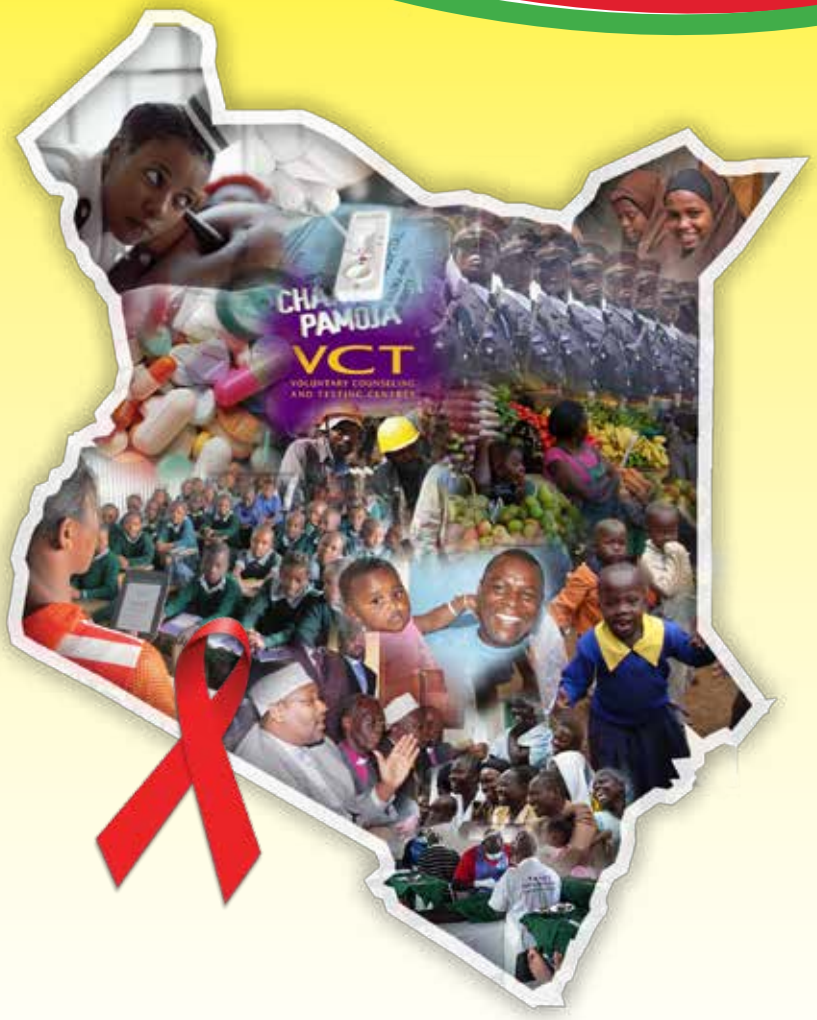
Ministry of Health

Kenya HIV Prevention Revolution Road Map

Count Down to 2030



HIV Prevention Everyone's Business

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HIV Prevention Everyone's Business

maisha!
National AIDS Control Council
www.nacc.or.ke

National STI and AIDS Control Programme
www.nascop.or.ke

June 2014


50% Reduction of New HIV infections
75% Reduction of New HIV Infections
Zero New HIV Infections
2015
2020
2030
Combination Prevention
Population Driven
Geographical Prioritization
Shared Responsibility

Acknowledgment

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Prof. Fred Segor,
Principal Secretary, Ministry of Health

List of Abbreviations

ART	Antiretroviral Therapy
BC	Behaviour Change
CHEW	Community Health Extension Workers
CHTC	Couple HIV Testing and Counseling
CSO	Civil Society Organisations
EBI	Evidence Informed Behavioral Interventions
EC	Emergency Contraceptives
EID	Early Infant Diagnosis
EMTCT	Elimination of Mother to Child Transmission
FP	Family Planning
GBV	Gender Based Violence
GIS	Geographic Information Systems
HPV	Human Papilloma Virus
HMIS	Health Management Information Systems
HTC	HIV Testing and Counseling
IGA	Income Generating Activity
KAIS	Kenya AIDS Indicator Survey
KEPH	Kenya Essential Package of Health
KNASA	Kenya National AIDS Spending Assessment
KNUT	Kenya National Union of Teachers
KUPPET	Kenya Union of Post-Primary Education Teachers
TIVET	Technical Industrial Vocational and Entrepreneurship Training
MNCH	Maternal, Neonatal and Child Health
MSM	Men Who Have Sex With Men
OST/MAT	Opioid Substitution Therapy/Methadone Assisted Therapy
PEP	Post Exposure Prophylaxis
PHDP	Positive Health Dignity and Prevention
PITC	Provider Initiated HIV Testing and Counseling
PLHIV	People Living With HIV
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
VMMC	Voluntary Medical Male Circumcision

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Foreword

The Government of Kenya with support from other partners has, for the last two and a half decades, invested in the AIDS response. It is estimated that Kenya has lost close to 1.7 million people over the years as a result of AIDS related complications; underpinning the importance of HIV in public health, sustainable development and economic growth dialogues. It is estimated that 1.6 million Kenyans are living with HIV and over 650,000 of them are currently accessing antiretroviral treatment. This situation is, however, compounded by the fact that close to 101,560 new HIV infections occur annually.

HIV continues to be a major challenge across all the 47 Counties in Kenya. It is, however, noted that some Counties have a considerably higher HIV burden than others. The Counties of Nairobi, Homabay, Siaya, Kisumu, Migori, Kisii, Nakuru, Kakamega, Mombasa and Kiambu are collectively home to over 800,000 citizens living with HIV. In addition, 65 percent of all new HIV infections occur in nine Counties.

The Kenyan HIV epidemic displays variable epidemiological dynamics with respect to modes of transmission, age and sex differentials. Girls, women and key populations such as sex workers, men who have sex with men, People Who Inject Drugs and people in prison are disproportionately affected by HIV.

Kenya has made significant progress in HIV prevention especially among children. However the reduction of new HIV infections among adults has been relatively slow. This HIV Prevention Road Map therefore draws from lessons learned on strategies, interventions and scientific development in HIV prevention globally. It provides guidance on how the country can accelerate and achieve a drastic reduction in new HIV infections in a manner which is evidence-informed, rights-based and gender sensitive. The process of developing this Road Map included review of globally available and accepted evidence of what works in HIV prevention, stakeholders' consultation and policy review processes. This document provides targets and milestones that set Kenya on a clear path towards the goal of Zero new HIV infections.

In recognition of the disparities of the HIV epidemic, this Road Map proposes that high-impact, evidence-based interventions should be sustained and targeted towards Counties and different population needs. It emphasizes the need for efficient delivery of combination prevention packages, synergistic integration of biomedical, behavioural and structural interventions and sustainable investment in HIV prevention research to sharply reduce the annual number of new HIV infections – from an estimated 101,560 in 2013 to near zero in 2030.

The document provides County Governments with the relevant strategic information required to make investment decisions for well-coordinated, targeted, costed, high-impact interventions to reduce new HIV infections.

This Road Map is an important tool to unify national and County level planning, financing and implementation of HIV prevention interventions.

