donors, a proportion that has steadily declined, leaving the system vulnerable. The National Health Accounts (NHA, 2019/20–2021/22) estimated that HIV accounts for an average of 20.3% of total health expenditure, underscoring the scale of investment required. Yet, as highlighted by the Kenya National AIDS Spending Assessment (KNASA, 2018/19), domestic expenditure has remained concentrated on recurrent costs such as salaries, with commodities and service delivery heavily donor dependent. Furthermore, Public Expenditure Tracking Surveys (PETS, 2022) revealed inefficiencies in disbursement, delayed cash flows, and leakages that weaken service delivery.

The National Quantification Report (2023/24–2026/27) highlighted the cost implications of sustaining treatment, with each new HIV infection requiring KES 14,710 annually, with estimated 2024 treatment costs of

KES 294 million to treat new infections alone. Preventing new infections could, however, generate KES 25 billion in savings over 20 years, emphasising the economic case for prevention and smart investment.

Despite the strategic importance of HIV financing, structural challenges persist. The Joint Annual Programme Review (JAPR, 2025) highlighted severe financial fragility within county health systems. Key concerns include fragmented planning and budgeting across HIV and related disease programmes, low allocation of resources for HIV, barriers to accessing and utilising allocated funds. Counties also face constrained fiscal space, heavy reliance on recurrent expenditures such as salaries, and frequent reallocation of health resources to other competing priorities all of which undermine HIV programme stability.

Kenya's Costing Framework (2022) and the Operational Plan for Enhancing Country Readiness to Sustain a Resilient HIV Response Beyond 2030 emphasise that vertical, disease-specific financing models are no longer sustainable. Instead, there is a need for integrated approaches, embedding HIV and other syndemic disease financing into the Universal Health Coverage (UHC) benefit package to reduce fragmentation, strengthen financial protection, and ensure equitable access to comprehensive services. This aligns with Kenya's UHC reforms under the Social Health Authority Act, the Primary Health Care Act, Facility Improvement Fund (FIF), and the Digital Health Act, which collectively aim to improve efficiency, accountability, and equity in health financing.

Financing for HIV should be embedded within national systems (through the Social Health Authority, Social Health Insurance Fund, and UHC platforms) while ensuring HIV-specific needs such as commodities, testing, and targeted prevention remain adequately resourced. Embedding these elements will help ensure that financing for HIV is not fragmented but aligned with comprehensive health priorities, while still maintaining the focus needed to safeguard Kenya's gains in the HIV response.

The framework promotes a data- and evidence-driven approach to guide the prioritisation and allocation of resources towards interventions and populations that yield the greatest impact in reducing new HIV infections, morbidity, and mortality. Routine programme data, epidemic appraisals, surveillance findings, community feedback, and modelling analyses will be systematically synthesised to identify where the needs are greatest, and which interventions deliver the best value for investment. This approach will ensure that limited financial resources are efficiently directed toward high-impact, cost-effective, and equitable interventions, particularly those addressing the needs of key and priority populations and underserved geographies.

Rationale

Financing remains the backbone of Kenya's HIV response. To protect the gains made and secure future progress, HIV funding must be fully integrated within the Universal Health Coverage framework. This requires moving beyond isolated budget lines toward pooled, efficient, and sustainable financing models that serve both HIV programmes and the broader health system. Table 6 presents the key elements that should be reflected.

Table 6. Summary integration plan for health system financing

Focus areas	Description	Interventions	Comprehensive integrated approach	Expected results
Strengthen domestic resource mobilisation	Implement resource mobilization and allocation strategies that are responsive to both HIV and broader health priorities.	Advocate for an increase in budgetary allocation for HIV within broader health budgets by both national and county governments. Explore innovative financing models such as earmarked health taxes, social-contracting, performance-based financing, infrastructure, and health bonds. Support public-private partnerships to supplement government resources and expand service coverage.	Develop and implement a unified resource mobilization strategy and harmonize budgeting and allocation processes to optimize resource use through a coordinated effort.	Sustainability of HIV financing
Mainstream HIV services into pooled funding mechanisms	Leverage existing pool funding mechanisms such as the Social Health Authority to sustain HIV financing.	Develop a country-led costing and expenditure reference for HIV and related diseases. Expand SHIF coverage for HIV prevention, treatment, and care, ensuring.	Advocate for integration of HIV services into SHA benefit packages. Mobilize for increased enrollment into SHIF. Allocate funds to cover SHIF premium payments for indigent individuals.	Guaranteed equity and access to health services. Financial protection for affected populations.
Diversify and safeguard financing for HIV commodities	Promote and support local manufacturers. Engage regional and international financing institutions to mobilize diversified investments for essential health commodities.	Develop and implement strategies that ensure sustainable financing of HIV & related health commodities. Develop investment cases for HIV and related commodities. Support private sector engagement in financing HIV response initiatives. Engage regional and international financing institutions to expand and diversify funding sources.	Advocate, secure, and allocate financing for HIV & related health commodities.	Sustainability of financing for HIV & related health commodities
Improve efficiency in resource utilization	Increase financial absorption rate through timely disbursement and utilization of resources. Strengthen joint technical and financial accountability structures.	Strengthen planning & budget execution to improve efficiency in the utilization of resources. Enhance accountability and transparency in county-level health budgets.	Promote and strengthen collaborative planning and budget execution processes and committees to improve efficiency and coordination. Develop and implement structures for technical and financial accountability.	Efficiency in resource use Strengthened accountability structures

Focus areas	Description	Interventions	Comprehensive integrated approach	Expected results
Improve financial data tracking systems	Adapt and utilise an integrated financial management system.	Establish robust systems for HIV-specific financial reporting at county level. Institutionalize the use of real-time monitoring tools to track allocations, disbursements, and expenditures.	Leverage existing interoperable financial systems that track HIV and related diseases allocations, expenditures, and outcomes.	Evidence-based resource allocation
Improve evidence-based prioritisation and allocation of resources	Use data and evidence to guide the prioritization and allocation of resources towards interventions with greatest impact.	Cost the essential package of services. Enhance utilization of evidence related to prevalence, incidence, risk, and vulnerabilities to prioritize allocation of resources to priority geographies and populations. Monitor the utilization of resources based on prioritization and routinely assess coverage gaps and adapt allocation of financial resources to address the gaps.	Leverage existing budgeting process at national and sub national level to share prioritization and advocate for allocation of resources.	Enhanced evidence-based prioritization and allocation of resources, enabling adaptive programming ensuring maximum population-level impact
Transparent, Inclusive, and Equitable Health Financing	Advance financial protection and ensure equitable access to HIV and related health services for all populations	Ring-fence funds for inclusion	Earmark dedicated budget lines within national and county health budgets to support disability-inclusive programming.	
		Advocate for Transparent Resource Allocation.	Establish and operationalize mechanisms to ensure that a defined and significant proportion of domestic HIV and syndemic financing is allocated directly and disbursed transparently to all	
		Incentivise Inclusive Service Delivery	Introduce a performance-based financing indicator that rewards health facilities demonstrating measurable improvements in serving persons with disabilities.	

Outcomes

- **Universal access** to affordable syndemic disease services.
- **Reduced catastrophic health** expenditures for households.
- **Sustainable financing model** beyond donor dependency.
- **Improved commodity availability and accessibility.**
- **Financial resources** are efficiently prioritised and allocated based on data and evidence to maximise impact and ensure equitable HIV service delivery.

3.2.4 Human resources for health

Goal: To build a **r**esilient, well-trained, and equitably distributed health workforce to deliver high-quality, evidence-based, people-centred care.

