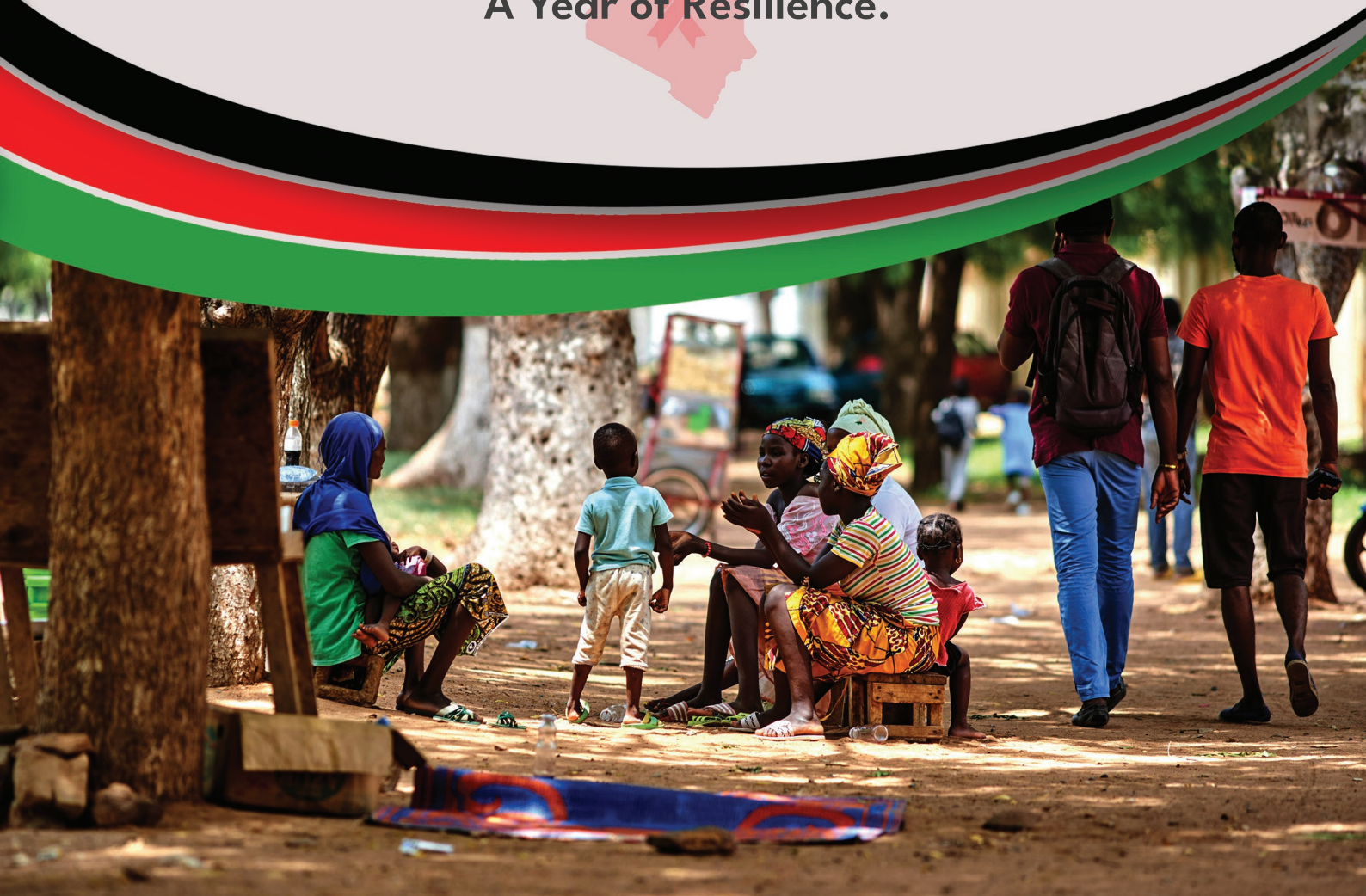
REPUBLIC OF KENYA

NATIONAL SYNDEMIC DISEASES CONTROL COUNCIL

KENYA AIDS RESPONSE PROGRESS

REPORT 2025

A Year of Resilience.



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Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ASAL	Arid and Semi-Arid Lands
BBS	Bio-Behavioral Survey
CARG	Community ART Group
CPM	Community Pharmacy Model
DSD	Differentiated Service Delivery
eMTCT	Elimination of Mother-to-Child Transmission
EMR	Electronic Medical Record
FSW	Female Sex Worker
FY	Financial Year
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
IIT	Interruption in Treatment
KAISF	Kenya AIDS Integrated Strategic Framework
KASF II	Kenya AIDS Strategic Framework II (2020/21–2024/25)
KES	Kenya Shilling
MAT	Medically Assisted Therapy
MOH	Ministry of Health
MSM	Men Who Have Sex with Men
MTCT	Mother-to-Child Transmission
NASCOP	National AIDS and STI Control Programme
NASA	National AIDS Spending Assessment
NCD	Non-Communicable Disease
NEPHAK	National Empowerment Network of People Living with HIV and AIDS in Kenya
NSP	Needle and Syringe Program
NSDCC	National Syndemic Diseases Control Council
OST	Opioid Substitution Therapy
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
RoC	Recipients of Care
SGBV	Sexual and Gender-Based Violence
STI	Sexually Transmitted Infection
TB	Tuberculosis
TG	Transgender
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
U=U	Undetectable Equals Untransmitable
VL	Viral Load
WHO	World Health Organization
WLHIV	Women Living with HIV

A Year of Resilience

> *Kenya's resilience lies in its ability to integrate, innovate, and sustain progress through evidence-driven leadership and inclusive health systems*

Kenya's HIV response continues to stand as a model of resilience, innovation, and leadership amid a changing public health and financing landscape. Over the past year, the country has sustained impressive progress in expanding access to HIV prevention, treatment, and care, while navigating the complex transition toward an integrated and domestically financed response that leaves no one behind.

In 2024, Kenya's HIV prevalence stood at 3.0 percent, with a higher burden among females (4.0 percent) compared to males (2.0 percent). There were an estimated 1,326,336 people are living with HIV, including 62,798 children and 132,018 young adults aged 15–24 years in the same year. Encouragingly, overall new HIV infections declined by 51.7 percent, from 41,416 in 2019 to 19,991 in 2024, while infections among adolescents and young people dropped by 56% percent during the same period. These gains reflect the sustained impact of programmatic investments in prevention, elimination of mother-to-child transmission, treatment scale up and youth-focused interventions

Even so, important challenges remain. AIDS-related deaths, recorded at 21,007 in 2024, remind us of the need for renewed focus on early diagnosis, treatment adherence, and retention in care. The mother-to-child transmission rate, though reduced from 10.8 percent in 2019 to 9.3 percent in 2024, remains above the global target of below five percent. Gaps in ART continuity particularly among men and children together with the rising burden of comorbidities such as non-communicable diseases, tuberculosis, malaria, and hepatitis, continue to test the strength of our response.

The 2025 Rapid Results Initiative (RRI) further illuminated Kenya's ability to adapt under pressure. Findings from 1,600 health facilities revealed that despite donor funding uncertainties, 99.8 percent of facilities sustained HIV service delivery through integration and task-shifting approaches, with 39.5 percent achieving full integration of HIV, TB, malaria, and family planning services into general outpatient departments. However, there is need for stronger supply chain to secure essential HIV test kits and ART and guard the country against commodity stockouts, underscoring the need for stronger supply chain resilience and county buffer systems. Facilities with integrated service delivery models and adequately

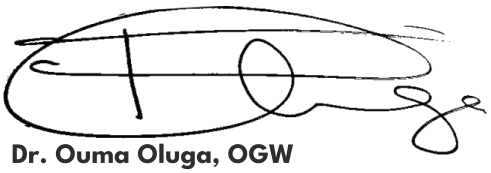
trained staff were 38 percent less likely to experience service disruptions, highlighting the pivotal role of human resources, digital systems, and joint planning in sustaining health system performance.

The report points to important shifts in the prevention landscape. Condom distribution declined significantly between 2019 and 2024, reflecting persistent supply and demand challenges. In 2024, only 35.9 million condoms were distributed nationally, meeting just 7 percent of the total annual requirement of 489 million, with high-burden counties such as Nairobi, Kisumu, and Homa Bay accounting for over 40 percent of total distribution. Meanwhile, PrEP initiation increased by 8 percent, and HPV vaccination uptake rose sharply, signaling advances in biomedical and integrated prevention. Kenya has also made notable progress in pharmacovigilance, the adoption of multi-disease diagnostic platforms, and early efforts toward local manufacturing of antiretrovirals, PrEP, and diagnostics critical steps toward long-term sustainability and health product security.

Despite these challenges, Kenya's determination to end AIDS as a public health threat by 2030 remains unwavering. Guided by the Kenya AIDS Strategic Framework II (KASF II) and now transitioning to the Kenya AIDS Integration Strategic Framework (KAISF 2025–2030), the country continues to align its HIV response with ongoing Universal Health Coverage (UHC) reforms. This integrated approach draws on the lessons of the HIV response to strengthen health systems more broadly, ensuring access, equity, and sustainability across all levels of care.

On behalf of the Ministry of Health, I commend our partners across government, civil society, and development sectors for their steadfast collaboration and leadership. Your commitment, innovation, and resilience have ensured that Kenya's HIV response remains adaptive, data-driven, and grounded in the strength of communities.

As we reflect on the year of resilience, this report stands as both a record of progress and a call to collective action. We must close the remaining gaps, deepen domestic ownership, and protect the gains that define Kenya's leadership in the global HIV response. Together, we will continue advancing toward a Kenya where every person can live healthy, free from new HIV infections, stigma, and inequality.



Dr. Ouma Oluga, OGW
Principal Secretary,
State Department for Medical Services, Ministry of Health
Republic of Kenya

Preface

Kenya's multi-sectoral approach to the HIV response stands as a beacon of what can be achieved when government, communities, and partners unite behind a shared vision. This collaborative effort has rekindled hope among individuals and families once burdened by the epidemic and revitalized communities that had been strained by the social and economic challenges of HIV and AIDS

Over the past decade, we have witnessed remarkable gains- a steady decline in new HIV infections, increased access to life-saving treatment, and improved quality of life for people living with HIV. These milestones reflect our nation's unwavering resolve to overcome one of the greatest public health challenges of our time. They also underscore the strength of our health systems, the dedication of our frontline workers, and the resilience of our communities.

The 2025 Progress Report captures these achievements, highlights lessons learned and identifies opportunities for continued improvement. It reminds us that while much has been accomplished, the journey is not yet complete. We must sustain the momentum by investing in innovations, strengthening community-led responses, and ensuring equitable access to services for all, especially the most vulnerable populations.

As we look ahead, our collective commitment must remain focused on closing the remaining gaps in financing, governance, human resources, service delivery, health products, and health systems. A fully funded and sustainable HIV response is essential to achieving our national and global goal of ending AIDS as a public health threat by 2030. Together, we can build a future where every Kenyan enjoys the right to health, dignity, and well-being.

Hon. Ahmed Ibrahim Abass
Board Chairperson,
National Syndemic Diseases Control Council

> *Over the past decade, we have witnessed remarkable gains more so a steady decline in new infections, increased access to life-saving treatment, and improved quality of life for people living with HIV.*

Letter of Appreciation

Douglas Bosire
Ag. Chief Executive Officer
National Syndemic Diseases Control Council

Dr Andrew Mulwa
Head, National AIDS and STI Control Programme
Ministry of Health, Kenya

On behalf of the National Syndemic Diseases Control Council (NSDCC) and the National AIDS and STI Control Programme (NASCOP), we take this opportunity to express our profound appreciation to all partners, stakeholders, and communities who have contributed to the development of the Kenya AIDS Response Progress Report 2025.

Kenya's HIV response continues to register significant progress, reflecting the strength of our partnerships and the resilience of our health systems. In 2024, an estimated 1,326,336 people were living with HIV (PLHIV). Of these, 97% knew their HIV status, 87% were receiving treatment, and 83% had achieved viral suppression. These achievements stand as a testament

"We extend our heartfelt gratitude to County Governments, Ministries, Departments and Agencies (MDAs), implementing partners, bilateral and multilateral agencies, and community-based organizations for their unwavering collaboration in advancing the national response."

to the dedication of our frontline health workers, community networks, and development partners who continue to champion the goal of ending AIDS as a public health threat.

This progress builds upon more than three decades of partnership and innovation, anchored on community-led models that place people at the center of the response. The 2025 World AIDS Day theme, "End AIDS in Adolescents and Young People," is a call to renew our collective focus on protecting and empowering the next generation. Adolescents and youth remain a vital part of the HIV response both as beneficiaries and leaders, driving innovation, equity, and sustainability.

We extend our heartfelt gratitude to County Governments, Ministries, Departments and Agencies (MDAs), implementing partners, bilateral and multilateral agencies, and community-based organizations for their unwavering collaboration in advancing the national response.

Special recognition goes to people living with HIV, under the leadership of the National Empowerment Network of People Living with HIV and AIDS in Kenya (NEPHAK), for their tireless advocacy in promoting access to care and combating stigma and discrimination.

We also acknowledge the invaluable contribution of the Multisectoral Strategic Information Committee, supported by the Clinton Health Access Initiative (CHAI), the Bill & Melinda Gates Foundation (through the University of Manitoba), and UNAIDS, whose technical support has been instrumental in producing this report.

Finally, we extend our appreciation to the dedicated teams from NSDCC, NASCOP, and County Governments, whose coordinated efforts under the leadership of Dr. Murugi Micheni ensured the successful completion of this report.

As we look toward the future, we reaffirm our shared commitment to sustaining the gains made, addressing remaining gaps, and ensuring that every Kenyan especially adolescents and young people have access to the services, rights, and opportunities needed to live healthy and productive lives.

Executive Summary

Indicator	Segregation	Progress	Towards Target
HIV Prevalence	Overall	**3.03%** Performance 2025	
	Female	**4.04%** Performance 2025	
	Male	**1.95%** Performance 2025	
Incidence per 1,000	Adults (15-49)	**1.2%** Performance 2019 **0.59%** Performance 2023 **0.5%** Performance 2025	Reduced by **0.7%**
New HIV Infections	Overall	**41,416** Baseline 2019 **22,154** Performance 2023 **19,991** Performance 2025 **10,354** Target 2025	Reduced by **52%**
	Children (0 – 14 years)	**6,806** Baseline 2019 **4,474** Performance 2023 **4,349** Performance 2025 **1,702** Target 2025	Reduced by **36%**
	Adolescents (10 – 19 years)	**6,166** Baseline 2019 **3,244** Performance 2023 **2,799** Performance 2025 **1,542** Target 2025	Reduced by **55%**

Indicator	Segregation	Progress	Towards Target
	Young Adults (15 – 24 years)	**14,410** Baseline 2019 **7,307** Performance 2023 **6,362** Performance 2025 **3,603** Target 2025	Reduced by **56%**
	Adults (15+ years)	**34,610** Baseline 2019 **17,680** Performance 2023 **15,641** Performance 2025 **8,653** Target 2025	Reduced by **55%**
	MTCT Rate	**10.8%** Baseline 2019 **8.6%** Performance 2023 **9.3%** Performance 2025 **5%** Target 2025	Minimal decline by **14%**
People living with HIV	Overall	**1,326,336** Performance 2025	
	Children (0-14 years)	**62,798** Performance 2025	
	Adolescents (10 – 19 years)	**80,252** Performance 2025	
	Children on ART	**68%** Baseline 2019 **85%** Performance 2023	Increased by **8%**

Indicator	Segregation	Progress	Towards Target
		75% Performance 2025 **95%** Target 2025	Missed Target
	Adults On ART	**77%** Baseline 2019 **94%** Performance 2023 **88%** Performance 2025 **95%** Target 2025	Missed Target
	PMTCT Coverage	**94%** Baseline 2019 **90%** Performance 2023 **90%** Performance 2024 **95%** Target 2025	Missed Target
HIV Related Deaths 	Overall	**20,997** Baseline 2019 **18,473** Performance 2023 **21,007** Performance 2025 **10,499** Target 2025	Increased by **0.05%** 
	Children (0-14)	**4,333** Baseline 2019 **2,304** Performance 2023	Increased by **38%** 

Indicator	Segregation	Progress	Towards Target
	 Children (0-14)	**2,685** Performance2025 **2,167** Target 2025	Reduced by **38%**
	 Adolescents (10 – 19 years)	**2,275** Baseline 2019 **1,215** Performance 2023 **1,165** Performance 2025 **1,138** Target 2025	Reduced by **49%**
	 Young Adults (15 – 24 years)	**2,621** Baseline 2019 **2,225** Performance 2023 **1,974** Performance 2025 **1,311** Target 2025	Reduced by **23%**

United in purpose, young people are leading the change to create safer, healthier communities free from HIV, unintended pregnancies, and gender-based violence.

Overview

The Kenya AIDS Response Progress Report 2025 summarizes the country's performance against key HIV indicators under KASF II, illustrating progress made towards the 2025 targets while highlighting areas that require accelerated action to sustain gains and address remaining gaps, as shown in Table 2 below.

Performance against KASF II Objectives

	2019	2024	Performance
Objective 1: Reduce new HIV infections by 75%	**41,416**	**19,991**	**Reduction by 52%**
Objective 2: Reduce AIDS – related mortality by 50%	**20,997**	**21,007**	**No reduction**
Objective 3: Micro – eliminate viral hepatitis and reduce the incidence of sexually transmitted infections	**Hepatitis B – 3.9%** **Hepatitis C – 2.6%**	**Hepatitis B-2.3%** **Hepatitis C-1.5%**	**Positivity reduced but remains above 1%**
Objective 4: Reduce HIV related stigma and discrimination to less than 25%	**2014**	**23.9% among women** **16.9 among men**	**Stigma and discrimination declined to 23%**
Objective 5: Increase domestic financing for HIV response to 50%	**32%**	**34%**	**Increase by 2%**

Source: NSDCC, Kenya HIV Estimates Report, 2025, MoH, Kenya Health Information System, KNBS, Kenya Demographic and Health Survey, NSDCC, National AIDS Spending Assessment, 2022.

In 2024 the national HIV prevalence stood at 3.0 percent, with higher rates among females (4.0%) compared to males (2.0%). Despite notable progress in prevention and treatment, an estimated 19,991 new HIV infections and 21,007 AIDS-related deaths were recorded in 2024, highlighting ongoing programmatic and structural gaps. The epidemic remains unevenly distributed across the country, with seven Counties **Nairobi, Kisumu, Homa Bay, Migori, Siaya, Kiambu, and Mombasa** accounting for 50 percent of all people living with HIV. These patterns underscore persistent regional disparities and the continued need for differentiated county-led interventions to achieve equitable epidemic control.