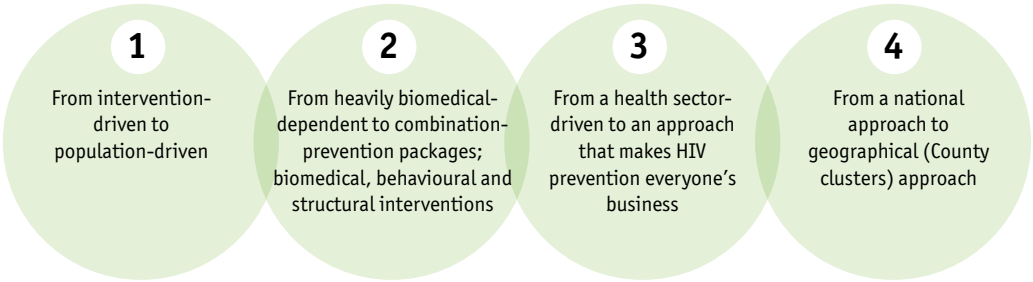
James Macharia,
Cabinet Secretary, Ministry of Health

Protecting the future

Young girls in their school dormitory at St. Monica Lodwar Girls Primary School in Turkana County *© UNICEF Kenya/2012/Noorani*

Executive Summary

This Road Map is a product of extensive stakeholder consultation led by the Government of Kenya through the National AIDS and STI and Control Programme (NASCOP) in partnership with the National AIDS Control Council (NACC)and other partners. The process included a review of globally accepted evidence of effective prevention strategies, the current status targets and milestones for HIV prevention in Kenya. This Road Map aims to revolutionise HIV prevention and drastically reduce new HIV infections and HIV related deaths. The HIV prevention goals are aligned to the Kenya Vision 2030 blue print, including five-year milestones. The Road Map proposes the following shifts in HIV Prevention paradigms:



Key elements

- **Geographic prioritization** - The country's 47 Counties are divided into three clusters- high, medium and low- based on geographical disparities in HIV incidence. This information is used to identify priority populations, and HIV incidence clusters will be reviewed annually to advise prevention

- **Combination prevention** - Mathematical models are used to prescribe the optimal combination of interventions, and required coverage for each cluster and County

- **Promoting efficiency** in delivery by drawing out implementation strategies and options in community and facility settings. The Kenya Essential Package of Health cycles are used to optimise and advise on provider delivery of HIV prevention services

- **Leveraging opportunities** identified in other sectors and emerging technologies through shared responsibility, forecasting and tracking progress

- **Emphasis on outcome** rather than process monitoring. It anticipates emerging technologies, aims to increase research uptake and outlines both national and cluster- specific research priorities

- **Trigger advocacy**, capacity strengthening and resource mobilization to deliver comprehensive HIV prevention measures that address the needs and rights of women and girls

Overall, this Road Map promotes detailed analysis of population and geographical disparities and emphasizes the need for innovative surveillance for HIV incidence coupled with effective linkage to services. Initiation of early antiretroviral therapy, implementation of structural interventions at scale, increasing knowledge of HIV status through innovations such as HIV self-testing, partner tracing and review of parental consent for HIV testing for adolescents are key components.

Providing an enabling environment for HIV prevention, human rights protection and stigma reduction for key populations and people living with HIV remain fundamental pillars of this Road Map. Interventions to address gender and cultural norms that increase vulnerability to HIV infection are emphasised. This Road Map also identifies the need for coordinated research with timely translation of research findings to policy and practice as central to achievement of the set targets.

The recommendation to build accountability, making HIV prevention everyone's business, draws from the need to address critical enablers and identify non-traditional stakeholders who are instrumental in ensuring sustainable structural and behavioural interventions are in place outside the health sector. County clusters will be reviewed on the basis of HIV incidence.

This Road Map aims to dramatically strengthen HIV prevention, with the ultimate goal of reducing new HIV infections to zero by 2030

Development of the Prevention Revolution Road Map

This Prevention Revolution Road Map is a product of a lengthy but fruitful consultative and reflective process on the status of HIV prevention in Kenya. In 2010, prompted by a disproportionately high rate of new HIV infections among women and girls, the Government in partnership with stakeholders convened a national symposium to discuss HIV prevention in this group. The forum, which brought together women's representatives from all parts of the country, recommended a shift in HIV prevention from heavily biomedical driven to one that addressed structural factors and barriers that increase women and girls' vulnerability. In the same year a landmark national symposium for key populations was held in Mombasa. The meeting called for a concerted multisectoral response to end new HIV infections that was inclusive of Key Populations. A convention held with religious leaders resolved to champion a family-based HIV prevention approach to end new HIV infections and reduce HIV related stigma.

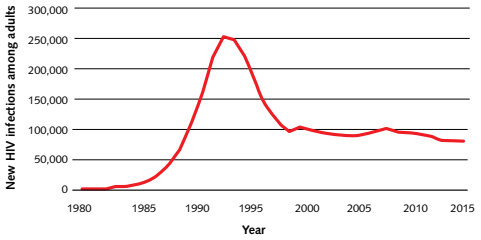
In 2011, building on the momentum and recommendations from stakeholders, the Government, through the leadership of NASCOP and NACC, formed a working group that brought together technical capacities from institutions including the Joint UN Team on HIV/AIDS (led by UNFPA, UNAIDS and WHO), PEPFAR (led by CDC and USAID), the International AIDS Vaccine Initiative, and LVCT- Health. This team, selected on the basis of indivual knowledge and experience, began a process of consultations with key stakeholders with the goal of proposing a paradigm shift in HIV prevention. The consultations culminated in the development of thematic papers, which together with existing epidemiologic data, formed the basis for the initial discussion for the development of the Road Map. In order to demonstrate impact of the proposed prevention shifts and value for investment , Spectrum mathematical modelling provided analysis of the investment case for the Prevention Road Map. Imperial College supported the analysis of data from the 47 Counties, providing evidence of the cost-effectiveness of geographical prioritization. A draft Road Map was then developed and submitted to a series of consultative meetings with stakeholders including County leadership, representatives from national and County level technical working groups, representatives of young people, sero-discordant couples, older people, key populations, business community, researchers, donors and other key stakeholders.

This process allowed the team to put together a draft Road Map that formed the basis for discussions and validation at the National HIV Prevention Summit in 2013. The summit brought together over 500 stakeholders from all 47 Counties. The participants were provided an opportunity to review the draft and provide comprehensive inputs that emphasized targeting and broadening the role of stakeholders in HIV prevention.

1.0 Introduction

Kenya has made significant progress in preventing the transmission of HIV through the implementation of evidence based interventions. According to HIV estimates and projections for 2013, there were approximately 1.6 million people living with HIV of whom 191,840 were children while an estimated 101,560 new HIV infections occurred. HIV related deaths have significantly reduced over the years due to the increase of number of people accessing treatment.

Estimated new HIV infections among adults (15+)



Sources: GOK HIV estimates and Projections, 2013

The number of new HIV infections among adults has stabilized at an unacceptably high rate

Sexual transmission accounts for 93.7% of all new HIV infections (MOT, 2008). Overall, there are marked gender disparities which characterise the HIV epidemic with higher prevalence amongst women at 7.6% compared to men at 5.6% . There is a treatment gap of over over 99,500 women and 64,900 men, in need of ART but not currently receiving treatment. ART coverage is 77% in eligible women compared to 80% in men.

The HIV epidemic in Kenya exhibits extreme geographical and gender disparities. National estimates and modelling indicate that 65% of new adult infections occur in nine of the 47 Counties. Within Counties, there are important variations in HIV burden, with the epidemic concentrated among certain populations.

Key populations contribute a disproportionately high number of new HIV infections annually despite their small population size. According to the MOT 2008, although these populations represent less than 2% of the general population, they contribute a third of all new HIV infections. Key populations in Kenya include sex workers, men who have sex with men (MSM) and people who inject drugs. Additionally, there are geographical disparities in the distribution of key populations across the Counties.