Background

Human resources for health are central to Kenya's HIV response. HRH supports better health outcomes, drives progress towards Universal Health Coverage, and strengthens health system resilience. Kenya's HRH landscape has been shaped by decades of vertical programming, devolution, and health sector reforms. The HIV response, heavily supported by PEPFAR and the Global Fund in the 2000s, expanded service access. However, it fostered parallel systems with donor-dependent personnel, weak integration, and sustainability concerns. The 2010 Constitution and subsequent devolution transferred HRH management to counties, improving local responsiveness. Nevertheless, it also introduced fragmentation, uneven staffing, limited training opportunities, weak supervision, and recurrent industrial actions. Counties today spend over half of their health budgets on salaries, leaving limited resources for service delivery improvements, hence the need for sustainable investment in workforce wellbeing. Despite these challenges, Kenya initiated task-shifting, integrated service models and adopted supportive policy tools like the HRH Strategic Plan (2021–2025) and SHA reforms that enhance workforce wellbeing and promote ethical practices.

Against this backdrop, KAISF 2025–2030 prioritises transitioning HIV-specific workforce into sustainable, integrated county and SHA financing frameworks. The KAISF supports capacity-building for multi-disease service delivery, strengthening HRH planning and deployment through interoperable HR information systems, and aligning training institutions with evolving service demands. These efforts are critical to embedding HIV and syndemic disease responses within Kenya's broader health architecture.

Rationale

Workforce integration is a cornerstone of strengthening health systems and sustaining high-quality service delivery. It focuses on alignment, standardisation, and continuous capacity development across national, county, facility, and community levels. An integrated workforce enables efficient use of resources, consistent human resource use and practices, and equitable access to services, while embedding skill transfer and long-term sustainability. This approach leverages schemes of service, workforce mapping, multi-partner coordination, and digital innovations to streamline HR management, supportive work environment, optimize HR costs, and foster learning ecosystems that build both current and future workforce readiness. Leveraging emerging technologies—particularly AI-powered training platforms and predictive learning tools—offers a unique opportunity to rapidly upskill frontline providers, support clinical decision-making, and embed continuous learning directly into the health system.

The framework promotes the use of data and evidence to strategically align the HIV workforce's capacity, skills, and deployment with programme priorities, identified service coverage gaps, and emerging needs. Human resource data, including workload analysis, service coverage data, and epidemiological trends will be utilised to inform equitable distribution and optimal deployment of healthcare workers across geographies and service delivery platforms including primary health delivery platforms. Efforts will focus on strengthening the capacity of healthcare workers, programme managers, and community providers to use routine data for planning, performance monitoring, and decision-making. This includes building competencies in data analysis, interpretation, and application to improve the quality, efficiency, and responsiveness of HIV services.

Table 7 presents the key strategic focus areas for HRH under KAISF 2025–2030. It outlines priority interventions and expected results.

Table 7. Summary integration plan for human resources for health

Focus area	Description	Interventions	Comprehensive integrated approach	Expected results
Improve workforce planning and optimisation.	To forecast, map, and align the health workforce with evolving population health needs and disease burdens, ensuring the right skills are in the right place for integrated service delivery.	Establish and implement HRH forecasting models to predict future staffing needs based on demographic and epidemiological trends for HIV and related diseases.	Integrate demographic and epidemiological data for HIV and other related diseases into HRH forecasting tools to inform staffing needs for service integration.	Strengthened preparedness and proactive data-driven HRH planning
		Conduct Workload Indicator Staffing Needs (WISN) assessment to appraise the workload pressure of the health workers in the facilities.	Apply WISN within the Ministry of Health's standard workload assessment framework to define staffing needs for integrated service delivery points.	Staffing needs profiles
		Review Human Resources for Health Norms and Standards Guidelines for the Health Sector to align workforce planning with health priorities and disease burden including aligning the lay cadres with community health systems.	Revise Human Resources for Health Norms and Standards Guidelines for the Health Sector to accommodate HCWs who can offer integrated services and expand the scope for community health workforce to provide integrated HIV services.	Equitable recruitment and deployment across counties and service areas
		Community workforce integration.	Advocate for the formal recognition and integration of Community Health Promoters and peer educators within the national Human Resources for Health (HRH) strategy, with clearly defined roles, standardised scopes of practice, structured training, certification, and remuneration pathways.	Optimisation of the community health strategy
		Review and implement Kenya Task Sharing Policy Guidelines to maximise use of available skills across cadres.	Train HCWs and community health workforce to provide integrated HIV services in line with the revised task-shifting/sharing policies.	Optimized use of available skills across cadres
		Strengthen integrated Human Resource Health Management Information System to support planning, deployment, monitoring and effective integrated service delivery.	Interface HRHIS with integrated service delivery data (HIS) to track workforce deployment and performance against the set indicators.	Real-time HRH data for planning, deployment and monitoring
		Promote a supportive and safe work environment that enhances staff wellbeing and productivity.	Institutionalise workplace wellness, staff welfare and safety programmes in line with HRH policies and procedure manuals to support service integration.	Improved staff morale, resilience, and retention

Focus area	Description	Interventions	Comprehensive integrated approach	Expected results
Strengthen capacity of community and facility-based health workforce for HIV and related diseases.	To build a competent, adaptable, and motivated workforce through integrated pre- and in-service training, continuous professional development, and performance management aligned with integrated care models.	Develop and implement an integrated training plan, curricula and training resource package for HCPs and community workforce in pre- and in-service education.	Incorporate integrated management of HIV and comorbidities as a core competency in pre- and in-service curricula for healthcare workforce.	Standardised and comprehensive training on HIV and related diseases for a multi-skilled workforce
		Institutionalise Continuous Professional Development and digital learning for integrated service delivery through MOH virtual academy.	Incorporate the integrated management of HIV and comorbidities modules into the virtual academy.	Standardised CPD accredited courses within the virtual academy
		Promote continuous professional development, cross-training, mentorship, support supervision and coaching, leveraging digital health technologies to enhance workforce adaptability.	Institutionalise interdisciplinary, integrated supportive supervision and leverage digital platforms for continuous professional development on patient-centred, integrated services.	Increased access to mentorship, coaching and training through innovative digital platforms
		Align performance management framework with staffing and HIV service integration agenda.	Link health worker performance appraisal tools with HIV integrated healthcare outcome indicators.	Enhanced staff productivity, efficiency and accountability on HIV integrated services
		Integrate Competency-Based Learning.	Ensure that all pre-service and in-service training for health care workers incorporates certified modules on Meaningful Community Engagement, Key Population Competency, and Stigma and Discrimination Reduction.	A competent, inclusive, and representative health workforce that delivers equitable, rights-based, and high-quality care to all
		Cross-Sectoral Capacity-Building.	Expand training beyond health professionals to include Faith Leaders, Community Health Promoters, and peer educators.	
		Integrate Disability Competency.	Embed disability awareness, communication skills (including basic sign language), and rights-based care within all pre-service and in-service training.	
		Inclusive Recruitment and Retention.	Promote the active recruitment, training, and retention of persons with disabilities as Community Health Promoters, peer educators, and facility-based staff.	
Build capacity to use data for decision-making.	To strengthen capacity of health care providers to use data for programme adaptation and decision-making.	Include routine data analysis and utilisation in all capacity-building modules. Provide mentorship to routinely use data and evidence in understanding gaps and develop plans to address the gaps.	Integrate data use modules within the pre-service and in-service training curriculum.	Enhanced skills and practice among health care workers to use data for decision-making and adaptive programming.

Outcomes

- **Effective use of evidence** to enhance deployment of skilled workforce at all service delivery points.
- **Optimised use of available skills** across the cadres at all service delivery levels.
- **Competent and skilled workforce** for integrated service provision.
- **Enhanced staff productivity** and accountability on HIV integrated services.
- **A healthy and motivated health workforce** providing high-quality, integrated and people-centred services.
- **Enhanced skills and practice of health care workers** to use data for decision-making and adaptive programming.

