2014/2015 - 2018/2019

Ministry of Health

KENYA AIDS STRATEGIC FRAMEWORK

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National AIDS Control Council

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Treatment/Therapy
ARV	Anti-Retroviral Drugs
BCC	Behaviour Change Communication
BMGF	Bill and Melinda Gates Foundation
CBO	Community Based Organisation
CCC	Comprehensive Care Centre
CCM	Country Coordination Mechanism
CHEWs	Community Health Extension Workers
CHW	Community Health Worker
CS	Cabinet Secretary
CSO	Civil Society Organisation
DHIS	District Health Information System
DOSH	Department/Division of Occupational Safety and Health
DTC	District Technical Committee
EBI	Evidence Based Intervention
eMTCT	Elimination of Mother to Child Transmission
ETR	End Term Review
EPHT	Environmental Public Health Tracking
FBO	Faith Based Organisation
FMS	Financial Management System
FSW	Female Sex Worker
GBV	Gender Based Violence
GoK	Government of Kenya
HBC	Home Based Care
HBTC	Home Based Testing and Counselling
HCBC	Home and Community Based Care
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPV	Human Papillomavirus
HR	Human Resources
HTC	HIV Testing and counseling
IEC	Information, Education, and Communication
IGAD	Intergovernmental Authority on Development
ILO	International Labour Organization
IPC	Infection Prevention and Control
KAIS	Kenya AIDS Indicator Survey
KASF	Kenya AIDS Strategic Framework
KDHS	Kenya Demographic and Health Survey
KEPH	Kenya Essential Package for Health
KNASP	Kenya National AIDS Strategic Plan
KP	Key Populations
LGBT	Lesbian, Gay, Bisexual and Transgender
MDAs	Ministries, Departments and Agencies
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MOT	Modes of Transmission
MSM	Men who have Sex with Men
MSW	Male Sex Worker
MTR	Mid-Term Review
NACC	National AIDS Control Council
NASCOP	National AIDS & STI Control Programme
NBTS	National Blood Transfusion Service
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organisations
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PITC	Provider-initiated Testing and Counselling
PLHIV	People Living with HIV and AIDS
PMS	Post Marketing Surveillance
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
PwD	People/Persons with Disabilities
PWID	People Who Inject Drugs
PHDP	Positive Health, Dignity and Prevention RBM Results Based Management
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Workers
TB	Tuberculosis
TOWA	Total War against HIV and AIDS
TTI	Transfusion Transmissible Infection
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medically Assisted Adult Male Circumcision
WHO	World Health Organisation

FOREWORD

Kenya is part of a dynamic African region experiencing economic growth and recently categorised as a low middle income country. The Constitution of Kenya reflects this changing context with health being a priority because improving development is particularly essential to building skilled and competitive workforce and lifting people's living standards.

Progress has been made with HIV prevalence dropping 2 percentage points in the last 5 years and new infections among children almost halved. HIV however, continues to contribute the highest mortality rates, burdening households and straining national health systems. With this understanding, the Kenya AIDS Strategic Framework exemplifies the firm commitment by key stakeholders to support National and County governments to deliver better health for all with a focus on cost effective and socially inclusive interventions to prevent and manage HIV and AIDS.

This Strategic Framework focuses on leadership in the HIV response. It emphasises an equitable HIV response that ensures no one is left behind. This is a priority for Kenya to achieve her goals. It promotes calibration of our efforts through effective prioritisation of interventions. It focusses on effective evidence-based investments, which target priority populations while ensuring that all Kenyans are reached and stigma and discrimination are reduced for improved health outcomes.

This Strategic Framework is aligned to the Constitution of Kenya, the Vision 2030, and the African Union goals on HIV control. It recognises the centrality of a multi-sectoral response to HIV and outlines roles and expected actions from different sectors and actors. A co-ordination and governance structure, led by the NACC, takes cognisance of Devolution and functions of different levels of Government, roles of other Government Ministries and Agencies and the need for strengthened stakeholder accountability for results.

Increasing domestic and sustainable financing for HIV is a priority for the Government. The KASF outlines an innovative leverage funding approach based in implementation of the HIV Fund that will increase resources, increase access to universal healthcare for those living with HIV and ultimately subsidise Kenya's future liability for HIV prevention and treatment.

In this regard, therefore, my Ministry is committed to facilitating achievement of the results articulated in this Strategic Framework. In doing so, we will build on the progress made so far through decades of hard work; unity of purpose, courage and commitment to step up the momentum towards ending the AIDS pandemic.

Hon. James Wainaina Macharia
Cabinet Secretary, Ministry of Health

PREFACE

The Kenya AIDS Strategic Framework (2014/15-2018/19) marks a milestone in the country's response to HIV in the wake of a new constitutional dispensation that has manifested itself in the peoples' desire for change, government accountability and democracy. At the heart of this change is the concept of devolution of political and economic power to 47 newly-created counties.

In developing this Strategic Framework for the country's HIV response, the National AIDS Control Council (NACC) has taken cognisance of the new governance structure in the country, which requires that we shift the characterisation of the HIV response from "crisis management" to "strategic and sustainable" mode. NACC understands the importance of engaging all stakeholders in developing the KASF; and in working together with our collaborators over the last several years, we have been able to register some marked progress in a number of critical areas in our HIV response.

On its part, the Government of Kenya, through the Constitution and the Vision 2030, has created an enabling and secure environment that allows the country to build a fair and unified society by addressing some central factors that affect human capital including the health of its population. This Strategic Framework requires that all actors pay particular attention to vulnerable and marginalised groups. This paradigm shift calls for the utilisation of social, behavioural, cultural, biomedical, scientific, technological and implementation science innovative interventions as inputs to make real progress in HIV prevention, treatment and impact mitigation.

Our key strategic objectives in the next five years include the following:

1. Reduce new HIV infections by 75%
2. Reduce AIDS related mortality by 25%
3. Reduce HIV related stigma and discrimination by 50%
4. Increase domestic financing of the HIV response to 50%

Let us all join hands as we deepen and strengthen our response while seeking innovative ways to sustain our response in all the counties. If we pull together our vision of a Kenya free of HIV infections, stigma and AIDS related deaths will be a reality.

Prof. Mary N. Getui, MBS

Chairman, National AIDS Control Council

ACKNOWLEDGEMENTS

It is with pleasure that we launch the Kenya AIDS Strategic Framework (KASF) 2014/15 to 2018/19, which seeks to provide the guidance for addressing the HIV and AIDS epidemic in Kenya taking cognizance of our administrative arrangements.

This AIDS Strategic Framework will provide direction to all stakeholders in the HIV response to deliver HIV programming. It draws on our past successes, and lessons learnt and gives us the opportunity to provide the direction for our future. It emphasizes a multi sectoral approach and accountability among partners. This framework has been developed through the efforts of a large number of people. Citizen participation as espoused in the Constitution has driven its development.

In particular, we thank the Cabinet Secretary, the Principal Secretary, the Director of Medical Services and the Ministry of Health at large. I thank NACC Council members, NACC staff and the NASCOP team. We wish to thank the Counties for their engagement, support and consultations. We thank the Council of Governors for the HIV and AIDS consultative forum and the Parliamentary Committee on Health. Development partners, public sector institutions, private sector players, civil society organisations, assorted technical working groups (TWG) members, faith-based organizations and communities, key population representatives, People Living with HIV (PLHIV), Persons with Disabilities (PwD) and the elderly brought their efforts, time to bear on the consultations. Government agencies in the public sector participated and we are grateful. It is from these engagements that we have put forth a vision, setting us on a trajectory that will assure our achievement of national and international HIV goals.

We wish to acknowledge with deep gratitude the contribution of various partners during the development, review and printing of this document. Specifically, we thank the UN Joint Team on HIV including UNAIDS, UNDP, WHO, ILO, UNICEF, UNWomen, UNFPA, UNODC, World Bank; the US Government for its support through the President's Emergency Plan for AIDS Relief (PEPFAR) and it's agencies USAID, CDC and DOD; the International AIDS Vaccine Initiative (IAVI), Bill and Melinda Gates Foundation (BMGF) and the Global Fund for HIV, TB and Malaria. We acknowledge the different levels of effort, financial and technical support by Implementing Partners who we cannot all name here.

NACC is committed to strengthened coordination, fostering collaboration and facilitating delivery of a successful HIV response.

NDUKU KILONZO, Ph.D

Director, National AIDS Control Council

EXECUTIVE SUMMARY

The Kenya AIDS Strategic Framework (KASF) 2014/15-2018/19, is the Strategic guide for the country's response to HIV at both national and county levels. The framework addresses the drivers of the HIV epidemic and builds on achievements of the previous country strategic plans to achieve its goal of contributing to the country's Vision 2030 through universal access to comprehensive HIV prevention, treatment and care.

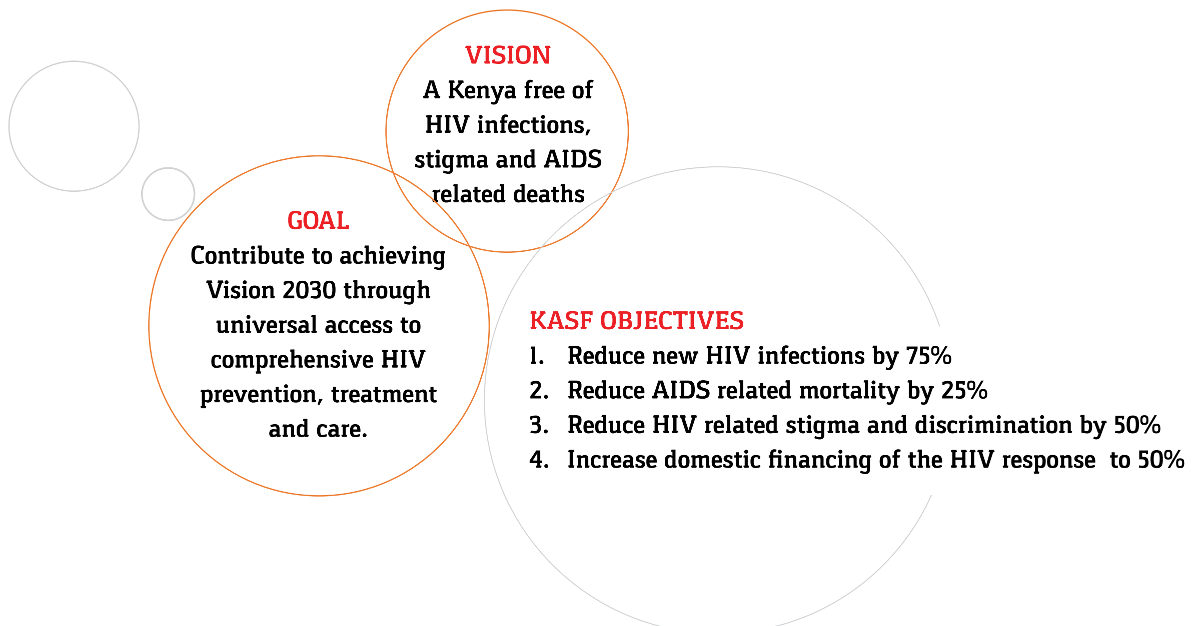
KASF is aligned with the Constitution of Kenya 2010, which envisions a new environment for the governance and management of the national HIV and AIDS response. The Constitution has not just changed the policy environment for the national HIV and AIDS response, but also presents a major paradigm shift in the governance framework for response.

This Strategic Framework, premised on Kenya's Vision 2030 description of HIV and AIDS as "one of the greatest threats to socioeconomic development in Kenya" marks a change in the approach of managing the national response from doing "business as usual" to evidence and results-based multi-sectoral and decentralised planning. KASF has also mainstreamed gender and human rights in all aspects of the response planning and service delivery.

The KASF 2014-2019 succeeds KNASP III that came to an end in June 2014. It builds on past KNASP successes, partnerships, leadership and legislations. The KASF also provides strategic policy, planning and implementation guidance and leadership for a co-ordinated multi-sectoral response to HIV and AIDS in Kenya.

The framework is aligned to the "Three Ones" Principles that guide the country's authorities and their partners and investment case approach with emphasis on geographical, population and intervention prioritisation, feasibility and sustainability for impact. Moreover, KASF is aligned with international, regional and national obligations, commitments and targets related to HIV and AIDS.

The KASF is driven by Kenya's long-term vision for HIV control by 2030 in line with Kenya's economic and development vision of creating a globally competitive and prosperous nation with a high quality of life by 2030.



STRATEGIC DIRECTIONS AND INTERVENTION AREAS	
Strategic Directions	**Priority intervention areas**
1 Reducing new HIV infections	■ Increase coverage of combination HIV prevention interventions ■ Prioritise populations and geographic locations for an equitable HIV response. ■ Leveraging on different sectors and emerging technologies for HIV prevention ■ Maximising on the efficiencies and effectiveness of an integrated HIV,TB/SRH prevention response
2 Improving health outcomes and wellness of all people living with HIV	■ Improve timely identification and linkage to care for persons diagnosed with HIV ■ Increase coverage of care and treatment with a particular focus on reducing the loss in the cascade of care ■ Scale up interventions to improve quality of care and improve health outcomes ■ Scale up nutrition interventions to improve nutrition status and improve health outcomes
3 Using a human rights approach to facilitate access to services for PLHIV, Key populations and other priority groups in all sectors	■ Remove barriers to access of HIV, SRH and rights information and services in public and private entities ■ Improve National and County legal and policy environment for protection of priority and key populations and people living with HIV ■ Improve access to legal and social justice and protection from stigma and discrimination in the public and private sector ■ Using Human rights approach to assist programs to pursue zero tolerance to stigma and discrimination.
4 Strengthening integration of health and community systems	■ Build a competent, motivated and adequately staffed workforce at National and County levels to deliver HIV services integrated in the essential health package. ■ Strengthen health service delivery system at national and county levels for the delivery of HIV services integrated in the essential health package ■ Improve access to and rational use of quality essential products and technologies for HIV prevention, treatment and care services ■ Strengthen community service delivery system at national and county levels for the provision of HIV prevention, treatment and care services
5 Strengthening research and innovation to inform the KASF goals	■ Resource and implement an HIV research agenda informed by KASF ■ Increase evidence-based planning and use of implementation science outcomes to optimise programming and policy changes ■ Strengthen synergies between HIV research and other disease and development areas
6 Promoting utilisation of strategic information for research and monitoring and evaluation (M&E) to enhance programming	■ Implement a unified and functional M & E framework under the NACC ■ Strengthen M & E capacity to effectively track KASF performance and the HIV epidemic at national and county levels and across sectors ■ Conduct regular evaluations of the HIV prevention and treatment cascade at the county level to gauge programme effectiveness
7 Increasing domestic financing for a sustainable HIV response	■ Promote innovative and sustainable domestic HIV financing options ■ Align HIV resources/investment to the Strategic Framework priorities ■ Maximise efficiency of existing delivery options for increased value and results within existing resources
8 Promoting accountable leadership for delivery of the KASF results by all sectors and actors	■ Build and sustain high level political and technical commitment for strengthened country and county ownership of the HIV response ■ Entrench good governance and strengthen multi-sector and multi-partner accountability to delivery of KASF results ■ Establish and strengthen functional and competent HIV co-ordination mechanism at the national and county level

01 INTRODUCTION

"It is only through combining the resources of all sectors that the KASF goals and objectives can be achieved"

Why the Kenya AIDS Strategic Framework

The policy environment of the HIV response is defined by the Constitution of Kenya, 2010 (which establishes a right "to the highest attainable standard of health") and the resulting devolution of the responsibility for the implementation of most health services including the HIV response at county level; the national development strategy, ***Vision 2030***, which underscores the importance of health as a key building block in transforming Kenya into a successful middle-income country; the HIV policy of 1999, which defines HIV as a disaster and provides a framework for a multi-sectoral response; and the Kenya Health Policy that prioritises the elimination of communicable diseases.

Since 2000, the country has developed strategic plans for the HIV response, which laid out specific results and strategies for delivering HIV services countrywide. For the period 2015-2019, there is a shift to the development of a strategic framework in order to take into account the devolution of most health services to county governments. The Kenya AIDS Strategic Framework (KASF) has been developed to guide the delivery of HIV services for the period 2015-2019. This framework succeeds the Kenya AIDS Strategic Plan 2009-2014. The KASF defines the results to be achieved in the next five years and offers broad strategic guidance to counties on the co-ordination and implementation of the HIV response. County governments will use the framework to develop HIV plans relevant to the local HIV epidemic.

This Strategic Framework is, therefore, a guide for coordination and implementation of the HIV response; and a resource mobilisation, allocation and accountability tool. It ensures that the HIV response remains multi-sectoral, key institutions both at national and county level play their critical mandates synergistically to achieve common results; and that there is flexibility to address micro effects of the HIV epidemic at the county level.

1.1.1 Development of KASF

This plan was developed through in-depth analysis of available data and a highly participatory process involving a wide range of stakeholders from government; civil society including non-governmental organisations, faith based organisations, networks of people living with HIV and key affected populations; private sector and development partners. Key aspects of the KASF development process include:

- **End term review of KNASP 2009-2014:** the KNASP review identified the achievements, strengths and weaknesses of the current HIV response and the gaps relevant to the HIV epidemic that need to be addressed under KASF 2015-2019.

- **Establishment of an oversight committee:** The KASF oversight committee provided leadership, policy and strategic guidance for the development of the KASF. This committee was chaired by NACC with membership from all sectors. It served as the overall decision making body in the KASF planning process.

- **KASF task force:** The Task Force provided technical leadership and guidance to KASF planning with a focus on the quality of the thematic frameworks developed by the Technical Teams. The Task Force provided technical feedback to the Technical teams, and provided advice and sought strategic and policy direction from the oversight committee.

- **Technical Teams:** These Teams reviewed available data and defined the results and strategic interventions for each thematic area of KASF. Teams established included HIV Prevention; Treatment, Care and Support; Social Inclusion, Financing, HIV Research; Health and Community Systems strengthening; Co-ordination, Governance, Leadership and Management; Monitoring and Evaluation and HIV Financing. Membership of the technical teams was open to provide a platform for wide stakeholder participation.

- **Citizen Participation:** Stakeholder consultations fora were held in all the 47 counties to collect information on the HIV epidemic, needs and challenges in accessing HIV services across the country. HIV implementers and networks of beneficiaries participated in the consultative meetings and provided their perspective on how the HIV response can be improved going forward.

- **Consultations with County governments:** Consultation was done with the Council of Governors including the members of County Executive Committees of the 47 counties and through dialogue led by Governors spouses.

- **Peer review of the strategic framework:** This was done by wide range of experts ranging from technical officers, program managers, academicians, researchers and civil society.

1.1.2 The context of KASF delivery

Devolution: The Constitution of Kenya 2010 provides the primary framework against which the KASF will be delivered. In particular, Article 6 (of Chapter 2) and chapter 11 broadly define and describe Kenyan devolution mechanism, dividing Kenya into 47 counties with assignment of functions to different levels of government that are *"distinct and Interdependent and are to undertake their mutual relations through consultations and co-operation"*. The implementation of the Constitution 2010 has necessitated new arrangements in co-ordination of the response at national and county levels as well as the monitoring and evaluation framework that are outlined in this KASF.

Prioritisation of the HIV epidemic: The HIV epidemic in Kenya is heterogeneous in nature, manifesting differently in different populations and geographic areas. The KASF recognises this by identifying priority populations and recommending actions tailored to address these differences.

Multi-sector responsibilities: Actual implementation of the KASF is the responsibility of a wide range of implementing partners from the public and private sectors and civil society. The Ministry of Health plays a key role in the multi-sectoral response, for technical direction and service delivery in biomedical areas of prevention, treatment and care.

Other sectors beyond health are impacted and have developed interventions and invested resources for the HIV response. National Ministries, State Departments, State Corporations and parastatals have established AIDS Control Units with budget line to coordinate mitigation of negative socio-economic impacts of HIV and AIDS through sectoral mainstreaming based on comparative advantages. For instance, the Education sector has invested in the policy on HIV, Labour and Social Security has made investments in social protection of Orphans and Vulnerable children (OVCs) while the road sub-sector has included HIV clause in the registration of contractors, construction contracts and projects.

County Governments are responsible for HIV services at the county level and have a responsibility to customise the KASF and mobilise the resources for the county multi-sectoral response to HIV and AIDS.

The Private Sector organisations have a responsibility to mainstream HIV and AIDS through workplace policies and programmes while NGOs, FBOs and CBOs form the core of the implementing agencies with a responsibility to implement workplace programmes and among other things carry out advocacy and community mobilisation for uptake of HIV prevention, treatment, care and support services. Development Partners support national and county priorities and facilitate implementation of KASF with funding, technical support and capacity building.

This KASF provides guidance on how to align these interventions for optimal efficiency of the HIV response. It is only through combining the resources of all sectors that the KASF goals and objectives can be achieved. The National Ministries, State Departments and their affiliated institutions will review their policies and identify steps that they can take to support the implementation of this KASF. The NACC will work with the various sectors and County Governments to encourage co-ordinated development of comprehensive HIV and AIDS plans and resource allocation.

Political will, leadership and commitment: The national and county governments have demonstrated commitment towards the HIV response. His Exellency the President of Kenya has made commitments on sustainable financing for Health and HIV. The Council of Governors commitment to supporting implementation of the KASF will facilitate development, implementation and monitoring of the county HIV plans. Meanwhile, the Senate and National Assembly have facilitated legislation towards HIV.

The National AIDS Control Council (NACC) under the Ministry of Health is accountable for delivery of the results of the KASF. To deliver this, the NACC is responsible for resource mobilization and alignment to KASF, co-ordination of partners (state, private and communities) and resources to enhance efficiency and effectiveness, and reduce duplication. The deliverables of the health sector are significant in the HIV response, and are driven by the National AIDS and STI Control Programme (NASCOP) responsible for the bio-medical and structural interventions of the HIV response.