Kenya has participated in global and regional partnerships to conduct cutting-edge HIV research. These collaborative research efforts have generated ground-breaking biomedical prevention findings on the efficacy of voluntary medical male circumcision, strategic use of ARVs for prevention as well as microbicide, PMTCT and HIV vaccine development. The country has also conducted epidemiological and behavioural studies that have informed strategic planning and programmatic efforts, including evidence of the disproportionate risk of HIV infection amongst MSM, people who inject drugs and sex workers.

This Prevention Road Map therefore draws from successes and lessons learned over the last three decades of Global AIDS response.

OVERVIEW OF **HIV EPIDEMIC** IN KENYA

NEW HIV INFECTIONS

101,560
Kenyans were infected with HIV in 2013

12,940
children were infected with HIV in 2013

50,530
Women were infected with HIV in 2013

38,090
Men were infected with HIV in 2013

12,940
New HIV infections among children (0-14 years) in 2013

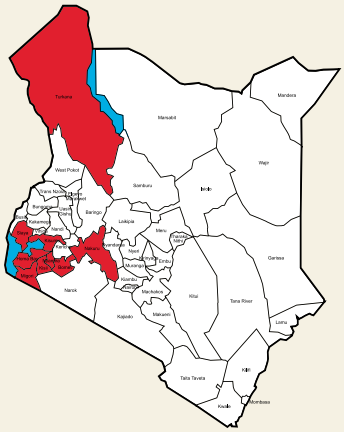
88,620 new HIV infections occured among adults in 2013

21%
of new adult HIV infections occur among young women aged 15-24 every year

- 2.5% Health Facility Related
- 3.8% Injecting Drug Use (IDU)
- 15.2% MSM and Prison
- 14.1% Sex workers and Clients
- 20.3% Casual heterosexual sex
- 44.1% Heterosexual sex within union

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

***65%** of new HIV infections occur in nine of the 47 Counties*



County	New HIV infections
Homa Bay	15,003
Kisumu	12,645
Siaya	12,059
Migori	8,292
Kisii	5,976
Nakuru	4,326
Turkana	3,141
Nyamira	2,507
Bomet	1,965

Sources: Kenya HIV Estimates Technical Report 2013
Modes of Transmission 2008

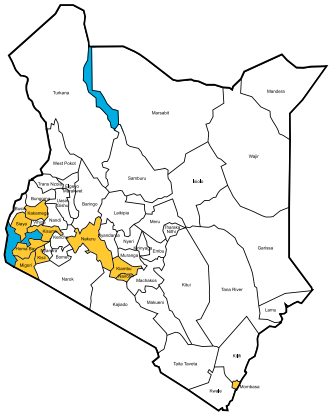
HIV BURDEN IN KENYA

1.6 million
Kenyans were living with HIV in 2013

191,840
Children (0-14 years) were living with HIV in 2013

National HIV Prevalence is 6%

5.6% | 7.6%



10 Counties with the Largest Number of People Living with HIV

County	Estimated PLHIV
Nairobi	177,552
Homabay	159,970
Siaya	128,568
Kisumu	134,826
Migori	88,405
Kisii	63,715
Nakuru	61,598
Kakamega	57,952
Mombasa	54,670
Kiambu	46,656

HIV PREVALENCE AMONG KEY POPULATIONS

Sex Workers
29.3%

Men Who Have Sex With Men
18.2%

People Who Inject Drugs
18.3%

TREATMENT COVERAGE (2013)

78%

80%

77%

42%

HIV RELATED DEATHS (2013)

58,465

20,765

27,310

10,390

Sources: Kenya HIV Estimates Technical Report 2013
NASCOP KEY POPULATION Estimates Concensus Report 2012

1.2 Progress and Status of HIV Prevention in Kenya

HIV prevention in Kenya is premised on the application of evidence based interventions to achieve set targets and goals as outlined in the national strategic plans. Over the years the country has invested in interventions to reduce sexual transmission of HIV among key groups – young people, sex workers, men who have sex with men. Other vibrant prevention programmes target prevention of new HIV infections among children, STI prevention among people living with HIV and voluntary medical male circumcision to reduce risk of HIV infection among men.

Progress

New HIV infections among children

2007 23,000
2013 12,940

44% reduction in new HIV infections

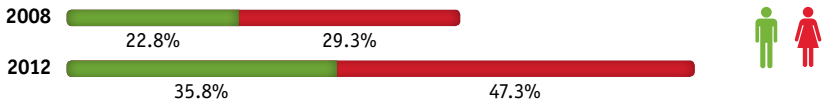
New HIV infections among adults

2007 95,000
2013 88,620

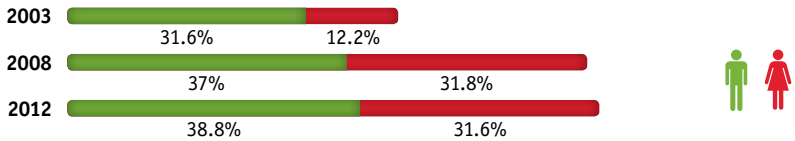
7% reduction in new HIV infections

Source: Kenya HIV Estimates Technical Report 2013

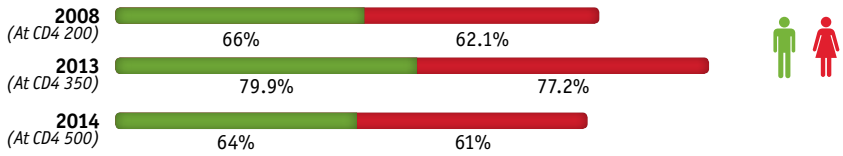
HIV Testing



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



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

Current Status

INTERVENTION	CURRENT STATUS	GAPS
HIV testing and counselling	• 63 % of men know their HIV status • 80 % of women know their HIV status	• Identification of new testers • Couple counselling and testing to identify sero-discordant couples • Retesting of high risk indiv PWIDals • Identification and linkage to care for PLHIV
Biomedical Intervention		
Condom use promotion and distribution	 • 43% consistent condom use among men 15-24 years with partner of discordant or unknown HIV serostatus in the past 12 months • 14% consistent condom use among men 25-64 years with partner of discordant or unknown HIV serostatus in the past 12 months • **11% consistent condom use among women 15-24 years with partner of discordant or unknown HIV serostatus in the past 12 months** • 5% consistent condom use among women 25-64 years with partner of discordant or unknown HIV serostatus in the past 12 months	• Low condom use with partners of unknown HIV status • Low use of condom use among women 15-49 with multiple partners (32%) • 89% of women aged 15-24 years reporting non use of condom use with partners of unknown status • Weak distribution channels for female condom use • Frequent stock-outs of both male and female condom use
Voluntary Medical Male Circumcision	530,000 VMMC performed against a target of 860000	Low coverage in non-circumcising communities (47%)
Elimination of mother to child transmission (EMTCT)	• 1.6 Million pregnancies annually • 87,000 HIV positive pregnant women annually • 70% of HIV-positive pregnant women receiving antiretrovirals • 12,940 new HIV infections among children • Only 44% skilled birth attendance	• Low retention of mothers in ANC • 10% of Positive ANC attendees not receiving PMTCT • 17% of newborns born to women living with HIV not tested for HIV
ART Coverage	• 78% National ART coverage among adults (CD4 < 350cells/ml) • 42% National ART coverage among children • 34% population level viral suppression	• HIV testing and linkage to care and treatment weak • High number of persons in need of ART • Low access to ART for children compared to adults
STI treatment	• 1.34% of women tested positive for syphilis in ANC • 81% of adults with HIV also have genital herpes	• STI treatment for PLHIV and key populations • Low coverage of HPV vaccination • Low screening for STI
Health facility HIV prevention	• 100% of the units of donated blood are screened for HIV, hepatitis and syphilis	• 2.5% of new HIV infections still health facility related
Behavioural Intervention		
Behaviour change programmes	• Average sexual debut for women is 17 years of age • Average sexual debut for men is 16 years of age • 30% of men 15-24 reported having two or more sexual partners in the past 12 months	• Lack of targeted behavioural interventions • Low coverage of behavioural interventions • Inadequately addressed structural barriers to behaviour change