3.2.5 Health information systems

Goal: To establish an integrated, country-owned health information ecosystem that consolidates HIV and syndemic disease data into a unified, intelligent national platform that enhances interoperability, real-time decision-making, and sustainable data governance.

Background

Kenya's health information system has historically been characterised by fragmented, donor-supported platforms that, while effective for programme reporting, have limited country ownership, sustainability, and scale. This framework prioritises reforms to establish a comprehensive, intelligent, and integrated digital health information system that ensures real-time and reliable data for decision-making. To achieve this, existing systems will be integrated with the National Health Analytics Intelligence Platform to enable seamless data exchange across programmes. This will be complemented by HIV and syndemic disease-focused dashboards and AI-driven predictive analytics to forecast disease trends and guide resource allocation. Additionally, strengthening community facility linkages will enhance the flow of community-level data into the national system.

Through the establishment of the DHA, and rollout of the Kenya Digital Health Superhighway, Kenya is moving from parallel, donor-dependent systems to a unified ecosystem guided by the Kenya Health Information System Interoperability Framework. These reforms are complemented by the adoption of the Programme Science approach, which ensures that data is not only collected but actively applied to identify gaps, inform policies, and support adaptive programming.

This reform agenda positions Kenya to achieve government ownership of health data, enhance accountability, and build a learning health system capable of advancing epidemic control, universal health coverage, and long-term resilience. An integrated HMIS will serve as the backbone for HIV and other syndemic disease monitoring, enabling interoperable data flows across HIV, TB, malaria, NCDs, and STIs. By embedding focused indicators into the unified platform, Kenya can move from fragmented reporting to real-time, evidence-driven decision-making, ensuring continuity of care and improved patient outcomes.

The framework emphasises the integration of research, routine data analysis, and innovation within HIV programmes to continuously identify, understand, and address coverage gaps across populations and geographies. Embedding research within implementation processes will generate timely, context-specific evidence on what works, for whom, and under what conditions, informing adaptive programming and equitable service delivery. Real-time data innovations, including digital dashboards, data visualisation tools, and integrated information systems will simplify data access, interpretation, and utilisation by decision-makers, programme implementers, and communities. To sustain a culture of evidence-based decision-making and continuous quality improvement, strengthening the capacity of health workers, programme managers, researchers, and community cadres to analyse, interpret, and apply data is critical.

Rationale

Implementation of health information systems (HIS) within the KAISF calls for a systematic, integrated approach that strengthens data infrastructure, enhances interoperability, and embeds a culture of evidence use across all levels of the health system. Table 8 outlines the strategic focus areas guiding the implementation of HIS reforms anchored on data quality, system integration, workforce capacity, and real-time use for decision-making and accountability.

Table 8. Summary integration plan for health information systems

Focus areas	Description	Interventions	Comprehensive integrated approach	Expected results
Enhance functionality and scope of health information systems.	Expand national and county-level information platforms to support integrated, real-time, and multi-disease data for service delivery and coordination.	Integrate the national health information system to capture HIV and related syndemic conditions.	Utilise a common national unique personal identifier (NUPI) such as a biometric or national identification number to facilitate patient identification and data exchange.	Integrated national reporting system
Achieve full interoperability across health information platforms.	Integrate EMRs, DHIS2/KHIS, LMIS, and community data systems to enable seamless data sharing, patient tracking, and programme alignment.	Deploy electronic medical records (EMRs) across all health facilities, ensuring system-wide inclusion of standardised disaggregation categories within data collection tools to support integrated, equity-focused service delivery and analytics.	Institutionalise facility-wide electronic medical records that are not disease specific and align to specific standards and protocols as stipulated in the existing frameworks.	Increased facility-wide EMR coverage by 2030
		Develop a standard guide for HIV and syndemic diseases.	Develop a standardised guide for HIV and syndemic diseases to promote consistency, integration, and institutionalisation within existing health policies and frameworks.	
		Integrate health-related data from core government departments and partners into an integrated visualisation dashboard.	Develop a country-owned repository that allows data exchange to the national platform.	Fully operational integrated dashboard
		Develop and standardise indicator manuals to measure and monitor the response to HIV and related comorbidities.	Implement data exchange standards, model context protocols, and interoperability requirements to enable seamless data sharing between systems.	Indicator manual developed and operationalised

Strengthen research, surveillance, and early warning systems.	Build capacity for implementation research and early warning systems to identify trends, respond to bottlenecks, and track syndemic interactions.	Develop and implement an HIV and other syndemic research agenda that prioritises operational and implementation research.	Implement the research agenda using the integrated data shared between systems.	A national HIV and other syndemic diseases research agenda developed and operationalised
				Increased proportion of priority operational and implementation research studies completed, and findings disseminated to inform adaptive programming and policy
Improve data quality, security, and use.	Institutionalise data quality audits, enforce data security protocols, and promote evidence-driven decision-making and accountability at all levels.	Implement integrated data quality protocols.	Implement data exchange standards, model context protocols, and interoperability requirements to enable seamless data sharing between systems. Implement regular data audits using the integrated data shared between the systems.	Established and operational integrated data quality protocols
		Implement AI-driven predictive analytics to forecast disease trends, detect hotspots, and optimize resource allocation.	Conduct AI-driven predictive analytics to forecast disease trends, detect hotspots, and optimize resource allocation by use of the integrated data shared between the systems.	Increased compliance to national data governance and security standards at national and county level
		Implement AI-driven predictive analytics to forecast disease trends, detect hotspots, and optimize resource allocation.		AI-driven predictive analytics integrated into national health information platforms
Build strategic information workforce capacity.	Train, mentor, and deploy health workers skilled in data collection, analytics, and use. Leverage AI and digital learning for rapid, scalable upskilling.	Strengthen the utilisation of virtual academies to deliver and scale up broadened strategic information (SI) courses for improved capacity-building and knowledge dissemination.	Operationalise virtual academies using standardised curriculum.	Annual capacity-building of HMIS-HRH on data management processes and effective programme coverage
		Skills development for strategic information capacity through continuous mentorship and OJTs.	Integrate on-the-job trainings.	
		Strengthen capacity for the practical application of Programme Science in the HIV response.		

Integrate Community-generated Data into Monitoring and Accountability systems.	Enhance the responsiveness, transparency, and equity of Kenya's integrated health response.	Institutionalise community data use.	Mandate the structured integration of data from Community-Led Monitoring (CLM) into national and county Monitoring and Evaluation (M&E) frameworks, ensuring that community-generated insights inform programme performance reviews, policy adjustments, and quality improvement processes.	An integrated and responsive data ecosystem where community-generated evidence directly informs decision-making, enhances accountability, and drives continuous improvement in the quality and equity of HIV and syndemic disease services
		Strengthen feedback loops.	Establish mechanisms for the routine inclusion of community-reported data—such as reports on stockouts, stigma, discrimination, or service quality—into national supply chain, quality assurance, and accountability systems.	
		Promote data triangulation.	Encourage joint analysis of community-generated and programmatic data during quarterly and annual reviews to identify service gaps, improve responsiveness, and foster shared accountability.	Availability of high-quality, disability-disaggregated data to inform planning, resource allocation, and monitoring of equitable progress in the HIV and broader health response
		Disaggregate Data by Disability.	Ensure that persons with disabilities are adequately represented in population-based surveys.	
		Inclusion in Population-based Surveys and Routine Monitoring		
		Data Governance and Quality Assurance	Strengthen data governance frameworks to standardize disability data elements, ensure data quality, and facilitate interoperability between health and social protection systems.	