1.1.3 Alignment with National, Regional and International Policy Frameworks

The KASF is aligned to various policy frameworks to ensure its contribution to overall human development and achievement of sub-national, national, regional and international health policy objectives. These include:

i. **Vision 2030,** which identifies health as a key building block for the transformation of Kenya into a successful middle income country. HIV contributes significantly into the country's disease burden and needs to be addressed to achieve the desired health outcomes.

ii. **Health Sector Strategic Plan**, which outlines the health and community systems development priorities to ensure effective health service delivery. It also provides policy guidance on human resource for health and procurement and supply of pharmaceuticals and other medical products and health information systems, which impact on the delivery of the HIV response. In addition, the health sector leads the implementation of a large proportion of the HIV response.

iii. **UN High Level Meeting Commitments:** The KASF is aimed at enabling Kenya to meet its international commitments to achieve universal access to HIV services and to reverse the impact of the epidemic. In this regard, the Strategic Framework seeks to attain international targets in reduction of new infections, treatment and care as well as reduction of HIV related stigma and discrimination. It is also aligned to the international indicators to enable the country meet required reporting standards.

iv. **Regional HIV frameworks:** The KASF takes into account the cross-border dimension of the epidemic and defines strategies that will contribute to the objectives of regional initiatives which include the IGAD, East African Community, African Union Global Commitment on HIV, Tuberculosis and Malaria.

1.1.4 The KASF Guiding Principles

Results-based planning and delivery of the KASF: HIV programming shall be linked to the KASF and demonstrate contribution towards results.

Evidence-based, high impact and scalable interventions: preference for resources and implementation shall be assigned to high-value, high-impact and scalable initiatives that are informed by evidence.

Multi-sectoral accountability: The KASF provides guidance for interventions and results for which multiple sectors are responsible and accountability mechanisms will be established through the NACC. This will serve to increase resources and accelerate results.

National HIV testing Guidelines: The policy document provides a framework for all HTC programmes in Kenya and was developed in the constext of existing Kenyan laws and policies.

County specific plans: County specific HIV plans from the Strategic Framework will guide the HIV response in the Counties.

Country ownership and partnership: All HIV stakeholders including the government, development partners, private sector, faith-based organisations and communities of people living with HIV and Kenyan communities shall align their efforts towards the results envisioned.

Rights-based and gender transformative approaches: The success of the HIV response is dependent on protecting and promoting the rights of those who are socially excluded, marginalised and vulnerable. This KASF is cognisant of this reality and is rooted in a rights-based approach.

Efficiency, effectiveness and innovation: Kenya is now a Low Middle Income country and thus donor resources may decline, further exacerbating the HIV funding situation. The KASF has taken active steps to explore and operationalise sustainable domestic funding options through improved efficiency in service delivery and innovative approaches aimed at achieving more at reduced cost without compromising on quality.

The KASF is aligned to various policy frameworks to ensure its contribution to overall human development and achievement of sub-national, national, regional and international health policy objectives

02 SITUATION ANALYSIS

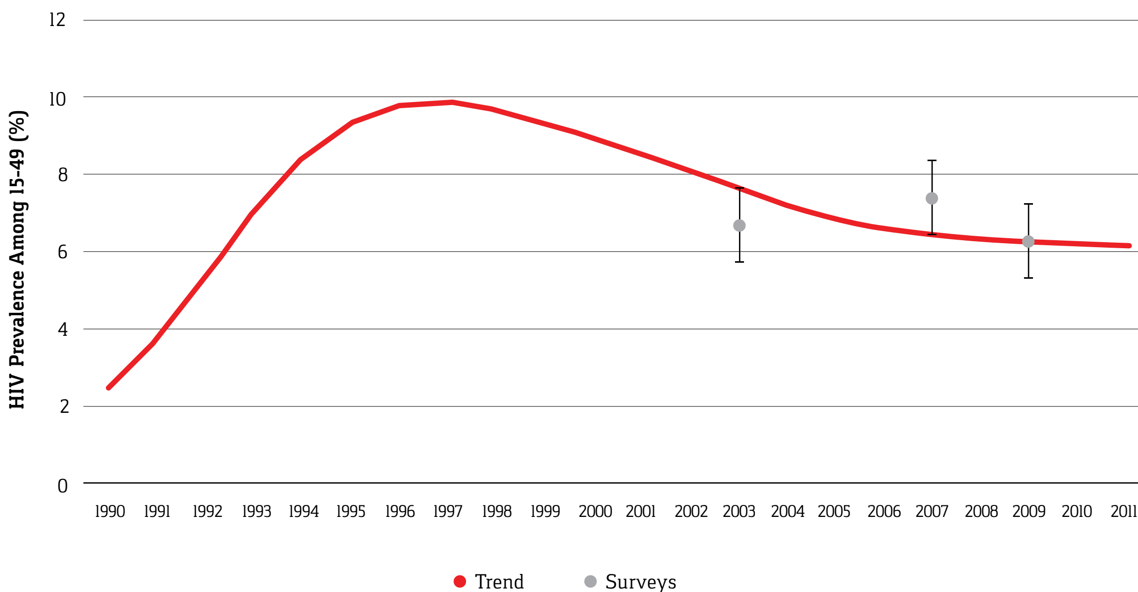
"The epidemic is deeply rooted among the general population in some regions of the country while there is also concentration of very high prevalence among key populations"

2.1

HIV epidemic analysis

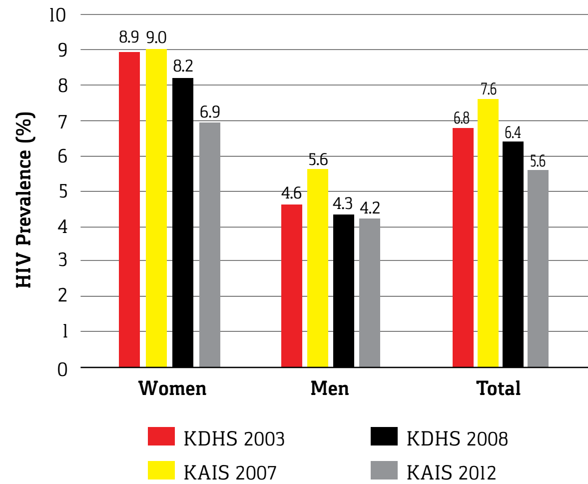
HIV prevalence trend: HIV prevalence in the general population reached a peak of 10.5% in 1995-96, after which it declined by about 40% to reach approximately 6.7% in 2003. Since then, the epidemic has remained relatively stable, with the prevalence ranging from 6.7% in 2003 to 5.6% in 2012. The stabilisation of the prevalence is largely attributed to the scale up of HIV treatment and care, while the reduction of new infections has been marginal. The major concern is how to significantly reduce infections while scaling up treatment and care. This trend is shown in the figure below.

FIGURE 1: **Trends in HIV prevalence**



HIV Prevalence by sex: as shown in the graph below, women are disproportionately affected than men and, therefore, are a key vulnerable population to be prioritised in this strategic framework.

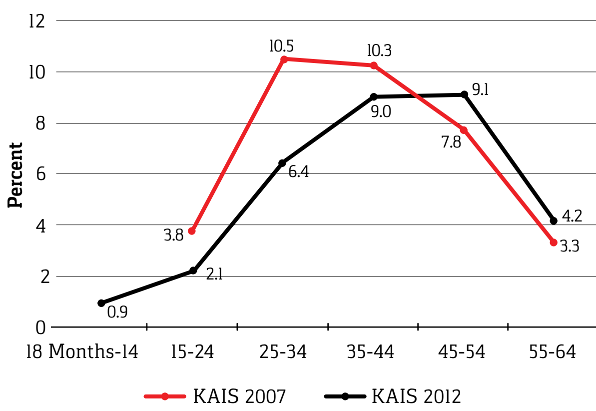
FIGURE 2: **HIV prevalence by sex**



Source: Kenya Demographic Health Survey 2003 and Kenya AIDS Indicator survey 2007,2008 and 2012

HIV Prevalence by age: HIV prevalence is highest among women and men aged 25 to 44 demonstrating the increasing need of HIV treatment and care by age. The data shows the need to target HIV prevention among this population category to reduce infection resulting from discordant couples and inter-generational sex. The graph below shows the HIV prevalence by age.

FIGURE 3: **HIV prevalence by age category**

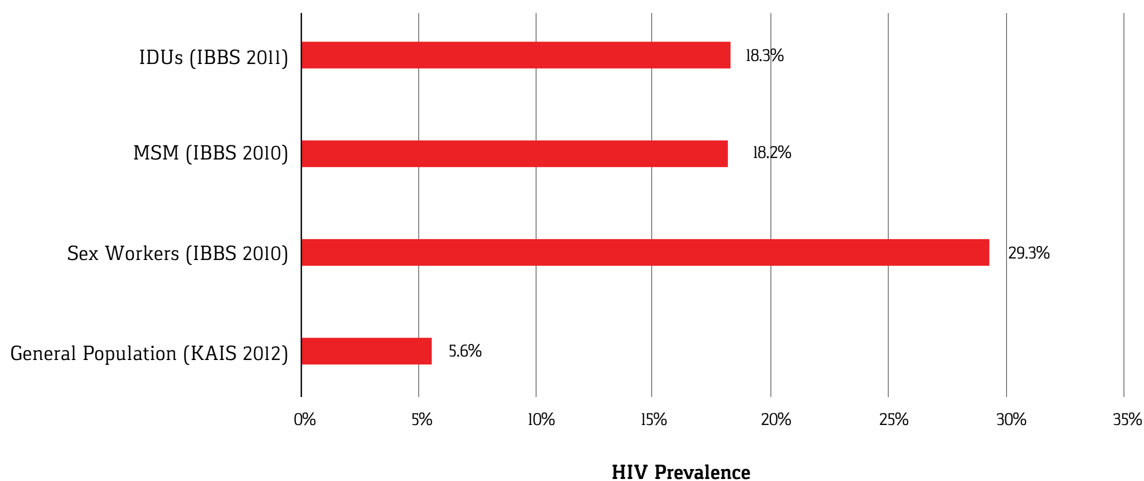


Source: KAIS 2007 and 2012

Prevalence among young people: Among young people, the odds of being infected by HIV are higher among young women aged 15-24 compared to young men. Prevalence among young women declined from 5.9% in 2003 to 4.5% in 2012 while prevalence among young men remained relatively stable (between 1.1 % and 1.5%) during the same period. Prevalence among young people 15-24 years would be largely attributed to new infections as opposed to the impact of the scale up of HIV treatment. Targeting young women is, therefore, a key priority for this HIV response.

Type of epidemic: Overall, the epidemic in Kenya is generalised and concentrated in some population. The epidemic is deeply rooted among the general population in some regions of the country while there is also concentration of very high prevalence among Key Populations. Strategies will be developed to target appropriate interventions at the two characteristics of the epidemic. The figure below compares the prevalence in the general populations and among the three Key Populations in the country.

FIGURE 4: **HIV prevalence among general and key populations**



Source: KAIS 2012, IBBS 2010-11

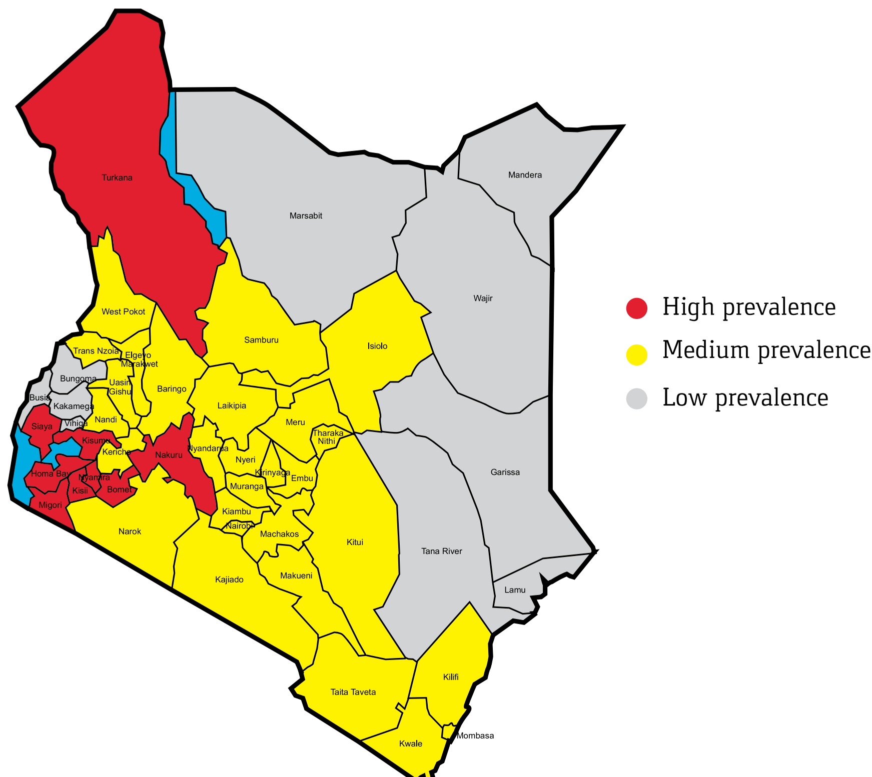
Regional variations: Prevalence estimates by county shows the geographical variability of HIV burden across the country - ranging from a low of 2.0% to a high of 27.1%. Ten counties with highest prevalence account for about 65% of the prevalence. There is a need to take into account these variations to develop geographically targeted interventions. The country HIV estimates, as shown in the table below, can inform programmatic priorities for each county.

TABLE 1: **HIV prevalence by county, 2013**

County	Adult Prevalence (%)	County	Adult Prevalence (%)	County	Adult Prevalence (%)	County	Adult Prevalence (%)
Homa Bay	25.7	Bomet	5.8	Uasin Gishu	4.3	Bungoma	3.2
Siaya	23.7	Kwale	5.7	Kitui	4.3	Baringo	3
Kisumu	19.3	Makueni	5.6	Nyeri	4.3	Meru	3
Migori	14.7	Nakuru	5.3	Isiolo	4.2	West Pokot	2.8
Kisii	8	Muranga	5.2	Vihiga	3.8	Elgeyo	2.5
Turkana	7.6	Trans Nzoia	5.1	Kiambu	3.8	Lamu	2.3
Mombasa	7.4	Samburu	5	Nyandarua	3.8	Garissa	2.1
Nairobi	6.8	Narok	5	Nandi	3.7	Mandera	1.7
Busia	6.8	Machakos	5	Laikipia	3.7	Marsabit	1.2
Nyamira	6.4	Kajiado	4.4	Embu	3.7	Tana River	1
Taita-Taveta	6.1	Kilifi	4.4	Kericho	3.4	Wajir	0.2
Kakamega	5.9	Tharaka-Nithi	4.3	Kirinyaga	3.3		

Source: Kenya HIV and AIDS Profile, 2014

FIGURE 5: **HIV prevalence by county, 2013**



New infections: An estimated 1.6 million people are living with HIV in Kenya. Total new HIV infections are estimated to have declined by about 15% in the last five years; from about 116,000 in 2009 to about 98,000 in 2013. As at 2014, new HIV infections are estimated to have stabilised at an average of 89,000 among adults and about 11,000 among children annually.

Over 80% of the total new infections in the country are among adults with 49% among women, 37% among men and 21% among young women. Children contribute to 11% of the new infections. Notably, Key Populations contribute significantly to the new infections. Sex workers contribute about 14%, MSMs 15%, People who inject drugs (PWIDs) 3.8%, casual heterosexual sex 20% and heterosexual sex among people in marriage relationships 44%. In terms of regional variations, 65% of the infections occur in 9 of the 47 counties in the country. The HIV epidemic in Kenya shows a pattern of stabilisation of infections at a high level thus presenting a challenge to reversing it. The factors driving the new infections in the country include:

i. Socio-cultural factors: High HIV stigma and discrimination, poor attitude to regular use of condoms, religious beliefs against condom use, gender inequalities including gender based violence and vulnerability of young girls, deepening poverty and food insecurity and widespread use of alcohol and substance abuse.

ii. High risk sexual behaviour characterised by high incidences of concurrent sexual relations linked to mobility, intergenerational sex, transactional sex, denial and marginalisation of LGBT groups.

iii. Biological factors including male circumcision and high prevalence of sexually transmitted infections

iv. Economic factors: Labour migration, increased cross-border travel, poverty and inequalities and vulnerability of adolescents, women and children

v. Political factors including internal and external conflict, poor enforcement of anti-discrimination laws, weak social and legal protection of vulnerable populations such as irregular migrants, sexual minorities and inconsistent political support/will among others.

The character of the HIV epidemic in Kenya shows a pattern of multi-epidemics. This requires a robust strategic framework containing micro strategies that address the disparities among population categories by sex and age, key populations as well as geographical areas.

2.2 Progress in implementation of the HIV response

2.2.1 Key Challenges and Gaps in the HIV response over time

- From KAIS 2012, 53% of Kenyans living with HIV did not know their HIV status; 16% had never tested (or received test results if tested) and 37% believed they were negative based on self-reporting.

- 11,000 children die unnecessarily each year due to poor access (37%) to life saving treatment.

- According to a recent study by Kaiser et al, most (83.6%) of HIV-positive married or cohabiting couples did not know their partners' HIV status[1]. Furthermore, according to KAIS 2012, awareness of a partner's status remained low (48% for women and 61% for men, aged 25-64), while persistent condom use was low among partners of discordant and unknown status, at 5% for women and 14% for men, aged 25-64.

- The KNASP III target for Prevention of Mother to Child Transmission (PMTCT) was not met, with the most up-to-date report indicating only 53% of pregnant women had accessed PMTCT services according to the Kenya National AIDS Strategic Plan (KNASP) III End Term Review (ETR) report.

- Insufficient financial resource allocation for policy implementation and monitoring in key prevention areas with over reliance on donor support for the national response.

- Prevention is lagging behind. There has only been a 9% decline in new HIV infections among adults over the last five years.

1. Kaiser, R., R. Bunnell, A. Hightower, A. A. Kim, and P. Cherutich, (2011) *Factors Associated with HIV Infection in Married or Cohabitating Couples in Kenya.*

- Poor enforcement of policy and legislative frameworks and generally national governance of prevention programmes
- Lack of specific policy and legal enforcement tools to address explicit needs of Key Populations and Persons with Disabilities (PwDs).
- Modest dissemination, uptake and implementation of policy guidelines developed for mainstreaming of human rights, gender, youth, children, PLHIV, PwDs, Key Populations and vulnerable groups in HIV and AIDS programming across sectors.
- Some communication activities implemented by stakeholders not aligned to the communication strategy of KNASP III.

2.3 Vision, goal and objectives of the KASF

Vision: A Kenya free of HIV infections, stigma and AIDS related deaths

Goal: Contribute to achieving Vision 2030 through universal access to comprehensive HIV prevention, treatment and care.

Objectives of KASF:

1. Reduce new HIV infections by 75%
2. Reduce AIDS related mortality by 25%
3. Reduce HIV related stigma and discrimination by 50%
4. Increase domestic financing of the HIV response to 50%

These objectives will be delivered through the following strategic directions

Strategic Direction 1 Reducing new HIV infections	**Strategic Direction** 2 Improving health outcomes and wellness of all people living with HIV	**Strategic Direction** 3 Using a human rights approach to facilitate access to services for PLHIV, Key populations and other priority groups in all sectors
Strategic Direction 4 Strengthening integration of health and community systems	**Strategic Direction** 5 Strengthening research and innovation to inform the KASF goals	**Strategic Direction** 6 Promoting utilisation of strategic information for research and monitoring and evaluation (M&E) to enhance programming
Strategic Direction 7 Increasing domestic financing for a sustainable HIV response	**Strategic Direction** 8 Promoting accountable leadership for delivery of the KASF results by all sectors and actors	

03

STRATEGIC DIRECTION I: REDUCING NEW HIV INFECTIONS

"To respond to the complex patterns of HIV epidemic, the Kenya HIV Prevention Revolution Road Map has set the country on an ambitious path to end new HIV infections by 2030"

3.1

Context

Key intervention areas

- Granulate the HIV epidemic to intensify HIV prevention efforts to priority geographies and populations
- Adapt and scale up effective evidence-based combination prevention
- Maximise efficiency in service delivery through integration
- Leverage opportunities through creation of synergies with other sectors

Expected results by 2019

- Reduced annual new HIV infections among adults by 75%
- Reduced HIV transmission rates from mother to child from 14% to less than 5%

There are geographic disparities with 9 of 47 counties accounting for 65% of new adult infections in 2013. Reduction of new HIV infection among adults has stabilised at approximately 90,000 annually and is driven by multiple partnerships among heterosexual relations, high rates of discordance, low knowledge of HIV status among those who are HIV infected (53%) and low condom use (KAIS 2012). Concentrated epidemic is seen in populations of men who have sex with men (MSM), sex workers and their clients, prison populations and people who inject drugs contributing to a third of new HIV infections (MOT 2008). There is evidence of heightened HIV risk among other vulnerable populations such as fishing communities, long-distance truck drivers, street children, persons with disabilities, migrant populations especially those in humanitarian crisis and mobile workers. HIV infection from vertical transmission has reduced by 44% between 2008 and 2013. Early sexual debut remains a challenge. Women and girls aged 15-24 account for 21% of new sexual infections with a prevalence of 4-6 times higher than boys of the same age.

To respond to the complex patterns of HIV epidemic, the Kenya HIV Prevention Revolution Road Map has set the country on an ambitious path to end new HIV infections by 2030.