INTERVENTION	CURRENT STATUS	GAPS
Structural Intervention		
Social Protection Cash Transfers for Orphans and Vulnerable Children (CT-OVC)	• Coverage of OVC households was 28.3% (150,000 households)	• Scale up of unconditional cash transfers known to decrease the risk of HIV in young people by decreasing likelihood of sexual debut by 23%, improve school enrolment, delay first pregnancy and decrease risky sexual behaviour
Building the Resilience of Women and Girls	• Small scale implementation of projects that combine behavioural and structural intervention across the country	• Scale up of combined behavioural and structural intervention to reduce gender inequalities and livelihood insecurity, thereby reducing Intimate Partner Violence
Girls enrolled in secondary school	• 48% of girls enrolled in secondary school (2009)	• Lower secondary school enrolment for girls (48%) vs boys (51%)

Targeted prevention interventions for key populations	
Current Status	**Gaps**
Coverage of services for key populations programmes • 70% of female sex workers • 55% of men who have sex with men • 24% of People Who Inject Drugs	• Low coverage of comprehensive interventions for key population • Inadequately addressed structural barriers to behaviour change and access to health services

Source: Kenya AIDS Indicator Survey 2007, 2012
NASCOP Programme Data 2013
Kenya AIDS Epidemic Update 2011
UNAIDS Global AIDS Estimates and Projections 2013
Kenya Demographic and Health Survey 2008/09
TRaC, 2012
Kenya HIV Estimates Technical Report 2013

The AIDS response in Kenya is multi-sectoral, coordinated by the National AIDS Control Council and implemented through periodic strategic plans

2.0 HIV Prevention Revolution Road Map

This Road Map addresses the gaps in the current HIV response and seeks to catalyze HIV prevention in Kenya. It is neither a formal guideline nor standard operating procedure for service delivery, nor is it intended to replace existing programming guidelines. Rather, the Road Map, based on current knowledge of effective interventions and expected funding for the response, aims to dramatically strengthen HIV prevention, with the ultimate goal of reducing new HIV infections to zero by 2030.

Overall Goal: Countdown to Zero New HIV infections by 2030

2.2 Objectives

The objectives of this Road Map are to:

- Provide guidance for geographical and population prioritization of HIV prevention interventions to optimise reduction of new HIV infections.
- Provide guidance for scale-up and implementation of combination (bio-medical, behavioural and structural) HIV prevention interventions.
- Provide guidance for monitoring and tracking progress in HIV prevention.

2.3 Guiding Principles

- Universal coverage
- Expanding innovation
- Strategic investments
- Evidence-based and result-driven
- Human rights and gender based
- Shared responsibility

2.4 Key Elements of the Road Map

- A common HIV prevention goal aligned with the Kenya Vision 2030 and five-year milestones.
- Geographic prioritization: This Road Map groups counties into three clusters, (high, medium and low), based on Kenya's geographical disparities in HIV incidence and draws on this to identify priority populations.
- Key age groups and sex disaggregated data informs service delivery and prioritization
- Combination prevention: Modelling is used to prescribe the optimal combination of interventions and required coverage for each cluster and counties.
- Efficiency in delivery: This Road Map outlines implementation strategies and options in community and facility settings. Kenya Essential Package of Health cycles are used to optimise provider contacts to deliver services.
- Leveraging: This Road Map identifies opportunities for leveraging other sectors and emerging technologies and making HIV prevention 'everyone's business' through shared responsibility.
- Forecasting and tracking progress: This Road Map emphasizes monitoring outcomes as opposed to processes. It anticipates emerging technologies, aims to increase research uptake and outlines both national and cluster- specific research priorities.

2.5 Proposed Shifts in HIV Prevention Paradigms

1 From intervention-driven to population-driven

2 From heavily biomedical-dependent to a combination-prevention package; biomedical, behavioural and structural interventions

3 From Health sector-driven to an approach that makes HIV prevention everyone's business

4 From a national approach to geographical (County clusters) approach

Re-thinking HIV Prevention

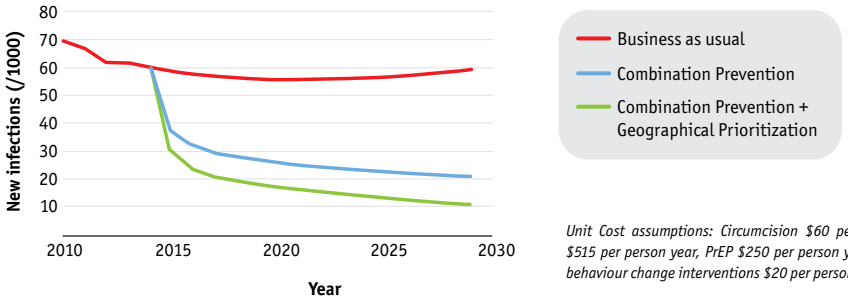
From National to County clusters approach	High, Medium, Low incidence cluster	Timely data on granularity of epidemics	Timely incidence surveillance
From intervention driven to populations -driven interventions	Age and sex disaggregation	Key populations	Bridging populations
From heavily biomedical-dependent to a mix combination of behavioural and structural	Combination prevention mix package by cluster and populations	Faster integration of research findings into policy & practices	Unified and coordinated Research and Development for HIV prevention
Making HIV prevention everyone's business	Leverage political leadership	Leverage social movements	Legal and structural reforms

3.0 Rationale for Combination Prevention and Geographic Prioritization of HIV Prevention in Kenya

Kenya will make significant gains by making fundamental shifts in the style and delivery of HIV prevention through an optimal effective HIV prevention approach that takes into account geographic disparities in HIV incidence, priority populations and a combination of biomedical, behavioural and structural interventions.

According to the Spectrum Model, a refocused and prioritised HIV prevention would avert 1,149,000 new HIV infections and 761,000 AIDS related deaths by 2030 at a cost USD 19.9 Billion[1].

Projected rate of new HIV infections over time nationally



Unit Cost assumptions: Circumcision $60 per person, ART $515 per person year, PrEP $250 per person year, sustained behaviour change interventions $20 per person year.

To determine the efficiency gains that could be obtained by combination prevention and geographic prioritization of interventions, mathematical models were developed[2]. The sexually active population in each County was stratified based on risk behaviour, and transmission modelled in sexual partnerships formed between risk groups. County data on sexual behaviour, circumcision rates, ART coverage, demography and prevalence were used to inform the models such that they are geographically specific.

These County specific models were used to assess the optimal configuration of interventions both within and across Counties to maximise achievable impact. Funds can be prioritised to those interventions in those Counties which could lead to the greatest reduction in number of new HIV infections (described here as the 'Combination Prevention + Geographical Prioritization'). In this way, funds are drawn to interventions in populations in which they can have the greatest impact.