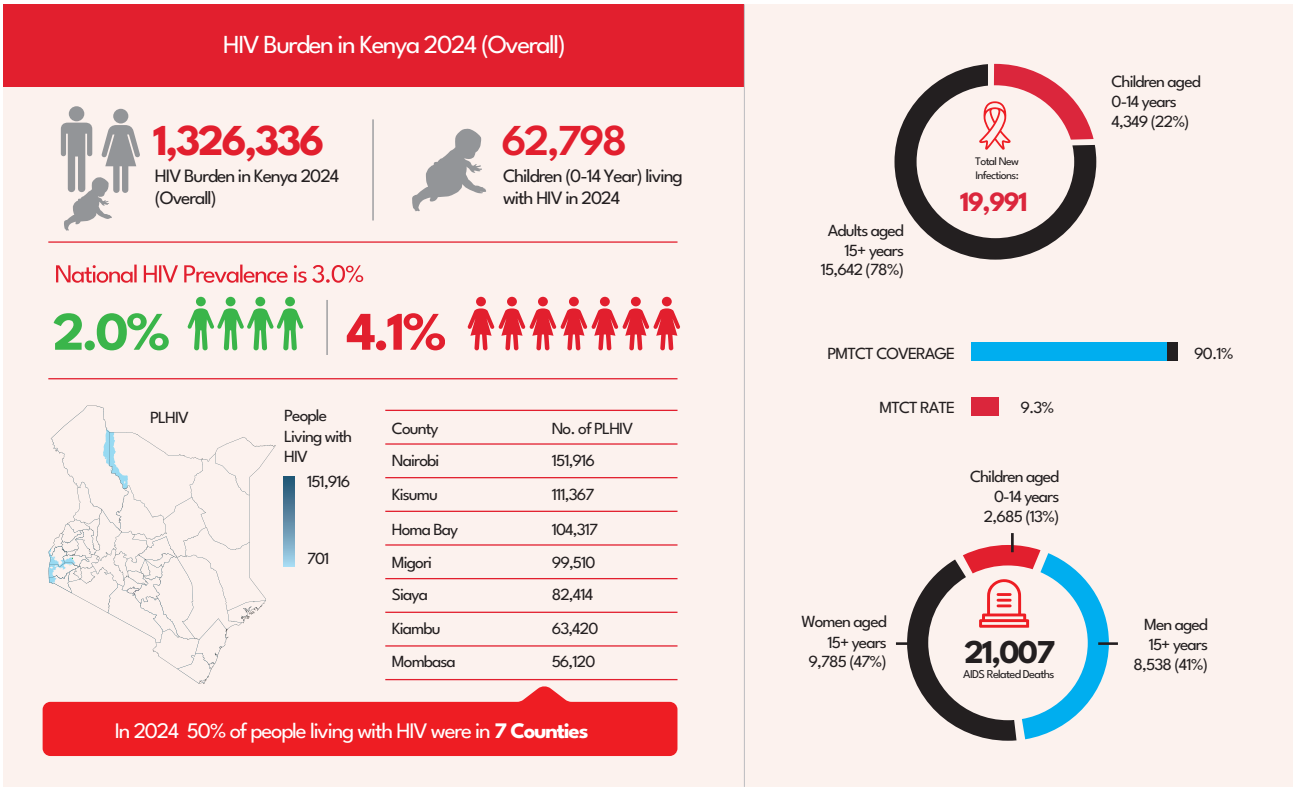
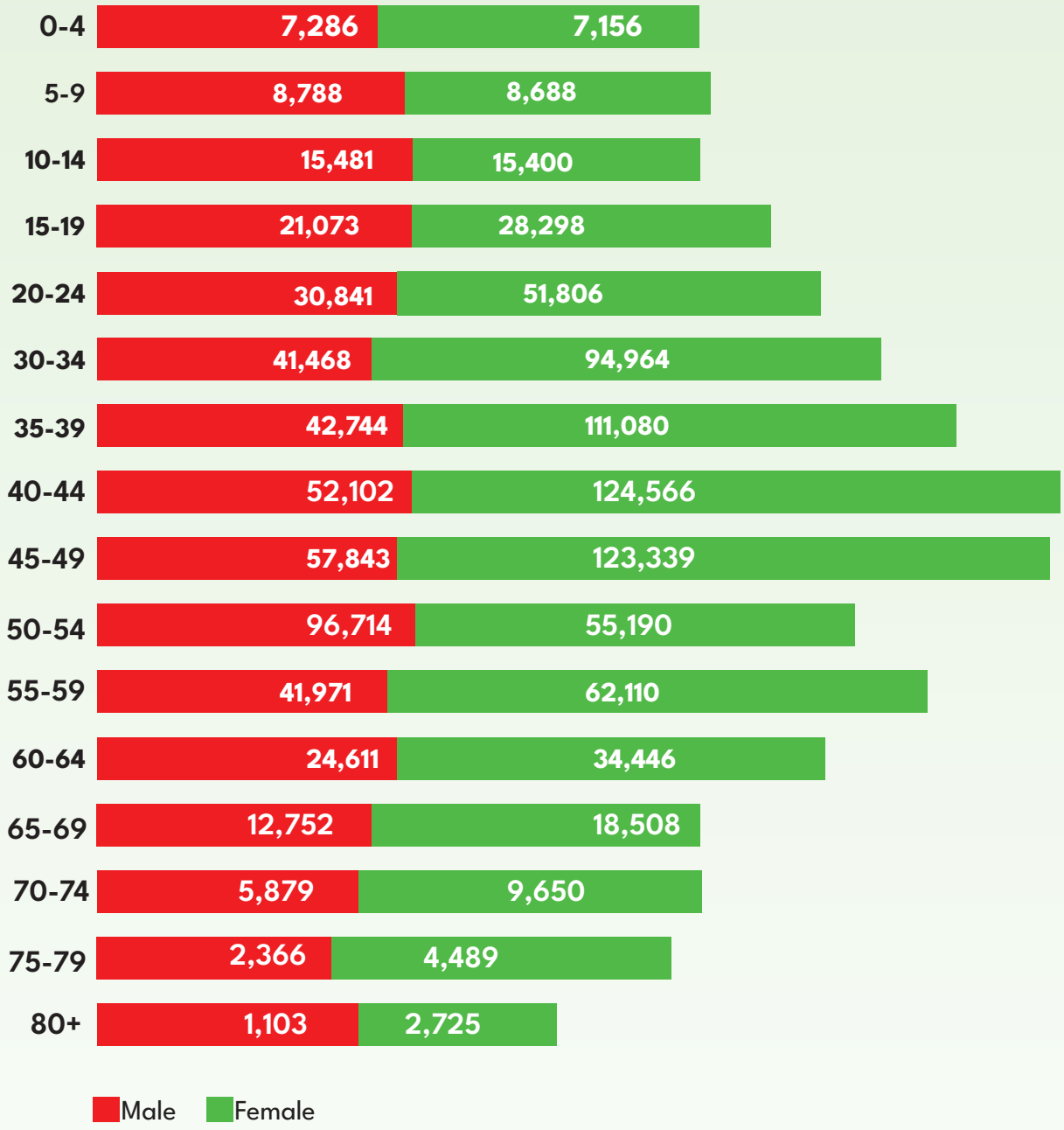


Figure 1: Status of the HIV Epidemic
Source: NSDCC, Kenya HIV Estimates Report, 2025

Kenya continues to face a substantial HIV burden, with an estimated 1,326,336 people living with HIV as of 2024, the majority being adults aged 15 years and above (1,263,538), while children aged 0–14 years account for 62,798 of the total.

> *Females accounted for 65% of all people living with HIV in 2024, and 63% of these women approximately six in every ten were aged between 30 and 54 years.*

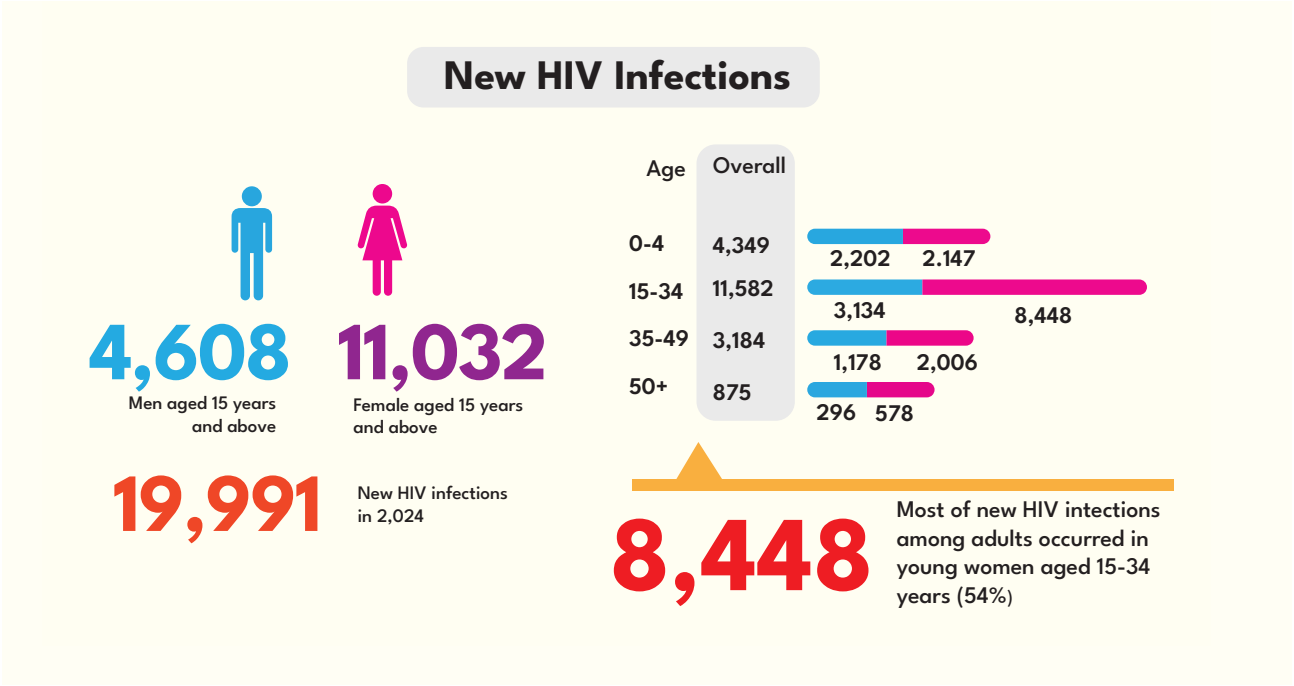
Estimated People living with HIV by sex and age, 2024



1.1 New HIV Infections

The 2024 distribution of new HIV infections reveals persistent age and gender disparities, with adolescent girls and young women remaining disproportionately affected, underscoring the need for sustained and targeted prevention efforts. Overall, new HIV infections declined by 52% between 2019 (41,416) and 2024 (19,991). However, the past year recorded a 19% increase, with new infections rising from 16,752 in 2023 to 19,991 in 2024. Children remain particularly vulnerable, accounting for 22% of all new HIV infections, an indication of the urgent need to strengthen the prevention of mother-to-child transmission (PMTCT) program. These trends call for intensified, age- and gender-responsive HIV prevention interventions to sustain progress and close emerging gaps.

> *Females continue to bear the greatest burden, representing 66% of new infections.*



Adolescents and young people aged 10–24 years accounted for 32% of all new HIV infections, with adolescent girls and young women comprising 8 out of every 10 new cases in this age group

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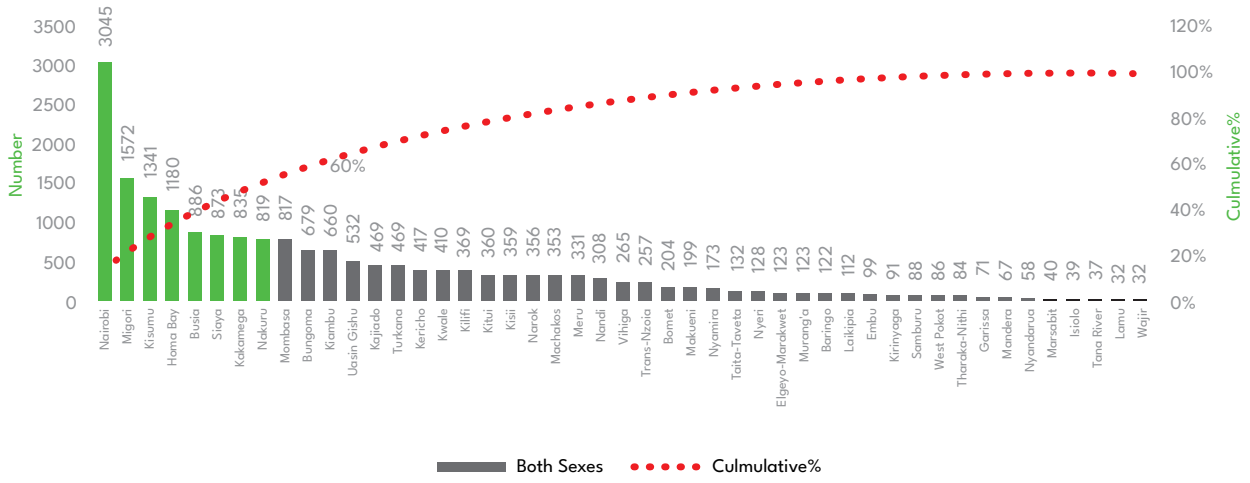
New HIV infection and geographies

Ten (10) counties, Nairobi, Migori, Kisumu, Homa Bay, Busia, Siaya, Kakamega, Nakuru, Mombasa, and Bungoma, accounted for 60% of all new HIV infections in 2024, underscoring the concentration of the epidemic in specific geographic areas.

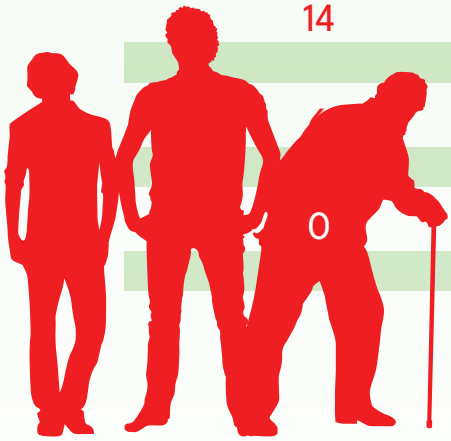
New HIV infections increased in 28 counties, signaling rising transmission likely driven by localized behavioral, structural, and service delivery gaps. Six counties recorded modest declines of less than 15%, while twelve counties achieved reductions exceeding 15%, and Garissa County reported no change. These disparities illustrate uneven progress in HIV prevention and control efforts across subnational levels.

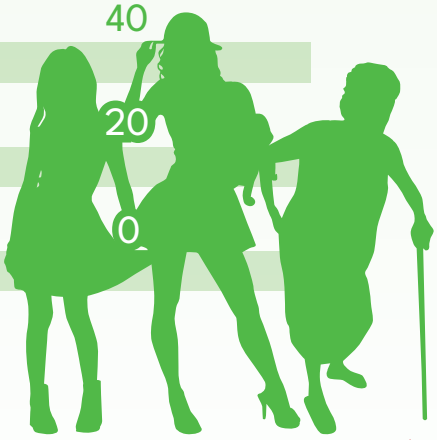


In a space led by courage and community, leaders and partners listen, learn, and celebrate the power of women who are redefining health responses through lived experience and collective action.

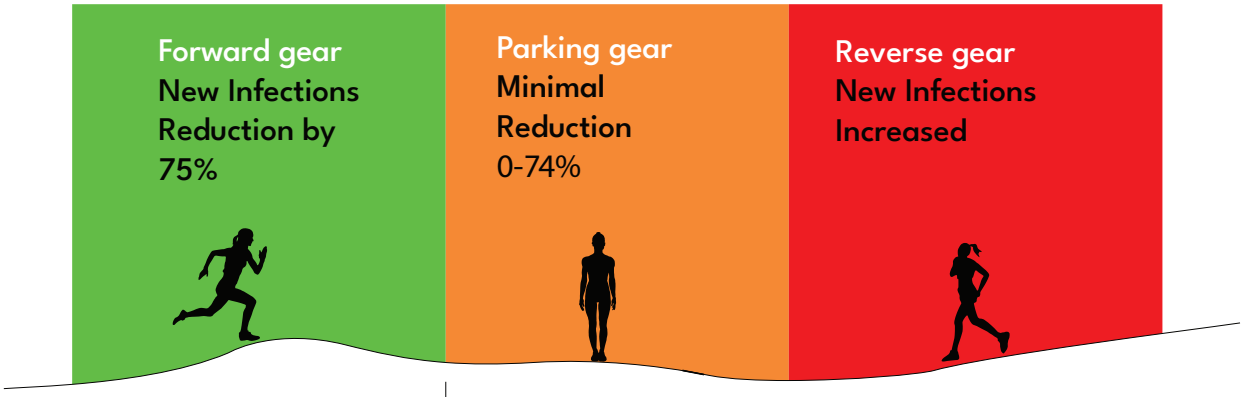
New HIV Infections by age and sex, 2024

Male	AGE & TOTALS	Female
2,202	0-14	2,147
	Total 4,349	
303	15-19	2,496
	Total 2,799	
999	20-24	2,564
	Total 3,563	
1,029	25-29	1,964
	Total 2,993	
803	30-34	1,424
	Total 2,227	
572	35-39	1,003
	Total 1,575	
377	40-44	637
	Total 1,014	
229	45-49	366
	Total 595	
130	50-54	213
	Total 343	
76	55-59	144
	Total 220	
44	60-64	97
	Total 141	
26	65-69	40
	Total 90	
14	70-74	40
	Total 54	
	75-79	20
	Total 27	
0	80+	0
	Total 0	





Change in new HIV infections by county 2024



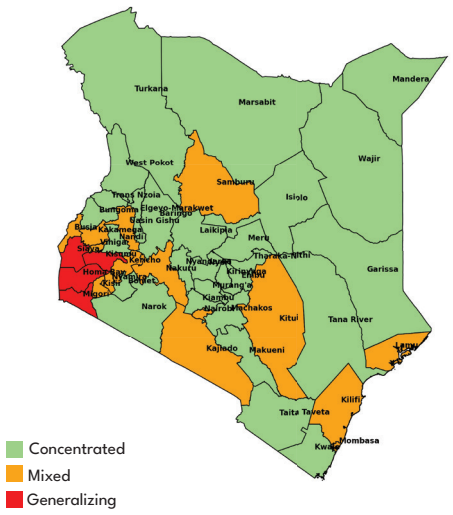
Elgeyo-Marakwet	Garissa	Nairobi
Wajir	Nandi	Vihiga
Mandera	Nyamira	Bungoma
Kisii	Samburu	Taita-Taveta
Machakos	Narok	Lamu
Kericho	Kilifi	Busia
Uasin Gishu	Kajiado	Isiolo
Nakuru		Kiambu
Bomet		Turkana
Baringo		Migori
Trans-Nzoia		Kirinyaga
Laikipia		Nyeri
		Murang'a
		Kwale
		Kakamega
		Nyandarua
		Tana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

Shifts in epidemic typology

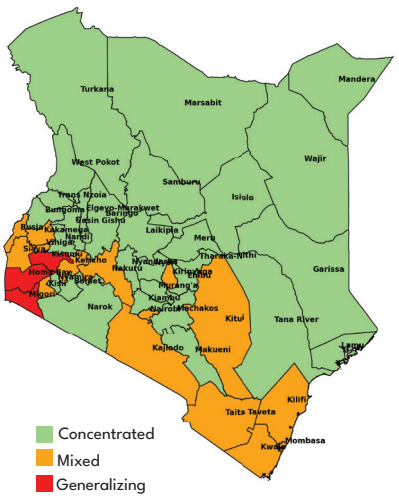
Epidemic typology classification is an important metric in defining geographies, populations, and programmes to be prioritized for an effective HIV prevention response. The epidemic typology across counties has shifted between 2022 and 2024. In 2022, four counties were classified as having a generalizing epidemic, 18 had a mixed epidemic, and 27 had a concentrated epidemic. By 2024, this distribution had changed to three counties with a generalizing epidemic, 14 with a mixed epidemic, and 30 with a concentrated epidemic. These shifts underscore the dynamic nature of Kenya's HIV epidemic and the critical need for counties to align their planning, resource allocation, and interventions with their evolving epidemic typologies.

> *Siaya County transitioned from a generalizing to a mixed epidemic, while Kirinyaga and Kwale Counties shifted from a concentrated to a mixed typology.*

Kenya County Typology 2022



Kenya County Typology 2024



Typology definations

Concentrated epidemics are those where ongoing transmission is within subpopulations at higher risk due to sexual practices or needlesharing networks.

Mixed epidemics occur when there is a substantial contribution from the general population's sexual behaviour patterns and defined subpopulations at risk due to shared networks of higher risk practices.

Generalising epidemics occur where HIV transmission is mainly sustained by high-risk sexual behaviour in the general population, without any substantial contribution by defined subpopulations at risk.

1.2 AIDS-Related Deaths

AIDS remains a major developmental and public health challenge, affecting the socio-economic and cultural fabric of society. The epidemic has significantly influenced Kenya's demographic composition and disrupted the country's social and economic structures, with its impact reflected in reduced life expectancy, increased infant and adult mortality, and a widening dependency ratio. In the last two years, AIDS related deaths increased by 3% from 20,480 recorded in 2023 to 21,007 in 2024.