FIGURE 6: **HIV prevalence by county Among 15-49**

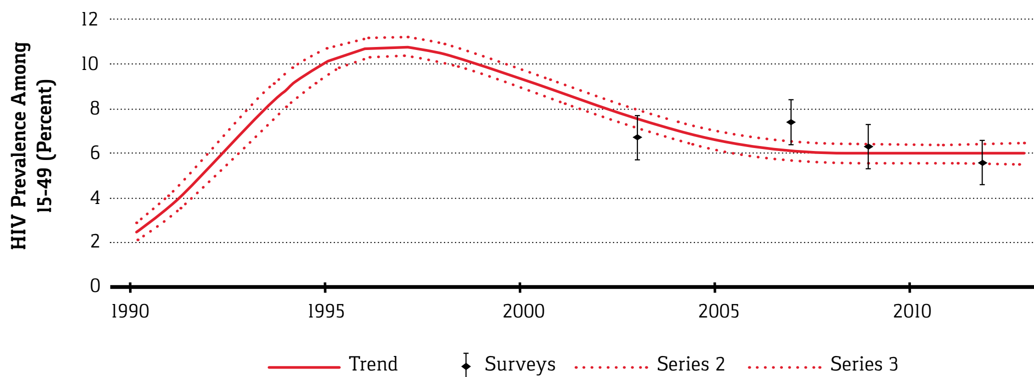
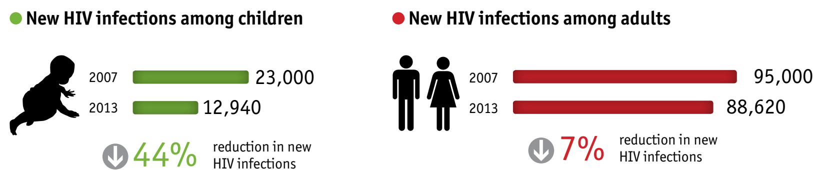
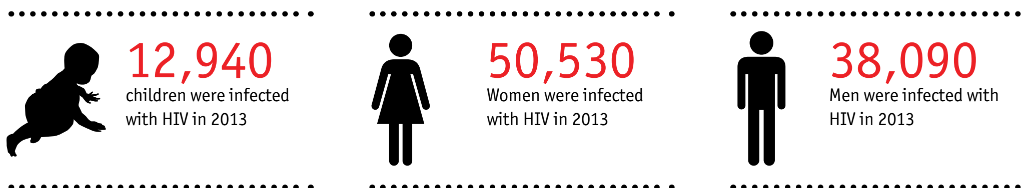
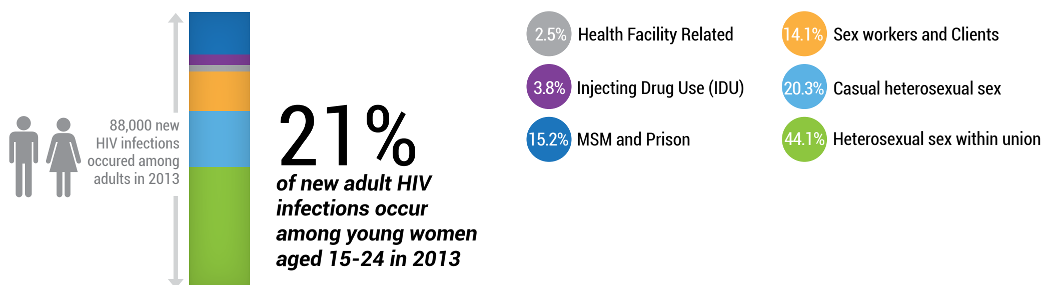


FIGURE 7: **Progress and status of HIV in Kenya**

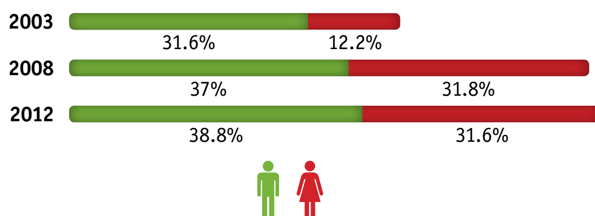


Source: Kenya HIV Estimates Technical Report 2013





Condom use at last sexual intercourse among people with multiple sexual partners



260,000 sero-discordant couples (one partner HIV+) in 2012

Sources: Kenya HIV Estimates Report 2014
Modes of Transmission 2008

3.1.1 Programme Gaps

A review of the five-year prevention programme shows that progress on reduction of new infection among adults was significantly slow. Key concerns include;

- Sexual behaviour change has been minimal with new infections marginally reducing despite scale up of behaviour change communication interventions in the last five years.
- Implementation of uniform, highly biomedical interventions with limited scale of evidence based behavioural and structural interventions despite evidence of varied needs of diverse populations at risk.
- Inconsistency in dissemination of educational messages on HIV risk reduction such as delay of sexual debut, reduction of multiple concurrent sexual partnerships and promotion of safer behaviours.
- Low utilisation of opportunities in other key sectors to increase efficiencies, address vulnerabilities, and create synergies to drastically reduce new infections.
- Low programme priority to address HIV related stigma and discrimination against PLHIV and violence against Key Populations.
- Inequity in distribution of condoms (especially female condoms) to priority populations.
- Low uptake of HIV Testing and Counselling for sexual partners and children,
- Low male engagement in interventions to eliminate mother to child transmission of HIV such as family planning, access to skilled birth delivery, antenatal and post-natal clinic attendance.
- Significantly high HIV infections among young girls and women of reproductive age, and late entry to treatment and care of HIV positive pregnant women.

3.1.2 Operational documents to facilitate HIV prevention

i. **The Kenya HIV Prevention Roadmap:** This Roadmap utilises a "know your epidemic approach" to characterise sources of new infections, coverage of services and identify optimal combination of services and cost requirements to end new HIV infections by 2030. The roadmap defines evidence-based bio-medical and structural interventions that are targeted to specific populations and geographic zones, thus giving each County Government, guidance on targeted investments that are costed for maximum impact.

ii. **Strategic Framework towards Elimination of Mother to Child Transmission of HIV and keeping Mothers Alive 2012-2015:** The framework sets clear targets and proposes a collective responsibility in working toward the elimination of MTCT. It aims at reducing mother-to-child transmission rate to less than 5% and HIV-related maternal mortality by 50%. This is to be achieved through political championship for community mobilisation and accountability, integrated and strengthened delivery of health services. Key interventions include primary prevention of HIV among girls and women, closing the gap on unmet need for family planning, provision of highly efficacious antiretroviral treatment to HIV infected pregnant women and strengthen care and support systems.

iii. A Strategic Framework for Engagement of the First Lady in HIV Control and Promotion of Maternal, Newborn and Child Health in Kenya 2013-2017. This strategy provides guidance for the engagement of the First Lady on political championship towards elimination of new HIV infections among children and promoting maternal and child health.

iv. National Guidelines for HIV Testing and Counselling , Couples and Prevention with Positives.

v) Policy Analysis and Advocacy Decision Model for Services for Key Populations in Kenya.

3.2

Priority intervention areas

3.2.1 Break down the HIV epidemic and intensify HIV prevention efforts in priority geographical areas and populations

The KASF provides national level prioritisation based on the Kenya County HIV estimates. County specific data outlined in the Kenya County HIV estimates and the County HIV profiles will provide data for county specific planning, prioritisation, HIV service implementation, monitoring and resource allocation.

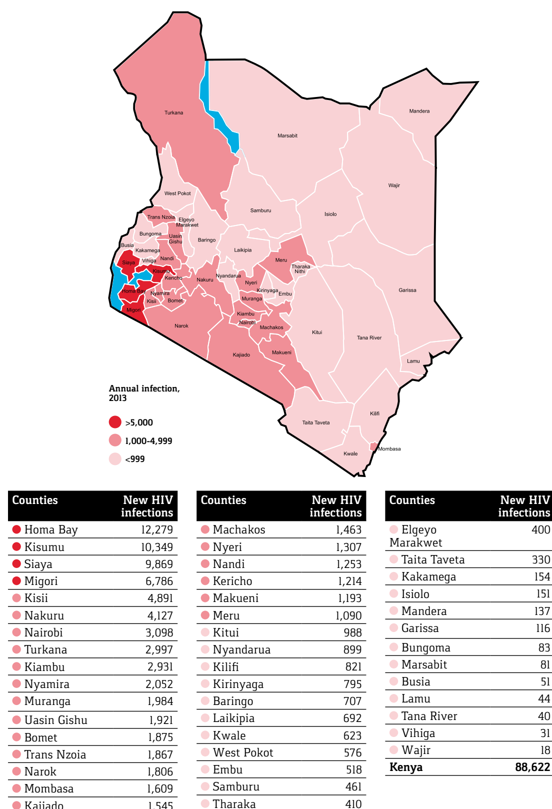
1. Geographic prioritisation of the epidemic

Counties are broken down for targeted interventions and optimum impact depending on their incidence.

TABLE 2: **County clusters and their incidence contribution**

County Cluster	Number of counties	Number of new infections	Total population	% contribution to new infections
High incidence	9	65,914	9.5M	65%
Medium incidence	28	34,499	25.4M	34%
Low incidence	10	1,160	6.8M	1%

FIGURE 8: **Estimated New HIV Infections among adults (15+) by County 2013**



Counties	New HIV infections
Homa Bay	12,279
Kisumu	10,349
Siaya	9,869
Migori	6,786
Kisii	4,891
Nakuru	4,127
Nairobi	3,098
Turkana	2,997
Kiambu	2,931
Nyamira	2,052
Muranga	1,984
Uasin Gishu	1,921
Bomet	1,875
Trans Nzoia	1,867
Narok	1,806
Mombasa	1,609
Kajiado	1,545

Counties	New HIV infections
Machakos	1,463
Nyeri	1,307
Nandi	1,253
Kericho	1,214
Makueni	1,193
Meru	1,090
Kitui	988
Nyandarua	899
Kilifi	821
Kirinyaga	795
Baringo	707
Laikipia	692
Kwale	623
West Pokot	576
Embu	518
Samburu	461
Tharaka	410

Counties	New HIV infections
Elgeyo Marakwet	400
Taita Taveta	330
Kakamega	154
Isiolo	151
Mandera	137
Garissa	116
Bungoma	83
Marsabit	81
Busia	51
Lamu	44
Tana River	40
Vihiga	31
Wajir	18
Kenya	**88,622**

9 High incidence counties: All prevention, treatment and care interventions need to be scaled up ensuring maximum coverage and quality. A good surveillance mechanism, a partnership accountability framework to harmonise interventions and track partner results are required. Key behavioural social and cultural drivers of HIV risk and vulnerability need to be addressed.

29 Medium incidence counties: Identification and categorisation of priority and bridging populations focusing on Key Populations, people living with HIV (including sero discordant couples), young girls and women and children and pregnant women living with HIV is required for each county. Also required is a good surveillance mechanism focusing on hotspots.

9 Low incidence counties: County specific characteristics that could increase HIV incidence in the future in these Counties are required. For instance, Busia, Vihiga, Kakamega have high burden of HIV although lower incidence. Key population interventions are required. Structural interventions, stigma and discrimination reduction are required. Surveillance should focus on tracking emerging hotspots.

2. Priority Populations

Risk of HIV is not equal for all populations. The priority populations who disproportionately contribute high number of new HIV infections in Kenya are as follows:

Key populations: Defined groups who, due to specific higher-risk behaviour, are at increased risk of HIV, irrespective of the epidemic type or local context. Legal, cultural and social barriers related to their behaviour increase their vulnerability to HIV. In Kenya they include: men who have sex with men; people who inject drugs and sex workers (SW). Despite their small number, they contribute an estimated 30% of new infections annually.

Vulnerable populations: Populations whose social contexts increase their vulnerability to HIV risk.

- ***Young girls and women***: these contribute up to 21% of all new infections and are heterogeneous; found among key populations, discordant couples, people living with HIV, in and out of school and across all geographic areas.
- ***People in prisons and other closed settings***: this refers to all places of detention within a country, and the terms "prisoners" and "detainees" refer to all those detained in criminal justice and prison facilities, including adult and juvenile males and females, during the investigation of a crime, while awaiting trial, after conviction, before sentencing and after sentencing.
- ***Fishing communities, truck drivers, street children, people with disabilities, migrant populations especially those in humanitarian crisis and mobile workers***. These populations are location specific and require targeted interventions as appropriate.

People Living with HIV: Kenya has approximately 1.6 million people living with HIV. There are an estimated 260,000 couples in ***HIV sero-discordant*** (one partner HIV negative) couples who significantly contribute to new infections.

Children and pregnant women living with HIV: Elimination of mother to child transmission is a priority result area in this KASF. All 4 prongs of eMTCT should be implemented at scale to achieve this goal including preventing HIV infections among adolescents and girls of reproductive health age who account for 70% pregnancies

3.2.2 Adapt and scale up effective evidence based combination HIV prevention

Combination Prevention describes a mix of behavioural, structural and biomedical interventions targeting specific populations based on their needs to optimally mitigate acquisition or transmission of HIV.

TABLE 3: **Interventions for scaling up evidence based combination HIV prevention**

Biomedical Interventions		
Interventions	**Recommended actions**	**Responsibility**
General population	▪ Innovative HIV testing and counselling (HTC) models ▪ Linkage of those testing HIV positive to care and early ART initiation ▪ Prevention and management of co infections and co morbidities ▪ Sustain Voluntary Medical Male Circumcision (VMMC) among traditionally non-circumcising communities. ▪ Implement strategies for early infant male circumcision. ▪ Support and ensure safe circumcision practices among the traditionally circumcising communities. ▪ Offer gender based violence care services including post exposure prophylaxis (PEP) for survivors. ▪ Eliminate Health Sector HIV transmission ▪ PrEP: Results from demonstration sites to inform scale-up to selected priority population.	▪ NASCOP ▪ Implementing Partners ▪ County government
Key Populations and Vulnerable Populations	▪ Provision of key commodities including lubricants and condoms ▪ Scale up and sustain needle and syringe programme (NSP) ▪ Initiate Medically Assisted Therapy for opioid dependents (MAT) ▪ Screening and management of HPV among FSW/MSM and Hepatitis B and C for PWID ▪ Alcohol screening and addiction support ▪ Scale up STI management in all health facilities ▪ Provide Pre-exposure prophylaxis services	▪ County Government ▪ NASCOP ▪ Implementing Partners

Interventions	Recommended actions	Responsibility
Adolescent and young women	▪ Establish youth friendly clinical services ▪ Offer age appropriate contraceptives, condoms, microbicides. ▪ Offer HPV screening and education ▪ Increase access to sexual and reproductive health services	▪ County Government ▪ NASCOP ▪ Implementing Partners
PLHIV and Sero discordant couples	▪ Offer HTC to partners and families of all HIV positive clients ▪ Provide ART to the infected partner and adherence support ▪ Provide pre-exposure prophylaxis	▪ County Government ▪ NASCOP ▪ Implementing Partners
Children and Pregnant Women Living with HIV	▪ Integrate Early infant diagnosis of HIV with immunisation services ▪ Deliver all 4 prongs of eMTCT at 100% of health facilities countrywide. Offer comprehensive interventions to prevent HIV among young women; ensure all HIV positive women of reproductive health age have access to family planning; ▪ Ensure all pregnant and lactating women are initiated on ART and all HIV positive children are offered ART ▪ Integrate eMTCT with MNCH services	▪ County Government ▪ NASCOP ▪ Implementing Partners
Behavioural Interventions		
General populations	▪ Stigma reduction campaigns ▪ Risk reduction counselling and skill building ▪ Male and female condom demonstration, distribution and skill building	▪ County Government ▪ NASCOP ▪ Implementing Partners
Key Populations and Vulnerable populations	▪ Behaviour change intervention using specific interpersonal tools and techniques including those in Braille ▪ Regular outreach and contact with Key Population through peer based education, treatment and support ▪ Offer harm reduction interventions to scale.	▪ County Government ▪ NASCOP ▪ Implementing Partners
Adolescent and young women	▪ Offer peer-to-peer outreach in school or outside school ▪ Implement evidence-based interventions (EBI) like Sister to sister, healthy choices for better future ▪ HIV and RCH related education in school or in the community	▪ County Government ▪ NASCOP ▪ Implementing Partners
PLHIV and Sero discordant couples	▪ Offer peer outreach and support services to create treatment and rights awareness as well as PSS to enhance adherence ▪ Implement Positive Health dignity and Prevention (PHDP) ▪ Implement appropriate evidence-based behavioural interventions and offer supported disclosure and support groups	▪ County Government ▪ NASCOP ▪ Implementing Partners
Children and pregnant women living with HIV	▪ Support groups of pregnant women ▪ Psycho social support services	▪ County Government ▪ NASCOP ▪ Implementing Partners
Structural Interventions		
	▪ Develop/review key policies impacting on HIV (Key populations, prisons, consent age for HIV prevention) ▪ EMTCT comprehensive policy and legal frameworks to promote access and protect rights of mothers and children ▪ Implement gender based violence prevention and response programmes ▪ Address the issue of violence against key populations through appropriate crisis response mechanisms ▪ Implement stigma reduction campaigns ▪ Utilise community health workers to strengthen linkages between communities and facilities ▪ Engage men on their role in HIV prevention and eMTCT ▪ Sensitise and engage communities and leaders such as religious leaders and elders on key populations and HIV to reduce stigma and increase service uptake ▪ Implement cash transfer programmes to keep girls in school and social protection of vulnerable families ▪ Strengthen workplace protection policies ▪ Strengthen protection of rights and empower key and vulnerable, populations Such as creation of drop-in centres, rights awareness ▪ Invest in girls and women leadership ▪ Accelerate access to social equity and justice for priority populations ▪ Address socio- cultural barriers that increase risk of HIV infection among communities ▪ Engage private sector to formalise a system to compliment the service delivery system and reporting requirements	▪ County Government and Non state actors ▪ NACC and NASCOP

3.2.3 Maximise efficiency in service delivery through integration and creation of synergies for HIV prevention

1. Increasing knowledge of HIV status and linkages to other services

HIV testing and counselling is a critical point of entry for HIV prevention care and treatment. Over half (53%) of people living with HIV in Kenya are unaware of their HIV status. Early diagnosis of HIV, initiation and retention in treatment are essential for viral suppression and reduction of new HIV infections.

TABLE 4: **Interventions for Increasing knowledge of HIV status and linkage to other services**

Intervention areas	Recommended actions	Responsibility
Adopt population and geography specific appropriate HTC approaches	▪ Scale up facility-based PITC and ensure linkage to care ▪ Deliver routine community-based HTC for priority and key populations ▪ Deliver door-to-door testing and community-based testing at population scale in high prevalence areas ▪ Undertake high yield and effective strategies for HTC for targeted geographic areas and populations	▪ NASCOP ▪ County Government
Strengthen HIV diagnostic infrastructure and systems	▪ Strengthen early infant HIV diagnosis infrastructure ▪ Expand innovative diagnosis strategies including point of care and self-testing ▪ Invest in adequate skilled staff, commodity security and quality assurance mechanisms	▪ NASCOP ▪ County Governments
Deliver targeted and integrated HIV testing and counselling	▪ Offer couples/partners HTC with supported disclosure options ▪ Deliver integrated HTC packages to include TB screening, family planning services, cervical cancer screening, other health checks such as blood pressure/sugar, weight and include other risk-reduction services (counselling, condoms with lubricants, STI screening) for priority population ▪ Identify and retain high risk individuals for regular HTC and screening ▪ Scale up Positive Health Dignity and Prevention (PHDP) intervention	▪ County Government and non state actors ▪ NACC and NASCOP
Strengthen linkages to care and treatment	▪ Obligate HTC and TB service providing points to account for linkage to prevention programmes, care and treatment ▪ Utilise community health extension workers (CHEWS) and community health workers (CHW) to link diagnosed individuals with facilities and support groups ▪ Strengthen engagement and leadership of networks of people living with HIV to mobilise and facilitate HTC	▪ County Government and non state actors ▪ NACC and NASCOP

TABLE 5: **Interventions for strengthening integration and linkages of services to catalyse HIV prevention outcomes**

Interventions	Recommended actions	Responsibility
Integrate HIV prevention into routine health care delivery mechanisms	▪ Integrate comprehensive HIV prevention messages, condom distribution, pre-and post exposure prophylaxis, GBV and fertility intention interventions into health services such as immunisation, reproductive, maternal, neonatal and child health as appropriate ▪ Strengthen capacity of service providers and increase demand for delivery of HIV prevention services including active engagement of private sector for EMTCT	▪ County Government and non-state actors ▪ NACC and NASCOP
Strengthen Community and Health Facility-level Linkages	▪ Equip and utilise peer educators, community health and outreach workers with commodities to effectively deliver stigma free prevention and provide effective referral for services ▪ Strengthen engagement and leadership of faith communities, people living with HIV, County/Sub-County administrators, councils of elders and political leaders for HIV prevention knowledge and interventions	▪ County Government and non-state actors ▪ NACC and NASCOP

TABLE 6: **Interventions targeting prevention of HIV in Health care settings**

Intervention areas	Recommended actions	Responsibility
Improve blood and injection safety	▪ Implement strategies to recruit and increase adult blood donors ▪ Introduce donor notification of HIV results at blood collection points and post testing for Transfusion Transmissible Infections (TTIs)	▪ KNBTS and implementing partners
	▪ Train health workers on infection prevention ▪ Implement quality assurance mechanisms for injection safety to eliminate HIV transmission in health care settings ▪ Institute mechanisms to report and receive PEP for all occupational exposures among health care workers	▪ County Government ▪ NASCOP
Medical waste and IPC management	▪ Improve disposal of medical waste in all levels of the health system to minimise risk of infection ▪ Improve the availability and accessibility of appropriate IPC equipment and infrastructure in all health care settings	▪ County Government

3.2.4 Leverage opportunities through creation of synergies with other sectors for HIV Prevention

HIV prevention interventions will leverage opportunities in other sectors at county and national level to implement evidence-based strategies. The HIV prevention roadmap provides detailed interventions.

- Targeted sectors include: Transport, media, mobile and web technology, education, tourism and hotels including bar and lodging, micro-finance, law, order and justice sectors.