Outcomes

- **Improved accountability,** transparency, and performance monitoring, fostering trust and sustainability beyond donor-driven cycles.
- **Evidence-driven policies,** practices, and investments that are guided by integrated data systems and assessment of coverage gaps.
- **Strengthened research,** surveillance, and early warning systems for HIV and other syndemic diseases based on coverage gaps.
- **Strengthened collation,** coverage analysis, and use of strategic information to inform policy and decision making across all levels.

3.2.6 Leadership and Governance

Goal: To strengthen inclusivity, leadership, governance, and coordination for a cost-effective, efficient, evidence-based and sustainable HIV response that is integrated within the existing health care system and improves health outcomes at national and county levels.

Background

Strong leadership, effective governance, and multisectoral coordination are key enablers to steer the transition of Kenya's HIV response from vertical and donor-funded towards an integrated sustainable locally funded programme within the existing health care system. As the country adopts an integrated approach,

it is essential to establish inclusive structures that align national and county priorities with the Universal Health Coverage agenda while upholding transparency, equity, and accountability in decision-making.

The framework underscores the critical role of leadership and governance in driving an evidence-informed HIV response. It promotes the systematic utilisation of data and evidence by national and county leaders to guide strategic decisions, set priorities, and ensure accountability for results. Strengthening governance structures will enable regular data reviews, progressive policy dialogues, legal reforms, and decision-making processes that are transparent, inclusive, and responsive to emerging trends and community feedback.

Rationale

The National Syndemic Diseases Control Council (NSDCC) provides strategic leadership, policy direction, advocacy and public education, resource mobilisation, and oversight for Kenya's response to HIV, and other syndemic diseases. Within the devolved health system, HIV/AIDS programme implementation is guided by county-specific plans aligned with national policies and standards. Coordination is facilitated through technical working groups, multisectoral forums, and interagency committees that engage government, civil society, development partners, public and private sector and communities. Despite these structures, siloed, partner-driven programmes continue to pose challenges, leading to fragmentation and inefficiencies. The KAISF addresses this through integration models that promote harmonised planning, joint service delivery, and resource sharing across disease areas and partners. These efforts are further supported by streamlined multisectoral frameworks, policy and legislative alignment, and human-centred approaches that strengthen governance and accelerate progress toward Universal Health Coverage. A dedicated HIV leadership and governance function will ensure adherence to HIV-specific policies, guide resource management, and drive the transition from a vertical, emergency-driven response to a sustainable, integrated approach embedded within the broader health system.

Multisectoral coordination & accountability

KAISF proposes a whole-of-government and whole-of-society coordination mechanism that aligns the mandates of both health and non-health sectors to address the complex and intersecting drivers of HIV and other related diseases, including poverty, gender inequality, stigma, discrimination, violence, limited access to education, and harmful social norms. This multisectoral approach ensures accountability and synergy across actors to deliver integrated, equitable, and sustainable responses.

The KAISF leadership and governance priorities for achieving an integrated response

Policy harmonisation: Aligning policies, systems, and frameworks to ensure HIV and other syndemic conditions are addressed through a single, coordinated approach consistent with the UHC agenda, Kenya Vision 2030, and the SDGs.

Service integration: Embedding HIV services within broader health and community systems so that prevention, care, and treatment are delivered alongside TB, malaria, NCDs, SRHR, and mental health services.

Multisectoral collaboration: Strengthening collaboration across sectors (health, internal security, education, gender, youth, social protection, finance, ICT) and partners. The approach emphasises joint planning, shared resources and community engagement to address overlapping structural and social drivers of HIV and other syndemic diseases.

Digital health and data use: Leveraging digital platforms such as Kenya's Human Resource for Health Information System (HRHIS), The Kenya Digital Health Agency (DHA) TibERbu HealthNet systems that inform decision-making, Programme Science, and accountability across sectors.

Community participation and accountability: Institutionalising community engagement through structured feedback, community-led monitoring, and advocacy platforms to ensure services remain people-centred and responsive.

County-driven response: Supporting counties to integrate syndemic responses into County Health Strategies, backed by technical assistance; financing models; and capacity-building, mentorship, and coaching.

Cross-cutting and emerging issues

The KAISF recognises that emerging global trends and cross-cutting issues such as pandemics and other public health challenges, climate change, economic shocks, and shifting donor priorities pose potential challenges to the effective implementation of strategies and delivery of targeted outcomes. Additionally, health service delivery in Kenya continues to be shaped by persistent disparities driven by social, economic, and geographic inequalities, which must be addressed to ensure an equitable and sustainable response to HIV and related syndemic diseases.

Key stakeholders

The KAISF recognises that effective implementation relies on the clear identification and coordination of key stakeholders involved in driving an integrated response to HIV and related syndemic diseases. Their coordinated roles are essential in ensuring efficient, inclusive, and sustainable service delivery across all levels. The key stakeholders for each pillar are listed in Table 9.

Table 9. Stakeholders for each pillar

Pillars	Key player
Health information systems	County Governments, Ministry of Health [Directorate of Digital Health, Informatics Policy & Research, Digital Health Agency), Ministry of Education, Social Protection, Implementing Partners, Ministry of Interior and National Administration, Ministry of Gender
Human resources for health	County Governments (County Public Service Board), Medical Training Institutions, Health Professional Bodies, Ministry of Education, Ministry of Health, Public Service Commission (PSC)
Health products and technologies	Pharmacy & Poisons Board (PPB), Kenya Medical Supplies Agency (KEMSA), Mission for Essential Drugs and Supplies (MEDS), Ministry of Health (Directorate of Health Products & Technologies, National AIDS & STI Control Programme), County Pharmacists Caucus, Pharmacy Society of Kenya (PSK), Kenya Association of Manufacturers (KAM), Kenya Pharmaceutical Association (KPA), National Assembly, Private Pharmacies
Service delivery systems	County Governments, Ministry of Health, Implementing Partners, Private facilities, Faith Based Sector, Communities
Health system financing	County Governments (Governors, MCAs) Budget Planners (Treasury Planning Units) Budgeting Economics Council (IBEC) SHA/SHIF, Private Sector, Faith Based Sector and communities and user departments.

The interventions, integration strategies, and expected results are described for each leadership and governance focus area on Table 10.

Table 10. Summary integration plan for leadership and governance

Focus area	Interventions	Integration strategy	Description	Expected results
Strengthening governance structures and accountability systems	Establish and operationalise multisectoral governance, coordination, and accountability structures at national, county and subcounty levels with membership from relevant stakeholders.	Establish a National Multisectoral Integration Steering Committee. Establish a technical secretariat for the National Multisectoral Steering Committee. Establish County and Subcounty Multisectoral Integration Coordination Committees.	To provide expert leadership, mobilise resources, and ensure accountability towards achieving the targets of this framework. To provide technical leadership and ensure that this framework is implemented with fidelity and monitored to measure progress. In each county, the County Executive Committee Member for Health, and the County Commissioner will co-chair the County Multisectoral Integration Coordination Committee. The NSDCC Regional Coordinator will serve as the secretariat for this committee. This committee will provide leadership at county and subcounty level for the integration response, mobilise resources, ensure compliance with national policies and guidelines, and promote accountability towards achieving the county integration targets.	Established Multisectoral Coordination Committees are functional, evidenced by meeting their mandated frequency (e.g., quarterly for national/ county, monthly for subcounty) and producing annual joint work plans.
Policy, guidelines, and technical support	Review and advocate for reforms of laws that criminalise key populations and fuel stigma.	Advocate for the removal of sections of the penal code that criminalise key populations.	This will help create a conducive and stigma-free society that allows KPs to access prevention and treatment services.	Improved access to health services by KPs.