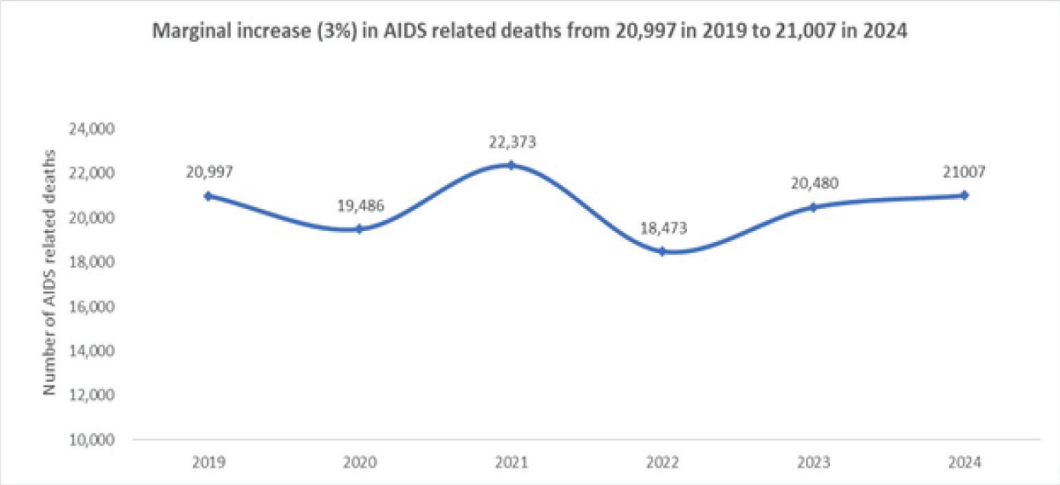


Figure 7: Trends in AIDS Related Deaths (2019–2024)
Source: NSDCC, Kenya HIV Estimates Reports.

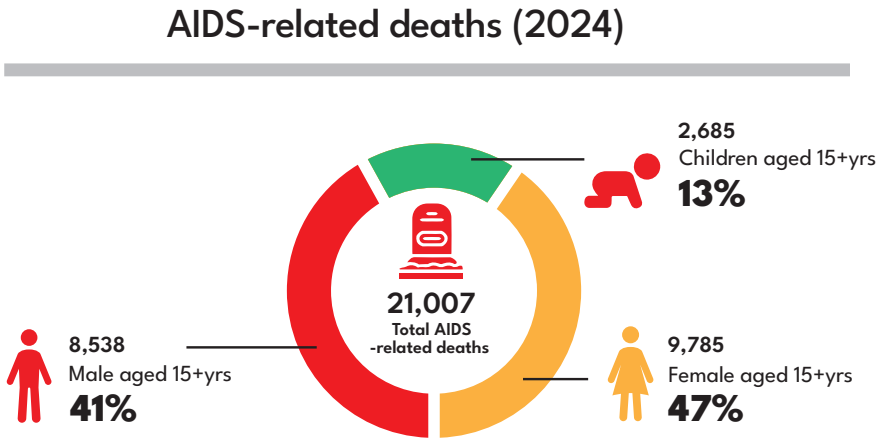
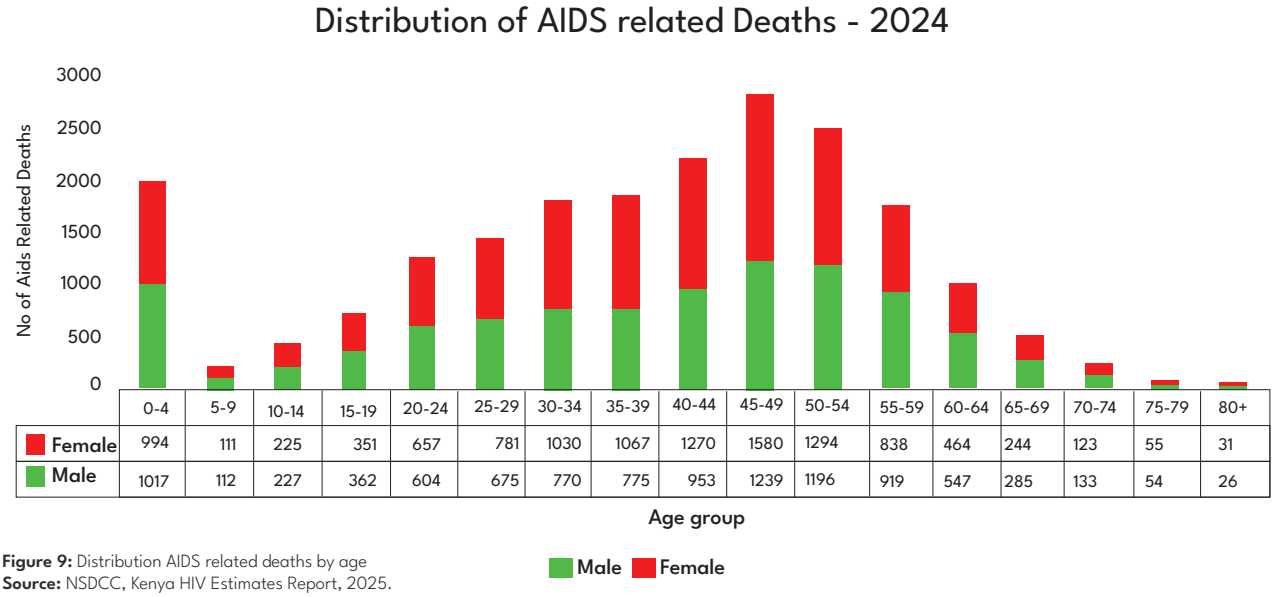


Figure 8: AIDS related deaths in Kenya
Source: NSDCC, Kenya HIV Estimates Report, 2025.

Among women, deaths were disproportionately more among those of reproductive age group of 15 to 49 who accounted for 61% of all AIDS related deaths among females in 2024. It is noted that 16% of all AIDS-related deaths (3,398 cases) occurred among children and adolescents aged 0 to 19 years, underscoring the vulnerability of this young population to the disease.

While men and boys account for 35% of all people living with HIV, close to half (47%) of all AIDS- related deaths occurred among men in 2024 attributed to late identification and poor treatment outcomes



	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+
Female	994	111	225	351	657	781	1030	1067	1270	1580	1294	838	464	244	123	55	31
Male	1017	112	227	362	604	675	770	775	953	1239	1196	919	547	285	133	54	26

Figure 9: Distribution AIDS related deaths by age
Source: NSDCC, Kenya HIV Estimates Report, 2025.

Of the 3,398 AIDS-related deaths reported among children and adolescents aged 0–19 years, 59% (2,011) occurred among those aged 0–4 years. Further, data indicate that half of all children were diagnosed outside the PMTCT window, significantly increasing the risk of mortality.

AIDS Related Death by Geography

In 2024 more than half of the age-specific AIDS deaths occurred in 10 counties (Nakuru, Nairobi, Kisumu, Homabay, Migori, Uasin Gishu, Mombasa, Siaya, Kajiado and Kiambu)

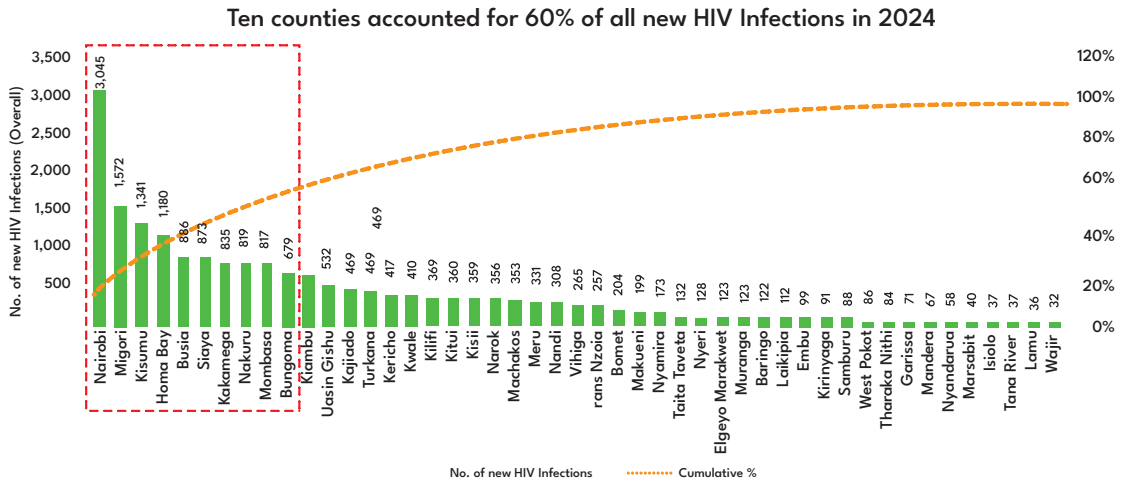
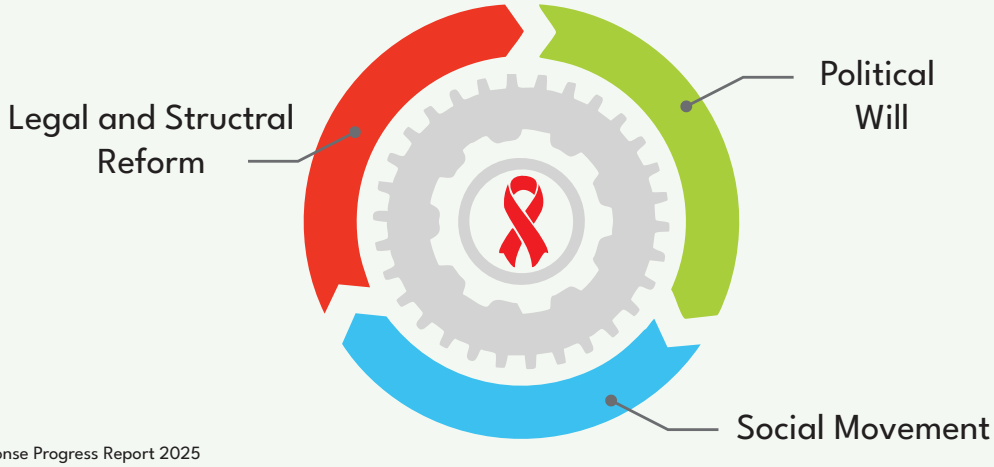


Figure 10: Distribution of AIDS related deaths by County
Source: NSDCC, Kenya HIV Estimates Report, 2025.

Prevention Options



1.3. HIV Prevention Interventions

Kenya's HIV prevention program in 2024 continued to focus on expanding coverage among key and priority populations while addressing emerging gaps in prevention uptake.

- **Pre-Exposure Prophylaxis (PrEP):** PrEP initiation among eligible populations increased 9-fold in the last 5 years from 18,381 in 2019 to 161,508. However, 58% of new initiations were from the general population rather than key or priority populations, indicating the need for more targeted outreach.
- **Voluntary Medical Male Circumcision (VMMC):** Uptake declined by 69% from 196,580 in 2019 to 61,360 in 2024, largely due to reductions in donor funding for VMMC activities.
- **Condom Distribution:** Condom distribution remained a cornerstone of HIV prevention in 2024, with approximately 35.9 million condoms distributed nationally with steady uptake reported in high-burden counties. Community-based and key population programs contributed nearly 60% of all distributions reflecting ongoing efforts to expand access through targeted outreach and integration with key population programs.

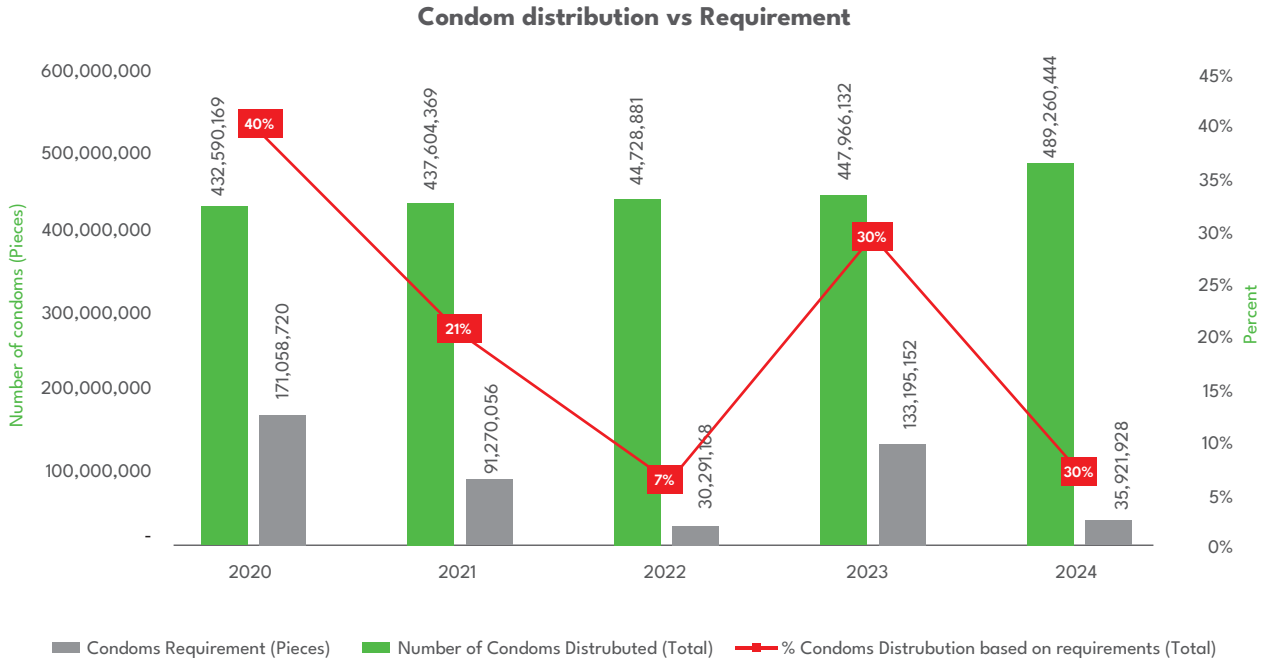


Figure 11: Gap between Condom Distribution and National Requirement (2020-2024)
Source: NASCOP and MoH, National Quantification report for HIV Commodities Reports, NSDCC and NASCOP, Kenya's Operational Plan for Enhancing Country Readiness to Sustain a Resilient HIV Response Beyond 2030, 2025.

- **Needle and Syringe Program (NSP) and Opioid Substitution Therapy (OST):** Distribution increased by 15% between 2023 and 2024. However, the number of PWID enrolled in Medically Assisted Therapy (MAT) decreased by 37%, raising concerns about continuity of harm reduction services.

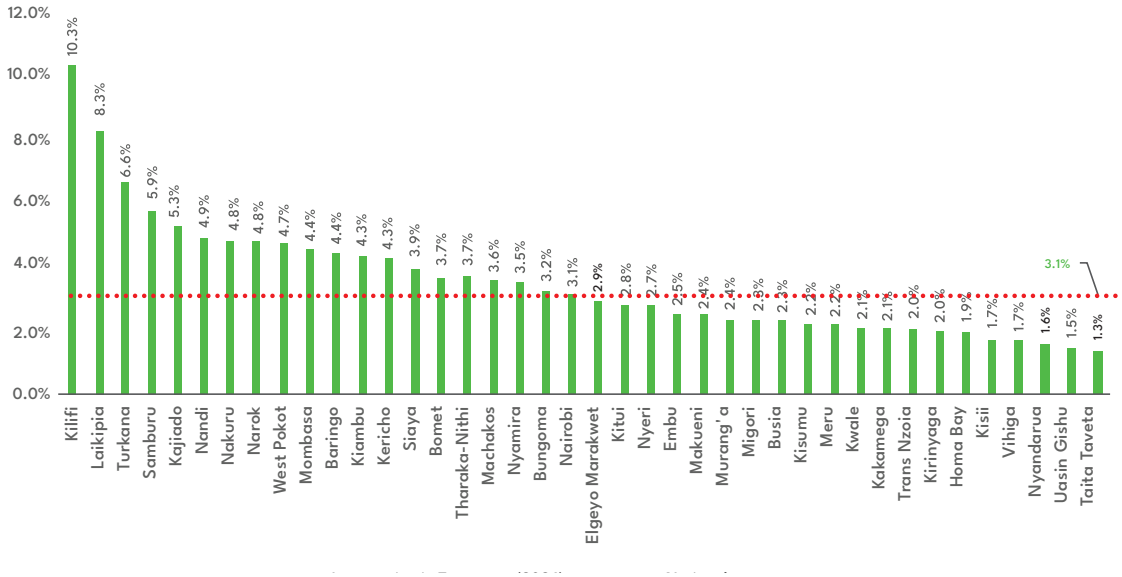
These findings underscore the need to sustain combination prevention programs, strengthen domestic financing, and address service disruptions caused by declining donor support.

1.4 Care and Treatment Program

Kenya continues to make progress in HIV testing, though challenges persist in treatment continuity and viral suppression.

- Knowledge of HIV Status: Increased from 93% in 2019 to 97% in 2024, reflecting successful testing strategies.
- Antiretroviral Therapy (ART) Coverage: Increased from 77% in 2019 to 87.7% in 2024 although missing the 95% target. Minimal gains recorded among children (75.1%, up from 73%).
- Viral Suppression: Decreased from 85% in 2019 to 83% in 2024, indicating challenges in adherence and treatment retention.

In 2024, approximately 3% of PLHIV on treatment experienced interruption in treatment, with the highest rates among men. Kilifi and Laikipia Counties reported the highest interruption rate at 10.3% and 8.3% respectively. Additionally, 16% of PLHIV presented with advanced HIV disease, emphasizing the need for earlier diagnosis and consistent treatment adherence.



1.5 HIV Comorbidities

HIV comorbidities are medical conditions that occur alongside HIV infection, resulting from the virus, long-term antiretroviral therapy (ART) use, or shared risk factors. These comorbid conditions increase the complexity of care or may worsen health outcomes if not properly managed. Common HIV comorbidities include tuberculosis (TB), Hepatitis B and C, sexually transmitted infections (STIs), non-communicable diseases (NCDs) such as hypertension, diabetes, and cardiovascular diseases, as well as mental health disorders like depression and anxiety. Addressing these comorbidities through integrated approaches is essential to improve the quality of life and treatment outcomes for people living with HIV.

> *People living with HIV are at greater risk than the general population for co-morbidities including non-communicable diseases such as hypertension, cardiovascular disease and diabetes- resulting in poorer health outcomes and increased costs for health systems*

Non-Communicable Diseases

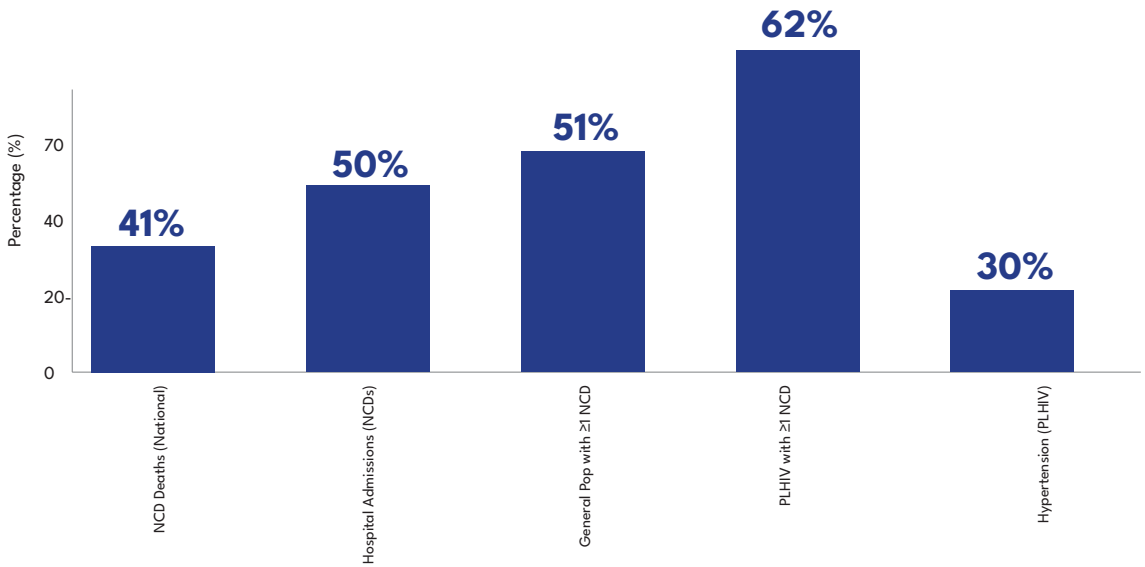
In Kenya, the growing burden of HIV comorbidities particularly non-communicable diseases (NCDs) such as hypertension, diabetes, cardiovascular diseases, cancers, and mental health disorders poses a serious threat to sustaining HIV treatment gains and achieving elimination goals. NCDs account for about 41% of all deaths and over half of hospital admissions nationally, while 62% of people living with HIV (PLHIV) have at least one NCD compared to 51% in the general population. As ART success prolongs life, ageing PLHIV are increasingly affected by multimorbidity, complicating adherence and straining systems designed for acute rather than chronic care. Strengthening integrated HIV–NCD care, surveillance, and differentiated service delivery for older PLHIV is critical to sustain progress toward Universal Health Coverage (UHC) and Ending AIDS by 2030.