TABLE 7: **Priority sectors to leverage HIV prevention**

Other sectors	Recommended actions	Responsibility
Education	▪ Increase knowledge on HIV and HIV status, STIs and HPV among teachers and students ▪ Address stigma reduction in schools ▪ Implement education policy, guidelines and teacher training that includes age appropriate HIV, sexual and reproductive health and rights ▪ Improve access to accurate information on sexuality through introduction of age appropriate comprehensive sexuality education in school curriculum ▪ Ensure girls stay in schools through social security programmes, conditional cash transfers, sanitary towels	▪ MOEST, Universities and NACC ▪ Health Ministry
Energy, infrastructure and ICT Sector	▪ Use public transport systems for prevention messages, condom distribution targeting the general and Key Populations. ▪ Promote a bold mass media HIV prevention campaign that challenges norms, attitudes and beliefs	▪ Private Sector transport associations
Tourism, Hotels (including bars and lodgings)	▪ Require HIV prevention messages and services in hotels, bars and lodgings	▪ NACC, NASCOP, Private sector
Religious Leaders	▪ Address notion of HIV healing through faith as a barrier to HIV treatment and adherence ▪ Conduct and adapt stigma-free HIV prevention campaigns	▪ NACC
Justice law and order	▪ Promote access to social equity and justice in the context of rights violation specific to HIV response ▪ Promote the use of Internal Security as an important contributor to an integrated response to HIV and AIDS by addressing the dangerous interaction between AIDS, drug and alcohol abuse, sex and child trafficking and sexual violence ▪ Scale up prison-based HIV and AIDS programmes that look into how to respond to HIV and AIDS and drug misuse in prison, system strengthening and provision of clinical services, prison based care, support and treatment.	▪ Ministry in charge of justice law and order ▪ NACC

Other sectors	Recommended actions	Responsibility
Public Service, Labour and Social Service	■ Promotion of effective social inclusion with no room for stigma and discrimination ■ Pursue "AIDS-Sensitive'" rather than "AIDS -Specific" social protection instruments including cash transfers , protection of orphans and vulnerable children (OVC) from the impoverishing effects of HIV and AIDS while potentially encouraging pro-poor growth ■ Close the gap of the unmet need for support services for Orphans and Vulnerable Children (OVCs) to ensure the protection, care, and support of at least 2.6 million children*. ■ Incorporate a transformative agenda that empowers women to access their rights and entitlements in terms of inheritance, education and labour market access both protecting and mitigating against HIV and AIDS ■ Expand workplace programmes on HIV and AIDS in the public, private and civil society sectors through policy development, implementation and review	■ Public Service, Labour and Social Service ■ Implementing Partners
CBS	■ Institutionalisation of HIV information sources for effective and efficient management of the HIV response	■ CBS
Treasury	■ Continuous use of economic evaluations of existing interventions to inform resource allocation decisions for the HIV programmes at national and county levels ■ Evaluate the role of donors and other actors in informing HIV resource allocation decisions ■ Support the operationalisation of the HIV Trust Fund as primary vehicle for mobilising and leveraging resources for health financing in the country	■ Ministry in charge of Treasury
Agriculture	■ Enhance the capacity and the political will of agricultural sector to respond actively to HIV and AIDS by providing empirical data to guide agricultural policy-makers in the areas of poverty reduction, food and nutrition security, use of antiretroviral drugs, and advancing gender equality.	■ Ministry in charge of Agriculture ■ NACC
Mining and Extractive	■ Focus attention on the mining and extractive industries in Kenya looking at the role of transnational corporations, corporate social responsibility and moral economy in the mining sector in line with economic empowerment, enterprise and entrepreneurialism, the role mining as big business in the political economy of HIV and AIDS Management	■ Ministry in charge of mining ■ NACC
Ministries, Departments and Agencies(MDAs)	■ Provide resources for HIV programmes - Report on the Performance contracting	■ MDAs
Universities	■ Provide resources ■ Undertake HIV prevention activities	■ All Universities ■ All MDAs ■ NACC
Kenya Prison Services	■ Integrate HIV testing and Counselling care and treatment for all ■ Facilitate use of HIV protection interventions	■ Kenya Prison service ■ NACC, NASCOP

* Lee, C. V et al: Orphans and vulnerable children in Kenya: results from a nationally representative population-based survey. J Acquir Immune Defic Syndr. 2014 May 1;66 Suppl 1:S89-97. doi: 10.1097/QAI.0000000000000117

04

STRATEGIC DIRECTION 2: IMPROVING HEALTH OUTCOMES AND WELLNESS OF PEOPLE LIVING WITH HIV

"Retention in care and treatment in the short and long-term will need clear identification of points of loss of patients within the cascade of care and addressing these at service delivery points and county levels"

4.1 Context

Key intervention areas

- Improve timely linkage to care for persons diagnosed with HIV
- Increase coverage of care and treatment and reduce loss in the cascade of care
- Scale up interventions to improve quality of care and improve health outcomes

Expected results by 2019

- Increased linkage to care within 3 months of HIV diagnosis to 90% for children, adolescents and adults
- Increased ART coverage to 90% for children, adolescents and adults
- Increased retention on ART at 12 months to 90% in children, adolescents and adults
- Increased viral suppression to 90% in children, adolescents and adults

Since 2003, annual AIDS related deaths have declined from apprixomately 167,000 to 58,465 in 2013.[2] In 2014, a quarter of all AIDS-related deaths occurred among children and adolescents 0-19 years[3], reflecting dispropritionately low ART coverage in these sub populations, high mother to child transmission rate estimated at 15% and gaps in quality of care[4]. By mid-2014, over 680,000 persons living with HIV including 60,000 children aged 0-14 received ART. These numbers are projected to increase with the roll out of the new 2014 ART guidelines that recommend early initiation of ART among children, adolescents and adults including pregnant and breastfeeding women. Over 60% of those who are HIV positive live in 10 counties in Kenya.

Current ART coverage for adults aged 15 and above is estimated at 51% and ART coverage for children 0-14 years at 36%.[5] Linkage to care for those in this age group who are aware of their HIV status is 89% (KAIS 2012). Retention in care at 12 months for those between 15 to 24 years is estimated at 68% with75% for adults and 82% for children 10-14 years (ref- cohort analysis of 2012)[6]. Retention in care at 36 months is at 66%, whereas at 60 months retention to care is at 61%.[7] Notable improvements are recorded in routine TB screening, integration of reproductive health services, nutrition interventions, laboratory monitoring and social and clinical efforts as a means to improving and monitoring the quality of care over time.

2 Ministry of Health (2014) Kenya HIV Estimates
3 Ministry of Health (2014) Kenya HIV Estimates.
4 Ministry of Health (2014) Kenya HIV Estimates.
5 NASCOP Estimates October 2014
6 National AIDS and STI Control Programme (2014) Preliminary Report Cohort Analysis.
7 National AIDS and STI Control Programme (2014) Preliminary Report Cohort Analysis

FIGURE 9: **Overview of HIV in Kenya**

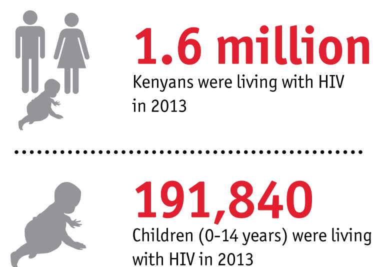
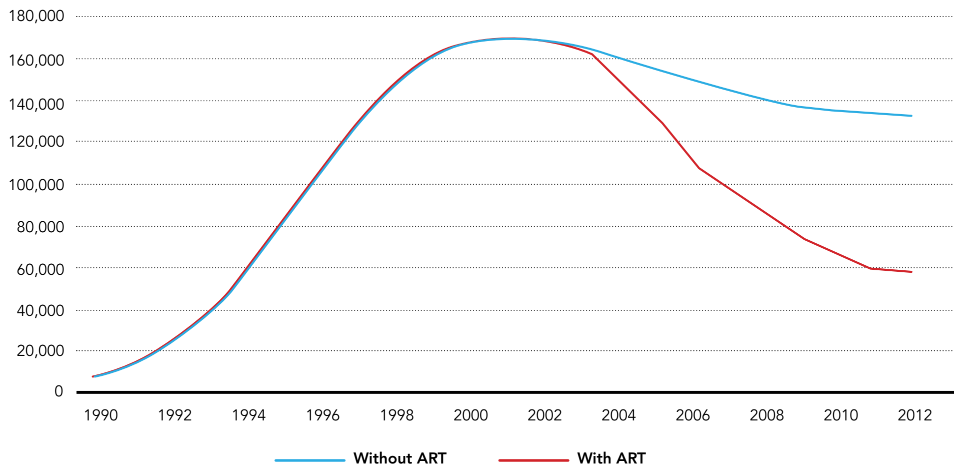


FIGURE 10: **HIV related deaths averted by ARTs**



4.1.1 Gaps

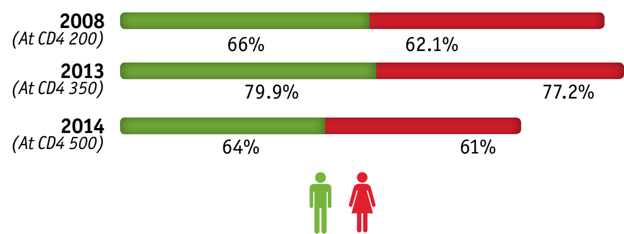
Health systems related barriers exacerbate the gaps in the cascade of care from identification, linkage, retention and viral suppression. These include limited access to and unequal geographical distribution of services, human resource inadequacies, poor referral and tracking mechanisms, commodity and supply related challenges and limited infrastructure for information management systems.

Diagnosis and linkage to care: Late or lack of HIV diagnosis and suboptimal linkage to care is a challenge. For key populations, legal barriers, stigma and negative provider attitudes reduce access to care.

Care and treatment coverage: There is disproportionately lower coverage of ART in children and adolescents. Sub-optimal integration of screening, prophylaxis and management of co-infections and co-morbidities result in high attrition of those enrolled. Persons living with HIV experience stigma impacting on disclosure and adherence, particularly among key and priority populations.

Gaps related to quality of care and treatment services and viral suppression: Quality of care, limited use of electronic medical records, evidence informed interventions at facility level and viral load monitoring need improvement. In addition, there is limited co-ordination and support to quality of care by other sectors such as learning institutions, nutrition, legal and social services.

FIGURE 11: **ART Coverage of eligible adults**



Sources: Kenya Demographic and Health Survey (2013, 2008/9
Kenya AIDS Indicator Survey (2012)
Kenya HIV Estimates Technical Report 2013

4.1.2 Operational documents to support strategic direction 2

- **Guidelines on use of Antiretroviral drugs in treating and preventing HIV, Rapid advice, 2014**
- **Kenya Quality Model for Health 2009**
- **Kenya HIV Quality Improvement Framework**

4.2

Priority intervention areas

The initiation of ART will be accelerated across all populations in the first two years of the KASF in line with the 2013 WHO ART guidelines with a focus on chronic disease management that ensures adherence to treatment and viral suppression. This will involve increased HTC and ensuring timely linkage and enrolling eligible persons into care within the next 2 years in order to achieve 80% coverage of all eligible adults in Kenya to 90% by 2019.

4.2.1 Improve timely identification, linkage and retention in care for persons diagnosed with HIV

Targeted HIV testing and counselling strategies wil be utilised to increase the detection rate for HIV positive cases. While testing programmes are required to link individuals to care, the point of linkage and subsequent follow up is critical to enrollment and retention in care and treatment. Identifying each individual on treatment for tracking and follow up will be essential to reduce losses in the treatment cascade, especially with the influx of patients expected during the scale up. The interventions recommended for linkage to care for those diagnosed with HIV are both population specific and general strategies. Priority strategies that will improve linkage to care include developing a national capacity to track and link points of testing and points of treatment. These will include:.

- Establish standardised national patient unique identifier and tracking mechanisms that can be originated at HTC service point.
- Enhancing peer mobilisation strategies for recruitment, enrolment and retention in care.

TABLE 8: **Recommendations to improve linkage and retention in care**

Population sub-groups	Recommended actions	Responsibility
General ART care	▪ Improve referral and patient management system and infrastructure. ▪ Establish standardised national patient unique identifier, defaulter tracking tools and mechanisms ▪ Public education and treatment literacy that is age and population specific and appropriate ▪ Strengthen facility and community linkages with inter- and intra- facility referral protocols and linkage strategies ▪ Ensure the identified gaps in HIV prevention and treatment cascade are addressed immediately	▪ Ministry of Interior ▪ MoH
Children living with HIV	▪ Integrate HIV testing, care and treatment services into maternal, neonatal and child health settings and services ▪ Public education and education of care givers	▪ MOH, County governments and implementing partners
Adolescents and youth	▪ Scale up integrated youth friendly services ▪ Utilise peer support and networks of adolescents living with HIV ▪ Utilise technology including social media for education, recruitment and retention in care	▪ MOH, County governments and implementing partners
Key and vulnerable populations	▪ Enhance peer mobilisation strategies for recruitment, enrolment and retention in care and extend flexible timings for care ▪ Integrate care services in drop-off centres ▪ Integrate alcohol and drug dependence reduction strategies in care services	▪ MOH, County governments and implementing partners

4.2.2 Increase coverage to care and treatment and reduce the loss in the cascade of care

The country aims to increase coverage in line with the 2014 Kenya ART Guidelines. The scale-up will increase the number of people under care and treatment, which is likely to increase the burden on the health system. Interventions that strengthen delivery of a range of services including education, cotrimoxazole preventive therapy, TB isoniazid preventive therapy and follow-up for retention at community levels will reduce the burden of care at the health facility level. All these pre-ART services are currently offered in diverse modalities and extent in Kenya. This calls for promotion of decentralised delivery of care services through the County Governments, health providers and implementing partners by encouraging them to develop functional models of pre-ART care within national guidelines while attaining the expected outcomes of healthcare.

Retention in care and treatment in the short and long-term will need clear identification of points of loss of patients within the cascade of care and addressing these at service delivery points and county levels and recognising that different counties will need to focus on different populations (by age, sex and sexual activity) depending on their situation and challenges in the cascade of care and treatment and reasons for attrition.

Almost 50% of non-HIV health care in Kenya is delivered by the Private Sector. Private Sector access to HIV commodities reporting will be strengthened. For non-healthcare private sector that provides HIV care for their staff, we shall provide an opportunity for strengthened treatment literacy in workplaces and develop private public partnerships so as to increase coverage and reduce the high dependence on public health systems.

TABLE 9: **Interventions to increase coverage to care and treatment**

Intervention areas/populations	Recommended actions	Responsibility
General ART Care	▪ Provide screening and diagnostic equipment for TB, NCDs, malnutrition, opportunistic infections together with those for HIV. ▪ Scale up prevention interventions for TB, OIs and other co-mobidities, water and sanitation-related diseases, vaccinations for preventable diseases (cervical cancer, hepatitis, pneumococcal) ▪ Cascade integrated HIV trainings for a skilled and competent workforce through innovative methods and technologies	▪ MOH ▪ County government ▪ Implementing Partners
Pre-ART services	▪ Use integrated and decentralised HIV delivery models that increase access to care and treatment at community and other non-ART service points ▪ Enhance treatment literacy, patient empowerment, psychosocial and adherence support and disclosure interventions with full involvement of Civil Society and communities, especially PLHIV	▪ MOH ▪ County government ▪ Implementing Partners
Children and Adolescent and youth	▪ Provide care givers with HIV education, literacy and empowerment ▪ Integrate HIV care treatment into youth friendly services ▪ Scale up the Ministry of Education programme for HIV education and treatment literacy, adherence and retention ▪ Utilise technology and social media to facilitate retention and adherence ▪ Standardise methodologies for disclosure by and to adolescents living with HIV	▪ MOH ▪ MOEST ▪ County government ▪ Implementing Partners
Key populations	▪ Scale up key population friendly HIV care and treatment services with peer mobilisation and support ▪ Reduce HIV stigma and discrimination to increase access to care and treatment	▪ MOH ▪ County government ▪ Implementing Partners

4.2.3 Improve quality of care and treatment outcomes

Improvement of quality of care and health outcomes involves continuous deliberate processes that involve routine analysis and use of health and programme data and strengthening of systems to meet patient and programme needs. National and county governments and other sectors shall put efforts towards the tracking and improvement of quality of care and health outcomes.

TABLE 10: **Interventions to improve quality of care and treatment outcomes**

Intervention areas	Recommended actions	Responsibility
Quality of care and monitoring treatment outcomes	▪ Strengthen capacity of counties to monitor quality of care and utilise care data for decision making ▪ Continuous quality improvement initiatives through health worker training and use of electronic records management systems ▪ Develop and implement surveillance plans, protocols and periodic surveys and cohort analysis ▪ Strengthen supply systems and ensure continuous availability of quality HIV commodities at the point of service delivery ▪ Implement periodic monitoring for adherence and disclosure	▪ NACC ▪ NASCOP ▪ County Government
Laboratory capacity	▪ Strengthen laboratory networks ▪ Put in place systems to assure quality and monitor adherence to laboratory protocols ▪ Reduce turnaround time for results and feedback	▪ MOH ▪ National ▪ County Government ▪ Implementing partners
Community based adherence support	▪ Promote age and population specific treatment education in community and other non-health facility based settings ▪ Use innovative mobile and web-based technology to increase adherence and follow up options ▪ Scale up use of people living with HIV peer support strategies	▪ MOH ▪ County Government ▪ Implementing partners

05

STRATEGIC DIRECTION 3: USING A HUMAN RIGHTS BASED APPROACH TO FACILITATE ACCESS TO SERVICES

"An enabling legal and policy environment is necessary for a robust HIV response at the national and county level to ensure access to services by persons living with HIV"

5.1 Context

Key intervention areas

- Remove barriers to access of HIV, SRH and rights information and services in public and private entities
- Improve National and County legal and policy environment for protection and promotion of the rights of priority and key populations and people living with HIV
- Reduce and monitor stigma and discrimination, social exclusion and gender-based violence
- Improve access to legal and social justice and protection from stigma and discrimination in the public and private sector

Expected results by 2019

- Reduced self-reported stigma and discrimination related to HIV and AIDS by 50%
- Reduced levels of sexual and gender-based violence for PLHIV, key populations, women, men, boys and girls by 50%
- Increased protection of human rights and improved access to justice for PLHIV, key populations and other priority groups including women, boys and girls
- Reduced social exclusion for PLHIV, key populations, women, men, boys and girls by 50%

Article 27 of the Constitution of Kenya 2010, outlaws discrimination on the basis of one's health status, provides for equality between men and women and allows the use of affirmative action to redress past discrimination. Kenya's HIV and AIDS Prevention and Control Act, 2006, provides the legal framework to address HIV providing for protection and promotion of public health, the appropriate treatment, counselling, support and care of persons infected or at risk of HIV infection. Access to justice is embedded in the establishment of the HIV & AIDS Tribunal.

The High Court of Kenya and the HIV and AIDS Tribunal have given positive decisions that have affirmed the rights of persons living with HIV. The HIV tribunal, however, remains underutilised due to its geographical location and limited public knowledge about it. However, punitive laws such as sections of the Penal Code and the Narcotic drugs and Psychotropic Substances Control Act have sections that are enforced in a manner that impacts negatively on provision of health services to key populations[8].

Stigma and discrimination have been identified as a barrier to HIV prevention and uptake of care and treatment services. The socially excluded, poor and vulnerable people who are living with HIV are unlikely to take up services, therefore negatively impacting on the ability to reach goals.

The Kenya Stigma Index Survey (2013) reported stigma and discrimination at over 45%. An estimated 15% of PLHIV reported discrimination by a health professional through disclosure of their sero-status without their consent, [9]. PLHIV face stigma and discrimination in their families, communities and within structures and institutions in which they seek services. Employment-related discrimination has been documented. Women living with HIV report higher stigma levels compared to

8 Study done by KELIN, KANCO, UNAIDS, NACC, UNDP http://kelinkenya.org/wp-content/uploads/2010/10/Human-Violation-book-final.pdf
9 http://www.kpmg.com/eastafrica/en/IssuesAndInsights/ArticlesPublications/Documents/People%20Living%20with%20HIV%20Stigma%20Index%20in%20Kenya.pdf

TABLE 11: **General Stigma and Discrimination in the previous 12 months**

Categories	Never	Once	A few Times	Often	Total Respondents
Exclusion from social gatherings	648 60.4%	116 10.8%	192 17.9%	117 10.9%	1073
Exclusion from religious activities/place of worship	836 79.1%	55 5.2%	97 9.2%	69 6.5%	1057
Exclusion from family activities	746 69.7%	78 7.3%	162 15.1%	84 7.9%	1070
Aware of being gossiped about	227 21.3%	56 5.2%	379 35.5%	406 38.0%	1068
Verbally insulted, harassed and/or threatened	463 43.7%	150 14.2%	312 29.4%	135 12.7%	1060
Physically harassed	645 61.9%	149 14.1%	189 17.9%	64 6.1%	1056
Physically assaulted	736 69.2%	150 14.1%	128 12.0%	50 4.7%	1064

men (4.9% versus 2.7%).[10] People experiencing stigma are more than four times more likely to report poor access to care[11]

Sexual and gender violence increases biological vulnerability to HIV, reduces ability to negotiate for safer sex, with long-term psychosocial outcomes that impact sexual risk taking behaviour. About 33% of girls and 17% of boys in Kenya are raped by the time they attain 18 years; 22% of girls aged 15-19 report that their first sexual intercourse to have been forced.[12] And few receive treatment. Gender inequalities and cultural practices including wife inheritance, sexual and gender based violence, early marriages and high attrition in school limit effective HIV prevention.

Data (2014) shows that 44% of female sex workers, 24% of men who have sex with men and 57% of persons who inject drugs were arrested or beaten up by police or city "askaris" in the last six months.