Focus area	Interventions	Integration strategy	Description	Expected results
Community engagement and service accessibility	Strengthen and operationalise a structured feedback and response mechanism by recipients of care and service providers to enhance accountability and inform decision-making.	Leverage existing technologies to get feedback on service accessibility and quality of care.	To create and maintain formal channels for patients and providers to give feedback, and to ensure this information is systematically used to improve services.	Improved equity in access to care, particularly for persons with disabilities and marginalised groups.
	Advocate for improvement of health infrastructure to make it increase accessibility for persons with disabilities and other vulnerable groups.	Integration of continuous quality improvement in service delivery.	Training and sensitisation of decision-makers.	100% representation of vulnerable, marginalised, most at risk, and recipients of care advocacy networks policy and decision-making processes.
Evidence-informed leadership and decision-making	Embed science to ensure that leadership receives data and other strategic inform ation in a user-friendly manner, motivating its use to inform national and subnational strategies and policies.	Embed Programme Science in leadership and governance by creating interactive dashboards to guide data use for decision making.	To ensure review fora at both national and county levels to enable cross-learning and benchmarking.	Improved programme performance and measurable health impact at national and county levels.
	Foster a culture of data demand and use at the leadership level, creating programme management systems that are evidence-driven and responsive to community needs.			

Outcomes

Inclusive, functional governance structures operational at both national and county levels.

Strengthened legal and policy environment grounded in rights-based principles.
Improved multisectoral coordination and accountability mechanisms.

Counties empowered with tools, guidance, and capacity to drive integration.
Policy advocacy networks activated to shape laws, budgets, and implementation.

Institutionalised community engagement in planning, oversight, and accountability.

Enhanced public trust in health and governance systems.

Health and social services responsive to the needs of key and vulnerable populations.

Leadership routinely leverages real-time data and evidence for planning and resource allocation.

Established culture of adaptive learning and results-based programme management.

Section 4. Operational Roadmap for the Kenya AIDS Integration Strategic Framework

4.1 Introduction

Integration within health systems can be operationalised through multiple modalities, including service co-location, one-stop differentiated service delivery models, decentralised community-based platforms, and harmonisation of parallel programmatic architectures. Each modality offers distinct pathways for improving system efficiency and responsiveness. Irrespective of the implementation model, the strategic intent remains consistent: to maximise resource utilisation, minimise fragmentation and service redundancies, enhance client experience, and improve health outcomes through comprehensive, person-centred care that addresses comorbidities and overlapping population needs, rather than managing isolated disease silos.

4.2 Linking KAISF with County Operational Plans

As the national blueprint for Kenya's HIV and syndemic disease response, the KAISF will guide the development and implementation of COPs. These are the mechanisms through which counties will adapt the framework to their unique epidemiological, demographic, and health systems contexts, thus ensuring alignment with devolved health strategies, UHC implementation priorities, and budget cycles. This two-way linkage will guarantee coherence between national and county priorities, enable local innovation within a shared accountability structure, and reinforce Kenya's whole-of-government approach to health. Table 11 indicates roles and responsibilities in the implementation process of this framework. At the national level, responsibilities include providing high-level leadership, policy frameworks, funding, and technical guidance for integrating HIV services. At the county level, the responsibility shifts to translating national policy into practice by coordinating local partners, managing service delivery through local health facilities, and ensuring services are accessible and responsive to community needs.

Table 11. Stakeholder roles and responsibilities in the implementation process

Institution/Actor	Roles and responsibilities
Ministry of Health - National Syndemic Diseases Control Council	Oversight role Provide strategic and technical leadership, policy guidance, and national coordination of KAISF; resource mobilisation; oversee monitoring, evaluation, and learning; ensure alignment with national health and development priorities. Lead technical stewardship, integrate KAISF into the health sector, and align with the UHC agenda and Kenya Vision 2030
County Governments	Develop and implement COPs aligned with KAISF; establish and operationalise county-level coordination platforms; allocate resources and oversee service delivery.
Other Government Ministries and Agencies (Education, Gender, Youth, Finance, Interior, ICT, Social Protection, and others)	Address structural and social drivers of HIV and syndemic diseases through cross-sectoral policies, resource mobilisation, and sectoral integration.
Civil society and community-based organisations	Mobilise communities, champion rights-based advocacy, deliver services to marginalised populations, and provide accountability feedback.
Development partners	Provide technical and financial support, align investments with KAISF priorities, and strengthen sustainability and transition of national and county systems.
Private sector	Support innovation, financing, workplace programmes, and contribute to service delivery and community engagement.
Communities and recipients of care, special needs population	Actively participate in governance and accountability structures, mobilise demand, provide feedback, and ensure services are responsive to community needs and realities.

4.3 Integration governance structures

This section provides a phased approach for national and county governments, partners, and stakeholders to operationalise the integration agenda. It is designed to guide the establishment of governance structures, align planning cycles, and ensure a coherent transition from vertical programming towards a sustainable, integrated health system. This roadmap is an essential tool for all implementers to synchronise efforts, manage the change process, and maintain accountability throughout the KAISF implementation period (2025–2030).

National Integration Coordination Structure

National-level leadership and coordination focuses on establishing the foundation for integration at the national level through strong leadership and coordinated action. It seeks to provide strategic direction, align priorities across sectors, and ensure that integration is guided by a coherent framework. Key activities will involve engaging and involving stakeholders and validating and disseminating the integration framework to national and county stakeholders.

This structure will comprise:

National Integration Steering Committee

This will comprise the NSDCC Director of Epidemiology and Strategy (Chair), chairpersons for the Technical Committees for the six pillars (Service Delivery, HRH, HPT, HMIS, Finance, Leadership & Governance), Council of Governors Representative, and the Integration Lead at NASCOP.

National Technical Committees

These will provide technical guidance on the six pillars of the framework. The established Core Review Team members (the committees' secretariat) and all relevant stakeholders as mapped out in Table 9 (Stakeholders for each pillar) will form membership of the committees.

County Integration Coordination Structure

County-level leadership and coordination lay the foundation for smooth rollout and long-term sustainability of the integration strategy. This phase will strengthen leadership and oversight at the county level to drive the integration agenda. County Integration Steering Committees (CISCs) will be established, supported by existing technical working groups to provide implementation guidance. Clear reporting and coordination mechanisms will link national, county, subcounty, and facility levels to ensure effective communication, alignment of priorities, and accountability across all stakeholders. This will be done through:

County Integration Steering Committee

The County Integration Steering Committee roles and responsibilities:

- Disseminate the National Integration Framework.
- Develop and implement the County Operational Plans in alignment with the national integration framework.
- Provide oversight and coordination across the health system's pillars.
- Monitor and evaluate the effectiveness of the progress of implementation.

Pool resources to implement the strategy.

The Chief Officer for Health, through the County Multisectoral Committee, will appoint members of the County Integration Steering Committee. The committee will be chaired by the County Director of Health, who will provide periodic updates to the Chief Officer for Health.

The committee will meet at least quarterly and provide regular reports to the County Multisectoral Committee through the Chief Officer for Health.

Proposed membership

- County Director, Health - Chair
- County Human Resource Manager/County Health Administrative Officer
- County Health records Information Officer
- County Pharmacist
- County Finance Manager/ Director Finance/Chief Officer Finance
- County AIDS & STI Coordinator
- County Multisectoral Coordinator
- County TB Coordinator
- County NCD Coordinator
- County Malaria Coordinator
- Community Health Strategy focal person
- Representative of Recipients of care

The committee may co-opt members as necessary.

4.4 Roadmap implementation matrix

The implementation matrix (Table 12) translates the strategic objectives of KAISF 2025–2030 into actionable national-level activities, with defined activities and annual performance targets. It serves as a coordination and accountability tool to guide implementation, monitor progress, and ensure alignment with Kenya's broader integrated health agenda, including Universal Health Coverage, primary health care reforms, and multisectoral syndemic responses.