Assuming a budget of $133 USD million per year, combination prevention would reduce the number of new HIV infections by 66% while combination prevention with geographical prioritization would reduce the number of new HIV infections by 80%

1 John Stover, 2013
2 Imperial College of London, 2013

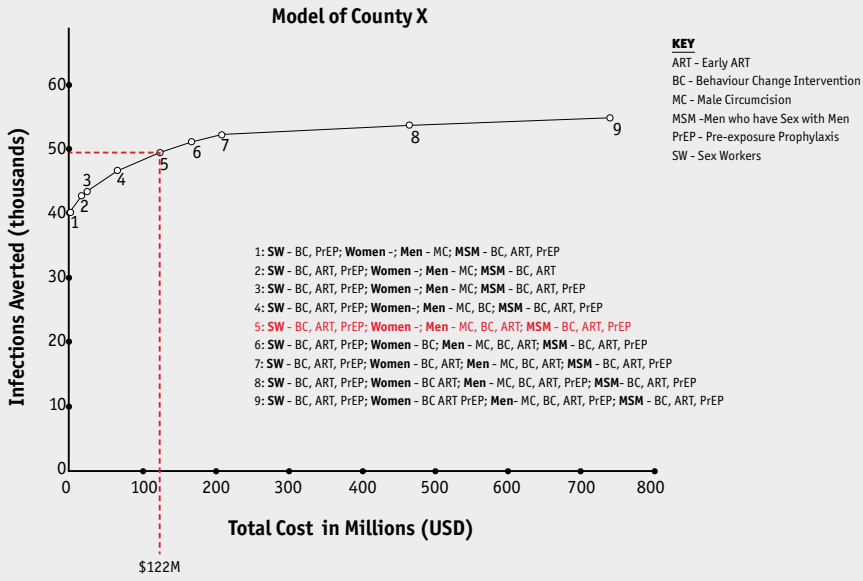
A comparison is made with an approach that does not account for geographical heterogeneity, such that the same set of interventions are funded in all Counties ('Combination Prevention') and a 'Business as Usual' approach, whereby no further prevention interventions are scaled up. The amalgamated National model presented on page 12 gives the number of new HIV infections across all Counties. These analyses are intended to act as a general guide and are not prescriptive. They should be used as a starting point for discussion in light of each County's specific context.

3.2 Geographical Prioritization Approach

The mixed nature of the epidemic in Kenya calls for HIV prevention interventions that are sensitive to local context and situations, rather than being generic. The disproportionate HIV burden across Counties must be reflected to ensure that the 47 Counties make informed decisions.

Example of County X HIV Prevention Revolution Model

Under the geographical prioritization strategy, County "X" receives a budget of $122.8 million for the period 2015-2030. Strategy 5 would provide the most cost effective package of interventions, averting the largest number of new HIV infections. Strategy 5 includes interventions for: behaviour change, early ART and PrEP for female sex workers and MSM, male circumcision and early ART for men (see key below). The model estimates that approximately 50,000 new HIV infections (y-axis) would be averted.



3.3 County clusters by HIV incidence

Counties are grouped into three clusters high, medium and low based on estimated number of new HIV infections (Kenya HIV Estimates Technical Report 2013). County clusters will be reviewed annually on the basis of HIV incidence. The table below shows the distribution of HIV incidence in the 47 Counties in Kenya.

Counties RANKED BY HIV INCIDENCE (FROM HIGHEST TO LOWEST)

	County	Population	New HIV infections (children)	New HIV infections (adults)	New HIV infections (total)	Incidence (%)	Ranking	% of contribution to national new HIV infections
	Kenya	**41,792,563**	**12,941**	**88,622**	**101,563**	**0.39**		**100.0**
High Incidence Cluster	Homa Bay	1,053,465	2,724	12,279	15,003	2.98	1	14.8
	Siaya	920,671	2,190	9,869	12,059	2.47	2	11.9
	Kisumu	1,059,053	2,296	10,349	12,645	2.13	3	12.5
	Migori	1,002,499	1,506	6,786	8,292	1.56	4	8.2
	Kisii	1,259,489	1,085	4,891	5,976	0.76	5	5.9
	Nyamira	653,914	455	2,052	2,507	0.59	6	2.5
	Turkana	973,742	144	2,997	3,141	0.59	7	3.1
	Bomet	824,347	90	1,875	1,965	0.44	8	1.9
	Nakuru	1,825,229	199	4,127	4,326	0.40	9	4.3
Medium Incidence Cluster	Trans Nzoia	932,223	90	1,867	1,957	0.38	10	1.9
	Narok	968,390	87	1,806	1,893	0.38	14	1.9
	Samburu	254,997	22	461	483	0.37	15	0.5
	Kajiado	782,409	74	1,545	1,619	0.34	11	1.6
	Uasin Gishu	1,017,723	92	1,921	2,013	0.33	13	2.0
	Muranga	1,022,427	65	1,984	2,049	0.32	12	2.0
	Nyeri	752,469	43	1,307	1,350	0.27	16	1.3
	Nandi	857,207	60	1,253	1,313	0.27	20	1.3
	Kiambu	1,760,692	96	2,931	3,027	0.26	17	3.0
	Laikipia	454,412	33	692	725	0.26	19	0.7
	Kericho	863,222	58	1,214	1,272	0.25	21	1.3
	Nyandarua	646,876	29	899	928	0.25	22	0.9
	Mombasa	1,068,307	171	1,609	1,780	0.24	18	1.8
	Makueni	930,630	65	1,193	1,258	0.24	24	1.2
	Machakos	1,155,957	80	1,463	1,543	0.22	25	1.5
	Baringo	632,588	34	707	741	0.22	26	0.7
	Kirinyaga	572,889	26	795	821	0.21	23	0.8

	County	Population	New HIV infections (children)	New HIV infections (adults)	New HIV infections (total)	Incidence (%)	Ranking	% of contribution to national new HIV infections
Medium Incidence Cluster	West Pokot	583,767	28	576	604	0.20	30	0.6
	Isiolo	150,817	8	151	159	0.19	29	0.2
	Elgeyo Marakwet	421,282	19	400	419	0.18	32	0.4
	Kitui	1,065,329	54	988	1,042	0.18	33	1.0
	Tharaka	384,379	22	410	432	0.18	28	0.4
	Taita Taveta	323,867	35	330	365	0.17	27	0.4
	Kwale	739,435	66	623	689	0.17	34	0.7
	Embu	543,158	28	518	546	0.16	31	0.5
	Nairobi	3,781,394	316	3,098	3,414	0.13	35	3.4
	Meru	1,427,135	59	1,090	1,149	0.13	36	1.1
	Kilifi	1,262,127	87	821	908	0.13	37	0.9
								34.5
Low Incidence Cluster	Lamu	115,520	5	44	49	0.07	38	0.0
	Garissa	409,007	14	116	130	0.05	39	0.1
	Marsabit	306,471	4	81	85	0.05	40	0.1
	Mandera	673,356	17	137	154	0.04	41	0.2
	Tana River	273,205	4	40	44	0.03	44	0.0
	Busia	523,875	58	51	109	0.02	42	0.1
	Kakamega	1,782,152	173	154	327	0.02	43	0.3
	Vihiga	595,301	35	31	66	0.01	45	0.1
	Bungoma	1,750,634	93	83	176	0.01	46	0.2
	Wajir	434,524	2	18	20	0.01	47	0.0
								7.2