5.1.1 Operational documents to support KASF

1. The Constitution of Kenya 2010
2. The HIV and AIDS Prevention and Control Act, 2006
3. The Political Declaration on HIV 2011
4. The Global Commission report on HIV and the Law

5.2 Priority Intervention areas

5.2.1 Remove barriers to access of HIV, SRH and rights information and services in public and private entities

Barriers to access to information are individual, community and structural. At community level, stigma and discrimination, gender inequalities, social norms and cultural practices dictate who can access what services. Adolescent and young people, especially women are more likely to be impacted negatively and not access services. Uptake of maternal health services including eMTCT care is also impacted.

Structural exclusion identified by the ETR included poor dissemination of information, uptake and implementation of policy guidelines, insufficient financial resource allocation and discriminatory service at facilities and other service delivery points.

10 Mugoya, Gc and Emst, K. (2014) Gender Differences in HIV-Related Stigma in Kenya. AIDS Care: Psychological and Socio-Medical Aspects of AIDS/HIV Volume 26, Issue 2.
11 http://www.avert.org/HIV-AIDS-stigma-and-discrimination.htm#sthash.RSf9SmBi.dpuf
12 KDHS, 2008/9.

TABLE 12: **Interventions to remove barriers to access services**

Sectors	Recommended actions
Health Sector	▪ Promote use of key population peer groups to enhance uptake of services ▪ Develop policies to protect priority populations when accessing HIV and health services ▪ Sensitise health care workers to reduce stigmatising attitudes in healthcare settings ▪ Develop and disseminate population specific and user friendly information including Braille ▪ Promote uptake of HIV pre and post-exposure prophylaxis among survivors of sexual violence and priority population
Social services sector	▪ Enroll PHIV, OVCs, Key Populations and other priority groups into the social protection programmes and provide HIV services ▪ Implement structural interventions that empower vulnerable populations, especially women
Religious sector	▪ Integrate HIV information and encourage service uptake in religious teachings ▪ Recommend and emphasize confirmation of faith healing claims through scientific tests ▪ Promote acceptance of priority population as part of the community for increased service uptake ▪ Engage men in HIV, sexual and reproductive health programmes and interventions and also offer them services
Communities	▪ Develop community groups and forums, and utilise persons living positively to campaign against HIV-related stigma and discrimination ▪ Educate communities on legal issues, rights and gender ▪ Invest in community programmes to change harmful gender norms, negative stereotypes and concept of masculinity
Media	▪ Facilitate campaigns to reduce stigma and discrimination, reduce gender violence and promote uptake of HIV services and prevention interventions

5.2.2 Improve national and county legal and policy environment for protection of PLHIV, key populations and other priority groups including women, adolescent, boys and girls

The need to have an enabling legal and policy environment has been identified by the Global Commission on Law and HIV[13] as a key intervention in the reduction of new infections. This, in addition to ensuring access to justice for PLHIV and key populations when violated, is key to ensuring HIV interventions are responsive to the human rights needs of these groups. An enabling legal and policy environment is necessary for a robust HIV response at the national and county level to ensure access to services by persons living with HIV.

The HIV and AIDS Tribunal, which aims to improve access to legal and social justice and protection from stigma and discrimination, is an under-utilised opportunity in the private sector by communities and individuals.

Gender inequalities and cultural practices including wife inheritance, sexual and gender based violence, early marriages and high attrition in school limit effective HIV prevention

13 Report available at http://kelinkenya.org/wp-content/uploads/2010/10/FinalReport-RisksRightsHealth-EN.pdf

TABLE 13: **Interventions to improve legal and policy environment**

Actors	Recommended actions
County Governments	▪ Sensitise law and policy makers on the need to enact laws, regulations and policies that prohibit discrimination and support access to HIV prevention, treatment, care and support. ▪ Review existing laws and policies to ensure they impact the response to HIV positively
National Government	▪ Review existing laws and policies to ensure they impact the response to HIV positively ▪ Sensitise law and policy makers on the need to enact rights-based laws and policies and the implications of a non-responsive legal and policy environment for key and priority populations for their HIV response
Law makers and Law enforcement agents	▪ Sensitise law makers and law enforcement agencies on HIV and the consequences of their interpretation and implementation of laws in the provision of HIV services to priority populations. ▪ Facilitate discussion and negotiations among HIV service providers, those who access services and law enforcement agencies to address law enforcement practices that impede HIV prevention, treatment, care and support efforts ▪ Implementation of HIV workplace programmes for law makers and enforcers
National Human Rights Institutes	▪ Facilitate access to justice and redress in cases of HIV-related discrimination or other legal matters ▪ Undertake legal literacy programmes to teach those who are living with or affected by HIV about human rights and the national and county laws relevant to HIV.
Health Sector	▪ Sensitise individual healthcare workers, health care administrators and healthcare regulators on their own human rights and skills and tools necessary to ensure patient rights are upheld.
Non State Actors	▪ Hold the national and county governments accountable to their constitutional and statutory obligations. ▪ In collaboration with other stakeholders, implement programmes aimed at upholding the rights of priority populations

5.2.3 Monitoring and evaluation for Stigma and discrimination, Gender Based Violence (GBV) by populations and county

TABLE 14: **Monitoring and Evaluation for stigma and discrimination and GBV**

Actor	Recommended Actions
National & County Government	▪ In collaboration, conduct measurement of HIV related stigma through People Living with HIV Stigma Index including in health care settings and communities ▪ In collaboration, conduct a national baseline survey to document the magnitude and nature of human rights violations and gender disparities in the context of HIV
County Governments	▪ Implementation of programmes aimed at reducing stigma and discrimination against priority populations

06

STRATEGIC DIRECTION 4: STRENGTHENING INTEGRATION OF COMMUNITY AND HEALTH SYSTEMS

"KASF aims to build a strong and sustainable system for HIV service delivery at both national and county level through specific health and community systems approaches, actions and interventions to support the HIV response"

6.1 Context

Key intervention areas

- Provide a competent, motivated and adequately staffed workforce at national and county levels to deliver HIV services integrated in the essential health package
- Strengthen health service delivery system at national and county levels for the delivery of HIV services integrated in the essential health package
- Improve access to and rational use of quality essential products and technologies for HIV prevention, treatment and care services
- Strengthen community service delivery system at national and county levels for the provision of HIV prevention , treatment and care services

Expected results by 2019

- Improved health workforce for the HIV response at both county and national levels by 40%
- Increased number of health facilities ready to provide KEPH-defined HIV and AIDS services from 67% to 90%
- Strengthened HIV commodity management through effective and efficient management of medicine and medical products
- Strengthened community-level AIDS competency

Provision of universal health coverage to its citizens by 2030, as articulated in its 2010 Constitution and further reaffirmed in Sessional Paper No. 7 of 2012 on Universal Health Care, is a key developmental commitment by the government. Major strides have been made in scaling up HIV prevention, treatment and care. To sustain the gains made to date and further scale up the response, the country needs to strengthen and integrate health and community systems.[14]

The KNASP III ETR and Kenya Health Sector Strategic and Investment plan 2014- 2030 (KHSSP) indicated that Kenya's healthcare system is characterised by lack of adequately trained personnel, uneven distribution of health personnel geographically and across the health sector; low staff morale, poor leadership and inadequate financing. Add to these weak governance systems, lack of accountability, weak and uncoordinated linkages and referrals; weak collaboration and co-ordination between and across both public and private sector health systems, lack of capacity for planning and monitoring including data analysis, and use of strategic information and lack of M & E tools for community health services.

There is inadequate integration of HIV services in primary health care, including mother and child health and sexual and reproductive health services at national and county levels. Sustained investments in health and community systems, especially human resources, pharmaceutical and laboratory infrastructure and systems, are inadequate. The ensuing prevention and treatment programmes and policies also need to be more sensitive to the needs of the poor and vulnerable populations, including key populations. Finally a sustained and effective national response needs stable and predictable funding.

KASF, therefore, aims to build a strong and sustainable system for HIV service delivery at national and county level through specific health and community systems approaches, actions and interventions to support the HIV response. The main aim is to improve not only general

14 Barker C., Mulaki A., Mwai, D., Dutta A,. (2014) 'Assessing County Health System Readiness in Kenya: A Review of Selected Health Inputs'. Washington, DC: Futures Group, Health Policy Project.

health outcomes but HIV response outcomes, considering that HIV services are delivered within existing health and community systems.

6.1.1 Operational documents to support KASF

1. Kenya Health Sector Strategic and Investment Plan 2014-2030
2. Kenya Health Policy 2014-2030
3. The 2012 Kenya Service Availability and Readiness Assessment Mapping
4. The Community Health Strategy

6.2 Priority Intervention Areas

6.2.1 Provision of a competent, motivated and adequately staffed health workforce at National and County levels to deliver HIV services integrated in the essential health package

The Kenya healthcare system experiences an acute shortage of qualified and competent Human Resources for Health (HRH). Other challenges to health human resources identified include the skewed distribution of health workers geographically, high levels of attrition; unfavourable working conditions; lack of adequate functional structures to support performance; weak staff performance appraisals; lack of a mechanism to link training institutions involved in pre-service training with the services and updates needed at facility level; and inadequate policy guidelines on competencies and skills required for specific cadres, coupled with inadequate facilities for in-service training.

Specific to the HIV response, the availability of adequate, technically competent and skilled personnel at the lower level health facilities (Tiers 2) is identified as a key challenge to the implementation of this framework. Further, the engagement of higher cadre health personnel in HIV service delivery, where they are available, remains sub-optimal. Human resource performance management systems to ensure monitoring of implementation of the strategic directions for prevention care and treatment of HIV as proposed in this framework are also of importance. This framework therefore proposes the below recommended actions to improve the health workforce for the HIV response at both county and national levels.

TABLE 15: **Interventions for a competent workforce**

Intervention areas	Recommended actions	Responsibility
Provision of competent, motivated and adequately staffed health workforce	▪ Recruitment of staff by the National and County governments to improve the overall staff: population ratio in line with the Kenya staffing norms, with a special focus on ensuring availability of adequate, competent and skilled clinical personnel in Tier 2 health facilities. ▪ Redistribution of staff by the National and County governments to ensure availability of appropriate competent and skilled clinical personnel in line with Kenya staffing norms, especially at Tier 2 health facilities. ▪ Institute mechanisms for Task sharing and mentorship for skills transfer to ensure delivery of the essential health package, including HIV prevention, treatment and care services ▪ Improve the human resource performance management system to ensure efficient and effective use of available human resources in delivery of health services, including HIV services ▪ Create incentives for health staff in terms of training, remuneration and other rewards, with a particular focus on high HIV burdened and disadvantaged areas ▪ Integrate and improve capacity building of staff in HIV management and leadership in general pre-service and in-service health training ▪ Support the development/revision of Health Human Resource Development Plan to guide HR needs of the health sector, taking into account additional needs to provide HIV prevention, treatment and care. ▪ Develop and implement a health staff retention policy that takes into account the additional burden of HIV ▪ Develop and implement a system for caring for care givers especially in areas with high burden of HIV.	▪ National and County Governments ▪ MOH

6.2.2 Strengthen health service delivery system at national and county level for the provision of HIV services integrated with essential health package

The general service readiness index for provision of HIV and AIDS services stands at 67%, implying only 67% of facilities are ready to provide KEPH-defined HIV and AIDS services. With continued scale-up of HIV interventions and in the absence of corresponding strengthening of service delivery structures, the quality of HIV services is compromised. Of the 9,000 health facilities in the country, only about 2,500 offer comprehensive HIV services that include treatment. A majority of PLHIV is unable to access care and treatment due to stigma and discrimination, prohibitive out of pocket expenses as well as transport and/or distance to service points. There are weak referrals and linkage systems for HIV services between health facilities. The number of health facilities that meet the basic/minimum standards for HIV service provision are few and there is low demand creation for HIV services due to high levels of stigma in the health system.

To be able to deliver effectively on the strategies for HIV prevention, treatment and care as proposed in this framework, the following are the recommended actions for an effective and efficient service delivery intervention from a health systems perspective.

TABLE 16: **Interventions for strengthening service delivery system**

Intervention areas	Recommended actions	Responsibility
Strengthened Health Service Delivery System for the provision of HIV services integrated with essential health package	▪ Adoption and implementation of Kenya HIV Quality Improvement Framework (KHQIF) as well as implementation of health workforce interventions that improve HIV technical skills and competencies ▪ Adoption of strategies to make comprehensive HIV services more accessible to key populations. ▪ Integration of HIV services in primary health care services, including hospital services, to allow meaningful and routine engagement of all cadres of health personnel in HIV prevention, treatment and care service provision ▪ Integration of HIV referral and linkage services into mainstream health services referral and linkage networks, including community linkages ▪ Upgrading of health facility infrastructure to be able to meet basic standards for HIV service provision ▪ Adapt legal frameworks to de-criminalise Key Population(s) activities and, thereby, increase their demand for and access to HIV services	▪ MOH ▪ National and County Governments ▪ Implementing partners

6.2.3 Improve access to and rational use of quality essential products and technologies for HIV prevention, treatment and care services.

Health products and technologies are key components of a strong health system. In the context of HIV programme, health products that support HIV services delivery are generally called HIV commodities. These include antiretroviral medicines (ARVs) and medicine for management of opportunistic infections (OIs), HIV test kits, CD4, Viral Load and other diagnostic test reagents, condoms, nutritional supplemental and therapeutic feeds.

Effective management of medicines and medical products is an important part of a high quality health system. However, the scenario in Kenya depicts a commodity system that has weak procurement and supply chain management systems, weak and parallel quality assurance programmes for PSM of HIV commodities, weak laboratory infrastructure (dilapidated or inappropriate), lack of high quality diagnostic equipment and appropriate diagnostic professionals for diagnosis of HIV/TB and other diseases especially at Tier 2 facilities, weak quality assurance (QA) interventions and supervision in the entire Laboratory system at all levels characterise the national system.

Periodic stockouts of HIV commodities, poor distribution of systems due to transport challenges, limited storage space and poor storage conditions in medical stores at the county and health facility level, are other challenges. There are also issues with weak and parallel HIV commodities Logistics Management Information Systems (LMIS), weak community involvement in PMS processes and weak capacity to generate, manage and utilise strategic information for effective and efficient PMS especially at county and health facility level.

To improve access to and rational use of quality essential products, technologies and HIV commodities for the proposed HIV prevention and treatment interventions, this KASF proposes the following recommended actions.

TABLE 17: **Interventions to improve access to commodities and HIV technologies**

Intervention areas	Recommended actions	Responsibility
Improve access to and promote rational use of quality essential Health products and technologies	▪ Strengthen HIV commodity management and supply chains monitoring at county and health facility level including pharmacovigilance (drug safety) and post marketing surveillance (PMS) ▪ Promote timely forecasting and quantification and periodic supply/procurement planning for HIV commodities ▪ Promote procurement efficiency for HIV commodities ▪ Infrastructural support for effective distribution and appropriate storage of HIV commodities at national, county and health facility level ▪ Promote appropriate prescription practices and rational use of HIV commodities ▪ Develop a robust LMIS to facilitate timely collection and transmission of quality commodity consumption and stock status data that is integrated into the HMIS ▪ Provision of adequate and functional HIV diagnostic equipment (VL, CD4.).that are well maintained (service contracts) and adoption of new technologies e.g. point of care CD4, self testing ▪ Introduction of facility-based IT systems to manage and monitor HPT supplies and link with national and county MoH Information System ▪ Development of an evidence based pharmaceutical supply chain management system linked to the government financial management system and the Health management information system: ▪ Establishment of county systems for co-ordinating and managing EHPT investments ▪ Expand the mandate and capacity of the NQCL to test EHPT ▪ Review and strengthen laboratory systems for effective diagnosis and monitoring of ART, especially for early detection of toxicities and treatment failure ▪ Decentralisation of comprehensive HIV services including laboratory networks to all health facilities, especially the lower level (Tier 2).	▪ NASCOP ▪ KEMSA ▪ Poisons and Pharmacies Board ▪ National Reference Labs

6.2.4 Strengthened community and workplace service delivery system at the national and county level for the provision of HIV prevention, treatment and care services

Community based organisations (including FBOs/NGOs/CSOs), workplaces and local community leadership play a critical role not only in promoting the ownership of the epidemic, but also in addressing the root causes of vulnerability to HIV, including skewed gender relations, harmful cultural practices, pervasiveness of stigma and discrimination and commonality of violence against Key Populations.

Some of the key challenges facing community and workplace-based HIV programmes include weak leadership and governance structures, inadequate financial, human and material resources, lack of capacity for planning and monitoring their programmes, poor quality data, incapacity to use strategic information, poor community linkages with formal health systems and lack of M & E tools for CHBC evaluation.

In addition, most of the funding in support of CBOs HIV programmes and activities is externally sourced thus often inadequate and /or unpredictable, HIV and AIDS related stigma and discrimination results in low demand and uptake of HIV services and the violation of the rights of PLHIV, there is weak involvement of community leaders in health interventions that undermine community mobilisation coupled with weak community involvement and participation in monitoring of resources dedicated to communities.

Considering the central role CBOs/FBOs/NGOs, CSOs and workplaces play in the national response, community and work-based programmes will be strengthened in KASF through the following recommended actions.

TABLE 18: **Interventions for strengthening community service delivery system**

Intervention areas	Recommended actions	Responsibility
Strengthened community and workplace service delivery system at national and county level for the provision of HIV prevention , treatment and care services	▪ Strengthen governance and leadership for community and workplace health actions at all levels ▪ Enhance human resource capacity for development and implementation of community and workplace health at all levels ▪ Strengthen institutional capacity for implementation of community and workplace actions and services at all levels ▪ Establish standards for guiding community and workplace health implementation and practice. ▪ Empower communities and workplaces to ensure improved capacity and capability to take charge of their health. ▪ Articulate an integrated, comprehensive and quality community and workplace health package for HIV prevention, treatment and care	▪ MOH ▪ County Governments ▪ Implementing partners

07

STRATEGIC DIRECTION 5: STRENGTHENING RESEARCH, INNOVATION AND INFORMATION MANAGEMENT TO MEET KASF GOALS

"To achieve the KASF goals, greater emphasis should be given to identification and implementation of high-impact research priorities, innovative programming and capacity strengthening to conduct research"

7.1

The Context

Key intervention areas

- Resource and implement an HIV research agenda informed by KASF
- Increase evidence-based planning, programming and policy changes

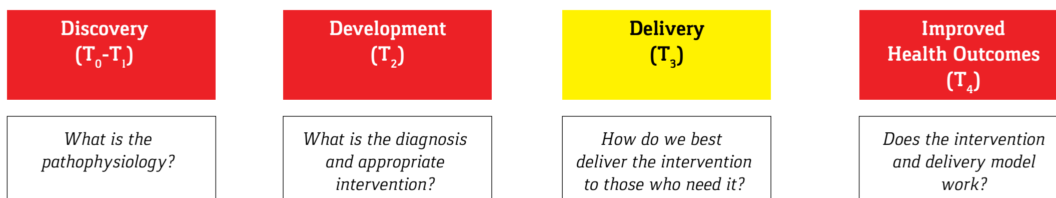
Expected results by 2019

- Increased evidence-based planning, programming and policy changes by 50%
- Increased implementation of research on the identified KASF-related HIV priorities by 50%
- Increased capacity to conduct HIV research at country and county levels by 10%

Kenya has an outstanding track record and leadership for biomedical, behavioural and structural research on HIV. This includes participation in global partnerships for demonstration of efficacy of treatment and pre-exposure prophylaxis as prevention, efficacy of prevention of mother-to-child interventions, discovery of broadly neutralising antibodies for HIV vaccine development, epidemiology and analytical studies to determine risk factors of HIV acquisition and modes of transmissions. Kenya has also conducted ground-breaking socio-behavioural and epidemiologic studies amongst different populations at risk (such as incidence and risk factors for MSM, Sex Workers and PWIDs) and evaluations of structural interventions (such as impact of cash transfer amongst adolescents). Different national surveillance studies (such as KAIS and MOT) provide valuable information for programmes and research (for example KNASP III was informed by evidence drawn from KAIS 1 and MOT Study). Most of these studies fall in the realm of T1 and T2 as illustrated in the figure below.

However, efficient translation of strong research findings into policies and practices (Level T3) remains weak. There are still research gaps in understanding drivers of the epidemic by populations and geography; in evaluating effectiveness and efficiency of various interventions in addition to the effectiveness of proven efficacious

FIGURE 12: **Structure of HIV research in Kenya**



biomedical interventions and technologies in the real world. Data and research on social determinants of health and their impact on incidence and mortality are scanty. There are limited studies on impact of stigma, discrimination, cultural practices, gender norms on prevention, mortality and quality of life. NGOs, hospitals and universities collect data and conduct research, which often is not captured in the national framework.

Timely translation of data and evidence for programming and policies are hampered by a multiplicity of data sources, disparity in methodologies and time frames and user-friendliness of data collected and generated at facility, county and national levels. Best practices in service delivery have been elucidated and there are many successful projects but scalability is unknown and not often achieved. Capacity for HIV research is unevenly distributed across counties. Inefficiency of approvals by Ethics Review Committee (ERC); limited use of technology and quality assurance mechanisms may impact on HIV research. A data revolution is needed to inform evidence-based programming, policy development and research priorities at county and country levels. HIV research is still largely dependent on donor-funding and sometimes not harmonised with national HIV research priorities.

7.2 Priority interventions

7.2.1 Resource and implement an HIV research agenda informed by KASF

There is need for a revised and unified research agenda for HIV to address emerging challenges and gaps and propel evidence-based policy and programming. To achieve the KASF goals, greater emphasis should be given to identification and implementation of high-impact research priorities, innovative programming and capacity strengthening to conduct research.