Table 12. Implementation matrix of the KAISF at the national level

Pillars	Interventions	Key activities	Expected output	Output indicators	5-year target	Target				
						Y1	Y2	Y3	Y4	Y5
Service delivery systems	Enhance community strategies for defaulter tracing, adherence enhancement and treatment support.	Develop an integrated community assessment tool.	Integrated community assessment tool.	Number of integrated community assessment tools	1	1				
		Develop the integrated HIV, VH and STI prevention and treatment guidelines.	Integrated guidelines.	Number of integrated guidelines	1	1				
	Optimize ART treatment for all subpopulations to improve patient health outcomes.	Finalise and operationalise the Essential Package for HIV Services under the Social Health Authority (SHA).	HIV services fully integrated into the UHC benefits package for sustainable financing.	Essential Package for HIV Services officially approved and launched by SHA.	1	1	1 (Package Launched)	0	0	

Pillars	Interventions	Key activities	Expected output	Output indicators	5-year target	Target				
Leadership and governance		Establish a national multisectoral integration steering committee.	Multisectoral committee established and operationalised.	Number of multisectoral committees established and operationalised	1	1	0	0	0	0
	Strengthen screening and treatment of major HIV-related co-infections and comorbidities.	Establish a technical secretariat for the national multisectoral steering committee.	Technical secretariat established and operationalised.	Number of technical secretariats established	1	1	0	0	0	0
	Establish and operationalize multisectoral governance, coordination, and accountability structures at national, county and sub-county levels with membership from relevant stakeholders.	Establish interactive dashboards to enhance decision-making	Visualisation dashboards for leadership and governance.	Number of dashboards created	1	1	0	0	0	0
	Establish and operationalize multisectoral governance, coordination, and accountability structures at national, county and sub-county levels with membership from relevant stakeholders.	Support development of county operational plans.	Developed county plans.	Number of county operational plans	47	47				
	Embed science to ensure that leadership receives data and other strategic information in a user-friendly manner, motivating its use to inform national and subnational strategies and policies.	Undertake mid-term review for KAISF and county plans.	Reviewed KAISF and county plans.	No. of MTR reports	48			48		
		Undertake End-term review for KAISF and county plans.	Reviewed KAISF and county plans.	No. of ETR reports	48					48
	Foster a culture of data demand and use at the leadership level, creating programme management systems that are evidence-	Undertake Joint Annual Programme reviews	Reviewed the programme.	No. of JAPR reports	5	1	1	1	1	1
	driven and responsive to community needs.	Review and advocate for reforms of laws that criminalise key populations and fuel stigma.	A more enabling legal environment for accessing health services.	Number of advocacy reports and policy briefs on legal barriers presented to Parliament., including the Standing Committee on Health, and the Departmental Committee on Justice and Legal Affairs	4	1	1	1	1	

Pillars	Interventions	Key activities	Expected output	Output indicators	5-year target	Target				
Health products & technologies	Foster a culture of data demand and use at the leadership level, creating programme management systems that are evidence-	Integrate HIV commodities into national and county budgets and KEML.	HIV commodities fully mainstreamed into KEML and county procurement plans.	Proportion of HIV commodities included in KEML and county plans.	100%	20%	40%	60%	80%	100%
	driven and responsive to community needs.	Establish national and county buffer stocks.	Functional 3-month buffer stock system for HIV commodities.	Proportion of facilities reporting no HIV commodity stockouts annually	100%	60%	70%	80%	90%	100%
	Foster a culture of data demand and use at the leadership level, creating programme management systems that are evidence-	Institutionalise integrated LMIS with real-time visibility.	National eLMIS integrated with DHIS2 for all HPT.	Proportion of facilities reporting through interoperable LMIS.	100%	100%	100%	100%	100%	100%
	driven and responsive to community needs.	Implement unified forecasting and pooled procurement.	Annual joint quantification and pooled procurement cycles established.	Proportion reduction in HIV commodity procurement costs compared to FY2024/25 baseline	50%	10%	20%	30%	40%	50%
	Review and advocate for reforms of laws that criminalize key populations and fuel stigma	Strengthen last-mile delivery systems (e.g., drones, integrated routes).	Efficient distribution network for all commodities operational.	Median resupply turnaround time (days) between national warehouses and facilities	≤7 day	≤7 day	≤7 day	≤7 day	≤7 day	≤7 day
	Integrate HIV and related diseases commodities into national and county essential medicines lists, budgets, and procurement through joint forecasting, quantification, and pooled purchasing.	Scale up multi-disease diagnostic platforms and reagents.	Expanded EID/VL/CD4/DR testing coverage nationwide.	Proportion of facilities with functional multi-disease platforms.	100%	100%	100%	100%	100%	100%
	To ensure uninterrupted availability of essential HIV and related disease commodities by integrating them into national and county essential medicines lists, budgets, and establishing robust buffer stock systems.	Strengthen pharmacovigilance and QA systems.	Integrated national PV dashboard and QA framework operational.	Proportion of ARV and PrEP batches tested for quality assurance	80%	20%	35%	50%	65%	80%
	Institutionalise integrated end-to-end LMIS with real time visibility for all HPT.	Promote local manufacturing of HIV commodities (PPPs, GMP, incentives).	Local production of ARVs, PrEP, condoms, and diagnostics expanded.	Proportion of HIV commodities manufactured locally	50%	40%	40%	40%	45%	50%
	Implement unified forecasting and pooled procurement for HIV and related diseases and comorbidities HPT.	Expand integrated "One-Stop Shop" dispensing models.	Integrated chronic disease dispensing models institutionalised.	Proportion of facilities providing integrated and innovative HPT dispensing services	≥75%	15%	30%	45%	60%	75%

Pillars	Interventions	Key activities	Expected output	Output indicators	5-year target	Target				
Health information systems	Strengthen last-mile delivery	Advocate for a national unique personal identifier (NUPI)	A national unique personal identifier operationalised.	National Unique Personal Identifier (NUPI) system developed and operationalised for health programmes	**1**			**1**		
	Scale up multi-disease diagnostic platforms.	Standardise indicators for the HIV and syndemic diseases response.	Standardised Indicator Set & Review Protocols.	National Indicator Manual for HIV and Syndemic Diseases developed and adopted	**1**	**1**				
	Strengthen adverse drug reaction (ADR) reporting systems with feedback loop to the providers and recipients of care.	Harmonise and integrate data systems to achieve system interoperability, scale digital infrastructure, and strengthen integrated surveillance.	Sovereign, integrated & scaled national data infrastructure.	Proportion of national and subnational health data systems interoperable within the sovereign, integrated national data infrastructure	**70%**	**14%**	**28%**	**42%**	**56%**	**70%**
		Operationalise Programme Science for data utilisation.	Developed and operationalised Programme Science guidelines & training.	Number of Programme Science guidelines developed and operationalised through national and county-level trainings	**1**	**1**				