Key Data Highlights the Scope of the Challenge:

National NCD Burden: NCDs are a leading cause of mortality in Kenya, accounting for approximately 41% of all deaths (WHO, 2023). The strain on the health system is significant, with hospital admissions linked to NCDs exceeding 50% (Kenya Health Policy 2014–2030).

- **Disproportionate Impact on PLHIV:** The prevalence of NCDs is markedly higher among PLHIV. Evidence shows that 62% of PLHIV have at least one NCD, compared to 51% in the general population (Clinical Infectious Diseases, 2020).
- **Specific Comorbidity Prevalence:** Among PLHIV, hypertension prevalence ranges between 20–40% in local studies. Furthermore, TB/HIV co-infection remains a major contributor to morbidity and mortality.
- **The Challenge of Multimorbidity**: As ART success prolongs life, ageing PLHIV are increasingly affected by multimorbidity. This complicates clinical management, jeopardizes ART adherence, raises healthcare costs, and strains health systems designed for acute rather than chronic care

Comprehensive NCD & HIV Data Landscape



Highlight:

Cancer remains a major cause of mortality, accounting for half of all deaths among individuals with TB/HIV co-infection and cancer, highlighting the growing burden of non-communicable diseases (NCDs) among people living with HIV.

TB/HIV Co-infection

TB/HIV co-infection remains a major contributor to morbidity and mortality. In 2023, one in every four (25%) people living with HIV had TB. TB screening and treatment coverage stood at 98%, reflecting strong integration of TB and HIV services. Screening for HIV within this population, together with the routine administration of Isoniazid Preventive Therapy, has led to a significant reduction in TB related mortality; a 25% decline from an estimated 10,000 deaths in 2015 to 8,000 in 2023. In 2023, males aged 15 years and above accounted for 66% of all notified Drug-Susceptible Tuberculosis (DSTB) cases among individuals aged 15 years and older. Notably, over half (51%) of these DSTB cases occurred among men aged 25–44 years, underscoring the heightened TB burden within this economically active age group.

TB HIV & Comorbidities 2022/ 2023

98%

HIV Testing Rate

The testing rate increased from 93% in 2022 to 98% in 2023.

HIV Testing

Year	%
2019	**98.3%**
2020	**98.2%**
2021	**97.2%**
2022	**93%**
2023	**98%**

25%

Coinfection Rate

The confection rate increased from 23% in 2022 to 25% in 2023

ART Uptake

Year	%
2019	**97.4%**
2020	**97.5%**
2021	**97.8%**
2022	**97%**
2023	**98.2%**

Treatment Outcomes by Comorbidities 2022

	Died	Failed	LTFU	TSR
Alcoholism	8%	1%	9%	80%
Asthma	6%	1%	12%	80%
Cancer	50%	0%	2%	48%
Cardiovascular	35%	0%	2%	62%
COPD	9%	1%	12%	77%
COVID 19	22%	1%	6%	70%
Drug Abuse	6%	1%	12%	79%
Diabetes	19%	1%	4%	76%
Liver	45%	1%	3%	50%
Smoker	7%	1%	8%	83%

Key:
TSR – Treatment Success Rate
LTFU – Lost to Follow Up
COPD – Chronic Obstructive Pulmonary Disease
COVID-19 – Coronavirus Disease 2019
ART – Antiretroviral Therapy

Figure 13: Trends in HIV Testing, ART Uptake, and TB/HIV Coinfection Outcomes
Source: National TB Program, TIBU System, 2023.

Cervical Cancer screening among Women living with HIV

Kenya recorded steady progress in HPV and cervical cancer screening among women living with HIV, with coverage increasing from 36% in 2022–2023 to 47% in 2023–2024. During this period, the number of screened clients rose from 194,078 to 212,261 out of a total of 836,285 HIV-positive women.

> *All women living with HIV are up to six times more likely to develop cervical cancer than HIV-negative women and should undergo cervical cancer screening at the time of diagnosis and at least once every year thereafter.*

1.6. Sexually Transmitted Infections (STIs)

Sexually transmitted infections (STIs) are primarily spread through sexual contact, though some can also be transmitted during pregnancy, childbirth, breastfeeding, or through infected blood and blood products, and other body fluids. Common STIs include chlamydia, trichomoniasis, gonorrhea, human papillomavirus (HPV), genital herpes, and syphilis. The total number of reported STI cases declined by 9%, from 324,629 in 2019 to 295,105 in 2024. Similarly, syphilis positivity among antenatal care (ANC) attendees decreased from 1.0% in 2019 to 0.7% in 2024, indicating progress in STI prevention and control. Programming on STI prevention and treatment needs more priority with specific sub populations.

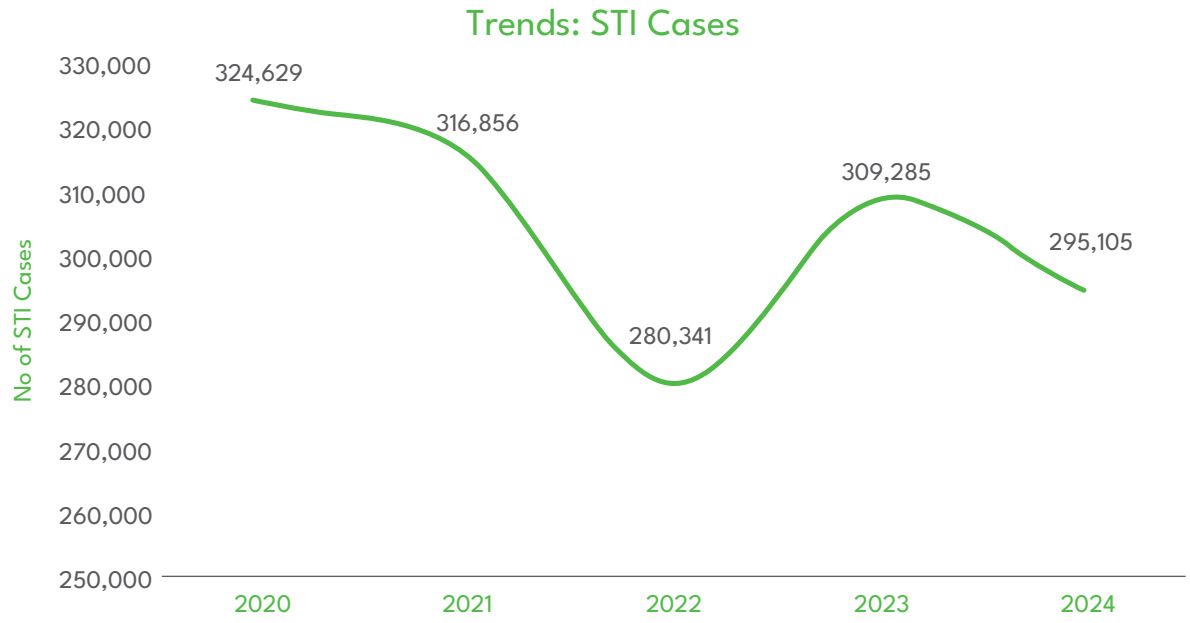


Figure 14: Annual Trend of Sexually Transmitted Infections
Source: Ministry of Health, Kenya Health Information System

1.7 Structural Barriers

Stigma, discrimination, and violence remain significant barriers to HIV service uptake and adherence, limiting progress toward epidemic control. They continue to undermine testing and treatment adherence, affecting the dignity, mental health, and social inclusion of people living with HIV (PLHIV), while weakening broader public health efforts. Reducing stigma and discrimination is therefore a key indicator of effective HIV prevention and control, with the global target aiming for fewer than 10% of PLHIV to experience stigma or discrimination in health care or community settings.

According to the Stigma Index Report 2024:

Figure 15: Structural barriers affecting HIV service delivery
Source: NEPHAK, Stigma Index Survey Report, 2024

1.8 Domestic Financing

Kenya's HIV response has long depended on donor funding, an approach that is increasingly unsustainable amid declining external support and the country's reclassification as a lower middle-income economy. According to the Kenya National AIDS Spending Assessment (KNASA) 2022, domestic resources currently account for 34% of total HIV financing. To enhance self-reliance, the Government aims to finance at least 50% of the national HIV response through domestic resources, guided by the Sustainability Operation Plan post-2030 launched on December 1, 2024. The country is exploring innovative financing models, strengthening local ownership through domestication of the HIV Prevention and Control Prototype Model Bill, and advocating for increased health allocations across all levels of government. Kenya is also transitioning from vertical programmes to integrated approaches addressing HIV and syndemic diseases within the Universal Health Coverage (UHC) framework, promoting efficiency, sustainability, and long-term impact.

Condom Financing: In 2024, Kenya's total condom requirement stood at 489, 260,455 pieces, translating to an estimated annual budgetary need of KES 3.06 billion to ensure adequate supply. However, only 35,921,928 condoms were distributed, meeting just 7% of the national requirement, showing a continuation of the declining trend in condom distribution versus the national need. This persistent shortfall, compounded by the fact that 80% of HIV commodities including condoms are donor-funded, exposes the country to supply chain vulnerabilities following stop-orders and pipeline disruptions. To address this, Kenya must accelerate local manufacturing, fiscal-incentives for private-sector investment, and county-level budget integration to strengthen commodity security, reduce donor dependency, and ensure sustained availability of condoms across all regions.

HIV Performance against Global Epidemic Control Metrics

The table below summarizes Kenya's HIV epidemic control performance from 2020 to 2024, highlighting key indicators reductions in new infections and mortality, and the incidence-prevalence and incidence-mortality ratios Using Global Epidemic Control metric. These metrics gauge progress toward Kenya's epidemic control and reveal areas needing strengthened programmatic focus.

HIV Performance against Global Epidemic Control Metrics

		2019 Country Performance	2024 Country Performance	Epidemic Control Metric	Reference Point	Comments
Percentage Reductions	New Infections	41,416	19,991	52%	≥ 75%	(New infections in 2024-New infections in 2019)/ New infections in 2019
	Mortality	19,486	21,007	-3%	≥ 50%	(Mortality in 2020-Mortality in 2024)/Mortality in 2020
Incidence-Prevalence Ratio (IPR)	New Infections (adults)		15,642	0.012	≤ 0.03	No. of new infections (Adults) per year/No. of adults living with HIV
	Adult PLHIV		1,263,538			
Incidence-Mortality Ratio (IMR)	New Infections		19,991	0.95	≤ 1	No. of new infections per year/ No. of deaths
	AIDS related deaths		21,007			

SECTION TWO:

PROGRESS BY AGE, GENDER AND GEOGRAPHY

2.1 Prevention of Mother to Child Transmission of HIV and Syphilis

Ante-Natal Care (ANC) coverage

From 2019 to 2024, Kenya has demonstrated consistent but uneven progress across key antenatal care ANC indicators. First ANC visit coverage declined slightly, from 84% in 2019 to 83% in 2024, with fluctuating uptake over the years. Initial HIV testing ranged between 68% and 74%, showing modest improvement after 2021 but still falling short of the universal testing target. Syphilis testing coverage fluctuated between 74% and 81%, reflecting limited progress and continued missed opportunities for integrated ANC screening.

The completion of at least four ANC visits remains the weakest point in the continuum persistently low at 61–62% over the review period, with no significant improvement since 2019. These trends underscore the need to strengthen ANC retention, comprehensive testing, and follow-up to ensure continuity of maternal care and improve outcomes for both mothers and infants.

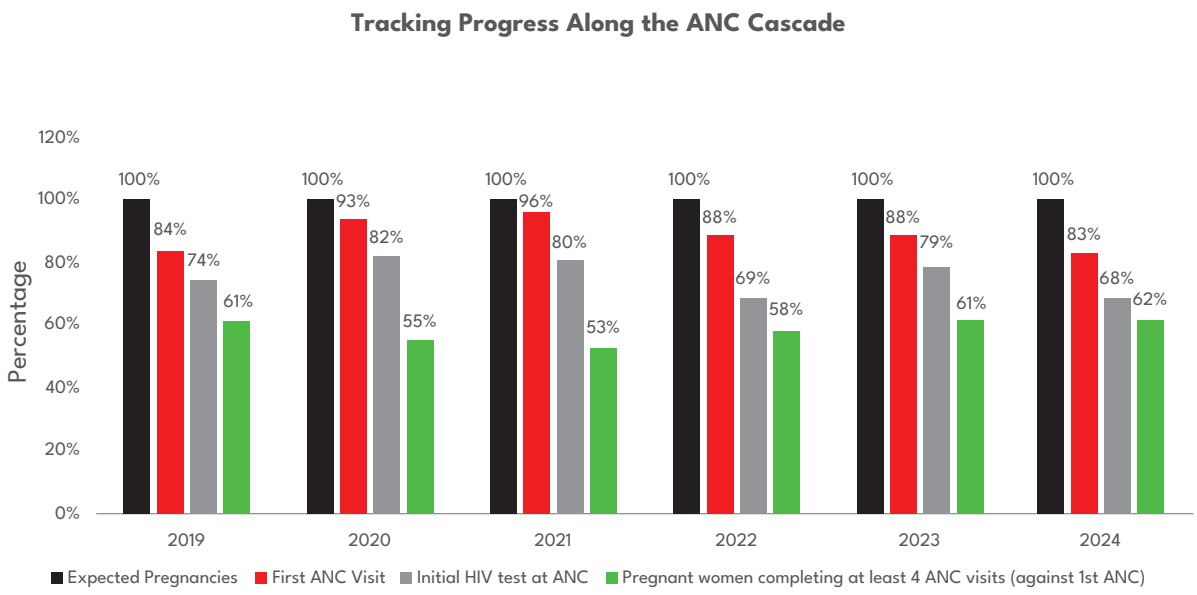
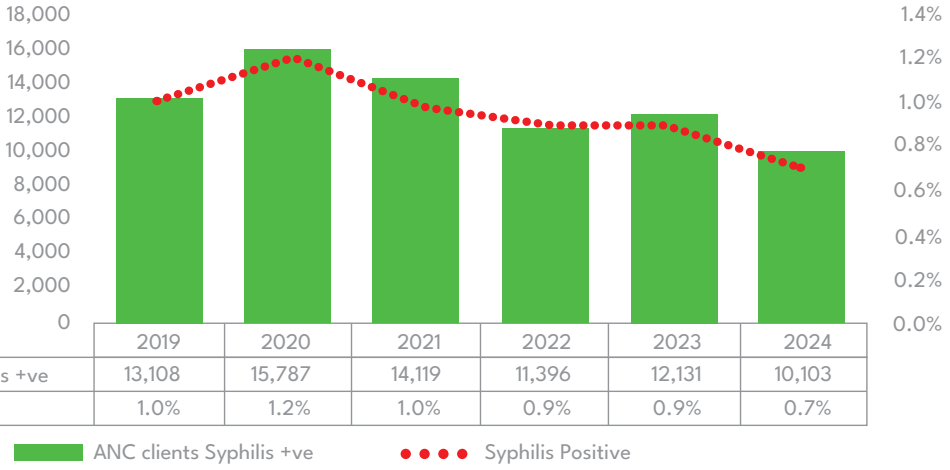


Figure 17: ANC Cascade Progress
Source: MoH, Kenya Health Information System,

Syphilis Screening and Positivity at ANC

Syphilis positivity among ANC clients has declined steadily from 1.2% in 2020 to 0.7% in 2024, with the number of positive cases reducing from 15,787 to 10,103 over the same period. While this decline reflects progress in syphilis prevention and control efforts, it also underscores the need to sustain screening coverage and timely treatment to prevent congenital syphilis and adverse pregnancy outcomes.

Epidemiological trends in syphilis positivity among ANC attendances, 2019-2024



	2019	2020	2021	2022	2023	2024
ANC clients Syphilis +ve	13,108	15,787	14,119	11,396	12,131	10,103
Syphilis Positive	1.0%	1.2%	1.0%	0.9%	0.9%	0.7%

Figure 18: Syphilis Positivity at ANC
Source: MoH, Kenya Health Information System

Mother to Child HIV Transmission Rate

Kenya's mother-to-child transmission rate of HIV generally decreased from 2019 at 10.8% to 2024 9.3%. However, it increased in the last year from 7.3% to 9.3%, surpassing the global target of less than 5%. This rise reflects persistent gaps in prevention, including missed ANC visits, poor ART adherence and retention, and delays in early infant diagnosis and treatment. Although 83% of pregnant women attend the first ANC visit, 38% fail to complete all four, disrupting continuity of PMTCT services. Over two-thirds of infant infections are linked to ART non-use or drop-off, underscoring the need for stronger follow-up, adherence support, and service integration. Urgent action is required to improve retention in care and accelerate progress toward the global eMTCT target.

More than

2/3

New HIV Infections

HIV infections among infants were due to non-use or drop off from ART

83%

of pregnant women

attended a first antenatal care (ANC) visit, leaving many without access to this critical entry point for maternal and child health services.

38%

Failing to complete fourth ANC

Gap widened further by the fourth ANC visit, with 38% of women who began care failing to complete the recommended fourth visit.

Source: MoH, Kenya Health Information System,

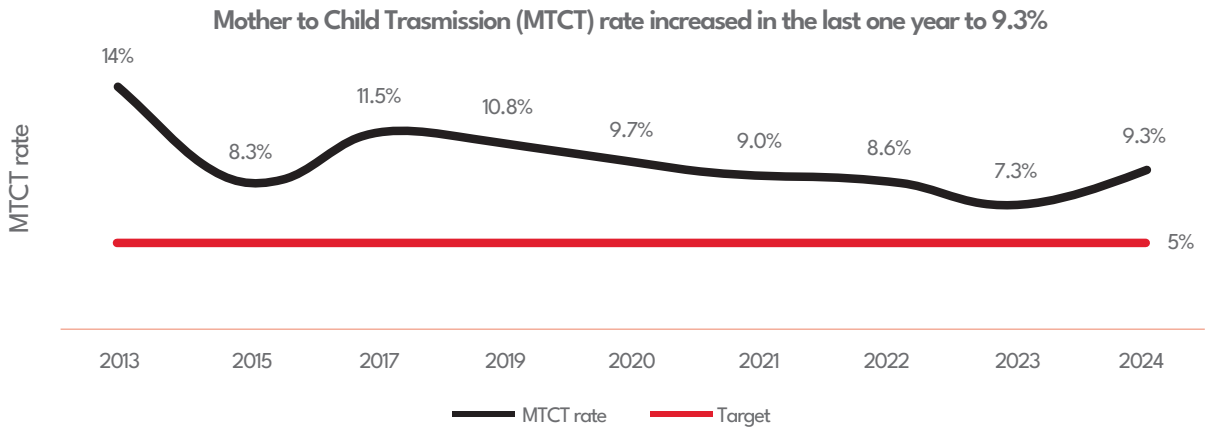


Figure 19: HIV Transmissions Rate from Mother to Child (2013-2024)
Source: NSDCC, Kenya HIV Estimates Report, 2025.