TABLE 19: **Interventions for resourcing and implementing HIV research agenda**

Implementation Research Priorities	■ Evaluate: scale-up of combination prevention; effectiveness of structural interventions; impact of scaling up Kenya treatment guidelines on HIV acquisition and morbidity at individual and community level; impact of stigma and GBV reduction programmes on HIV incidence and mortality; impact of new technologies and programmes in priority populations. ■ Granulate drivers of new HIV infections in priority and bridging populations ■ Costing and cost effectiveness of interventions and models of care delivery
Behavioural Research Priorities	■ Determine socio-behavioural, cultural and gender-related factors as determinants of health outcomes and adherence to treatment; drug, alcohol and substance use on HIV acquisition, care and treatment outcomes; predictors of loss to follow up, defaulting and retention; drivers of mortality and associations between aging and treatment; determinants of stigma reduction ■ Understand risk perceptions, adherence and retention in HIV prevention
Biomedical Research Priorities	■ Investigate less adherent dependent and cost-effective prevention technologies (such as microbicides, preventive and therapeutic vaccines and cure), long-acting PrEP and PEP, and ARVs for treatment; interaction of HIV with non-communicable diseases and geriatric diseases; better treatment for children and the elderly living with HIV. ■ Determine optimal multi-purpose prevention (STIs, HIV and pregnancy) technologies and options ■ Assess associations of hormonal contraception on HIV acquisition and treatment
Analysis	■ Characterise young women at high HIV risk ■ Implement bio-behavioural survey framework for key and vulnerable populations ■ Integrate GBV and IPV data collection in HIV survey ■ Create and maintain a HIV research and best practice data base

TABLE 20: **Interventions for Implementation of research on KASF-related priorities**

Intervention area	Recommended actions	Responsibility
National HIV research agenda	▪ Develop national HIV research agenda through a consultative process to complement the Health Research agenda ▪ Strengthen synergies between HIV research and other health research areas such as TB and SRH	▪ NACC ▪ NASCOP ▪ KEMRI ▪ IAVI ▪ Research institutions
Implement research agenda at National & County levels	▪ Invest in in-country capacity for sound research and peer reviewed publication ▪ Strengthen co-ordination and tracking of HIV research ▪ Sensitise Ethics Review committees on KASF priorities ▪ Strengthen Ethics Review committees to facilitate high quality HIV-related studies (fast track mechanisms; quality assurance, complex biomedical trial designs, key populations and adolescent ethics and sensitivities ▪ Strengthen county HIV research capacities including epidemiologic surveillance, good laboratory and clinical practice and ethics	▪ KEMRI ▪ NACC ▪ NASCOP ▪ NACOSTI ▪ KAVI-UON ▪ Research institutions ▪ Universities ▪ Development Partners
Resource the HIV agenda	▪ Develop HIV research financing strategy in alignment with the Health Bill and NACOSTI plans by 2015 ▪ Integrate research funding in KASF funding priorities and develop resource mobilisation plan ▪ Advocate for allocation of 20% of health research budget through a sound investment case ▪ NACC allocate 10% of HIV resources to research funding through competitive transparent processes	▪ MOH ▪ NACC ▪ NASCOP

7.2.2 Increase evidence-based planning, programming and policy changes

A stronger emphasis on research and innovation to generate timely evidence to inform scale up of policy, programmes and interventions that can save lives and improve health is critical in fast tracking achievement of the KASF goals. NACC's leadership collation of existing Kenyan and global research and strategic dissemination for policy and practice will be prioritised.

TABLE 21: **Interventions for increasing evidence planning and programming**

Key Interventions	Recommended actions	Responsibility
HIV information portal for Kenya research, synthesising data routinely	▪ Establish a multi-sectoral and interactive web-based Kenya HIV research hub with geographic mapping of all research on HIV, TB and SRH; ▪ Develop and disseminate regular review of papers on key research findings, local innovations, systematic reviews and their policy, funding and practice implications	▪ NACC ▪ MoH Research Unit, KEMRI, UNAIDS, IAVI
Reviews of research	▪ Publish systematic reviews of research on the KASF priorities and draft research briefs biennially ▪ Invest in capacity development within responsible agencies for research reviews and collation	▪ NACC ▪ NASCOP, KEMRI, WHO
Communities of practices	▪ Establish communities of practice (CoP) on the KASF priorities to review evidence and propose policy recommendations	▪ NASCOP
County Research engagements	▪ Establish standing or ad hoc research committees to identify county research priorities, determine policy changes from existing research and disseminate findings	▪ NACC, KEMRI, NASCOP

08

STRATEGIC DIRECTION 6: PROMOTE UTILISATION OF STRATEGIC INFORMATION FOR RESEARCH AND MONITORING AND EVALUATION TO ENHANCE PROGRAMMING

"As the routine monitoring and evaluation systems become more accessible, a renewed focus on improving data quality, demand and use of data for decision making at national and county and health facility levels will be given priority"

8.1 Context

Key intervention areas

- Strengthen M&E capacity to effectively track the KASF performance and HIV epidemic dynamics at all levels
- Ensure harmonised, timely and comprehensive routine and non-routine monitoring systems to provide quality HIV data as per national, county and sector priority information needs
- Establish multi-sectoral and integrated real time HIV platform to provide updates on HIV epidemic response accountability at county and national level

Expected results by 2019

- Increased availability of strategic information to inform HIV response at national and county level
- Planned evaluations, reviews and surveys implemented and results disseminated in timely manner
- M&E Information Hubs Established at National Level and County Levels and providing comprehensive information package on key KASF Indicators for decision making

Kenya's response to the evolving HIV epidemic is largely influenced by strong commitment to availing quality data in a timely manner for effective evidence-informed decision making. This underpins the need to strengthen M&E capacity at all levels to generate and use evidence for decision making. This has now been further strengthened by the Constitution that requires participation of the people in decision making; transparency and accountability among other elements of good governance and stewardship. Monitoring and evaluation of national multi-sectoral response to HIV and AIDS continues to rely on a variety of systems; data sources, routine, periodic collection and collation systems, which are supported and maintained by various stakeholders. The HIV surveillance system in Kenya has been characterised by a set of high quality national level surveys (KAIS and KDHS) and facility-based HIV sero-prevalence surveys. The data from these sources is used to provide trends in HIV prevalence and incidence. IBBS surveys and research studies have also been conducted in a number of cities and urban centres to track HIV-related risk behaviour and the burden of HIV and AIDS among Key Population groups. The routine monitoring systems, established nation-wide, are a major source of strategic information for monitoring and evaluation of the HIV programme.

The achievement in HIV Programme monitoring has, however, not been without challenges. The M&E system is faced with gaps in strategic approach on co-ordination, ownership and meaningful data use for decision-making and planning among various stakeholders, various levels and sectors. Another important gap is that both the programmatic data available for routine monitoring of programmes, and the sentinel surveillance data that facilitates modelling trend analysis are not sensitive enough to adequately detect emerging trends in the epidemic. The analytical capacities at the county level are weak and will need to be strengthened to effectively address the strategic data needs at that level. County ownership and recognition of the importance of effective and efficient M&E system are yet to be established.

The M&E system is based on sub-systems linked to non-routine (surveys and special studies) and routine (programmatic) sources of data. In general, the sub-systems are both not well harmonised and not comprehensive enough to address the comprehensive set of indicators required for the multi-sectoral approach.

There is need to strengthen the existeing country level M&E system so as to make it more flexible to respond to the data needs of both National and County governments, and to facilitate generation of high quality and timely strategic information for HIV response at all levels.

Kenya relies to a great extent on population-based surveys to provide information on the HIV epidemic. The Kenya AIDS Indicator Surveys and the Kenya Demographic and Health Surveys and other special surveys have in the past been key sources of national and sub-national HIV information. Data from these sources has been used in modelling and generating trend analysis of key HIV-related indicators. To effectively address the specific needs of counties, there is need to cascade data collection and anaylsis up to county level. However, a major challenge facing M&E has been over-dependence on external funding. This has often meant delays or incomplete implementation of planned M&E activities including population-based surveys. To ensure timely implementation of M&E activities at both the national and county level, sustainable financing of M&E needs strengthening at all levels.

8.1.1 Operational Documents to Support KASF

1. HIV programme M&E framework
2. HIV Estimates Report and County profiles
3. Kenya AIDS Epidemic Update Report 2012

8.2 Priority Intervention Areas

As the routine M&E systems become more accessible, a renewed focus on improving data quality, demand and use of data for decision making at national and county and health facility levels will be given priority. This will, therefore, require adequate funding for M&E activities, ownership and support for HIV M&E system and data quality assurance at national, county and sector levels. To achieve this, the following recommended actions shall be undertaken during the implementation period of the KASF.

TABLE 22: **Interventions for the M&E priority areas**

	Recommended actions	Responsibility
Strengthening M&E capacity to effectively track the KASF performance and HIV epidemics at all levels	▪ Align the country M&E system to the new governance structure ▪ Conduct national and county M&E engagements ▪ Conduct M&E capacity assessment and capacity development at national and county levels ▪ Establish and sstrengthen functional multi-sectoral HIV M&E co-ordination structure and partnerships at national and county levels ▪ Develop comprehensive HIV M&E systems guidelines, tools and standard operating procedures ▪ Put in place ssustainable financing for HIV M&E planned activities	▪ NACC ▪ MOH ▪ National and County Governments ▪ Implementing partners
Ensure harmonised, timely and comprehensive routine and non-routine monitoring systems to provide quality HIV data at national and county levels	▪ Strengthen HIV M&E data management at national and county level ▪ Harmonise and create linkages between data collection tools and databases ▪ Conduct periodic data quality audits and verification ▪ Conduct M&E supervision ▪ Scale up coverage of ongoing HIV programme surveillance and surveys ▪ Honour global, regional, national and county HIV reporting obligations ▪ Strengthen routine and non-routine HIV information systems	▪ NACC ▪ MOH ▪ National and County Governments ▪ Implementing partners
Establish multi-sectoral and integrated real-time HIV platform to provide updates on HIV epidemic response accountability	▪ Establish a multi-sectoral HIV programming web-based data management system ▪ Promote data demand and use of HIV strategic information to inform policy and programming ▪ Develop and implement KASF evaluation agenda ▪ Create and strengthen M&E Information Hubs at national and county Level	▪ NACC ▪ MOH ▪ National and County Governments ▪ Implementing partners

09

STRATEGIC DIRECTION 7: INCREASING DOMESTIC FINANCING FOR SUSTAINABLE HIV RESPONSE

"The dwindling resources available for HIV programming call for smarter investments of every shilling where it will have the greatest impact and in the most efficient way"

9.1

Context

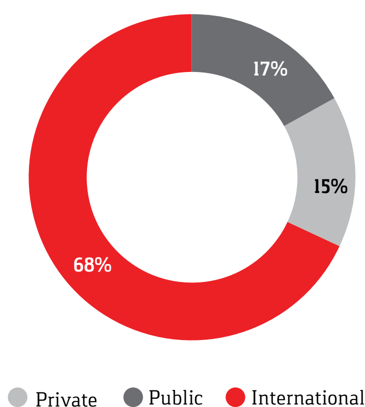
Key intervention areas

- Maximise efficiency of existing delivery options for increased value and results within existing resources
- Promote innovative and sustainable domestic HIV financing options
- Align HIV resources/investment to strategic framework priorities

Expected results by 2019

- Increased domestic financing for HIV response to 50%

FIGURE 13: **Estimated HIV funding gap**



With the fourth largest HIV epidemic globally, the envisaged rapid scale-up of high-impact HIV investments under this Strategic Framework and a changing HIV funding landscape, new ways of resourcing HIV for Kenya are needed. Data suggests that the cost of the national HIV/AIDS response amounted to over 2% of GDP annually in 2009/10 to 2011/12. Approximately 68% of the national AIDS response is externally funded. Although the government allocation towards the HIV and AIDS response has more than doubled under the KNASP III implementation period - rising from USD 57.49 million in 2006/7 to USD 153 million in 2012/13 (NACC, 2014) - there remains a sustainability challenge for the response.

Consequently, the dwindling of resources available for HIV programming call for smarter investments of every shilling where it will have the greatest impact and in the most efficient way (Schwartländer *et al.,* 2011).

Heterogeneities ranging by a factor of up to 40 (Wang'ombe et al., 2013) exist within unit costs of providing HIV services in health facilities. Data (NACC, UNAIDS and OPM, 2012) shows that Kenya could achieve twice as much output with the same amount of resources. Thus, the fiscal *space for HIV could be expanded by improving the efficiency of HIV programmes and contribute to financial sustainability (UNAIDS, 2012).*

Globally, the unprecedented global support towards universal access to HIV prevention and treatment has evolved into an agenda of shared responsibility and commitment to end the AIDS epidemic[15]and achieve universal health coverage. Kenya's economy has been rebased, making it a middle income country. This will have implications on Kenya's requirements for counterpart financing, terms for commodities and drugs, existing and future financing agreements.

15 "To end the AIDS epidemic by 2030 would mean that AIDS is no longer a public health threat. It means that the spread of HIV has been controlled or contained and that the impact of the virus on societies and on people's lives has been marginalized and lessened," (UNAIDS, 2014).

9.2

Resource requirements for KASF

The total gross resource need is estimated at USD 5,486.4 million for the five-year period. The cost will rise from USD956.2 million in 2014/15 to USD1,190.4 million in the final year of the Strategic Framework due to planned scaling up of key HIV interventions.

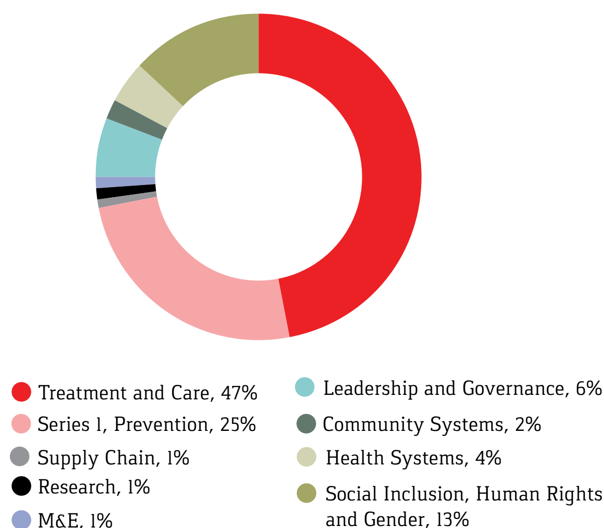
TABLE 24: **Resources required for implementing KASF (in USD millions)**

KASF interventions	2014/15	2015/16	2016/17	2017/18	2018/19	Total
Prevention	210.3	239.5	270.3	302.4	327.6	1,350.1
Treatment and care	461.2	504.3	526.8	536.4	529.7	2,558.3
Social inclusion, human rights and gender	87.4	113.5	141.3	171.3	203.7	717.2
Health systems	60.7	54.9	45.0	40.4	21.2	222.2
Community systems	30.4	27.4	22.5	20.2	10.6	111.1
Leadership and governance	75.9	77.1	75.1	70.7	63.7	362.5
Monitoring and Evaluation	15.2	15.4	15.0	14.1	12.7	72.5
Research	7.6	8.6	9.4	10.1	10.6	46.3
Supply chain	7.6	8.6	9.4	10.1	10.6	46.3
Grand total	956.2	1,049.2	1,114.9	1,175.8	1,190.4	5,486.4

Source; NACC and USAID Health Policy Project (2014)

Treatment and care will account for the highest share of the total resources, (47%), followed by prevention (25%), social inclusion, human rights and gender-based violence (13%), leadership and governance (7%) and health systems (4%). In a context of limited resources and to maximise allocative efficiencies, it is critical that resource allocation shall be aligned to these KASF priorities.

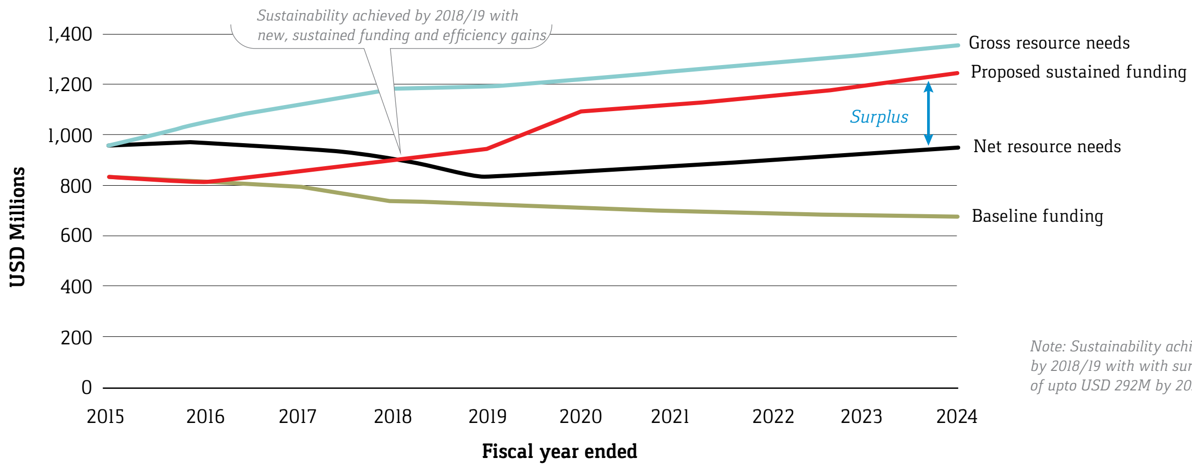
FIGURE 14: **Proportion of resource needs per KASF programmatic area**



Source: NACC and USAID Health Policy Project (2014)

Comparing needs and projected resources available (figure 7-2), reveals a significant and growing funding gap. To close this resource gap, this Strategic Framework shall promote innovative and domestic financing of the response through a leveraging model by maximising efficiencies and adopting innovative sustainable financing options in support of greater Country and Counties' ownership of the response.

FIGURE 15: **Estimated HIV funding gap**



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Baseline funding	829	814	797	735	724	713	699	688	680	674
Proposed sustained funding	829	814	852	898	940	1,087	1,114	1,148	1,190	1,238
Gross resource needs	956	1,049	1,115	1,176	1,190	1,212	1,249	1,283	1,317	1,352
Net Resource needs	956	971	948	911	833	848	874	898	922	946

Source: NACC (2014)

9.3

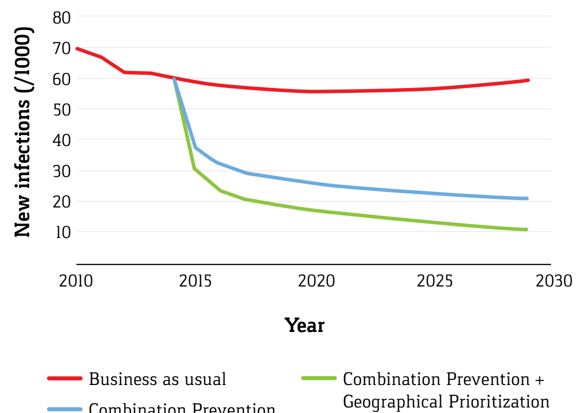
Priority intervention areas

9.3.1 Maximise efficiency by refocusing our existing efforts to deliver better results to Kenyans within current funding levels

1. Align the HIV/AIDS response with local context

The shift towards a decentralised design of HIV policies and programmes that are calibrated to county specific circumstances is essential and should be cascaded to the county level. An approach that targets interventions towards who needs them and where they are needed will reduce HIV incidence by over 10% immediately (see Figure 5 below), and this effect could grow to a 30% reduction in annual HIV incidence after a 15-year period, thereby setting the country on a path to ending the AIDS epidemic (Anderson *et al.*, 2014).

FIGURE 16: **Projected rate of new HIV infections due to population and geographical targeting**



Source: *MoH, 2014(a)*

2. Promote effective cost-saving models of HIV/AIDS service delivery

To guarantee that every dollar invested in HIV programming is used to achieve the highest possible health outcome, service delivery will be altered in line with the available evidence.

Immediate areas of cost savings:

- Implement on-the-job training models utilising harmonised HIV training curriculum: Thenew devolved system requires expansion of HIV training and mentoring for healthcare workers at national and county levels. (Mukui, et al., 2012). A harmonised training curriculum delivered on-site could reduce training cost by up to 70%.
- Rationalise ART collection systems to reduce the distribution and referral cost associated with laboratory referrals.
- Use innovative time-bound strategies for returns where long-term static service delivery has low yield.
- Maximise full-time equivalents of health personnel and reducing absenteeism from facilities will reduce high HIV costs.
- Integration of HIV/RH and MNCAH services

HIV treatment and related commodities: Options to increase competition among suppliers and improve transparency in the ART tendering process including price benchmarking, robust allocation of preference points, price stability, reliability of need estimates, and transparency of the process will be strengthened.

4. Address inefficiencies in the "above service" and "cross-sectoral" cost of achieving the HIV and AIDS target Coverage

Actions beyond the health sector are important factors affecting HIV/AIDS service delivery (including the ensuing efficiencies) and are addressed by other sectors. The cost or efficiencies required to optimise the gains to be made from the health service delivery need to be better understood.

Important cost lines such as leadership, governance, and M&E require further understanding of efficiency of key cost drivers to identify options for innovative and cost-effective interventions that maximise efficiency.

There are costs and efficiencies to be gained in strengthened co-ordination of implementing partners to align to county and epidemic priorities, reduce duplication, double counting of results and enhance county ownership of the HIV response. A partnership accountability framework should be implemented.

To deliver the high impact results outlined in the KASF, options for financing to counties and implementing partners based on results should be explored. This strategic framework shall develop a Results Based Financing Framework that will have the following three outcome levels to it:-

(I) Contribution to overall national health indicators in the spirit of achieving UHC

(II) Meeting specific HIV intervention targets

(III) Efficiency in delivery on the basis of efficiency gains

Implemented at scale, the efficiencies in key cost drivers will yield approximately 30% efficiency saving to the current resource needs and enhance predictability in flow of funding as shown in Fig.17.