Pillars	Interventions	Key activities	Expected output	Output indicators	5-year target	Target				
Health system financing	Integrate innovative HPT dispensing models for HIV and related diseases and comorbidities.	Advocacy for increased budgetary allocations for HIV within broader health budgets by both national government and counties.	Increased budgetary allocations for HIV by national and county governments.	Proportion of domestic resources mobilised over the total health budget	**%** **100%**	**Y1** **60%**	**Y2** **70%**	**Y3** **80%**	**Y4** **90%**	**Y5** **100%**
	Integrate the national health information system to capture HIV and related Syndemic conditions.	Pursue innovative financing models such as earmarked health taxes, social-contracting, performance-based financing, infrastructure and health bonds.	Increased resources for HIV.	No of innovative models for increasing resources for HIV	**4**		**1**	**1**	**1**	**1**
	Integrate the national health information system to capture HIV and related Syndemic conditions.	Support PPPs to supplement government resources and expand service coverage.	Increased PPPs.	No. of PPPs that supplement resources for HIV	**20**	**4**	**4**	**4**	**4**	**4**
	Deploy electronic medical records (EMRs) across all health facilities, ensuring system-wide inclusion of standardised disaggregation categories within data collection tools to support integrated, equity-focused service delivery and analytics.	Develop a country led costing and expenditure reference for HIV and related diseases.	Country led costing and expenditure reference for HIV and related diseases.	Country-led costing report	**1**	**1**		**1**		
	Integrate health-related data from core government departments and partners into an integrated visualisation dashboard.	Develop a module that covers SHIF coverage for HIV prevention, treatment, and care.	A module within SHIF that covers HIV prevention, treatment, and care.	A module within SHIF that covers HIV prevention, treatment, and care	**1**		**1**			
	Advocate for an increase in budgetary allocation for HIV within broader health budgets by both national and county governments.	Develop and implement strategies that ensure sustainable financing of HIV & related health commodities.	A strategy that outlines sources of sustainable financing of HIV & related health commodities.	A strategy document	**1**	**1**				
	Explore innovative financing models such as earmarked health taxes, social-contracting, performance-based financing, infrastructure, and health bonds.	Develop investment cases for HIV and related commodities.	Investment case reports for HIV and related commodities.	No. of Investment case reports	**4**		**1**	**1**	**1**	**1**
		Support private sector engagement in financing HIV response initiatives.	Increased local manufacturing of HIV commodities.	Proportion of commodities that are produced locally	**50**	**40**	**40**	**40**	**45**	**50**
	Develop a country-led costing and expenditure reference for HIV and related diseases.	Engage regional and international financing institutions to expand and diversify funding sources.			**8**		**2**	**2**	**2**	**2**
	Develop a module that covers SHA coverage for HIV prevention, treatment, and care.	Strengthen planning & budget execution to improve efficiency in the utilisation of resources.		No. of planning and budgeting committee trainings done at county level						
		Develop and implement structures for technical and financial accountability.		Guidelines to support accountability and transparency in county-level health budgets.						
	Develop and implement strategies that ensure sustainable financing of HIV & related health commodities.	Conduct a national HIV service costing study to inform domestic budgeting.	Standardised cost data for HIV services available for SHA and county budgeting.	A national "cost catalog" for HIV services developed and disseminated.	1	1 (Study completed)	0	0	0	

Pillars	Interventions	Key activities	Expected output	Output indicators	5-year target	Target				
HRH	Develop investment cases for HIV and related commodities.	Develop a national HRH forecasting model based on demographic and epidemiological data.	Functional HRH forecasting and planning model.	National HRH forecasting model developed and disseminated to counties for adoption	1	1	0	0	0	
	Support private sector engagement in financing HIV response initiatives	Review and update national HRH norms and standards guidelines to support integrated service delivery.	Revised HRH norms and standards guidelines for integrated HIV and related disease services.	HRH norms and standards guidelines reviewed and approved	1	1	0	0	0	
	Engage regional and international financing institutions to expand and diversify funding sources.	Review Kenya Task Sharing Policy Guidelines.	Revised Kenya Task Sharing Policy Guidelines.	Reviewed and approved Kenya Task Sharing Policy Guidelines	1	1				
	Strengthen planning, & budget execution to improve efficiency in the utilisation of resources.	Develop and roll out a national integrated HRH information system.	Integrated national HRH-HIS platform established.	National HRHIS linked with HIS	1	1	0	0	0	
	Enhance accountability and transparency in county-level health budgets.	Develop standardised national pre-service and in-service curricula for integrated HIV and related disease management.	Standardised integrated training curricula developed.	% of pre-service and in-service training programmes updated to include integrated HIV modules	100%	25%	50%	75%	100%	
	Establish robust systems for HIV-specific financial reporting at county level.	Institutionalise CPD and digital learning for integrated service delivery through the MOH Virtual Academy.	CPD framework and digital training platforms established.	% of national-level health workforce completing CPD on integrated care annually	90%	30%	50%	70%	90%	
	Institutionalise the use of real-time monitoring tools to track allocations, disbursements, and expenditures.									
	Establish and implement HRH forecasting models to predict future staffing needs based on demographic and epidemiological trends for HIV and related diseases.									
	Review Human Resources for Health Norms and Standards Guidelines for the Health Sector to align workforce planning with health priorities and disease burden including aligning the lay cadres with community health systems.									
	Review and implement Kenya Task Sharing Policy Guidelines to maximise use of available skills across cadres.									
	Strengthen integrated Human Resource Health Management Information System to support planning, deployment, monitoring and effective integrated service delivery.									

Pillars	Interventions	Key activities	Expected output	Output indicators	5-year target	Target				
	Develop and implement an integrated training plan, curricula and training resource package for HCPs and community workforce in pre- and in-service education.									
	Institutionalise Continuous Professional Development and digital learning for integrated service delivery through MOH virtual academy.									

Section 5. Comprehensive integrated strategies to achieve each objective

The comprehensive integrated strategies described in Table 13 emphasise a shift from vertical programming toward an integrated and people-centred approach that spans the entire continuum of HIV services. This approach focuses on scaling up evidence-based biomedical, behavioural, and structural interventions while ensuring effective linkage to care, continuity of treatment, viral suppression, and long-term health and wellness. Prevention efforts prioritise the rapid introduction and expansion of emerging technologies such as PrEP, long acting injectables, and HIV self-testing. These efforts are further supported by strengthened programmatic integration with primary health care to improve efficiency, equity, and sustainability, especially in the context of diminishing external financial support.

Implementation is guided by a strong Programme Science approach, with routine embedding of operational research, community-led monitoring, and real-time data analytics to drive continuous learning, resource optimisation, and course correction. Community engagement and accountability are central, with affected populations actively shaping, delivering, and evaluating interventions.

Table 13 provides comprehensive strategies to achieve KAISF objectives in support of Kenya's commitment to end AIDS as a public health threat by 2030, while reinforcing long-term health system resilience and equity.

The following are the key strategic objectives under HIV programming that each county and at the National level will aim to achieve between 2025 and 2030.

	Health System Building Block	Strategic Objectives and Impact Results
1.	Service Delivery	Reduce new HIV infections to less than 1000 new HIV infections in adults (>15 years) and to less than 200 in children (0-14 years) by 2030.
		Reduction of syphilis at ANC to less than 1% by 2030.
		Reduce AIDS-related deaths by 50% by 2030.
		Lower HIV-related stigma, discrimination, and human rights violations to below 10% by 2030.
2.	Leadership and Governance	Strengthen national and county leadership to coordinate HIV programming and ensure accountability for HIV outcomes.
3.	Health Financing	Achieve 100% domestic financing of the HIV response by 2030.
		Improve efficiency and value-for-money in HIV spending through cost-effective models (integration, task-shifting, differentiated care).
4.	Human Resources for Health	Strengthen and retain a skilled HIV workforce through training and mentorship (clinicians, nurses, HTS providers, laboratory staff, community health workers).
5.	Health Information System	Achieve integration of the HIV programme into Kenya's broader health system in 47 counties by 2030.
6.	Health Products and Technologies	Guarantee continuous availability of essential HIV commodities (ARVs, PrEP/PEP, HIV test kits, viral load reagents, STI medications) ensuring early forecasting and procurement.
		Scale up HIV-specific innovations such as HIV self-testing kits, long-acting PrEP, point-of-care viral load testing, and optimized paediatric ARVs.