Note: Children are 0-14, adults are 15+

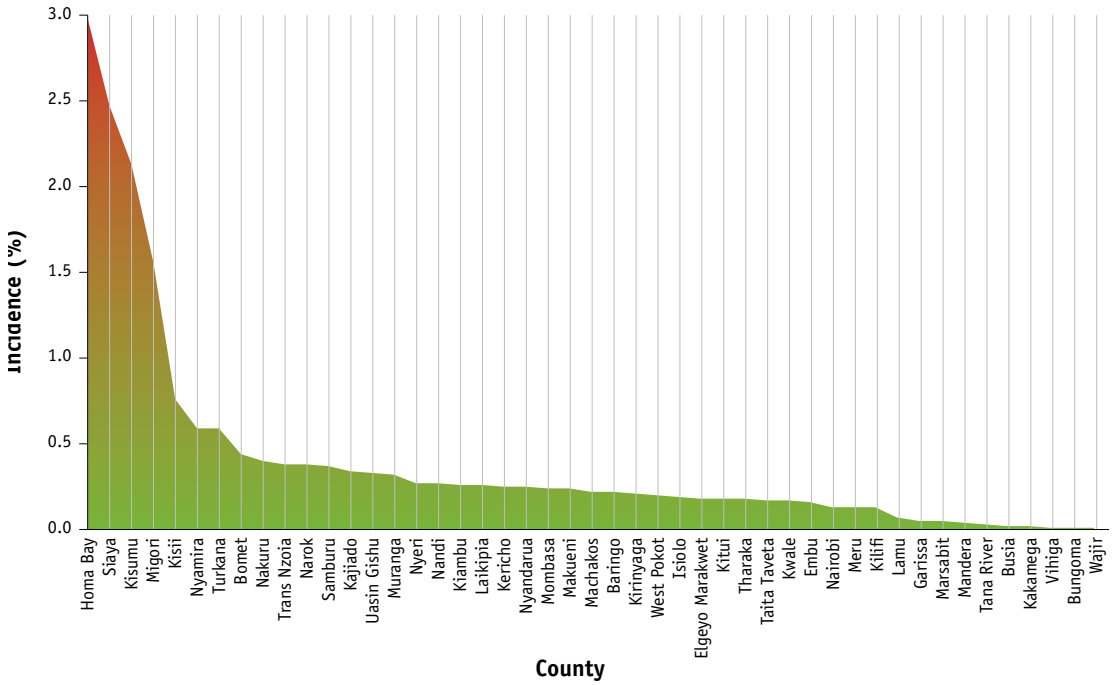
Summary Table Showing the 3 County Clusters and Contribution to National New HIV Infections

County Cluster	Number of Counties	Total number of new HIV infections	Total estimated population	% contribution to new HIV infections
High HIV Incidence	9	65,914	9,572,409	65%
Medium HIV Incidence	28	34,499	25,356,108	34%
Low HIV Incidence	10	1,160	6,864,045	1%

Note: Annual County incidence rates will influence categorization of Counties into the different clusters (Incidence rate is calculated as the percentage of Number of new HIV infections/Total County population less people living with HIV)

Data Source: HIV and AIDS County profiles NACC and NASCOP 2013

HIV incidence rates across 47 Counties



3.4 HIV Burden in Counties

Early ART initiation has been shown to reduce transmission and reduce HIV related morbidity among people living with HIV. In this section, Counties are ranked based on the estimated number of people living with HIV (Kenya HIV Estimates Technical Report 2013). This information will be used for planning, financing and implementation of County efforts in care, treatment and social protection for people living with HIV, orphans and vulnerable children (OVC). The ranking will be reviewed annually on the basis of HIV burden.

	County	Population	Prevalence Total (%)	Prevalence men (%)	Prevalence women (%)	# adults LHIV	# children LHIV	# people LHIV	Rank
	Kenya	**41,792,563**	**6.04**	**5.6**	**7.6**	**1,407,615**	**191,836**	**1,599,451**	
10 High HIV Burden Counties	Nairobi	3,781,394	6.8	5.3	8.4	164,658	12,894	177,552	1
	Homa Bay	1,053,465	25.7	23.7	27.4	140,600	19,370	159,970	2
	Kisumu	1,059,053	19.3	17.8	20.6	118,500	16,326	134,826	3
	Siaya	920,671	23.7	21.8	25.3	113,000	15,568	128,568	4
	Migori	1,002,499	14.7	13.6	15.7	77,700	10,705	88,405	5
	Kisii	1,259,489	8.0	7.3	8.5	56,000	7,715	63,715	6
	Nakuru	1,825,229	5.3	4.5	7.5	53,700	7,898	61,598	7
	Kakamega	1,782,152	5.9	4.4	7.3	48,500	9,452	57,952	8
	Mombasa	1,068,307	7.4	4.5	10.5	47,800	6,870	54,670	9
	Kiambu	1,760,692	3.8	2.0	5.6	42,400	4,256	46,656	10

County	Population	Prevalence Total (%)	Prevalence men (%)	Prevalence women (%)	# adults LHIV	# children LHIV	# people LHIV	Rank
Turkana	973,742	7.6	6.5	10.8	39,000	5,736	44,736	11
Muranga	1,022,427	5.2	2.8	7.7	28,700	2,881	31,581	12
Machakos	1,155,957	5.0	2.9	6.8	27,100	4,135	31,235	13
Bungoma	1,750,634	3.2	2.4	4.0	26,100	5,086	31,186	14
Uasin Gishu	1,017,723	4.3	3.7	6.1	25,000	3,677	28,677	15
Bomet	824,347	5.8	4.9	8.2	24,400	3,589	27,989	16
Kilifi	1,262,127	4.4	2.7	6.3	24,400	3,507	27,907	17
Trans Nzoia	932,223	5.1	4.4	7.3	24,300	3,574	27,874	18
Narok	968,390	5.0	4.3	7.1	23,500	3,456	26,956	19
Nyamira	653,914	6.4	5.8	6.8	23,500	3,238	26,738	20
Makueni	930,630	5.6	3.3	7.6	22,100	3,372	25,472	21
Meru	1,427,135	3.0	1.8	4.1	20,200	3,082	23,282	22
Kajiado	782,409	4.4	3.8	6.3	20,100	2,956	23,056	23
Kwale	739,435	5.7	3.5	8.1	18,500	2,659	21,159	24
Kitui	1,065,329	4.3	2.5	5.8	18,300	2,792	21,092	25
Nyeri	752,469	4.3	2.3	6.3	18,900	1,897	20,797	26
Busia	523,875	6.8	5.1	8.4	16,100	3,138	19,238	27
Nandi	857,207	3.7	3.1	5.2	16,300	2,397	18,697	28
Kericho	863,222	3.4	2.9	4.8	15,800	2,324	18,124	29
Nyandarua	646,876	3.8	2.0	5.6	13,000	1,305	14,305	30
Kirinyaga	572,889	3.3	1.7	4.8	11,500	1,154	12,654	31
Vihiga	595,301	3.8	2.8	4.7	9,900	1,929	11,829	32
Taita Taveta	323,867	6.1	3.7	8.7	9,800	1,409	11,209	33
Embu	543,158	3.7	2.2	5.0	9,600	1,465	11,065	34
Baringo	632,588	3.0	2.6	4.3	9,200	1,353	10,553	35
Laikipia	454,412	3.7	3.2	5.3	9,000	1,324	10,324	36
Tharaka	384,379	4.3	2.5	5.8	7,600	1,160	8,760	37
West Pokot	583,767	2.8	2.4	4.0	7,500	1,103	8,603	38
Samburu	254,997	5.0	4.3	7.1	6,000	883	6,883	39
Elgeyo Marakwet	421,282	2.5	2.1	3.5	5,200	765	5,965	40
Mandera	673,356	1.7	0.6	2.9	3,900	1,271	5,171	41
Garissa	409,007	2.1	0.8	3.6	3,300	1,075	4,375	42
Isiolo	150,817	4.2	2.5	5.7	2,800	427	3,227	43
Marsabit	306,471	1.2	0.7	1.6	1,500	229	1,729	44
Lamu	115,520	2.3	1.4	3.2	1,300	187	1,487	45
Tana River	273,205	1.0	0.6	1.5	1,200	172	1,372	46
Wajir	434,524	0.2	0.1	0.3	500	163	663	47

Note: Counties ranked based on absolute estimates of people living with HIV
Adults = 15 years of age and above

Three Counties have hyper-endemic HIV prevalence rates (over 15%) - Homa Bay, Kisumu and Siaya

3.5 Combination Prevention Approach

Combination prevention is a term used to describe a mix of behavioural, structural and biomedical interventions targeting specific populations based on their needs to optimally mitigate acquisition or transmission of HIV. Evidence on effective and promising structural interventions for HIV prevention such as micro-finance and gender transformative approaches have demonstrated positive HIV outcomes and reduction in gender based violence. Cash transfers have been shown to reduce girls' vulnerabilities, keeping them in school and reducing HIV incidence. Behavioural interventions such as changing risk perceptions, addressing multiple partnerships and the need for uptake and adherence to HIV interventions have also demonstrated impact on HIV incidence.