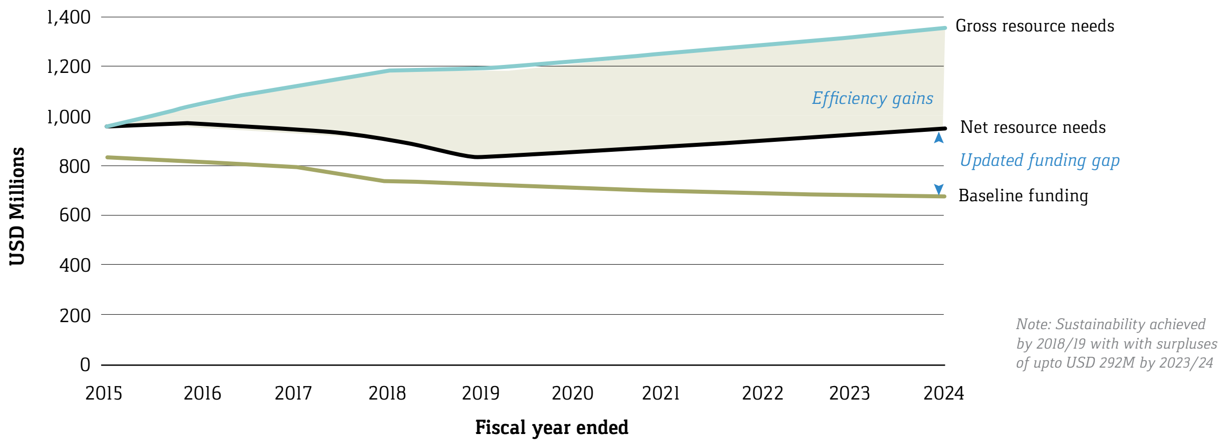
9.3.2 Fund the private-public HIV investment fund for HIV and AIDS to raise and leverage domestic resources

Kenya is transitioning to Universal Health Care (UHC) to ensure that all people have access to affordable quality healthcare services. Attaining the long-term goal of UHC requires additional investment in national health insurance coverage, which calls for new financing options. A long-term goal is to finance parts of the HIV/AIDS services through the National Hospital Insurance Fund[16].

Ongoing reforms aim to increase the membership (contributors, not counting dependents) of the NHIF to about five million by 2020, and 12 million by 2030, at

16 NACC, UNAIDS and OPM (2012) Sustainable financing for HIV/AIDS in Kenya. s.l. : Oxford Policy Management: Oxford

FIGURE 17: **Net resource needs to implement KASF (in USD)**



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Gross resource needs	956	1,049	1,115	1,176	1,190	1,212	1,249	1,283	1,317	1,352
Efficiency gains	-	79	167	265	357	363	375	385	395	406
Net Resource needs	956	971	948	911	833	848	874	898	922	946

Source: NACC (2014)

which stage the NHIF would cover more than 60% of the population. Including ART in the package offered by the NHIF would require an estimated US$345 million in 2014 (excluding overhead costs). The total revenue of the NHIF is projected by OPM (2012) at US$470 million in 2014/15. Provided that access to ART is the same for NHIF membership than otherwise (probably an under-estimate), the costs of antiretroviral treatment for NHIF membership would amount to US$ 76 million (treatment only) or US$90 million (including overhead), corresponding to 16% or 19% of the revenue of the NHIF. The subsidies accrued by persons living with HIV, will require to be financed if NHIF will retain its current packages to its membership.

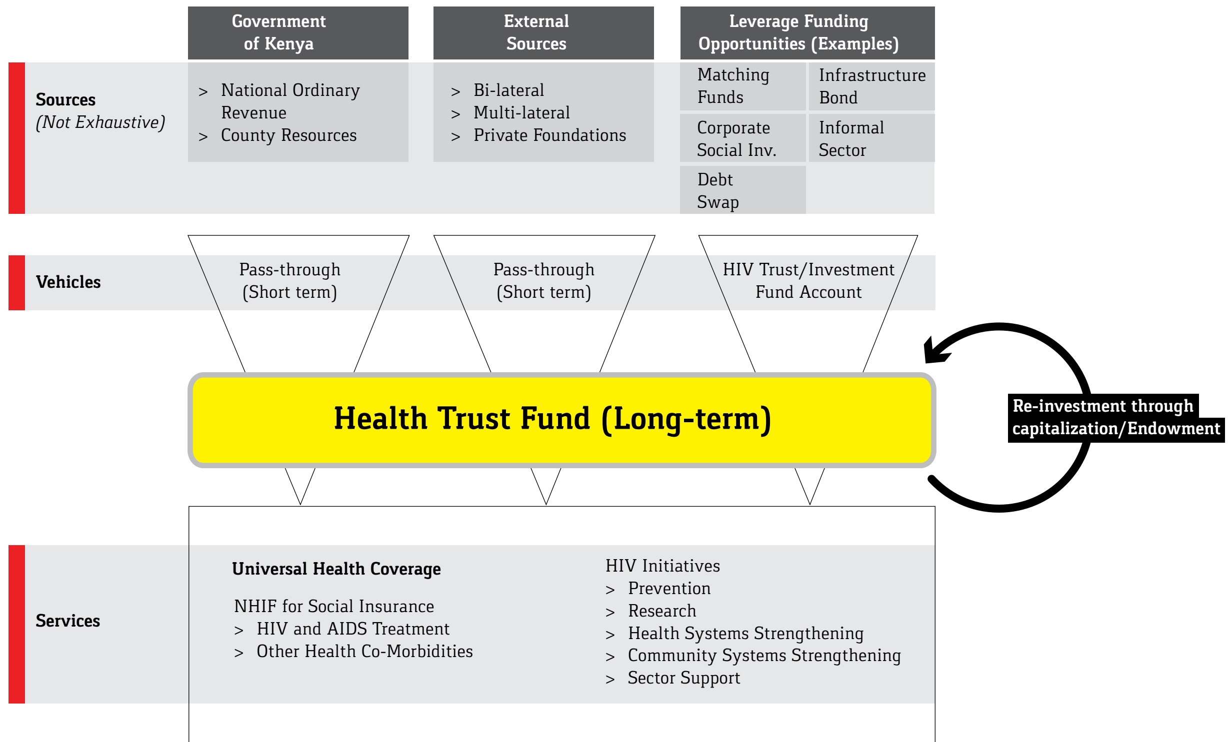
This data excludes the cost of HIV prevention. Reduction of incidence is the only long-term strategy to decrease required premiums in the future. The long-term plan towards health insurance will be accompanied by short term plans to pool funds needed to catalyse domestic financing, build funds to deliver prevention and capitalise a health trust fund to support insurance needs not only for HIV but all conditions that affect those living with HIV.

HIV Trust/Investment Fund

Setting up an HIV investment unit within the NACC: In the short-term, starting fiscal year 2015/16, the unit will focus on developing a model for sourcing leverage funding and resourcing the fund. The fund shall be set up within NACC as mandated under the Public Finance Management Act. The Fund will implement innovative financing mechanisms to draw new resources that will be ring-fenced for high priority areas and interventions and underfunded areas within the HIV response as identified in this Strategic Framework.

Trust/Investment Fund: The HIV Trust Fund shall adapt a leverage model to raise and leverage National and County resources. It shall aim to contribute to and catalyze the investment for a broader health fund that will subsidize Government liability in HIV investment and Prevention costs. It will ultimately facilitate Kenya's drive towards Universal Health Coverage. It will have a Governance framework, leveraging best-in-class fund administration and governance frameworks.

FIGURE 18: **Short and long term fund structure for financing HIV and AIDS**



Source: NACC 2014

Funding sources for the HIV investment Fund: To capitalise the HIV innovative fund, diverse funding sources shall be used to leverage Government financing:

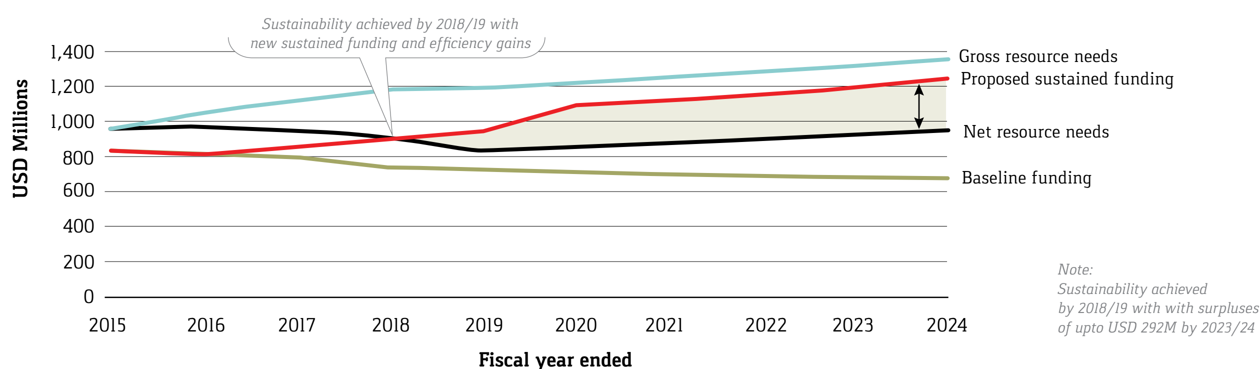
- Debt swap options
- AIDS lottery
- Corporate Social Investment (CSI)
- Infrastructure HIV resources
- Health bond
- Portion of interest from dormant funds,
- Organised informal sector contributions

Source: *NACC, 2014; NACC, UNAIDS and OPM, 2012*

Any feasible sustainable financing approach will need to include the government earmark for HIV programmes and services. Government allocation (at National and County levels) is proposed to be increased to 2% of GoK ordinary revenue to HIV, hedging potential reductions in current investment of 1%.

This is estimated to raise USD423 million in 2018/19 and when combined with domestic private sector funds can finance up to 55% (USD566 million) of the KASF net resource needs. As global solidarity remains critical to HIV financing in the short-to-medium term, these innovative and sustainable resources will be supplemented by international funding to meet the full net resource needs.

FIGURE 19: **Funding scenario analysis**



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Baseline funding	829	814	797	736	724	713	699	688	680	674
Proposed sustained funding	829	814	852	898	940	1,087	1,114	1,148	1,190	1,238
Gross resource needs	956	1,049	1,115	1,176	1,190	1,212	1,249	1,283	1,317	1,352
Net Resource needs	956	971	948	911	833	848	874	898	922	946

Source: NACC (2014)

9.3.3 Align current HIV investment to KASF priorities:

To optimise the AIDS investment, both government and development partners' funding (both project support and on-budget support) will be aligned to KASF priorities.

Government of Kenya domestic investment will be in the form of allocation at the national level towards the HIV and AIDS components in the health sector and other sectors such as Education, Prisons, Labour and Social Security, Agriculture; government ministries, departments and agencies (MDAs) for HIV and AIDS activities in their plans and budgets. The allocation will also be used for HIV and AIDS research and co-ordinating HIV and AIDS at the national and county levels. This will include allocation by County governments towards their HIV response.

Efforts in scaling up the conditional cash transfer programmes in country will be enhanced with the understanding that the conditionality is an incentive to the poor to invest in their own capital in order to break an inter-generational poverty cycle. Education and health in this KASF will continue to be used as the most important factors that enable future generations to escape from poverty through the already established country's Social Protection Mechanisms for OVCs, Youth, Women, PWD, the Elderly among others.

TABLE 25: **Recommendations for aligning HIV investment to KASF priorities**

	Recommended actions	Responsibility
GoK resources	▪ Track government allocations to the different government agencies ▪ Engage the Commission on Revenue Allocation to consider HIV as an added parameter or consideration in resource allocation ▪ Develop a HIV investment criteria for resource allocation to counties to align resource to needs ▪ Facilitate implementation of deliberate measures to unblock the financial, human, infrastructural, institutional (within the health system) and structural (outside the health system) bottlenecks that impact absorptive capacity to financing HIV programmes	NACC
Development partners	▪ Strengthen development partners HIV forum to facilitate alignment with KASF ▪ Facilitate quantification of county resource needs through relevant information on county support	NACC
Implementing partners	▪ Implement a partnership accountability framework (National and County level) to ensure alignment of resources to KASF priorities ▪ Facilitate planning by reporting contribution to KASF annually	NACC

10

STRATEGIC DIRECTION 8: PROMOTING ACCOUNTABLE LEADERSHIP FOR DELIVERY OF THE KASF RESULTS BY ALL SECTORS

"Efforts shall be made to promote good governance practices by identifying, developing and nurturing effective and committed leaders for the HIV and AIDS response"

10.1 Context

Key intervention areas

- Build and sustain high level political and technical commitment for strengthened country and counties' ownership of the HIV response
- Entrench good governance and strengthen multi-sector and multi-partner accountability for delivery of KASF results
- Establish and strengthen functional and competent HIV co-ordination mechanism at the national and county level

Expected results by 2019

- Good governance practices and accountable leadership entrenched for the multi-sectoral HIV and AIDS response at all levels
- Effective and well-functioning stakeholder co-ordination and accountability mechanisms in place and fully operationalised at national and county levels
- An enabling policy, legal and regulatory framework for the multi-sectoral HIV and AIDS response strengthened and fully aligned to the Constitution of Kenya 2010.

The Constitution of Kenya 2010 provides a new legal and policy environment upon which the HIV response will be implemented. Articles 10(2) and 73 outline key defining elements of good governance and leadership while Article 21 (3) bestows on all State organs and all public officers the duty to address the needs of vulnerable groups within society.

In 2013, the National AIDS Control Council was placed under the Ministry of Health to strengthen co-ordination without losing its mandate. As a national state organ responsible for results in the HIV response, it is required, under Article 6(3), to ensure reasonable access to its services in all parts of the republic.

County planning, prioritisation, implementation, monitoring, resource allocation and budgeting of programmes and interventions in counties are functions under the devolved government. Thus, counties are responsible for implementation of HIV services and programmes across different sectors. In this regard, the County Government Act, 2012, requires the County Executive Committee to design a performance management plan to evaluate implementation of county policies by the county public service. It further requires that the County Governor submits the county plans and policies to the county assembly for approval together with an annual report on the implementation status.

To facilitate working relations between National State Organs and County Governments, a framework for management of intergovernmental relations is provided in Article 189. The operability of the framework is dependent on entrenching good governance practices

that build accountable leadership capacity for the multi-sectoral HIV/AIDS response while establishing effective stakeholder, intergovernmental and sectoral co-ordination mechanisms.

In the context of shrinking resources, there is increased call for ownership of the HIV response by the country. Country ownership of the HIV response has been identified as including: a strong political engagement and inclusive leadership; full engagement of civil society, communities and people living with HIV; high quality strategic information; robust national strategic plans with smart investment decisions; strong partnership with a shared responsibility and mutual accountability; effective co-ordination, capacity development and integration of HIV into health and country development strategies.

10.1.1 Gaps

The Constitution of Kenya 2010 has fundamentally changed the governance framework for the multi-sectoral response. The third Kenya National HIV and AIDS Strategic Plan (KNASP III) 2009-2012) End Term Review (ETR) also found that despite the existence of an inclusive national stakeholder co-ordination and participation framework, the co-ordination mechanisms established especially at the decentralised levels lacked synergy in terms of service delivery and accountability for results. The governance and leadership landscape for HIV and AIDS in Kenya has also been characterised by challenges of inadequate country ownership, community participation, stakeholder engagement, co-ordinated development partner support and weak leadership capacity especially at the decentralized levels.

10.2 Priority intervention areas

10.2.1 Build and sustain high-level political commitment for strengthened country ownership of the HIV response

High levels of political goodwill are required to effectively address the impact of HIV in Kenya. Most importantly is the need to leverage on on-going political priorities.

- Youth and women are identified as high priority in the Vision 2030 and in government
- Maternal and child health is prioritised by the government. This provides an opportunity to deliver the results for HIV prevention among youth, who account for 70% of pregnancies.
- The First Lady's strategy for HIV control, maternal and child health that is prioritised in counties is an opportunity to accelerate eMTCT targets to reach Kenya's MDG goals.
- The Performance Contracting mechanism of the government that has HIV indicators is an opportunity for sector actors to set their HIV targets and align their quarterly reporting to attainment of these targets. This will also facilitate tracking of government resources.
- The President's commitment to increased sustainable financing provides an opportunity to accelerate establishment and operationalisation of the HIV fund and resource seed funds as articulated in the domestic financing section.

TABLE 26: **Recommendations for country ownership**

Country Ownership actors	Recommended actions
The Presidency	▪ Provide direction to the public sector including government ministries, departments, agencies and state institutions on the national response ▪ Report to the nation and the National Assembly on the measures taken and the progress achieved in the implementation of KASF and Kenya's international obligations on HIV and AIDS. ▪ International advocacy
The Judiciary	▪ Advance the aspirations of Kenyans by ensuring adherence to the rule of law and enforcement of the Bill of Rights ▪ Create dialogue between the leadership of the Judiciary and the national and county governments aimed at establishing the sufficiency of the courts to meet the national and county governments on matters relating to HIV
Members of the National Assembly	▪ Provision of democratic governance of the country's HIV response ▪ Deliberate and resolve issues of concern of the people of Kenya on matters relating to HIV ▪ Determine the allocation of revenue between the levels of government hence influencing HIV resource allocation ▪ Exercise oversight of state organs to ensure effective governance and leadership of the HIV response
Senate	▪ Participate in law making function of parliament by considering , debating and approving bills concerning counties including those related to HIV response ▪ Determine the allocation of revenue going to counties hence influencing HIV revenue allocation at counties ▪ Exercise oversight of state organs to ensure effective governance and leadership of the HIV response
The National AIDS Control Council	▪ Provide effective strategic multi-sectoral leadership for the response ▪ Develop and review national policies, strategies, regulations and guidelines relevant to the HIV and AIDS response in collaboration with partners ▪ Co-ordinate stakeholders ▪ Explore new and innovative approaches to HIV and AIDS interventions and achievement of the KASF results ▪ Co-ordinate with partners to develop a research agenda, and identify, conceptualise and articulate areas for research and knowledge building ▪ Co-ordinate advocacy work and information and knowledge management. ▪ Mobilise, manage and disburse resources for HIV and AIDS ▪ Provide technical support and capacity building ▪ Advise the Government on any and all matters concerning KASF implementation and HIV and AIDS response.
National and County Government Coordinating Summit	▪ Provide in its programme a special session on the state of HIV and AIDS in Kenya and the country efforts towards ZERO
Council of Governors (COG)	▪ Provide a forum for consultation amongst county governments including sharing of information on the performance of the counties in the implementation of County HIV and AIDS strategic plans and HIV and AIDS Control Programmes
The Intergovernmental Budget and Economic Council	▪ Provide a forum for consultation and co-operation between the national government and county governments on sustainable and innovative domestic HIV and AIDS financing
The County Governments (County Executive and Legislative Assemblies)	▪ Provide effective leadership and support for the county level multi-sectoral HIV and AIDS response ▪ Ensure high level political support and commitment to county HIV and AIDS response ▪ Report on the measures taken and the progress achieved in the implementation of County AIDS Strategic Plan and the KASF ▪ Design a county HIV and AIDS response performance management plan to evaluate performance of the county HIV and AIDS Control Programmes ▪ Establish and oversee the County HIV and AIDS Control Programmes ▪ Ensure equitable access to HIV and AIDS services ▪ Coordinate stakeholders in implementing KASF and county HIV and AIDS strategic plans and programmes ▪ Mobilize local communities to participate in HIV and AIDS campaigns ▪ Develop enabling county level policies, legislation or guidelines for HIV and AIDS response ▪ Mobilise and allocate adequate resources for HIV and AIDS response

10.2.2 Entrench good governance and strengthen multi-sector and multi-partner accountability to delivery of KASF results

Efforts shall be made to promote good governance practices by identifying, developing and nurturing effective and committed leaders for the HIV and AIDS response. In the life of the KASF good governance and ownership of the Country response shall be deliberately entrenched.

There is need for target-setting in the counties and the various other sectors involved for the KASF to deliver on the targets identified. The availability of HIV estimates for each county that outline the HIV burden including numbers of treatment and gaps, new infections, eMTCT coverage, orphans and vulnerable children will facilitate target-setting and, therefore, development of county HIV plans and strategies.

TABLE 27: **Recommended actions on Stakeholder accountability**

Intervention areas	Recommended actions	Responsibility
Policies and systems	▪ Develop and implement systems that strengthen good governance of the HIV response ▪ Build capacity of partners for resource management and accountability through institutionalised technical support mechanisms	▪ NACC ▪ National and County Governments, Partners
Stakeholder accountability	▪ Reform and strengthen the HIV inter-agency co-ordinating committee for monitoring of the HIV response ▪ Build capacity of stakeholder networks of faith communities, civil society, key populations and persons living with HIV to promote strong accountable institutions that hold duty bearers accountable for the HIV response	▪ NACC and Partners
Development partners accountability	▪ Strengthen the development partners HIV forum focusing on alignment to KASF priorities	▪ NACC
Implementing partners accountability	▪ Develop and implement a partnership accountability mechanism based on targets and results for national and county levels of interventions	▪ NACC
Private Sector Accountability	▪ Review reporting mechanisms to leverage on regulatory institutions in order to capture private sector contribution to the HIV response	▪ DOSH
Multi-sectoral accountability	▪ Reform performance contracting to facilitate target setting and align sector reporting to NACC results against targets	▪ NACC and Partners
KASF Governance	▪ Establish a KASF monitoring committee to oversee tracking of progress towards results	▪ NACC and Partners

10.2.3 Establish functional HIV co-ordination mechanism at national and county level

With the change in the overall national governance architecture as a result of the new Constitution, co-ordination of stakeholders and management of HIV and AIDS within a devolved structure has become more complex, challenging and dynamic. The structure and process of co-ordination and management of the response, therefore, demands innovation, clarity of roles and responsibilities linked to institutional mandates and comparative advantages at various levels including national, county, decentralised, intergovernmental and sectoral levels.