Table 13. Comprehensive integrated strategies to achieve KAISF objectives

Objective	Strategic focus area	Programme area	Intervention	Comprehensive integrated strategy	Expected results
Reduce new HIV infections to less than 1000 new HIV infections in adults (>15 years) and to less than 200 in children (0–14 years) by 2030.	Optimize prevention programmes targeting populations at high risk of acquiring HIV.	Elimination of mother-to-child transmission of HIV	Accelerate efforts towards elimination of mother-to-child transmission of HIV, syphilis, and hepatitis B.	Implement point-of-care testing for HIV, syphilis, and hepatitis B using a single blood draw. Provide integrated pre-test counselling and initiate combination prevention/therapy immediately. Strengthen the mother-baby pair continuum. Empower Community Health Promoters (CHPs) to offer demand creation for PMTCT, bilateral referrals, adherence monitoring and follow-up. Offer integrated differentiated service delivery models specific for PMTCT mothers (i.e., integrated peer support groups for pregnant and breastfeeding women).	Reduced MTCT rate of HIV, and transmissions for syphilis & hepatitis B
		Key and vulnerable populations	Strengthen HIV prevention among populations with heightened risk.	Integrate HIV prevention services into OPDs and other service delivery points, through trained personnel conducting integrated risk assessments for HIV, TB, STIs, and substance use. Offer integrated KP-friendly services in the same visit.	Reduced HIV infections among populations with heightened risk
		Priority populations	Strengthen HIV prevention among populations with heightened risk.	Offer integrated and comprehensive services for priority populations in the same visit. For AYP, establish integrated youth health services addressing the syndemic of HIV, teenage pregnancies, and SGBV. For mobile populations, embed services into emergency packages and use portable health records.	Reduced HIV infections among populations with heightened risk
		HIV prevention (PEP, PrEP and condoms)	Scale up HIV combination prevention.	Mainstream PEP, PrEP and condom services into emergency departments, primary care, reproductive health services and any other relevant service delivery points with protocols addressing concurrent syndemic risks.	Increased access to integrated HIV combination prevention strategies
		Voluntary Medical Male Circumcision (VMMC)	Prioritise effort of VMMC in priority geographies to 80%.	Embed VMMC within general surgical services. Offer integrated HIV and other related services like comprehensive health education covering HIV prevention, sexual health, screening for NCDs, and linkage to other relevant services for VMMC clients.	Increased access to VMMC and other integrated men's health services for HIV prevention
		Cervical cancer among WLHIV	Optimize screening and management of cervical cancer to 80%.	Integrate cervical cancer screening into not only HIV clinics but also outpatient and emergency departments.	Increased % of WLHIV screened for cervical cancer during routine HIV care visits Reduced proportion of WLHIV with cervical cancer
	Enhance access and efficiency to quality HIV testing.	HIV testing services	Ensure optimal screening and testing of HIV and a sustained achievement of over 95% of the estimated population living with HIV Knowing their status.	Implement integrated testing services across all clinical points using multi-disease algorithms. Use integrated testing platforms for HIV, TB, malaria, etc. Implement integrated community HIV services through outreaches and Community Health Promoters.	Increased proportion of PLHIV identified
	Strengthen targeted public education & advocacy strategies to enhance awareness & knowledge on HIV and related syndemic diseases in schools and community.	Community and school health HIV programmes	Integrate HIV and sexual reproduction health education into school health programmes, and public community education programmes.	Develop integrated health education curricula. Empower CHPs to deliver comprehensive health messages on HIV, STIs, TB, and NCDs during household visits. Use media and social platforms to advocate for integrated HIV and related conditions messaging.	Increased HIV & SRH literacy in schools and communities

Objective	Strategic focus area	Programme area	Intervention	Comprehensive integrated strategy	Expected results
Reduce AIDS-related deaths by 50% by 2030.	Strengthen access to quality, integrated, patient-centred approaches for the care and management of HIV and related diseases.	Ensure 95% ART coverage.	Optimize ART treatment for all subpopulations to improve patient health outcomes.	Strengthen integrated chronic disease clinics managing HIV alongside hypertension, diabetes, and mental health disorders using integrated protocols. Empower CHPs to offer demand creation for ART, bilateral referrals, adherence monitoring, integrated differentiated service delivery and follow-up.	Increased proportion of PLHIV accessing care and treatment services
		Achieve 95% viral load suppression.	Achieve population level sustained viral suppression by strengthening client follow-up and improved adherence monitoring approaches.	Integrate viral load monitoring with management of other chronic conditions through combined follow-up visits and coordinated lab testing. Empower CHPs to trace and monitor suspected treatment failure interrupters in ART treatment (IIT).	Increased proportion of PLHIV with suppressed viral load
	Reduce morbidity and mortality from advanced HIV disease (AHD) and related comorbidities.	Integrated management of HIV co-infections & comorbidities	Strengthen screening and treatment of major HIV-related co-infections and comorbidities.	Implement integrated screening and management protocols across all service points for TB, NCDs, STIs, Hepatitis, and NTDs. Strengthen the hub (Centres of Excellence) and spokes in all the 47 counties.	Increased % of PLHIV accessing integrated screening and management of comorbidities
Achieve 100% integration of the HIV programme into Kenya's broader health system in 47 counties by 2030.	Conduct integrated facility & community-based strategies (including outreaches) for screening & testing, case finding, risk assessment, and access to prevention interventions for HIV and related syndemic diseases.	Integration of HIV in the community strategy	Expand the scope of primary care givers to cover HIV.	Expand the scope of CHPs to provide integrated syndemic services during household visits, including combined screening for HIV, TB, malaria, NCDs.	Increased proportion of Community Health Promoters (CHPs) offering integrated HIV and syndemic services.
		Minimise treatment interruption to <5%.	Enhance community strategies for defaulter tracing, adherence enhancement and treatment support.	Deploy CHPs to conduct integrated defaulter tracing for HIV/TB/NCDs and provide adherence support for multiple conditions.	Reduced treatment interruption rates.
		Achieve 90% TB/HIV/NCDs/STIs/Hepatitis/NTDs service integration.	Strengthen screening and management of TB/HIV/NCDs/STIs/Hepatitis/NTDs and comorbidities among PLHIV.	Implement integrated screening and management protocols across all service delivery points. Empower healthcare workers to conduct comprehensive assessments identifying multiple conditions simultaneously.	Increased proportion of health facilities implementing integrated screening and management protocols for co-infections and comorbidities
Reduce syphilis at ANC to less than 1% by 2030	Reinvigorate and scale up prevention, management and control of STIs and viral hepatitis (VH).	STIs & viral hepatitis	Scale up targeted prevention and management of STIs and VH.	Implement integrated screening for STIs/viral hepatitis at all points using shared platforms. Provide standardised treatment and link to chronic care. Strengthen prevention through condoms, vaccination, and integrated counselling through facility and community channels.	Increased optimisation on effective prevention, control, and management of STIs and viral hepatitis

Objective	Strategic focus area	Programme area	Intervention	Comprehensive integrated strategy	Expected results
Reduce HIV-related stigma, discrimination and other human rights violations, including violence that is not SGBV, to less than 10% by 2030.	Implement inclusive anti-stigma campaigns to promote awareness of syndemic diseases and foster a supportive environment, free from discrimination.	Stigma in health care settings/community & institutions	Institutionalise progress monitoring of HIV-related stigma and discrimination and other health and human rights violations.	Develop comprehensive anti-stigma programmes addressing discrimination based on HIV status alongside stigma related to TB, mental health, and other chronic diseases.	Reduced stigma index
	Strengthen integrated gender-based violence (GBV) response mechanisms to ensure coordinated prevention, timely identification, and comprehensive care for survivors.	Violence prevention in all populations	Promote gender equality and address all forms of violence.	Strengthen violence prevention and response mechanisms within health and community systems with survivor-centred care. Integrate GBV risk assessment and response into multiple service points (maternal health, OPDs). Establish referral pathways to integrated support services. All children (0–14) should be classified to be having AHD, to allow proper management and follow up.	Increased access coverage for the provision of integrated GBV services Reduced violence among all populations

Contributors

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