The bio-medical toolkit for HIV prevention includes evidence-based interventions such as male circumcision, condom use, STI treatment and use of ARVs for those who are living with HIV. Also included are efforts to prevent new HIV infections among children, keep mothers alive and the provision of ARVs as pre and post exposure prophylactic medication.

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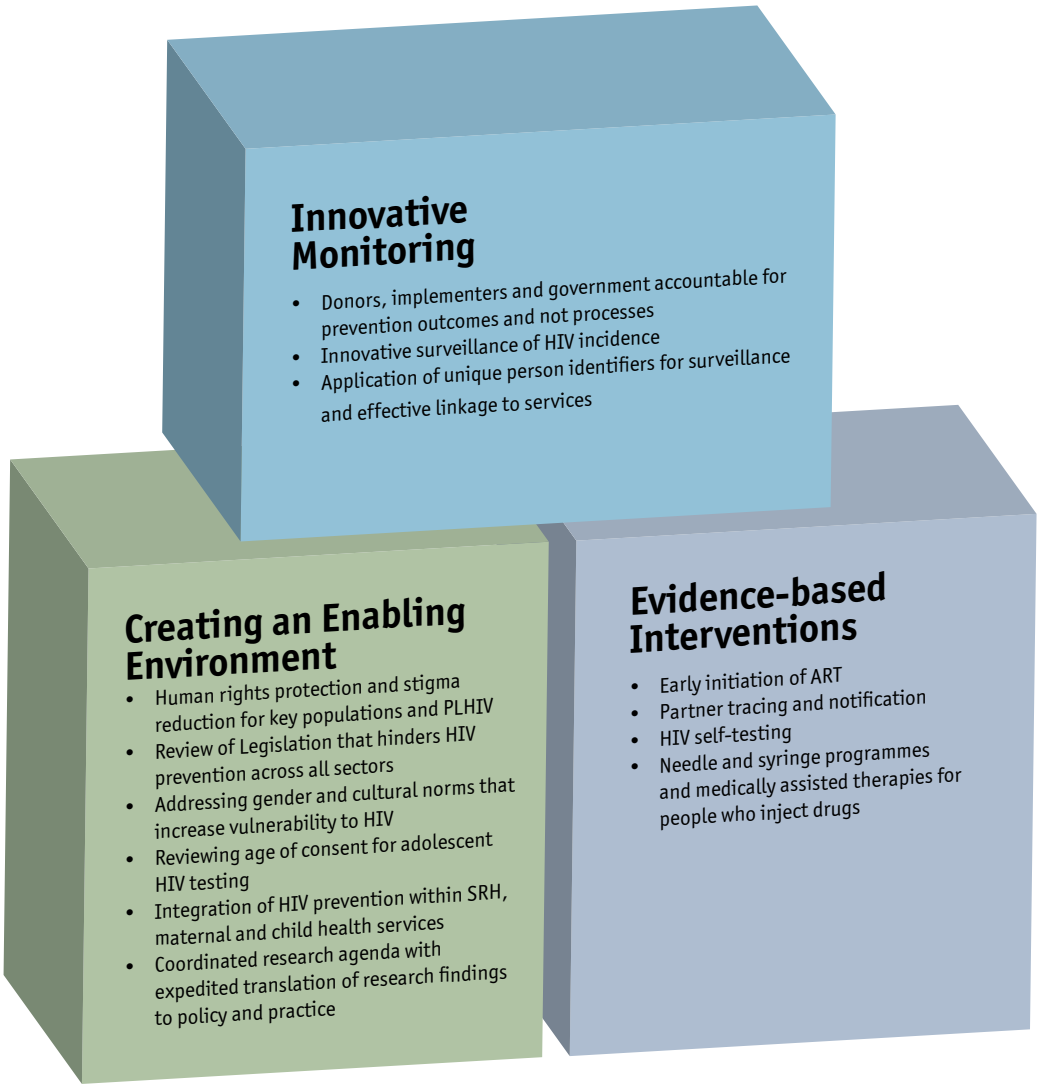
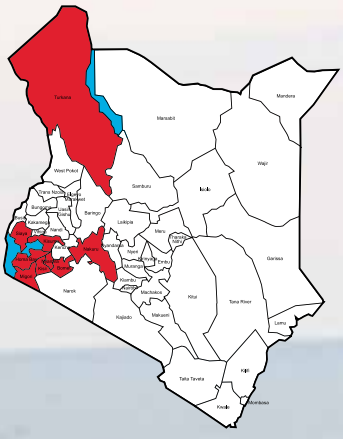
Successful HIV Prevention programmes require a combination of evidence-based, mutually reinforcing biomedical, behavioural, and structural interventions.

4.0 Combinations of Packages for County clusters

The proposed biomedical, structural and behavioural interventions are those evaluated and demonstrated to have impact in reducing HIV incidence. Interventions are prioritised by age and population for the 47 Counties based on incidence clusters. Recommended structural and behavioural interventions are examples drawn from evaluated evidence based interventions (EBIs). See appendix 1 for their descriptions.



HIGH INCIDENCE CLUSTER: ***65%*** *of new HIV infections occur in nine of the 47 Counties*



County	New HIV infections
Homa Bay	15,003
Kisumu	12,645
Siaya	12,059
Migori	8,292
Kisii	5,976
Nakuru	4,326
Turkana	3,141
Nyamira	2,507
Bomet	1,965