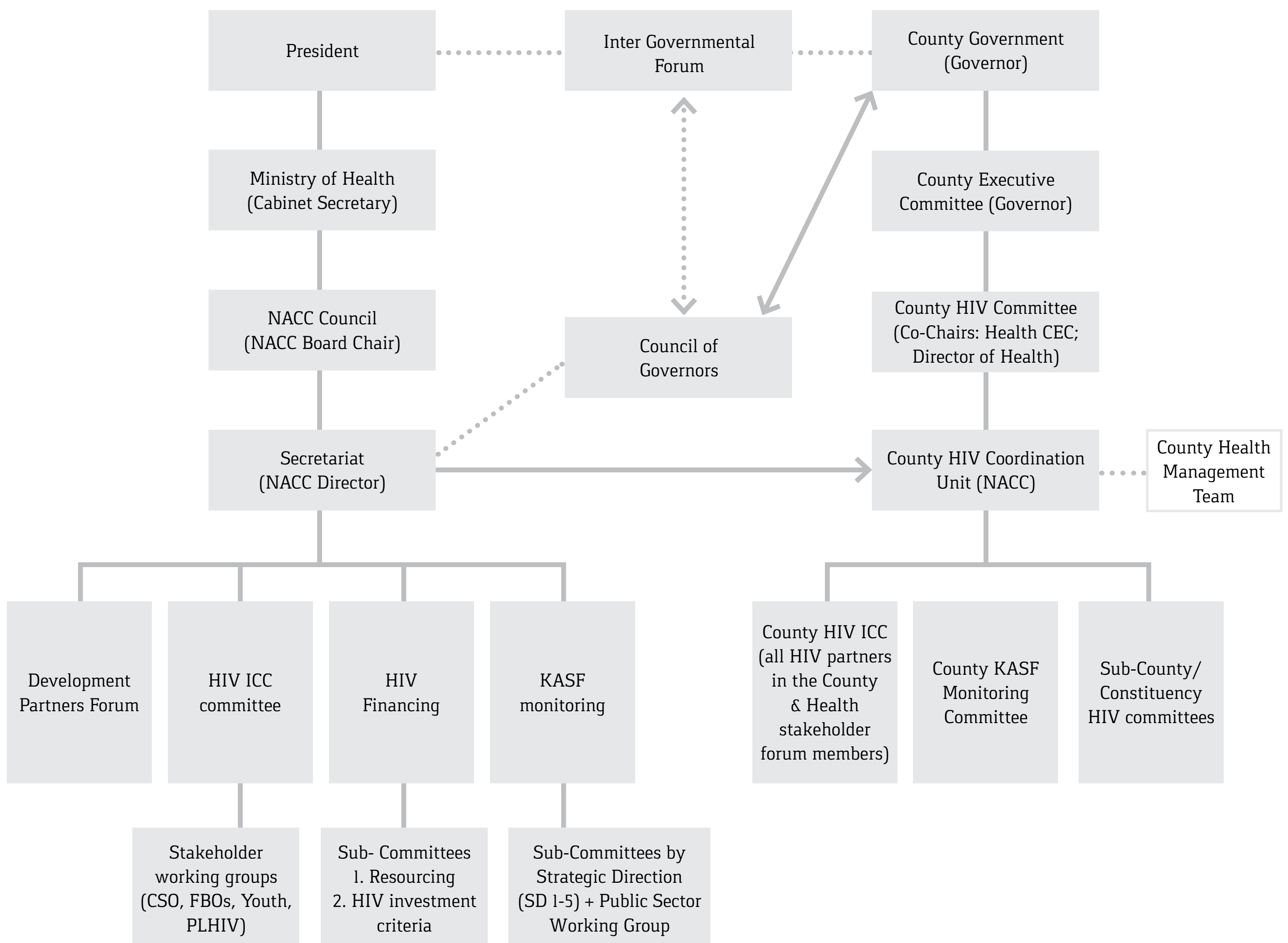
The KASF aims to review, strengthen and establish effective and well-functioning stakeholder co-ordination mechanisms that draw on intergovernmental mechanisms and strengthening of sectoral co-ordination for accountability of results of the KASF. NACC will ensure coherence and close collaboration among CSOs, FBOs, the private and public sector stakeholders to align and harmonise HIV activities in the country. This process will be undertaken within the first two years of the KASF and will aim at improving efficiency and effectiveness of the co-ordination to promote equality, strategic partnerships and alliances, stakeholder accountability for results and synergise efforts.

The co-ordination structure will align with various legislative instruments that have defined different levels of service delivery and co-ordination within the national and devolved government system to the lowest administrative level. It will aim to achieve the following six basic purposes:

- Ensuring that mandates, roles and responsibilities among the institutions, stakeholders and sectors at different levels of the national and devolved systems are clearly defined.
- Enabling all state and non-state actors to play an effective role in promoting and implementing the KASF at different levels of the HIV and AIDS service chain.
- Fostering and maximising efficiency and effectiveness, strategic partnerships, public participation, stakeholder co-ordination and accountability at various levels of the delivery chain.
- Minimising conflicts between and among the stakeholders at different levels in the KASF implementation structure.
- Ensuring accountability for performance and results by all implementing partners at various levels.

National AIDS Control Council at National level:	
1.	HIV ICC and advisory
	a. Stakeholder committees
2.	KASF monitoring committee
3.	Development partners forum
4.	Financing Committee
HIV co-ordination Unit at County level	
1.	County ICC
2.	County KASF monitoring committee
3.	Sub-County HIV co-ordination committees

FIGURE 20: HIV Coordination Infrastructure for KASF Delivery



The co-ordination infrastructure for the implementation of this Strategic Framework aims to achieve results by exploiting opportunities enshrined in the Constitution of Kenya (2010). Adequately addressing the co-ordination mechanism of the HIV response through improvement in resourcing and monitoring of investments in HIV will create synergies with existing structures of governance at the national and county levels.

The co-ordination infrastructure of the KASF, which should be read as a Public-Private Partnership model, strives for genuine governmental, non-governmental, development partners, stakeholder representation and participation at national and county levels with the following roles and responsibilities for the different actors:

1. President: The President chairs Cabinet meetings and co-ordinates the functions of ministries and government departments responsible for supporting and reinforcing NACC's role as a multi-sectoral co-ordinating agency for the HIV response in the country.

2. Governor: The Governor shall implement national and county legislation to the extent that the legislation requires and is responsible for the delivery of a range of services, planning and prioritisation of resource allocation to address HIV burden in the county.

3. Cabinet Secretary (Ministry of Health): Accountable individually and collectively to the President for the exercise of his powers and the performance of the Ministry of Health functions, the CS Health will play a critical role in providing strategic leadership and decision-making during the KASF implementation period.

4. NACC Board: As a multi-stakeholder representation of the several players in the HIV response and deriving its mandate from the laws of Kenya, the NACC board shall be accountable for the delivery of the results of the KASF and offering strategic leadership and oversight in the implementation of the Strategic Framework through the NACC Secretariat.

5. NACC Secretariat: The NACC Secretariat will facilitate delivery of the Strategic framework including accountability of different sectors and partners, decisions of the Board, and be accountable for the facilitation of sustainable financing and aligning existing resources to the KASF delivery. The Secretariat shall be responsible for co-ordination of the response through committees (ICC, HIV Financing, KASF Monitoring and development partners) as well as those made by the county governments' committees on HIV and health management.

6. HIV ICC Committee: Shall comprise of the various Stakeholder Working Groups representing the various constituencies eg CSO, FBOs, Youth, PwD, PLHIV

7. HIV Financing: Shall comprise of technical experts in the area of HIV resource mobilisation and investment criteria that will be responsible for the evaluation of the sustainability of HIV financing options.

8. KASF Monitoring:
   a. Shall comprise sub-committees of the five Strategic Direction areas of Prevention, Treatment, Human Rights, Systems Strengthening and Research. These sub-committees shall themselves comprise technical persons and institutions responsible for different areas.
   b. The Public Sector Working Groups (education, agriculture, mining & extractives, tourism, justice, law and order, transport, prisons, universities, labour & social security): shall facilitate and monitor actions and results outlined in the KASF for other sectors. The Performance Contracting mechanism shall be strengthened. In particular, NASCOP shall be responsible for the results of bio-medical interventions in the KASF.

9. County HIV Committee: Accountable to the county governor for the performance of their functions and the exercise of their powers on matters relating to HIV. This committee shall be responsible for the effective delivery of the HIV response at the county level. The committee shall be co-chaired by the County Health Executive and the County Director of Health with membership from the sub-county HIV committees, HIV partners, implementers, PLHIV and the special interest groups in the county.

10. County HIV Co-ordination Unit: This will be the responsibility of the NACC Secretariat at the county level. The unit shall co-ordinate the day-to-day implementation of the strategic framework at the county level, working very closely with the County Health Management Team and the various Ministries departments at the county level with a direct link with the NACC Secretariat at the National level.

ANNEXES

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APPENDIX 2:

The Kenya AIDS Strategic Framework was supported by a team of consultants, peer reviewers and the KASF Secretariat. The NACC is immensely grateful to every stakeholder for sharing their pearls of wisdom, and to the Technical Review Team, editor and reviewers for their insights and comments throughout the development of the KASF.

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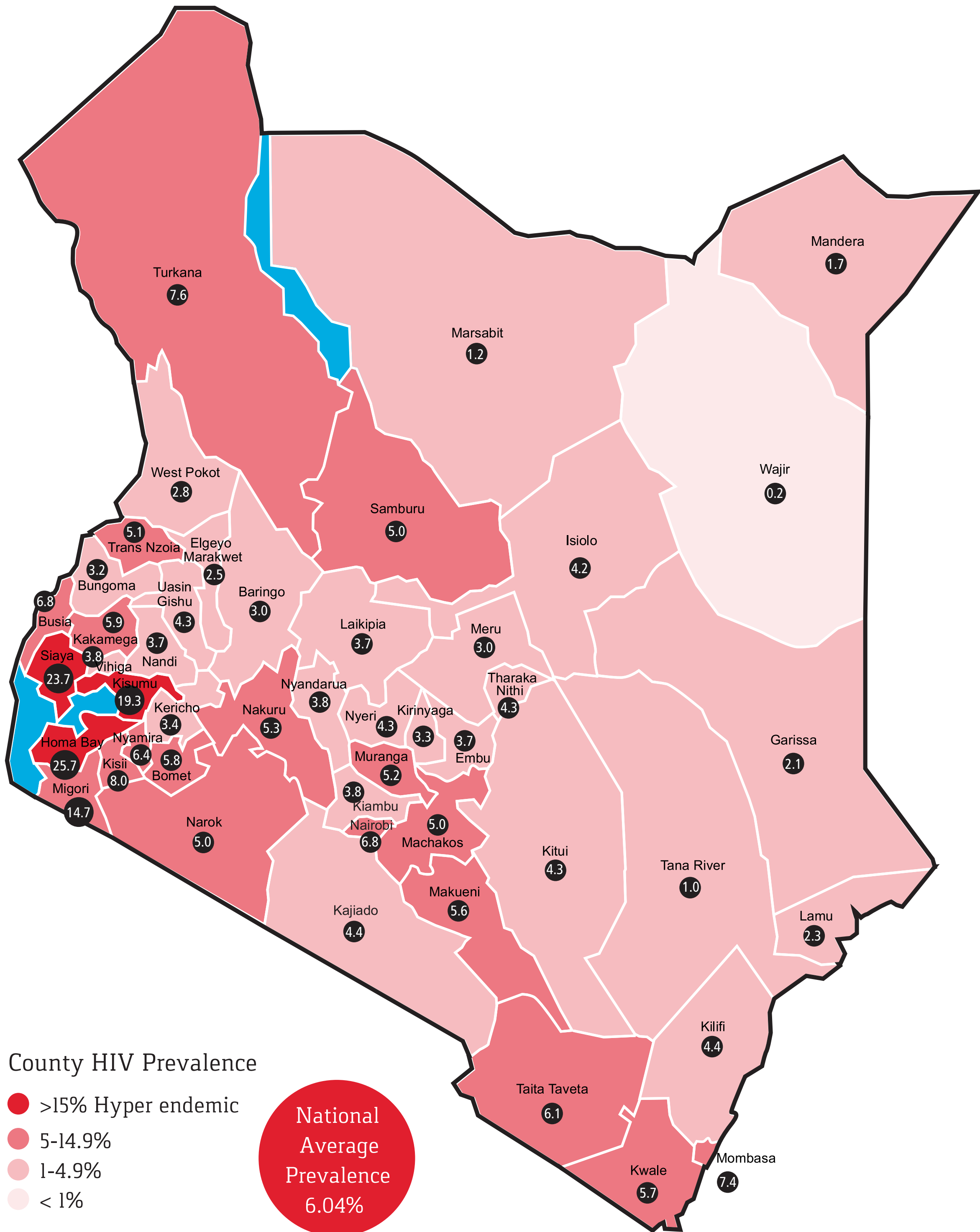
Owing to unavailability of space, the names of members of the Oversight Committee, the Taskforce and Working teams have not been included in the printed version of the KASF, but are available online via the following link: *https://www.dropbox.com/sh/n5nqxw7j6ke8zul/AAA7Yh5jMd5wShXe3QiAt84pa?dl=0*

Estimated Adult HIV Prevalence by County in Kenya



County HIV Estimates for 2013

	TOTAL		ADULTS (15+)					CHILDREN (0-14)					ART				ADULTS (15-64) PREVALENCE		PROPHYLAXIS	
Counties	Population	People Living With HIV	HIV Prevalence	Living With HIV	New HIV infections annually	HIV-Related Deaths	Need for ART	NLiving With HIV	New HIV Infections annually	HIV-Related Deaths	Need for ART	Need for PMTCT	Adults receiving ART	Adult ART coverage (%)	Children receiving ART	coverage among Children (%)	Male	Female	Maternal Prophylaxis	%
Kenya	41,792,563	1,599,451	6.04	1,407,615	88,622	48,072	760,694	191,836	12,941	10,393	141,608	79,036	596,228	79	60,141	42	5.6	7.6	55,543	70
Baringo	632,588	10,553	3.00	9,200	707	525	4,498	1,353	34	73	952	540	2,406	53	345	36	2.6	4.3	160	31
Bomet	824,347	27,989	5.80	24,400	1,875	1,393	11,930	3,589	90	195	2,525	1,433	4,511	38	407	16	4.9	8.2	474	36
Bungoma	1,750,634	31,186	3.20	26,100	83	864	17,164	5,086	93	249	3,578	1,500	10,982	64	1,140	32	2.4	4.0	1,083	53
Busia	523,875	19,238	6.80	16,100	51	533	10,588	3,138	58	153	2,207	925	19,398	183	1,657	75	5.1	8.4	938	52
Elgeyo Marakwet	421,282	5,965	2.50	5,200	400	297	2,542	765	19	42	538	305	978	38	89	17	2.1	3.5	124	28
Embu	543,158	11,065	3.70	9,600	518	326	5,540	1,465	28	63	1,046	446	5,132	93	513	49	2.2	5.0	371	61
Garissa	409,007	4,375	2.10	3,300	116	521	1,649	1,075	14	69	755	220	786	48	73	10	0.8	3.6	42	12
Homa Bay	1,053,465	159,970	25.70	140,600	12,279	3,395	70,837	19,370	2,724	1,234	15,235	9,674	49,738	70	6,331	42	23.7	27.4	5,515	62
Isiolo	150,817	3,227	4.20	2,800	151	95	1,616	427	8	18	305	130	969	60	92	30	2.5	5.7	124	77
Kajiado	782,409	23,056	4.40	20,100	1,545	1,147	9,827	2,956	74	161	2,080	1,181	5,219	53	372	18	3.8	6.3	846	51
Kakamega	1,782,152	57,952	5.90	48,500	154	1,605	31,896	9,452	173	462	6,648	2,788	21,014	66	2,224	33	4.4	7.3	2,005	60
Kericho	863,222	18,124	3.40	15,800	1,214	902	7,725	2,324	58	126	1,635	928	9,299	120	832	51	2.9	4.8	835	51
Kiambu	1,760,692	46,656	3.80	42,400	2,931	1,207	23,747	4,256	96	180	3,041	1,500	24,104	102	2,011	66	2.0	5.6	1,518	75
Kilifi	1,262,127	27,907	4.40	24,400	821	1,021	13,868	3,507	87	179	2,459	1,387	9,884	71	1,087	44	2.7	6.3	1,476	113
Kirinyaga	572,889	12,654	3.30	11,500	795	327	6,441	1,154	26	49	825	407	5,831	91	559	68	1.7	4.8	314	55
Kisii	1,259,489	63,715	8.00	56,000	4,891	1,352	28,214	7,715	1,085	492	6,068	3,853	13,629	48	1,169	19	7.3	8.5	1,240	33
Kisumu	1,059,053	134,826	19.30	118,500	10,349	2,861	59,703	16,326	2,296	1,040	12,840	8,153	62,280	104	6,881	54	17.8	20.6	5,917	86
Kitui	1,065,329	21,092	4.30	18,300	988	622	10,561	2,792	54	120	1,994	849	9,273	88	1,269	64	2.5	5.8	698	54
Kwale	739,435	21,159	5.70	18,500	623	774	10,515	2,659	66	136	1,864	1,052	3,227	31	292	16	3.5	8.1	855	67
Laikipia	454,412	10,324	3.70	9,000	692	514	4,400	1,324	33	72	931	529	2,391	54	161	17	3.2	5.3	183	48
Lamu	115,520	1,487	2.30	1,300	44	54	739	187	5	10	131	74	700	95	80	61	1.4	3.2	147	319
Machakos	1,155,957	31,235	5.00	27,100	1,463	921	15,640	4,135	80	177	2,953	1,258	11,542	74	1,609	54	2.9	6.8	1,085	68
Makueni	930,630	25,472	5.60	22,100	1,193	751	12,754	3,372	65	145	2,408	1,026	9,705	76	1,480	61	3.3	7.6	825	59
Mandera	1,025,756 (2009)	5,171	1.70	3,900	137	615	1,948	1,271	17	81	892	260	77	4	27	3	0.6	2.9	11	3
Marsabit	306,471	1,729	1.20	1,500	81	51	866	229	4	10	163	70	746	86	93	57	0.7	1.6	100	205
Meru	1,427,135	23,282	3.00	20,200	1,090	686	11,658	3,082	59	132	2,201	937	9,615	82	1,052	48	1.8	4.1	526	37
Migori	1,002,499	88,405	14.70	77,700	6,786	1,876	39,147	10,705	1,506	682	8,419	5,346	34,927	89	3,136	37	13.6	15.7	3,732	88
Mombasa	1,068,307	54,670	7.40	47,800	1,609	2,000	27,168	6,870	171	351	4,817	2,717	26,490	98	1,995	41	4.5	10.5	1,764	38
Muranga	1,022,427	31,581	5.20	28,700	1,984	817	16,074	2,881	65	122	2,058	1,015	7,177	45	656	32	2.8	7.7	468	40
Nairobi	3,781,394	177,552	8.00	164,658	3,098	3,579	102,103	12,894	316	448	9,398	4,982	93,714	92	6,988	74	5.3	8.4	9,700	133
Nakuru	1,825,229	61,598	5.30	53,700	4,127	3,065	26,255	7,898	199	429	5,558	3,154	16,345	62	1,677	30	4.5	7.5	1,692	53
Nandi	857,207	18,697	3.70	16,300	1,253	930	7,969	2,397	60	130	1,687	958	6,507	82	664	39	3.1	5.2	546	46
Narok	968,390	26,956	5.00	23,500	1,806	1,341	11,490	3,456	87	188	2,432	1,380	4,351	38	296	12	4.3	7.1	445	34
Nyamira	653,914	26,738	6.40	23,500	2,052	567	11,840	3,238	455	206	2,546	1,617	6,886	58	972	38	5.8	6.8	785	51
Nyandarua	646,876	14,305	3.80	13,000	899	370	7,281	1,305	29	55	932	460	5,596	77	592	63	2.0	5.6	255	46
Nyeri	752,469	20,797	4.30	18,900	1,307	538	10,586	1,897	43	80	1,355	669	10,471	99	924	68	2.3	6.3	463	58
Samburu	254,997	6,883	5.00	6,000	461	342	2,934	883	22	48	621	352	700	24	55	9	4.3	7.1	50	15
Siaya	920,671	128,568	23.70	113,000	9,869	2,728	56,932	15,568	2,190	992	12,244	7,775	46,413	82	5,285	43	21.8	25.3	5,547	108
Taita Taveta	323,867	11,209	6.10	9,800	330	410	5,570	1,409	35	72	988	557	2,903	52	194	20	3.7	8.7	341	52
Tana River	273,205	1,372	1.00	1,200	40	50	682	172	4	9	121	68	660	97	31	26	0.6	1.5	61	42
Tharaka	384,379	8,760	4.30	7,600	410	258	4,386	1,160	22	50	828	353	4,177	95	538	65	2.5	5.8	172	31
Trans Nzoia	932,223	27,874	5.10	24,300	1,867	1,387	11,881	3,574	90	194	2,515	1,427	6,618	56	725	29	4.4	7.3	464	24
Turkana	855,399 (2009)	44,736	7.60	39,000	2,997	2,226	19,068	5,736	144	311	4,036	2,291	3,791	20	778	19	6.5	10.8	409	14
Uasin Gishu	1,017,723	28,677	4.30	25,000	1,921	1,427	12,223	3,677	92	200	2,587	1,469	17,614	144	1,895	73	3.7	6.1	466	29
Vihiga	595,301	11,829	3.80	9,900	31	328	6,511	1,929	35	94	1,357	569	6,324	97	769	57	2.8	4.7	680	63
Wajir	434,524	663	0.20	500	18	79	250	163	2	10	114	33	66	26	5	4	0.1	0.3	0	0
West Pokot	583,767	8,603	2.80	7,500	576	428	3,667	1,103	28	60	776	441	1,062	29	121	16	2.4	4.0	92	25

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