The rate of mother-to-child transmission of HIV increased from 7.3% in 2023 to 9.3% in 2024, surpassing the global target of less than 5%. More than half of these infections (58.7%) were due to mothers not receiving ART during pregnancy (24.6%), discontinuing treatment during breastfeeding (20.1%), or dropping off treatment during pregnancy (14.0%), highlighting the urgent need to optimize PMTCT programmes to ensure treatment continuity

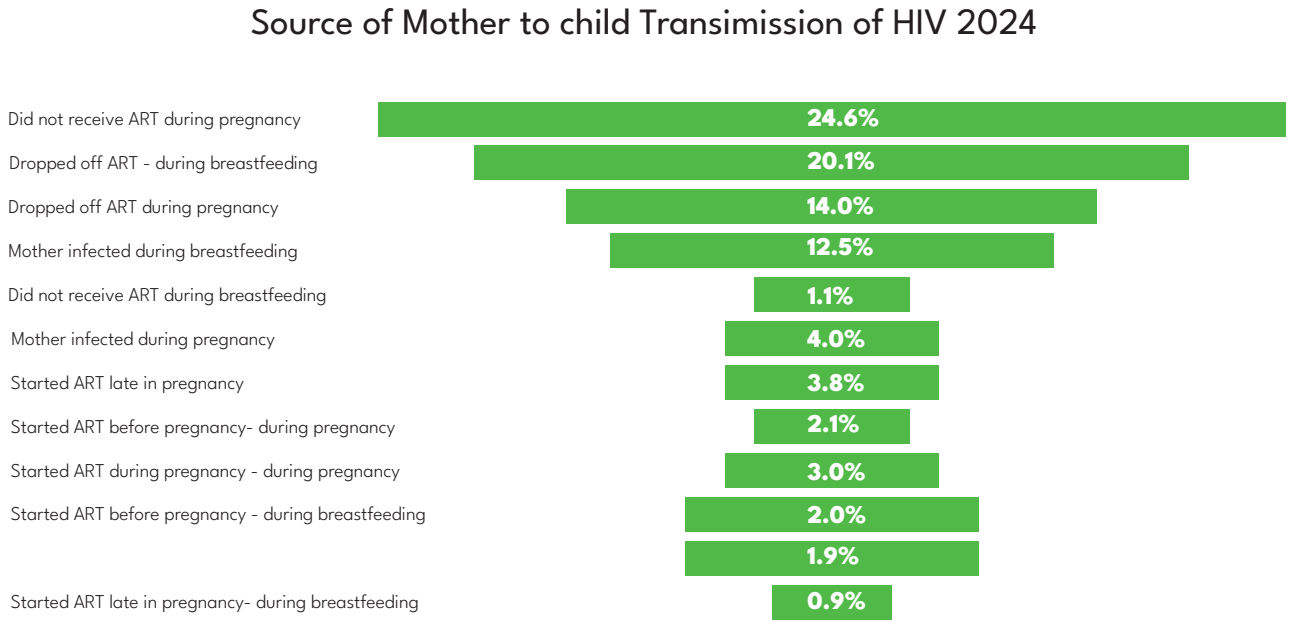


Figure 20: Source of New MTC HIV Transmissions Rate
Source: NSDCC, Kenya HIV Estimates Report, 2025.

Marked geographical disparities persist in mother-to-child transmission of HIV across counties. Between 2019 and 2024, MTCT rates increased significantly in several arid and semi-arid counties, including Isiolo (from 11.4% to 27.5%), Samburu (15.4% to 26.0%), and Marsabit (11.4% to 19.9%), highlighting widening inequities in service coverage and treatment continuity.

In contrast, notable declines were observed in high-burden counties such as Homa Bay, Siaya, and Kisumu, where MTCT rates fell by more than three percentage points, reflecting stronger programme performance and retention in care.

These patterns underscore the need for targeted interventions in underserved counties, strengthened maternal ART adherence, and improved access to PMTCT services across all regions.

District	2019 MTCT Rate	2024 MTCT Rate	% Difference
Isiolo	11.4%	27.5%	16.1%
Samburu	15.4%	26.0%	10.6%
Marsabit	11.4%	19.9%	8.5%
Kilifi	11.2%	19.6%	8.4%
Tana River	11.2%	18.5%	7.3%
Baringo	15.4%	22.5%	7.1%
Wajir	28.5%	33.4%	4.9%
Bungoma	9.7%	14.5%	4.8%
Meru	11.4%	15.9%	4.5%
Nyamira	9.1%	13.5%	4.4%
Elgeyo-Marakwet	15.4%	18.1%	2.7%
Kwale	11.2%	13.3%	2.0%
Kisii	9.1%	11.1%	2.0%
Kiambu	9.0%	10.4%	1.4%
Murang'a	9.0%	9.3%	0.3%
Vihiga	9.7%	10.0%	0.3%
Nyandarua	9.0%	8.9%	-0.1%
Mombasa	11.2%	11.1%	-0.2%
Mandera	28.5%	28.2%	-0.2%
Taita-Taveta	11.2%	10.7%	-0.5%
Nairobi	10.1%	9.5%	-0.6%
Uasin Gishu	15.4%	14.6%	-0.8%
Tharaka-Nithi	11.4%	10.2%	-1.2%
Nandi	15.4%	13.8%	-1.6%

District	2019 MTCT Rate	2024 MTCT Rate	% Difference
Homa Bay	9.1%	6.7%	-2.4%
Kirinyaga	9.0%	6.1%	-2.9%
Nyeri	9.0%	6.1%	-2.9%
Migori	9.1%	6.1%	-3.0%
Siaya	9.1%	6.1%	-3.0%
Busia	9.7%	6.6%	-3.2%
Kisumu	9.1%	6.0%	-3.2%
Kakamega	9.7%	6.1%	-3.6%
Trans-Nzoia	15.4%	11.6%	-3.8%
Kitui	11.4%	6.6%	-4.7%
Embu	11.4%	6.6%	-4.8%
Lamu	11.2%	6.2%	-5.1%
West Pokot	15.4%	10.3%	-5.1%
Machakos	11.4%	6.1%	-5.2%
Makueni	11.4%	6.1%	-5.2%
Garissa	28.5%	23.2%	-5.3%
Turkana	15.4%	9.7%	-5.7%
Laikipia	15.4%	8.1%	-7.2%
Kericho	15.4%	8.0%	-7.3%
Bomet	15.4%	6.4%	-9.0%
Kajiado	15.4%	6.1%	-9.3%
Nakuru	15.4%	6.1%	-9.3%
Narok	15.4%	6.1%	-9.3%

Source: NSDCC, Kenya HIV Estimates Report, 2025.

2.2 Ending AIDS Among Children 0-14 Years

Overall Prevalence and Burden

In 2024, approximately 62,798 children (0-14 years) were living with HIV. Between 2019 and 2024, Kenya achieved major gains in reducing pediatric HIV, with new HIV infections falling by 36% from 6,806 to 4,349, and AIDS-related deaths in this age group dropping by 38% from 4,333 to 2,685. However, a slight rise in new HIV infections and deaths after 2022 highlights the need to strengthen treatment adherence, retention, and PMTCT programs to sustain progress toward ending pediatric HIV

> *With new HIV infections among children rising from 3,743 in 2023 to 4,349 in 2024, and AIDS-related deaths increasing to 2,685, urgent action is needed to strengthen PMTCT services, improve treatment retention and adherence, and ensure timely access to care for children living with HIV.*

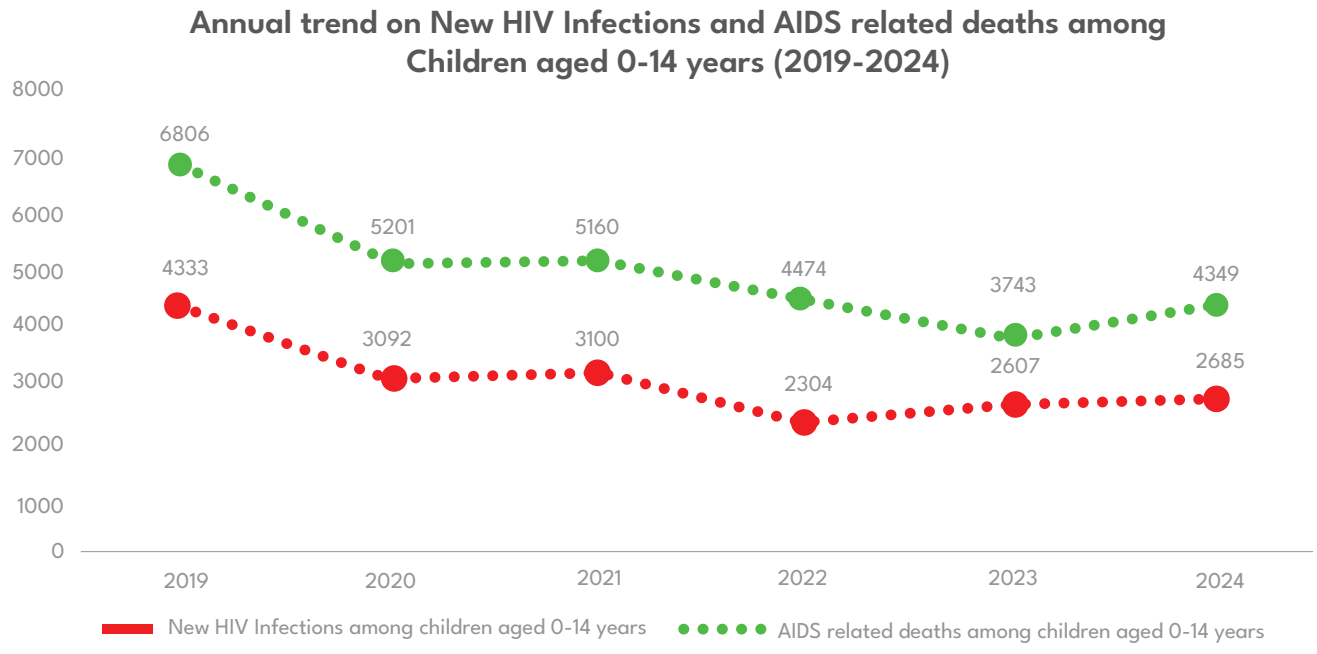


Figure 19: New HIV infections and AIDS-related Deaths in Children
Source: NSDCC, Kenya HIV Estimates Report, 2025.

HIV Care and Treatment: The 95-95-95 Cascade

In 2024, Kenya did not meet the global 95–95–95 HIV treatment targets among children aged 0–14 years, with 87% of children living with HIV being diagnosed, 75% of those diagnosed receiving treatment, and 66% of those on treatment achieving viral suppression.

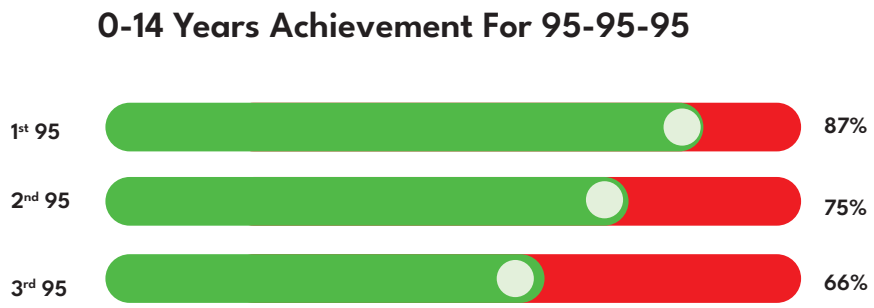


Figure 20: Status of 95-95-95 cascade among children
Source: NSDCC, Kenya HIV Estimates Report, 2025.

These results reveal critical gaps across all three stages of the HIV care cascade, showing that many children are still not being reached, retained in care, or achieving optimal treatment outcomes.

Interruption in Treatment (IIT)

Overall, 2.4% of children aged 0–14 years interrupted HIV treatment nationally, with notable geographical disparities in treatment continuity across counties.

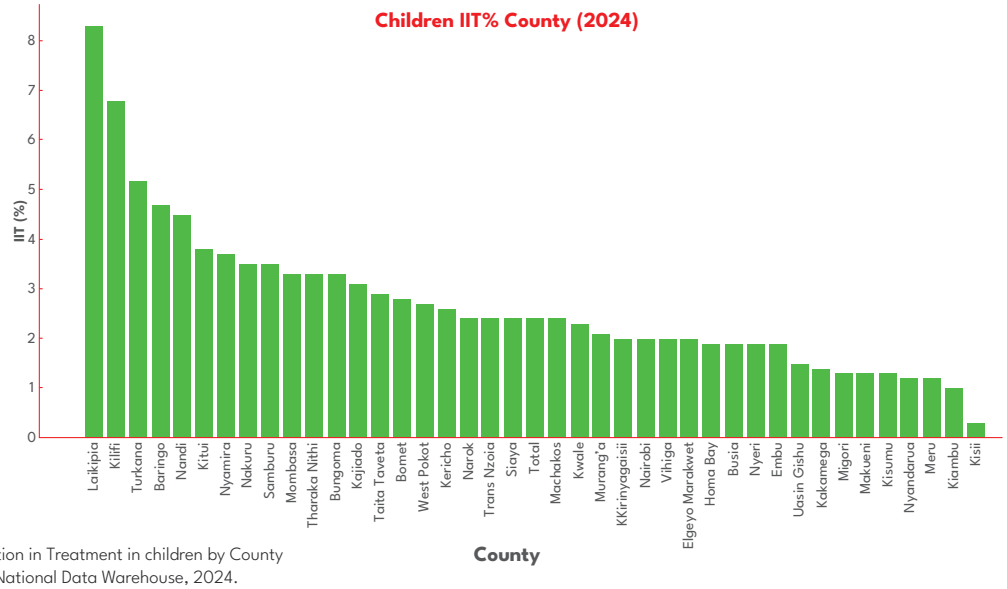


Figure 21: Interruption in Treatment in children by County
Source: NASCOP, National Data Warehouse, 2024.

Laikipia (8.3%), Kilifi (6.8%), and Turkana (5.2%) counties recorded the highest rates, while Kisii (0.3%) had the lowest. This variation suggests that some counties face greater challenges in maintaining consistent pediatric HIV treatment, highlighting the need for targeted interventions to improve retention and adherence.

2.3 Adolescents and Young People aged between 10 and 24 years

Adolescents aged 10–19 years account for 80,252 people living with HIV, with 2,799 new infections and 1,165 AIDS-related deaths reported among them. Among young adults aged 15–24 years, there are 132,018 people living with HIV, 6,362 new infections, and 1,974 AIDS-related deaths, reflecting persistent gaps in prevention, treatment, and retention. Given that adolescents and young people aged 10–24 years constitute 34% (approximately 16 million) of Kenya's population, this group remains central to epidemic control, underscoring their continued vulnerability and the need for targeted interventions

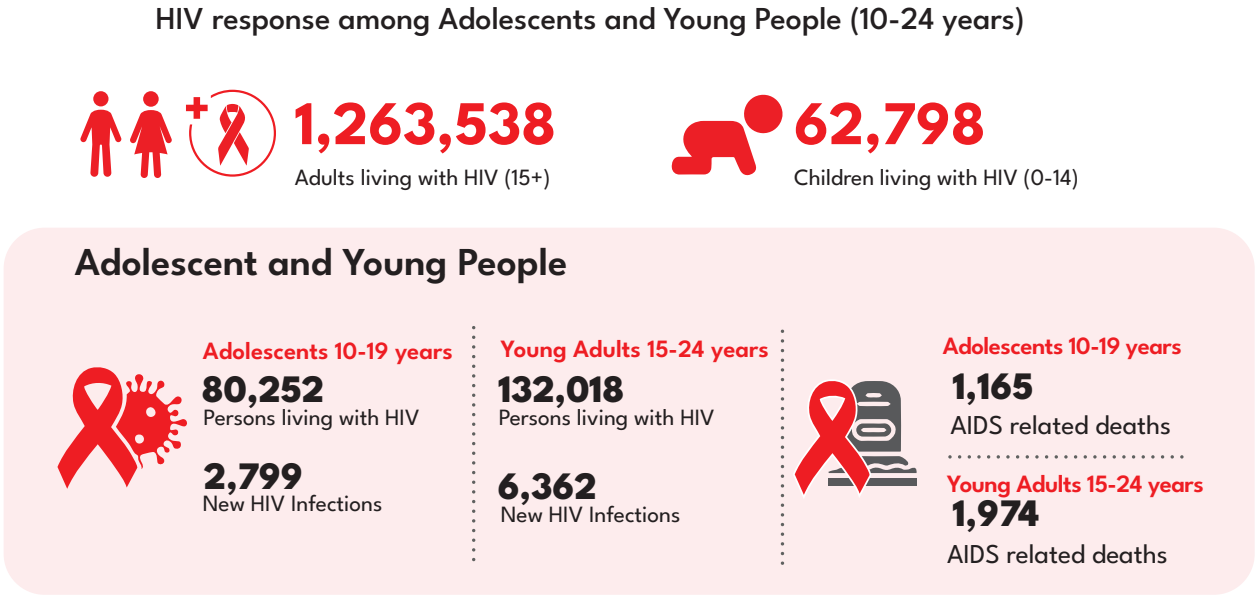


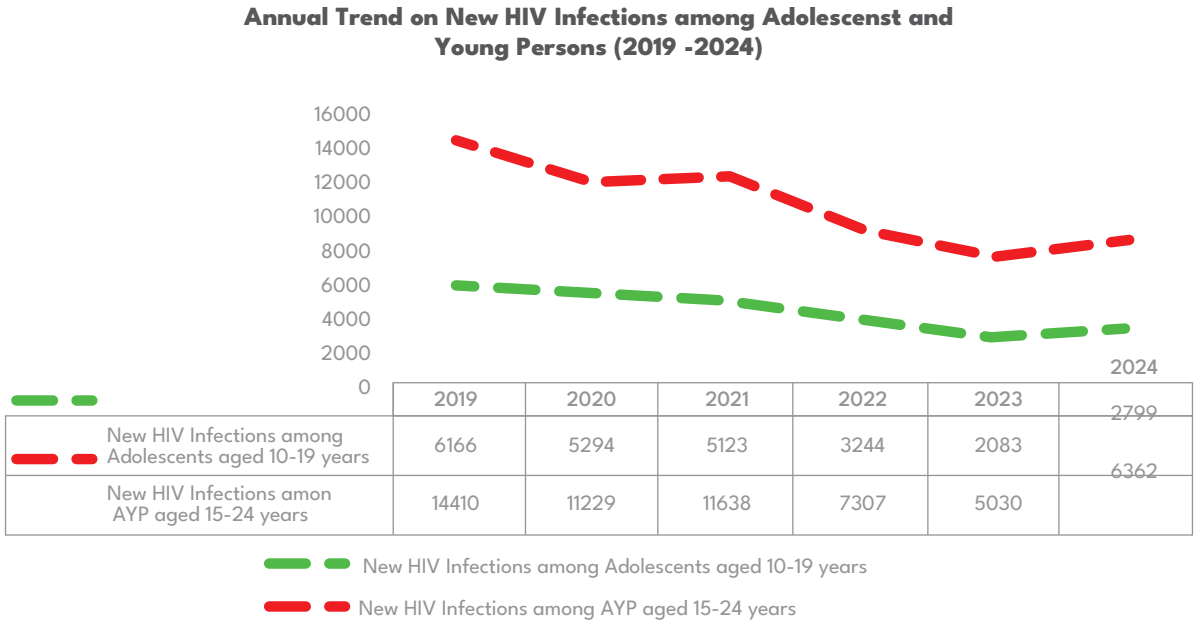
Figure 22: Status of HIV among AYP
Source: NSDCC, Kenya HIV Estimates Report, 2025.

Between 2019 and 2024, Kenya recorded a steady decline in new HIV infections among adolescents and young people, though a slight increase observed in 2024 marks a concerning reversal of this downward trend, signaling emerging gaps in prevention efforts and the need for renewed focus on sustaining progress. Among adolescents aged 10–19 years, new HIV infections dropped from 6,166 in 2019 to 2,799 in 2024, while among young people aged 15–24 years, infections declined from 14,410 to 6,362 over the same period.

Youth are not just beneficiaries, we are changemakers driving Kenya's HIV response. Every young voice counts in shaping an AIDS-free Kenya where equity, inclusion, and innovation thrive. Through youth-led solutions, digital health, and access to SRH services, we're breaking stigma, overcoming challenges, and working hand in hand with government and partners to build a healthier, more inclusive future.

Loise Atieno, Program Manager
MAONO AFRICA

Adolescents and young people aged 15–24 years contribute approximately one-third (31–35%) of all new HIV infections in Kenya. Within this group, adolescent girls and young women remain disproportionately affected—three to four times more likely to acquire HIV than their male peers. This heightened vulnerability is most evident among girls aged 15–19 years, when many initiate sexual relationships, often with older partners. The burden also varies geographically, with the highest HIV incidence observed in Nairobi, Homa Bay, Migori, Kisumu, Siaya, and Kakamega, underscoring the need for targeted, data-driven responses in high-prevalence regions



	2019	2020	2021	2022	2023	
New HIV Infections among Adolescents aged 10-19 years	6166	5294	5123	3244	2083	
New HIV Infections amon AYP aged 15-24 years	14410	11229	11638	7307	5030	

Figure 23: Trend of New HIV Infections among AYP
Source: NSDCC, Kenya HIV Estimates Report, 2025.

Between 2019 and 2024, AIDS-related deaths among adolescents and young people showed an overall decline, reflecting progress in treatment access and care outcomes. Deaths among adolescents aged 10–19 years dropped from 2,275 in 2019 to 1,166 in 2024, while among young people aged 15–24 years, deaths declined from 2,621 to 1,974 over the same period. The modest decline between 2023 and 2024 indicates that while progress continues, more targeted interventions are needed to sustain viral suppression and prevent AIDS-related mortality among young populations

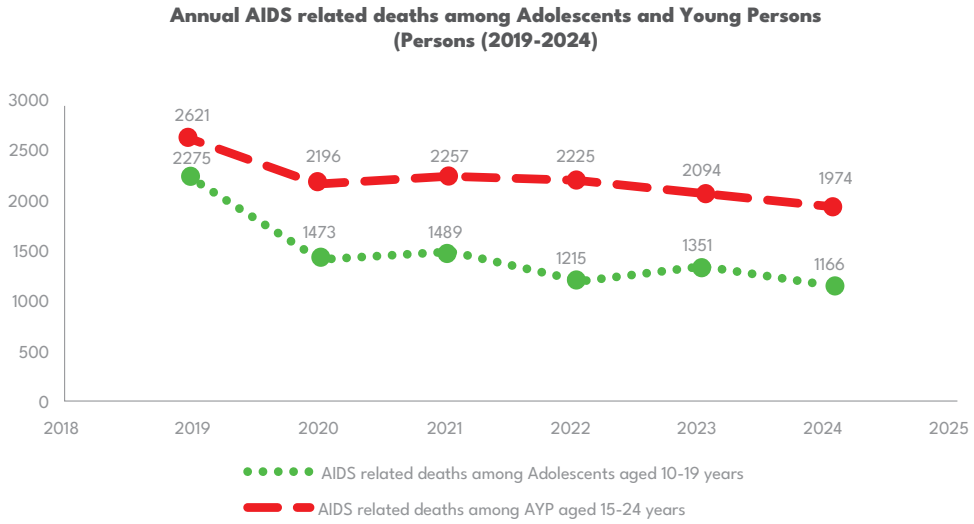


Figure 24: AIDS-related deaths among AYP
Source: NSDCC, Kenya HIV Estimates Report, 2025.

Performance towards the commitment to end new HIV infections, adolescent pregnancies, and sexual and gender-based violence (The Triple Threat) Among Adolescents

In 2024, Kenya continued to face the Triple Threat of new HIV infections, adolescent pregnancies, and sexual and gender-based violence that displays strong geographical co-occurrence

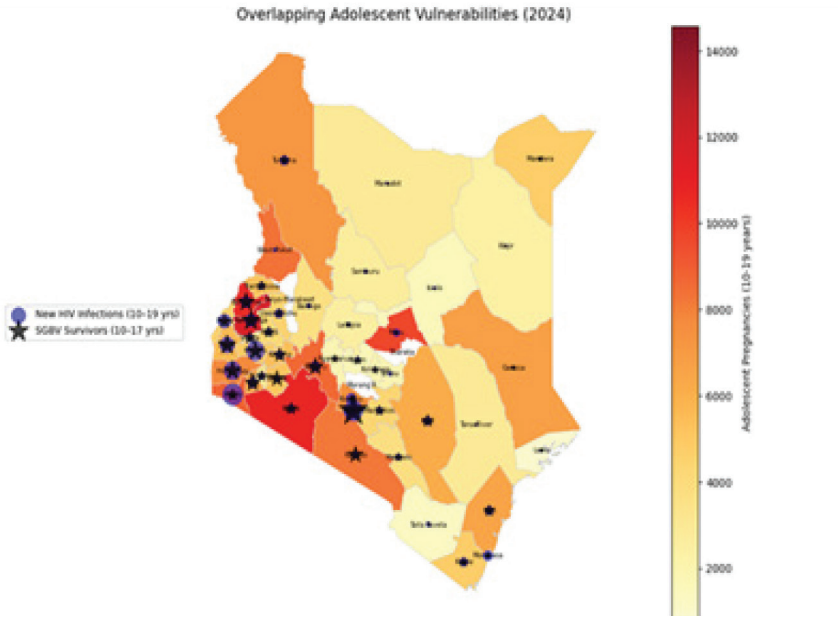


Figure 25: Geographical Distribution of the Interlinked Triad of Adolescent Vulnerabilities
Source: NSDCC, Kenya HIV Estimates Report, 2025, MoH, Kenya Health Information System.

An estimated 2,799 new HIV infections and 1,137 AIDS-related deaths were reported among adolescents, translating to about 54 new infections and 22 deaths every week, with young women aged 15–24 years accounting for 31% of new adult infections. Adolescent pregnancies made up 16% (240,915) of all pregnancies, including 9,857 among girls aged 10–14 years, indicating high levels of unprotected sex and increased HIV vulnerability. In addition, 17,361 SGBV cases were reported among adolescents aged 10–17 years, representing 36% of all national cases, and highlighting the urgent need for accelerated, coordinated, and multisectoral interventions to safeguard adolescent health and wellbeing.

National overview of the Triple Threat in the country

New HIV Infections

2,799
Estimated new HIV infections

Every week
54
new HIV infections

1,137
Estimated AIDS related deaths

Every week
22
deaths

Adolescent Pregnancies

In 2024
16%
(240,915)
of all pregnancies were among adolescents aged 10-19

Sexual and gender-based

In 2024
17,361
reported cases of Sexual and Gender Based Violence among adolescents aged 10-17 in 2024.

Represents
36%
of total SGBV cases reported in 2024

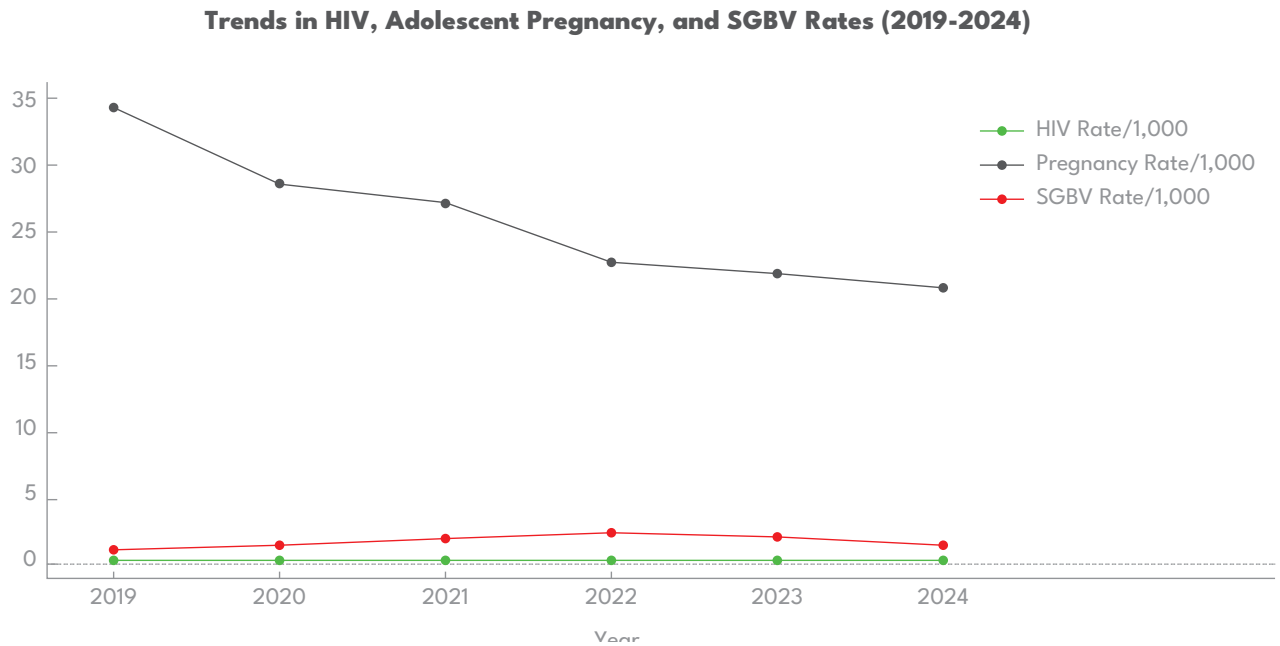
Adolescent pregnancies indicate exposure to Unprotected sex which increases the risk to new HIV infections.

9,857
Adolescents aged (10-14) attended ANC clinics

31%
of adult new HIV infections occur among young women aged 15-24 in 2023

Adolescents pregnancies disrupt schooling and have a significant impact on various health and socio-economic development indicators.

Status and Trends of the Three Threats



Since 2019, sexual and gender-based violence (SGBV) against adolescents has more than doubled, emerging as the most urgent and escalating component of the Triple Threat. In contrast, new HIV infections among young people have declined by over 50%, reflecting the impact of intensified prevention efforts and youth-friendly services. Adolescent pregnancy rates, though still high, have also fallen by nearly 40%, signaling progress in reproductive health education and access to contraception. These trends show significant progress in HIV and pregnancy reduction but underscore the need to prioritize SGBV prevention and response as a growing threat to the health and wellbeing of adolescents and young people in Kenya.

2.4 HIV Among Adults aged 15 years and above

HIV prevalence remains higher among women aged 15–49 years (4.1%) compared to men (2.0%). In 2024, an estimated 1,263,538 adults aged 15 years and above were living with HIV, the majority of whom 836,286 were women, representing 66% of adults living with HIV, compared to 427,253 adult men.

Distribution of adults living with HIV by age and sex

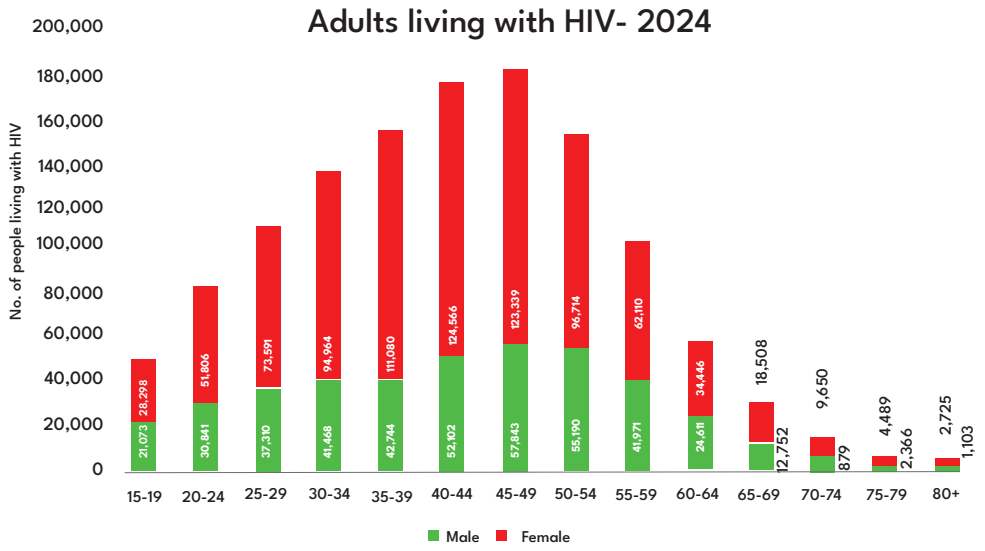


Figure 28: Distribution of adults living with HIV by age and sex
Source: NSDCC, Kenya HIV Estimates Report, 2025

Six in every ten adults living with HIV are aged 30–54 years, reflecting the long-term survival of those infected earlier, largely due to expanded access to treatment. This demographic shift underscores the need to prepare for a middle-aged population living with HIV, with significant implications for the health system. It calls for a stronger focus on chronic disease prevention and management, sustained treatment adherence, and integrated models of care that address comorbidities and provide comprehensive social and psychosocial support for those aging with HIV.

Distribution of People living with HIV by county- 2024

More than half (51%) of people living with HIV were in 7 counties (Nairobi, Kisumu, Homa Bay, Migori, Siaya, Kiambu and Mombasa)

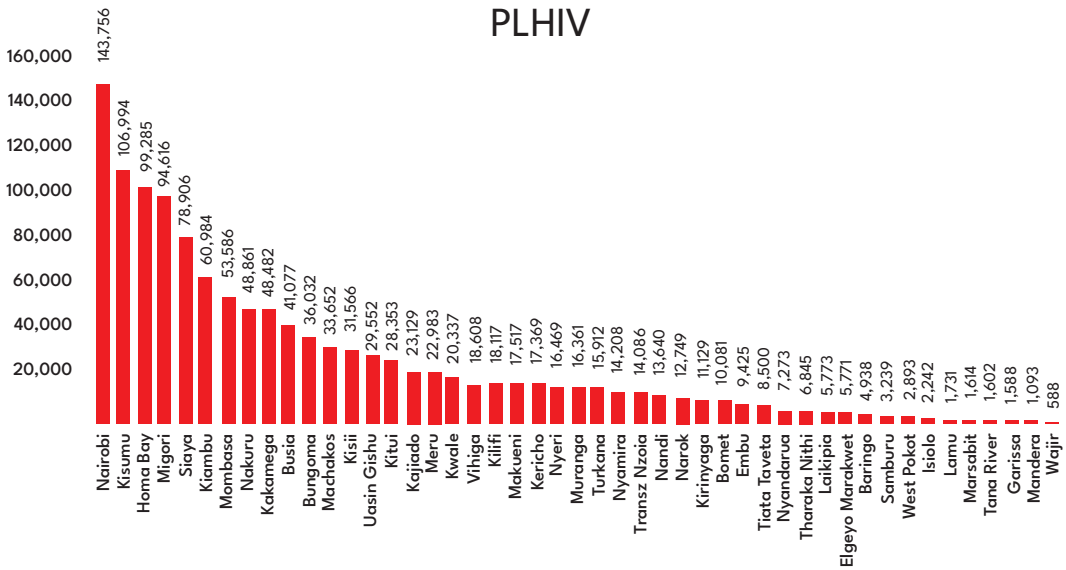


Figure 29: Distribution of adults living with HIV by county
Source: NSDCC, Kenya HIV Estimates Report, 2025,

New HIV infections

An estimated 15,641 adults aged 15+ acquired new HIV infections in 2024, representing 78% of all new HIV infections that year. Further, adult females accounted for 71% (11,032) of adult new infections compared to 4,608 (29%) among adult men.

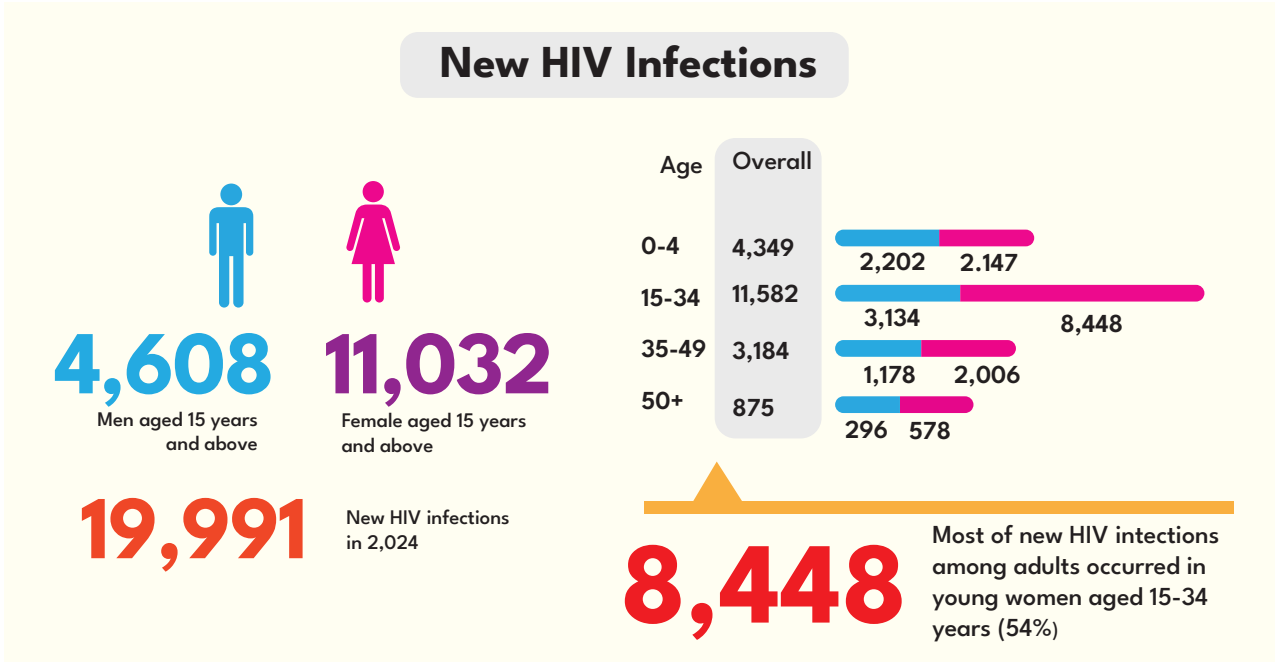


Figure 30: Overview of New HIV Infections
Source: NSDCC, Kenya HIV Estimates Report, 2025,

Trends in reducing new HIV infections among adults

Substantial decline of 55% in new HIV infections recorded among adults, from 34,610 in 2019 to 15,641 in 2024, indicating significant progress in reducing HIV transmission.

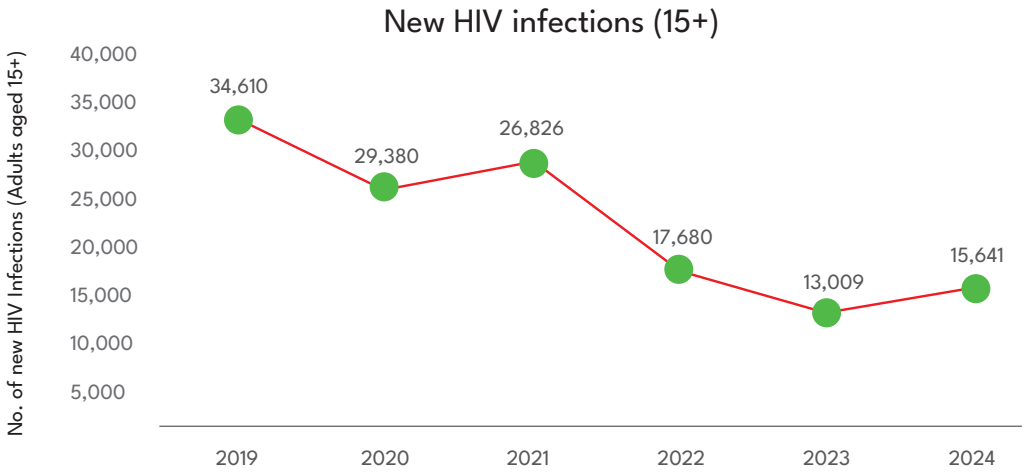


Figure 30: Tren of New HIV Infections
Source: NSDCC, Kenya HIV Estimates Report, 2025,

Adult New HIV Infections By Age Group

Majority of new HIV Infection occur among young people aged between 15-29 years. Young adult women aged 15–29 years continue to be three times more likely to acquire new HIV infections than their male counterparts, highlighting persistent gender disparities in HIV vulnerability among young people.

Geographical distribution of new HIV Infections among adults aged 15+

Ten (10) counties (Nairobi, Migori, Kisumu, Homa Bay, Siaya, Busia, Mombasa accounted for 62% of adult new HIV infections in 2024.

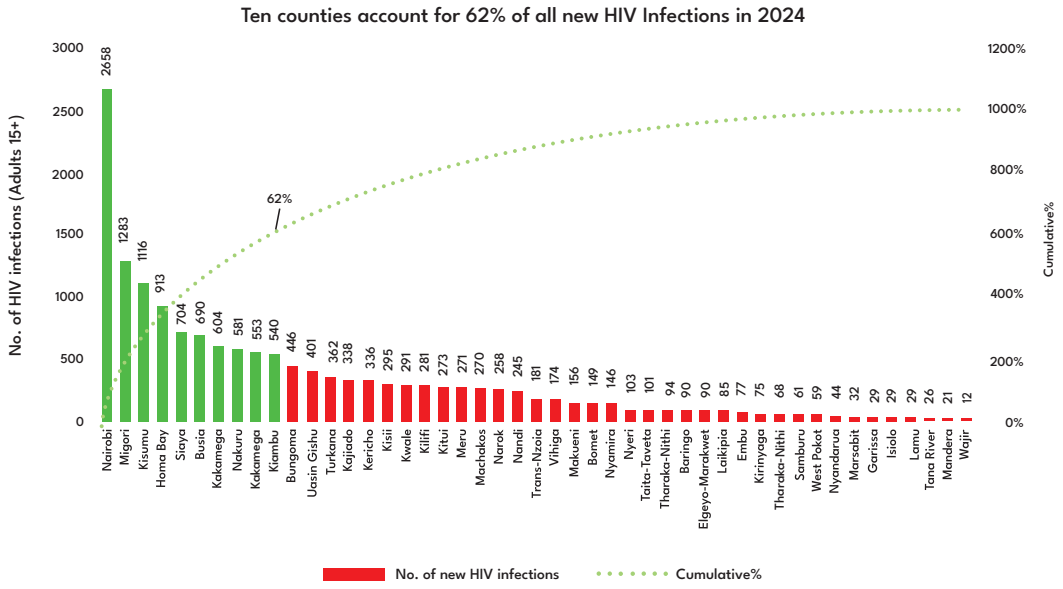


Figure 30: Geographical distribution of New HIV Infections
Source: NSDCC, Kenya HIV Estimates Report, 2025,

HIV Care and Treatment: The 95-95-95 Cascade

In 2024, Kenya achieved the 95% identification target, with 98% of adult women and 95% of adult men aware of their HIV status. However, treatment coverage remained below optimal levels, reaching 90% among women and 84% among men, indicating the need to strengthen linkage to and retention in care, particularly for men.

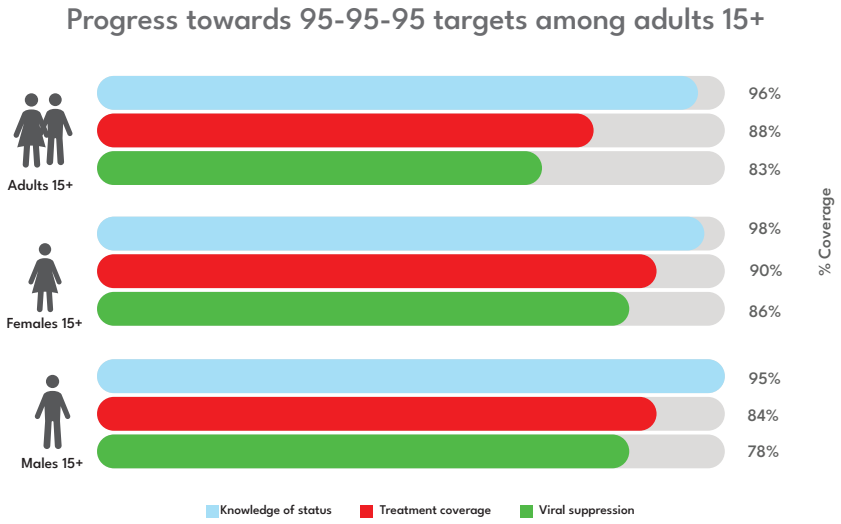


Figure 30: Progress of 95 95 95
Source: NSDCC, Kenya HIV Estimates Report, 2025,

Viral suppression coverage remained below target among both men and women, at 86% and 79% respectively, underscoring the need to strengthen linkage, retention, and adherence to treatment.

County disparities in treatment coverage

Only four counties, Homa Bay, Siaya, Kisii, and Machakos, achieved the 95 percent treatment target in 2024. However, no county met the treatment target among adult men in the same year, highlighting persistent gender disparities in treatment access and retention.

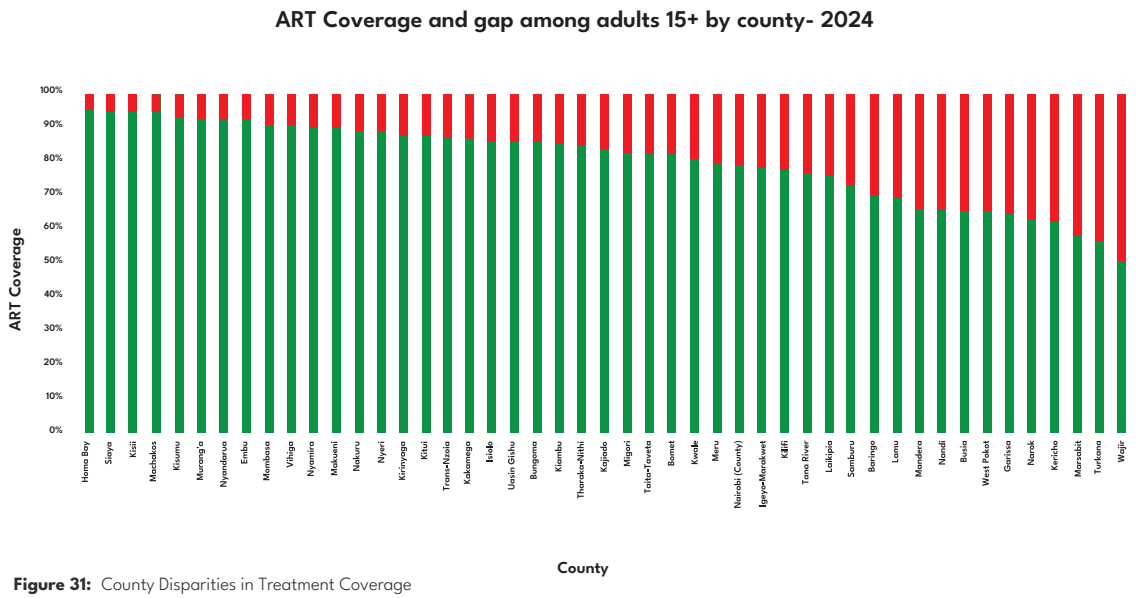


Figure 31: County Disparities in Treatment Coverage
Source: NSDCC, Kenya HIV Estimates Report, 2025,

Treatment interruption

Adult men recorded higher treatment interruption rates at 3.3% in 2024 compared to 3.0% among adult women. Among male adults aged 15 years and above, twenty counties reported interruption rates above 3.3%, with Kilifi County recording the highest rate at 11.7% in 2024. Among female adults, 18 counties recorded high IIT above the national average with Kilifi County recording the highest IIT at 10.0%, while Taita Taveta had the lowest at 1.0%.

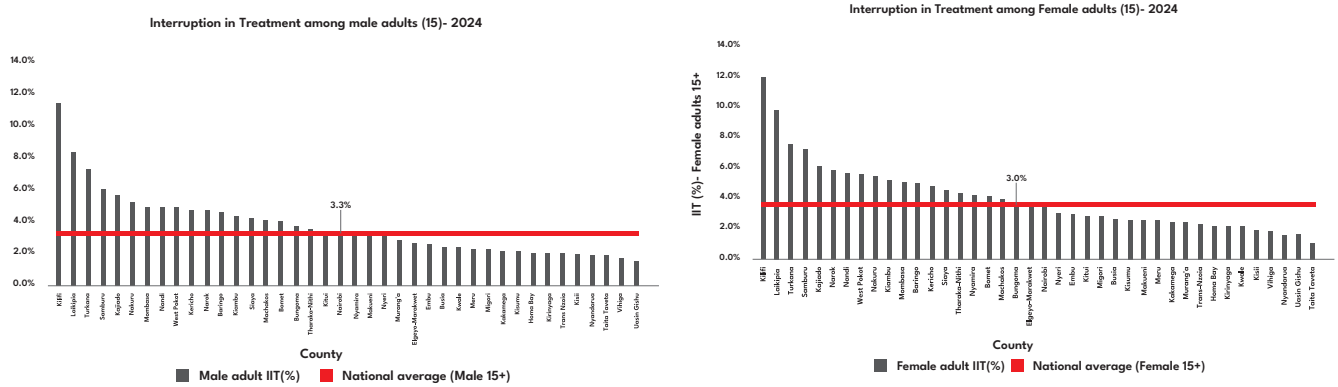


Figure 32: Gender Disparities in Treatment Interruption
Source: NSDCC, Kenya HIV Estimates Report, 2025,

AIDS-related deaths

In 2024, a total of 18,321 adults aged 15 years and above (87% of all deaths) lost their lives to AIDS related causes, with a near-even split between males (47%) and females (53%).

AIDS-related deaths among adults increased by 10% from 16,664 in 2019 to 18,321 in 2024

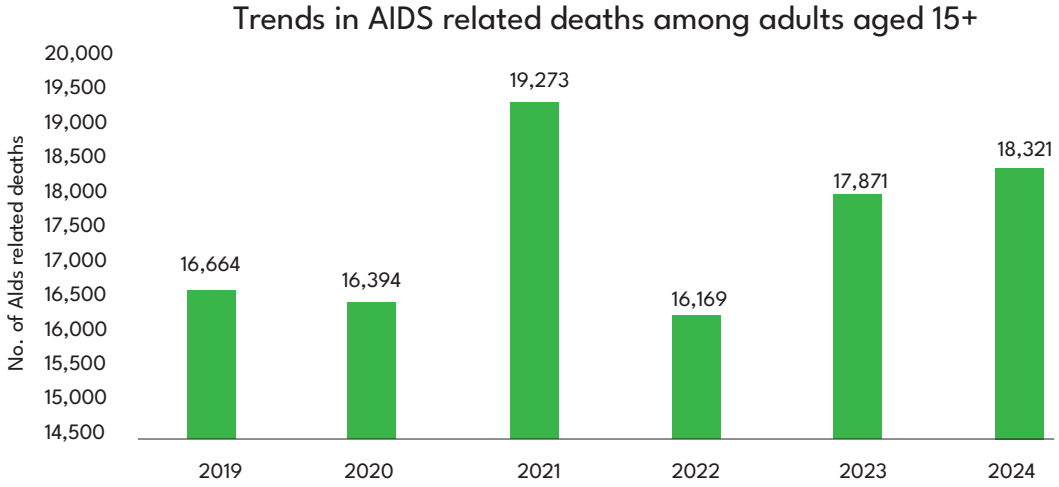


Figure 33: Trends in AIDS related deaths among adults aged 15 years and above
Source: NSDCC, Kenya HIV Estimates Report, 2025,

Geographical distribution of AIDS related deaths among adults aged 15 years and above

In 2024, an estimated half of all AIDS related deaths among adults aged 15 years and above occurred in 10 counties: Nakuru, Kisumu, Homa Bay, Uasin Gishu, Nairobi, Mombasa, Siaya, Kajiado and Kiambu.

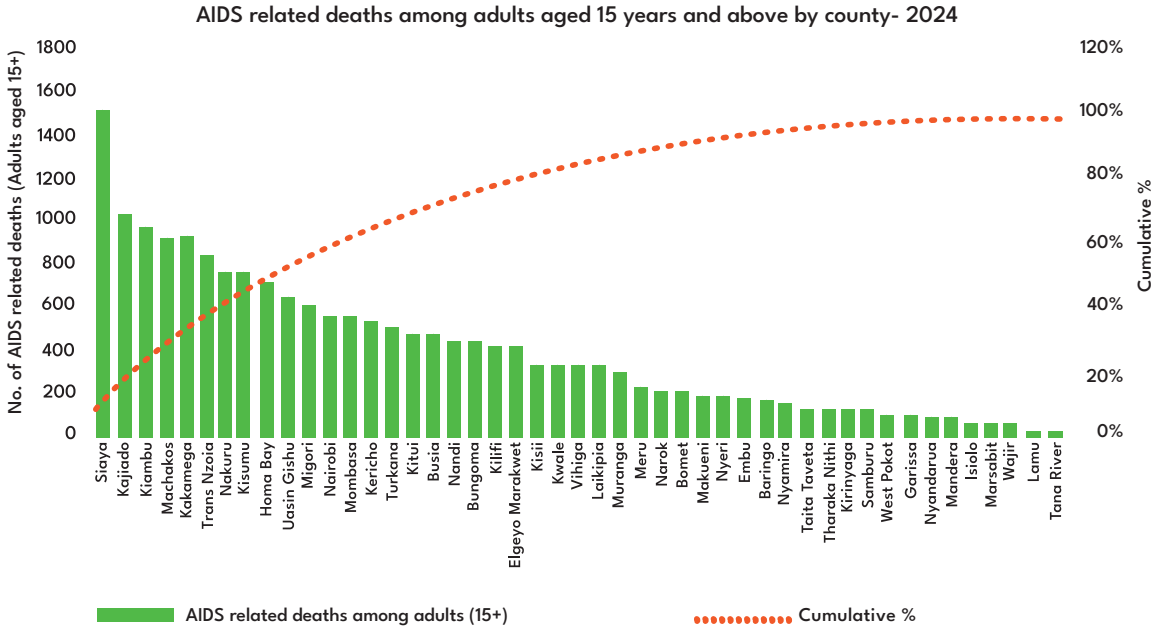
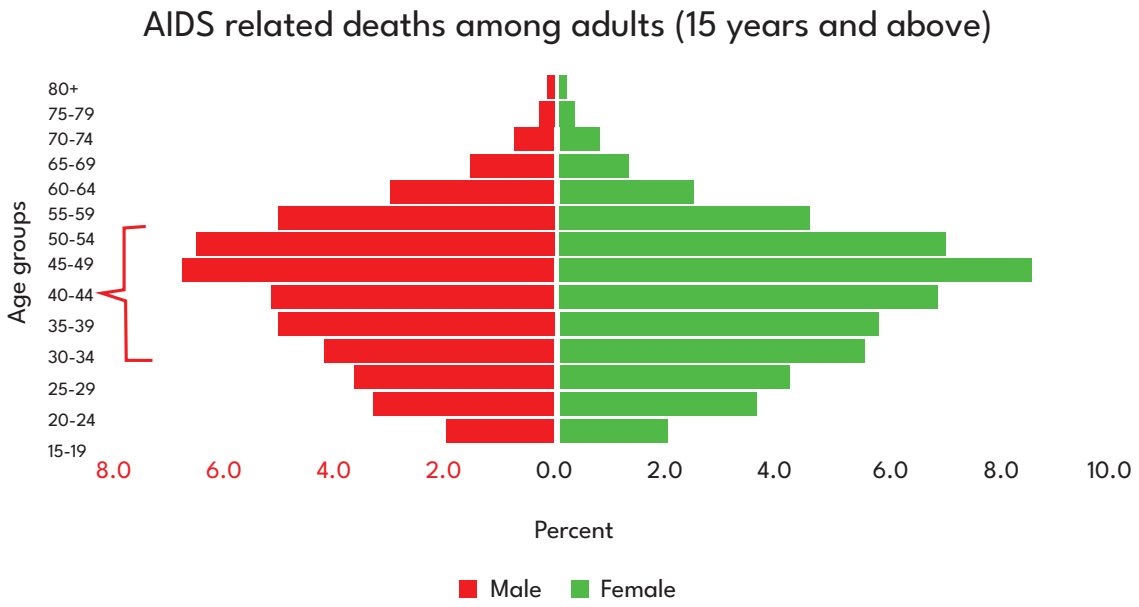


Figure 34: AIDS-related deaths among Adults by County
Source: NSDCC, Kenya HIV Estimates Report, 2025,

Distribution of AIDS related deaths by age and sex

More than half (53%~11,173) of AIDS related deaths occurred within the 30 to 54 age group.



While adult men accounted for 34% of all people living with HIV, close to half (47%) of all AIDS related deaths occurred among men in 2024.

Burden of Drug & Substance Abuse

In 2022, 17.5% of Kenyans reported using at least one drug or substance of abuse in the past month, men (30.7%) far exceeding women (6.4%). Alcohol and substance abuse fuel mental health illness, risky behavior and lost productivity, with men being disproportionately affected.

Use of multiple drugs and other substances is more common in men than in women (12.8% vs. 1.3%).
Gender Differences in Drug and Substance Use in Kenya, 2022

Burden of Drug & Substance Abuse

In 2022, 17.5% of Kenyans reported using at least one drug or substance of abuse in the past month, men (30.7%) far exceeding women (6.4%). Alcohol and substance abuse fuel mental health illness, risky behavior and lost productivity, with men being disproportionately affected.

Gender Differences in Drug and Substance Use in Kenya, 2022

SUBSTANCE OF USE	MALE	FEMALE	OVERALL
Alcohol	30.3	10.1	19.3
Tobacco	23.7	4.1	13.1
Khat	13.8	2.1	7.4
Cannabis	3.1	0.3	1.6

Figure 36: Gender Differences in Drug and Substance Use in Kenya, 2022
Source; National Authority for the Campaign Against Alcohol and Drug Abuse 2022

2.5 Key Populations

The key populations of female sex workers (FSW), men who have sex with men (MSM), people who inject drugs (PWID), and transgender persons remain a critical priority group in Kenya's HIV response, as they continue to face a significantly higher risk of HIV infection.

Key Population typology	KPSE I, 2018*	KPSE II, 2020**	BBS 2024***	HIV Prevalence-2010	HIV Prevalence-2024
FSW	167,940	197,096	285,505	29.3%	27.5%
MSM	32,580	61,650	164,722	18.2%	19.1%
PWID	16,063	26,673	30,641	18.7%	9.1%
TG	4,305	Not done	7,521	No data	22.0%

Figure 37: AIDS-related deaths among Adults by Gender
Source: NASCOP, KPSE 2024, *Integrated Bio-behavioral Survey among key populations in Kenya, 2010, 2024

Key populations account for about 14 percent of all new HIV infections in the country, underscoring the need for targeted, inclusive, and rights-based interventions that guarantee equitable access to prevention, treatment, and care services. Female sex workers have an HIV prevalence nine times higher than the general population, men who have sex with men have a prevalence more than six times higher, and people who inject drugs have a prevalence three times higher. Transgender persons experience an HIV prevalence seven times higher than the general population. HIV Prevalence among Key Populations by county- 2024

Typology	County	HIV Prevalence (%)	Comment
Female Sex Workers (FSW)	Kisumu	44.2	Above national average
	Kisii	30.1	Above national average
Men who have Sex with Men (MSM)	Nairobi	36	Higher than national average
	Kiambu	33.2	Higher than national average
People Who Inject Drugs (PWID)	Kilifi	11.6	Elevated prevalence
	Nairobi	11.2	Elevated prevalence
	Mombasa	10.6	Elevated prevalence
Transgender Persons	Mombasa	25.5	Higher than national average
	Kilifi	22.2	Higher than national average

Figure 38: HIV Prevalence among Key Population Groups
Source: Bio-behavioral Survey among key populations in Kenya, 2024

HIV prevalence among key populations by age

Figure 39: HIV Prevalence among Key Population Groups by age
Source: Bio-behavioral Survey among key populations in Kenya, 2024

Prevalence of Sexually Transmitted Infections and Viral Hepatitis

The burden of STI and VH remains significant among key populations. According to the IBBS 2024, the prevalence of active syphilis was highest among transgender people at 5.6%, followed by MSM at 4.7%, FSW at 0.9%, and PWID at 0.3%. TG also recorded the highest prevalence of Chlamydia trachomatis infection at 9.6%, followed by both FSW and MSM at 8.9%, and PWID at 1.0%. Neisseria gonorrhea infections were most prevalent among FSW at 5.9%, followed by MSM (5.7%), TG (5.1%), and PWID (1.1%). Hepatitis B virus (HBV) infection was particularly high among PWID at 14.1%, compared to 5.7% among MSM, 5.4% among FSW, and 3.4% among TG. Hepatitis C virus (HCV) infection was also concentrated among PWID, with a prevalence of 9.6%.

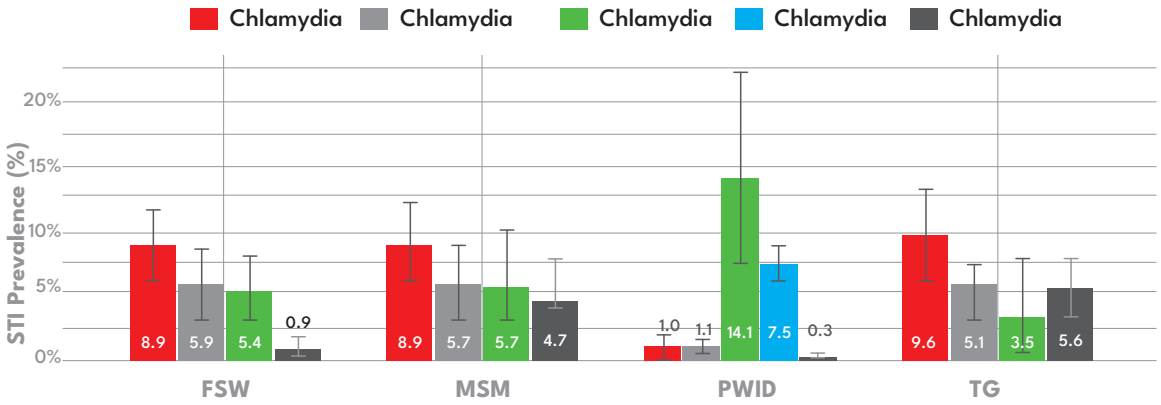


Figure 40: STI Prevalence among Key Population Groups
Source: Bio-behavioral Survey among key populations in Kenya, 2024

Violence among key populations

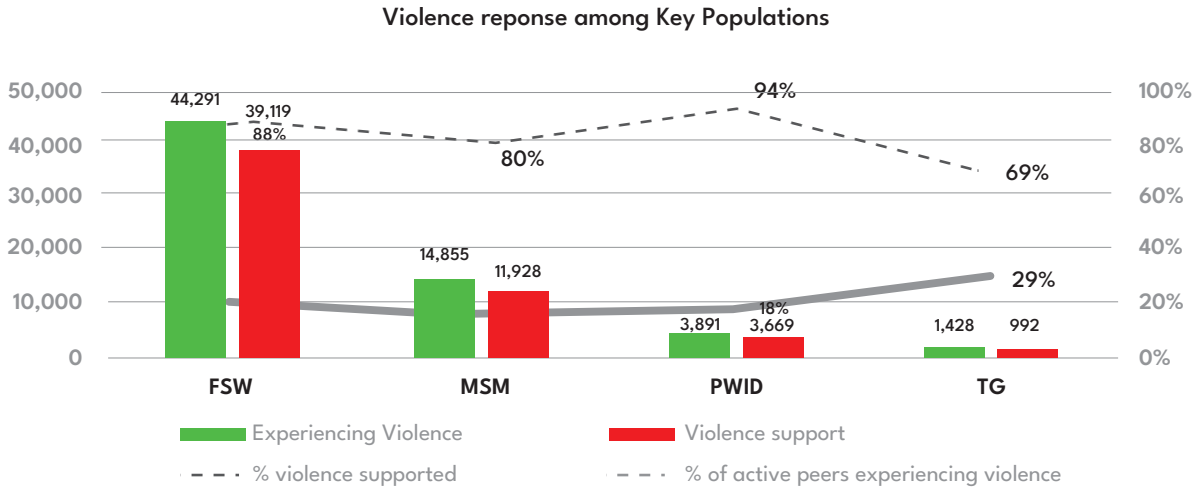


Figure 41: Violence among key populations
Source: Ministry of Health, Kenya Health Information System, 2024

The transgender population reported the highest levels of violence, with 29% of active peers experiencing violence, yet had the lowest access to violence response support at 69%. FSW followed, with 21% of peers reporting experiences of violence, while 17.8% of PWID and 17.0% of MSM also reported violence. These findings highlight critical gaps in both violence prevention and response mechanisms, particularly for transgender people who face compounded risks due to stigma, discrimination, and social exclusion.

Coverage Cascades of Key Population Programmes

Coverage Cascades of Key Population Programmes
Using a Programme Science approach, coverage gaps were analyzed through an effective programme coverage cascade (Lancet, 2024), which assesses how well interventions reach and serve intended populations. This structured approach helps identify where along the service delivery chain key population programmes lose effectiveness, guiding targeted action to improve reach, access, and impact. The cascade includes four key domains:

- **Required coverage** defines the estimated subpopulations that should benefit from specific services and sets targets for programme outputs and outcomes.
- **Availability coverage** measures the capacity of programmes to provide these services within prioritised geographies and populations.
- **Contact coverage** assesses the extent to which target populations are reached and engaged by service providers.
- **Utilisation coverage** measures actual uptake of services relative to targets and links directly to observed programme outcomes.

Contact coverage by year and typology of key populations
The HIV program contact coverage performance was low across typologies of Female Sex Workers (73%), Men who Have Sex with Men (53%), People Who Inject Drugs (71%) and Transgender People (65%) in 2024 highlighting significant contact gaps.

KEY POPULATION TYPOLOGY	% COVERAGE 2020	%COVERAGE 2021	% COVERAGE 2022	% COVERAGE 2023	% COVERAGE 2024
FSW	101%	83%	93%	118%	73%
MSM	203%	104%	124%	113%	53%
PWID	126%	63%	85%	57%	71%
TG	14%	22%	73%	74%	65%

Figure 41: Contact coverage by year and typology of key populations
Source: Ministry of Health, Kenya Health Information System, 2020-2024

Applying a Programme Science Approach to Identify Gaps and Strengthen Key Population Programming

A 2025 gap analysis of key prevention and treatment programmes identified several priority gaps, providing an opportunity to strengthen embedded research and learning. The findings will guide the development of targeted, equity focused approaches to address these gaps and accelerate progress toward population level impact.

i. Gaps from HIV testing coverage

While HIV testing programmes faced a consistent 8% gap in test kit availability across all groups, the outcomes diverged significantly: among female sex workers, 19% had no clinic contact and 22% did not get tested; similarly, 18% of people who inject drugs were not contacted and 22% did not utilize services; and for transgender people, 13% were not reached and 23% did not get tested. This contrasts sharply with men who have sex with men, who achieved near-universal testing uptake despite the same supply challenge, highlighting a critical disparity in programme outreach and engagement.

ii. Gaps from Condom coverage

Despite a systemic 54% condom stockout rate across facilities, population-specific gaps emerged: 12% of FSWs were unreached by peer educators and 57% had unmet condom needs, while 22% of PWID and 28% of TG people lacked adequate peer contact, culminating in severe utilization gaps where 29% of MSM, 48% of PWID, and 68% of TG people did not receive sufficient condoms, collectively undermining HIV prevention efforts.

iii. Gaps from PrEP coverage

A systemic PrEP shortage, affecting 63% of facilities, was compounded by eligibility screening gaps (13% of FSW, 19% of MSM, and 9% of PWID not screened), culminating in severe under-utilization where 68% of eligible FSW, 66% of eligible MSM, and 90% of eligible PWID were not initiated on the preventative treatment.

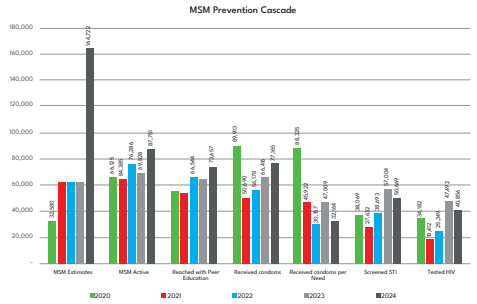
iv.Gaps from Harm reduction coverage

Despite 37% of drop-in centers facing needle and syringe shortages and 22% of PWID being unreached by peer educators, the harm reduction gap was most severe in treatment access, with 18% lacking clinic contact and a substantial 68% of those requiring medically assisted therapy not enrolled.

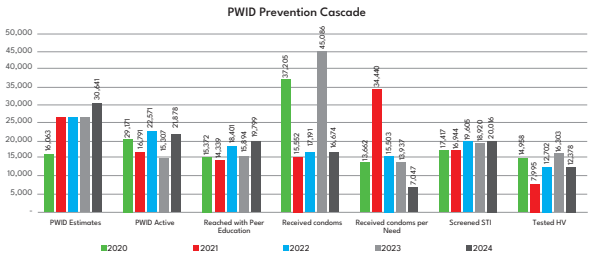
v. Gaps from Treatment coverage

While ART commodities were widely available with only a 3% stockout rate, critical contact and utilization gaps persisted: 69% of FSW, 58% of MSM, 66% of PWID, and 68% of transgender people living with HIV were not in contact with ART clinics, resulting in 65%, 53%, 62%, and 33% not utilizing treatment respectively, revealing systemic failures in linkage and retention rather than supply.

MSM Prevention Cascade

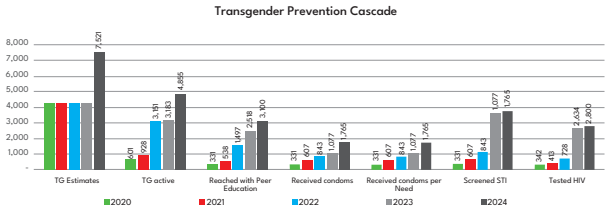


PWID prevention cascade



FSW Prevention cascade

Transgender Prevention cascade



HIV Testing Coverage

Quarterly HIV testing remains below target across all key population typologies; signaling the need to strengthen differentiated service delivery models for these population groups.

i. Among female sex workers (FSWs), 46 percent did not test for HIV, even though 79 percent of the active population were screened for sexually transmitted infections (STIs) by clinical teams. Fifteen percent of active FSWs did not receive peer education in 2024, and there was a substantial gap in condom provision relative to need.
ii. Among men who have sex with men (MSM), 53 percent did not test for HIV despite 58 percent being screened for STIs. Sixteen percent of active MSMs did not receive peer education in 2024, although 88 percent received condoms, and 6 percent of those who received condoms did not receive peer education, highlighting persistent outreach service delivery gaps.
iii. For people who inject drugs (PWID), 90.5 percent received peer education and 76.2 percent received condoms, yet only 42.3 percent of those who received condoms were supplied according to need.
iv. Among transgender persons, the active population grew by 52.3 percent; however, only 63.9 percent received peer education, 36.4 percent received condoms, 77.2 percent were screened for STIs, and 57.7 percent tested for HIV.

Prevention outcomes

• Condom usage

Findings from the 2024 IBBS indicate that condom use among all key populations remains below global targets. Among sub-populations, condom use at the last sexual encounter with a casual or one-time partner was lowest among transgender persons (60.9%). Among FSW, 77.0% reported condom use with a one-time client, while 75.7% of MSM reported condom use with a casual partner.

• PrEP knowledge and use among key populations

Awareness and use of oral pre-exposure prophylaxis (PrEP) vary across key populations. Knowledge of PrEP was highest among FSW at 92.8%, followed by transgender persons at 89.4%, MSM at 86.2%, and PWID at 78.3%. FSW also reported the highest proportion of ever using PrEP (41.3%), followed by MSM (33.7%), while PWID and TG had lower levels of PrEP use at 27.6% and 15.6%, respectively. Current PrEP use ranged from 8.7% among PWID to 31.0% among FSW.

• Treatment cascades

Progress toward the 95–95–95 targets among key populations shows mixed trends, with all three groups achieving high testing and treatment coverage but lagging in viral suppression. Among FSW, 94.5% are aware of their HIV status and 97.7% of those diagnosed are on treatment, yet only 86.9% are virally suppressed, suggesting gaps in adherence. Among MSM, 93% are aware of their HIV status and 99% of those diagnosed are on treatment, yet only 89% are virally suppressed, suggesting gaps in adherence and continuity of care. People who inject drugs show similarly strong testing (95%) and treatment uptake (99%), but viral suppression remains at 89%, likely influenced by unstable living conditions, stigma, and co-occurring substance use challenges. Transgender people exhibit slightly lower testing coverage (92%) but have strong treatment (99%) and viral suppression (92%) outcomes, reflecting the impact of community-led service models.

• Stigma and discrimination

Experiences of stigma and discrimination remain widespread among key populations as reported during IBBS 2024. Nearly half of FSW (46.7%) and transgender persons (52.1%), and about two-thirds of PWID (67%) reported experiencing stigma. Among all typologies, MSM reported the lowest levels of stigma. Discrimination within healthcare settings was highest among PWID (78.6%), compared to 48.4% among transgender persons and 44.9% among MSM.

People with disabilities need to be included in policy-making, especially in decisions that directly affect us. We must be part of conversations that strengthen our meaningful involvement in Kenya's HIV and syndemic disease response. We should actively participate in program design, implementation, and monitoring; address barriers to equitable access to prevention, treatment, and care services; promote disability-inclusive health policies and data systems; and build partnerships that ensure no one is left behind in the national response.

Catherine Syokau, National PWD TWG

2.6 Persons living with Disabilities

Persons living with disabilities (PWDs) in Kenya face stigma, discrimination, and limited access to sexual and reproductive health information and services, increasing their vulnerability to HIV infection. Women and girls with disabilities are particularly at risk due to higher levels of sexual violence and exploitation. Although data remain limited, a study among deaf people found that nearly 7 percent were living with HIV; significantly above the national average. Access to health and HIV services remains inadequate, hindered by physical and informational barriers, stigma, and a lack of inclusive programming. Few PWDs receive sexual education, and information materials are rarely adapted to their communication needs. Only 16 percent of women with disabilities aged 12–49 use any form of contraception compared to 20 percent of all women, and 13 percent use a modern method compared to 16 percent nationally. The 2023 Support Needs Assessment found that over half of PWDs required financial assistance to access health services, and privacy during testing is often compromised due to the shortage of trained VCT counsellors. Persistent misconceptions that persons with disabilities are sexually inactive or not at risk of substance use continue to marginalize them from HIV policy, prevention, and care efforts.

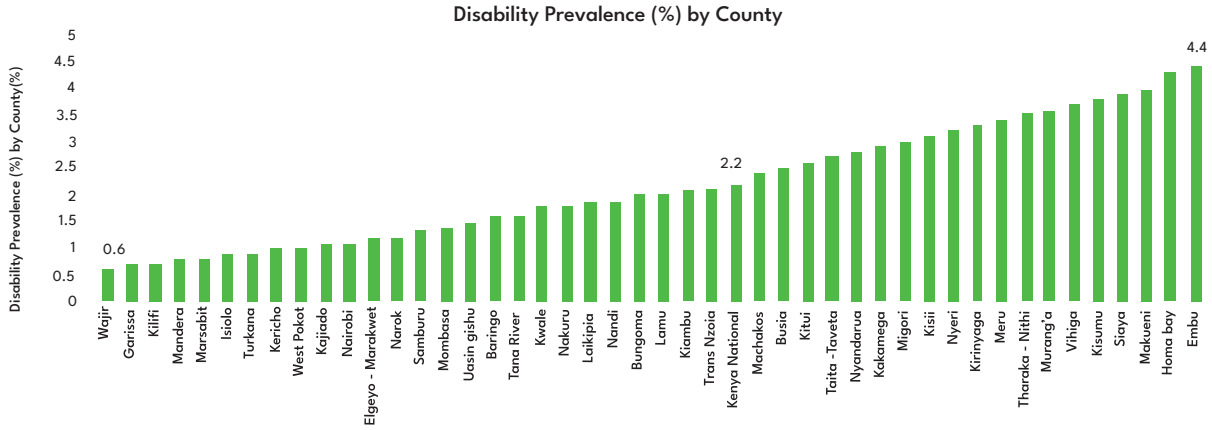


Figure 42: Percentage Distribution of Persons with Disabilities by Sender and Support Needed to Access Health and Rehabilitation Services
Source: Kenya National Bureau of Statistics (KNBS), 2019 Kenya Population and Housing Census: Analytical Monograph on Disability Volume XV, April 2022

Strengthening Community Leadership in the HIV Response

Communities remain central to Kenya's HIV response, playing vital roles in advocacy, service delivery, and accountability. Through the Ministry of Health, the National Syndemic Diseases Control Council (NSDCC), and NASCOP, structures and platforms have been established to enable meaningful community engagement at all levels of policy and programme implementation. Communities, including key and vulnerable populations, people living with HIV, and adolescents and young people, continued to lead and implement community-based and community-led interventions that expand access to HIV prevention, treatment, and care services.

Working alongside health facilities and county governments, peer mentors such as adherence counsellors, mentor mothers, and other peer cadres partnered with Community Health Promoters to reach their peers with essential services. Communities have also been instrumental in creating demand for HIV and TB services, promoting messages such as "Undetectable Equals Untransmittable (U=U)," and addressing stigma and discrimination. Notably, women living with HIV have been engaged as mentor mothers in the Prevention of Mother-to-Child Transmission (PMTCT) programme, supporting their peers to maintain treatment and prevent transmission to infants which is a key driver of Kenya's progress toward eliminating mother-to-child transmission.

In scaling up treatment, communities have worked with NASCOP and county governments to expand Differentiated Service Delivery (DSD) models, including Community ART Groups (cARGs) and Community Pharmacy Models (CPMs). These models provide individualised HIV treatment and strengthen community ownership while reducing the burden on health facilities. Community pharmacies not only dispense ART refills but also support recipients of care in monitoring treatment and adherence.

Communities have also played a vital role in improving service quality through community-led monitoring. In 2024, networks of recipients of care monitored access, availability, and quality of HIV, TB, and malaria services in 25 high-burden counties, generating evidence used by county governments to improve service delivery. Supported by the Global Fund, this model demonstrates how community feedback strengthens health systems, protects human rights, and enhances accountability across the HIV response.

SECTION THREE

INTEGRATION AS THE PATHWAY TO SUSTAINABILITY AND SYSTEM RESILIENCE

As Kenya moves closer to ending AIDS as a public health threat, lessons from this reporting period highlight that fragmented service delivery, unequal access, and limited resources continue to hinder universal coverage. Integration provides the clearest pathway to address these challenges by aligning programmes, systems, and resources to deliver people-centred, efficient, and sustainable care.

Through integration, Kenya can strengthen service delivery platforms, optimise the use of existing infrastructure and workforce, and improve outcomes across HIV, TB, malaria, non-communicable diseases, and mental health. Integrated systems promote equity by ensuring that individuals receive comprehensive care within a single continuum, while reducing duplication, enhancing accountability, and advancing progress toward Universal Health Coverage (UHC).

The next phase of Kenya's HIV response will prioritise deeper integration across all pillars of the health system, embedding innovation, digital transformation, and community leadership to sustain epidemic control and build resilience against emerging health threats.

HIV Integration in the Kenyan Context

Kenya's integration agenda seeks to embed the HIV response within a holistic and sustainable health system that promotes access, efficiency, and reduced stigma. Integration spans service delivery, community engagement, health information systems, financing, and policy coordination.

The World Health Organization (WHO) identifies six building blocks of a strong health system: effective and equitable delivery service, a skilled and motivated workforce, reliable information systems, access to health products and technologies, sustainable health financing, and strong leadership and governance. Together, these elements strengthen efficiency, equity, and resilience toward achieving UHC.

The Kenya AIDS Strategic Framework (KAISF) 2025–2030 is anchored on these six building blocks, guiding the country's transition to an integrated and sustainable HIV and syndemic disease response. Each pillar defines strategic priorities that promote efficiency, coordination, and innovation, ensuring that HIV prevention, treatment, and care remain central to Kenya's broader UHC agenda.

Table 3 provides a snapshot of the six pillars, their priority areas, the corresponding integrated strategies, and the recommended interventions that collectively define the national response. Together, these elements form a coherent roadmap for sustaining gains, addressing emerging challenges, and advancing a resilient and inclusive health system for all Kenyans.

Pillar	Priority Area	Integrated Strategy	Recommended Interventions
 Service Delivery	Optimize HIV service delivery models; address programmatic gaps; strengthen community-based responses	- Target interventions for counties and sub-populations - Integrate digital health with unique identifiers - Ensure quality service accountability - Reinforce peer-to-peer community engagement	- Implement targeted county and population interventions - Deploy digital health systems with unique IDs - Strengthen community social intelligence systems - Support peer initiatives
 Leadership, Governance, Accountability	Strengthen governance and accountability frameworks; modernize legal and policy environment	- Enhance multi-sectoral accountability mechanisms - Review and update legal frameworks for HIV prevention and treatment - Develop integrated implementation plans at national and county levels	- Establish monitoring and evaluation systems - Coordinate resource alignment and policy enforcement - Promote inclusive and evidence-based governance processes
 Health Products & Technologies (HPT)	Ensuring access to essential commodities; scale-up combination prevention interventions	- Facilitate availability of condoms, lubricants, medicines - Adopt scientific advancements in prevention and treatment	- Strengthen supply chains for HIV commodities - Expand biomedical prevention options targeting key populations
 Health Information Systems (HIS)	Develop integrated digital data systems; strengthen M&E; implement unique ID tracking	- Promote data integration and sharing across programs - Monitor progress with robust indicators - Use unique identifiers for service tracking	- Build interoperable health information platforms - Regular data quality assessments - Strengthen feedback loops for program improvement
 Health Financing	Align financial resources with priorities; promote sustainability and efficiency	- Optimize domestic and external funding mechanisms - Prioritize allocation for equity and epidemic control	- Enhance budget planning and execution - Establish sustainable financing models - Strengthen financial accountability systems
 Human Resources for Health (HRH)	Build workforce capacity; engage community health workers and peers; address regional disparities	- Conduct needs assessments - Strategic training and mentorship programs - Scale community and peer health initiatives	- Recruit and retain health workers in underserved areas - Implement continuous capacity development - Foster community health worker integration

Contributors

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This progress report was designed and laid out by Sanday Thomas.

ENDING **AIDS** AS A PUBLIC **HEALTH THREAT** BY **2030**

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