Lake Victoria

4.1 Recommended Combinations of Packages for County clusters

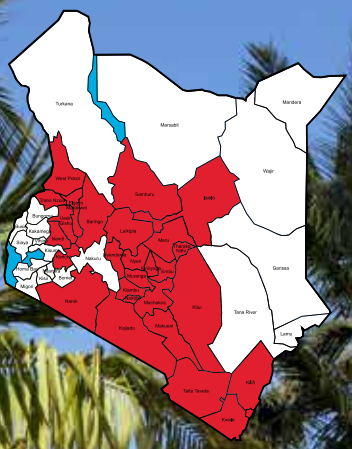
HIGH INCIDENCE CLUSTER

65% of all new HIV infections	Age group/ sex	Available Biomedical Interventions		Behavioural interventions	Structural interventions
		Community Settings	Facility Settings		
General Population					
	0 – 5 years	• Integration of HIV testing in immunisation programmes	• Infant male circumcision • Early infant diagnosis • HIV testing for children • Paediatric ARV for all HIV positive children	• Exclusive breastfeeding for up to 6 months • Male engagement in child HIV testing and HIV prevention for children	• Training of pre-school teachers and community health workers as agents of communication for child HIV testing • Social protection
	5 – 9 years	• HIV and sexual and Reproductive Health Education clubs in schools	• HTC, VMMC, PEP, Post rape care	• Life skills training-. Stepping Stones: Creating Futures	• Promote Child Rights protection, GBV elimination programmes, Sexual and reproductive education at school • Social protection
	10-14 years	• HIV and sexual and Reproductive health education Clubs	• HTC, VMMC, PEP, Post rape care, HPV vaccines	• Life skills training e.g., Stepping Stones: Creating Futures	• Initiatives to keep girls in school, GBV elimination programmes, sexual and reproductive education at school, Community mobilisation for legal action against sexual offenders
	15 – 19 years	• HIV & STI testing, sexual and Reproductive health and HIV education, condom use	• HTC, VMMC, PEP, Post Rape Care, Emergency Contraception, HPV vaccines	• Healthy Choices	• Economic empowerment through micro-finance -IMAGE programmes • Review requirement of parental consent for HIV testing • Programmes to keep girls in school • Address intergenerational sex
	19 and above	• HTC, CHTC, condom use, VMMC	• PITC, Family Planning, VMMC, PEP, Post rape care, EC, HPV vaccines	• Sustained large Scale Evidence-based Interventions (EBIs), alcohol reduction campaign • Positive Health, Dignity and Prevention • Promotion of condom use campaign	• Economic empowerment -IMAGE • Programmes to prevent Gender-Based Violence • Protection from cultural issues directly linked to HIV risk such as wife inheritance • Promote Post HIV test clubs
Bridging Populations					
Truck drivers, migrants, fishing communities		• Mobile HTC, • Sexual and Reproductive Health Services, CHTC, condom use, VMMC	• ART – Regardless of CD4 count, PrEP, PEP, eMTCT	• Positive Health, Dignity and Prevention • Promotion of condom use campaign	• Enact maximum working hours policies • Conditional Economic Support-IMAGE

HIGH INCIDENCE CLUSTER					
Priority Populations					
People Living with HIV		• Linkage to care • Treatment adherence • eMTCT, condom use	• ART – regardless of CD4 count, eMTCT, Viral load monitoring	• Positive Health, Dignity and Prevention, condom use, CHTC, disclosure to partner	• Zero stigma and discriminatory by-laws • Universal access to HIV and sexual and reproductive health services
Discordant couples		• Linkage to care • Treatment • Adherence to treatment • eMTCT, condom use, CHTC	• Treatment for HIV Prevention, PrEP, EMTCT, VMMC, FP	• Motivation for HIV negative partner to stay negative, CHTC, disclosure to partner, partner prevention, EBAN	• Assisted Partner (s) notification for people living with HIV
Young women at risk (15-24 years)		• HTC and STI screening including anal screening, HPV screening and education, female and male condom use, Family Planning and Emergency contraception,	• PEP	• EBI-Healthy choices • Positive Health, Dignity and Prevention, condom use, CHTC, Risk perception training	• Programmes to keep girls in school, • Conditional Economic Support-IMAGE • Campaigns to motivate those tested HIV negative to adopt risk reduction and stay negative • GBV reduction programmes • Messages on intergenerational sex
Sex workers		• Male and female condom use • Frequent and regular HTC, STI screening including anal and cervical cancer screening	• STI treatment, Treatment for regardless of CD4 count, PrEP, PEP, EMTCT, HPV vaccines	• Campaigns and recognition to motivate those tested HIV negative to adopt risk reduction and stay negative • Positive Health, Dignity and Prevention • Alcohol and Substance abuse programmes	• 100% condom use policy • Recognition of negative status since previous HIV test • Promote human rights • Safe spaces • Conditional Economic Support-IMAGE • GBV prevention programmes • Health care providers and Police sensitivity trainings
Men who have Sex with Men		• Male condom use, lubricants • Frequent and regular HCT, STI, HPV screening and vaccines, Anal STI screening.	• STI treatment, ART – regardless of CD4 count, PrEP, PEP, EMTCT, HPV vaccines	• Campaigns to motivate those tested HIV negative to adopt risk reduction and stay negative • Positive Health, Dignity and Prevention • Reduction of number of partners • Alcohol and Substance abuse programmes	• Human rights protection of MSM • Safe spaces/drop-in centres • Social support -M-powerment • Psycho social support mechanisms • GBV prevention programmes • Health care providers and Police sensitivity trainings

HIGH INCIDENCE CLUSTER					
People Who Inject Drugs		• Peer education on HIV prevention • Comprehensive service package for PWID. • Regular HTC, sexual and reproductive health care, TB and Hepatitis B & C screening • Sterile needle and syringe kits, Safe disposal of used injecting equipment, • Integrated ART and Medically Assisted Therapy	• STI screening and treatment, eMTCT, family planning • ART – regardless of CD4 count, PrEP, PEP, Needle and syringe exchange programmes • Medically assisted therapy,TB treatment, Vaccination for Hepatitis B and C	• Addiction counselling on alcohol and substance abuse • Safer injecting practices, • Reduction of sexual partners, • Positive Health, Dignity and Prevention • Motivate for HIV negative status • GBV prevention programmes	• Key Population policy review • Human rights protection of people who inject drugs, safe spaces/drop-in centres, legal aid • Psychosocial support mechanisms/mental health • Health care providers and police sensitivity trainings, • Basic hygiene kits and child care support for females who use/inject drugs, • Economic enhancement via vocational training and IGAs
Prison communities and other uniformed forces		• Frequent and regular HTC, STI screening	• HTC, STI, HPV screening, • STI treatment, ART – regardless of CD4 count, • PEP, • eMTCT	• Risk reduction for HIV negative testers • Positive Health, Dignity and prevention • EBI- e.g., START	• Psycho social support mechanisms for reintegration • Review of Prison policy on HIV prevention to include condom use, PrEP, safe injecting needles, and conjugal visits

MEDIUM INCIDENCE CLUSTER: ***34%*** *of new HIV infections occur in 28 of the 47 Counties*



County	New HIV infections (total)
Nairobi	3,414
Kiambu	3,027
Muranga	2,049
Uasin Gishu	2,013
Trans Nzoia	1,957
Narok	1,893
Mombasa	1,780
Kajiado	1,619
Machakos	1,543
Nyeri	1,350
Nandi	1,313
Kericho	1,272
Makueni	1,258
Meru	1,149

County	New HIV infections (total)
Kitui	1,042
Nyandarua	928
Kilifi	908
Kirinyaga	821
Baringo	741
Laikipia	725
Kwale	689
West Pokot	604
Embu	546
Samburu	483
Tharaka	432
Elgeyo Marakwet	419
Taita Taveta	365
Isiolo	159

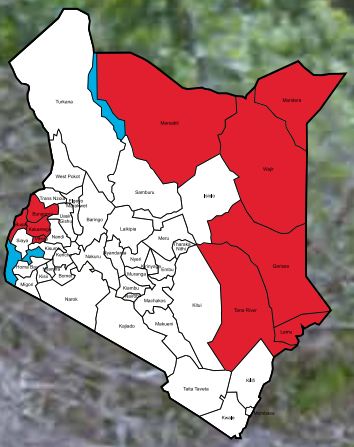
Mombasa, Kenya © Shutterstock

MEDIUM INCIDENCE CLUSTER					
34% of new HIV infections	Age group/ sex	Available Biomedical Interventions		Behavioural interventions	Structural interventions
		Community Settings	Facility Settings		
General Population					
	0 – 5 years	• Integration of HIV testing in immunisation programmes	• Infant circumcision • Paediatric ARV for all HIV positive children • ART for all HIV positive pregnant women for PMTCT	• Exclusive breastfeeding for all up to 6 months	• Training of pre-school teachers and community health workers as agents of communication for child testing • Social protection
	5 – 9 years	• HIV and sexual and reproductive health education clubs in schools	HTC, VMMC, PEP, Post rape care	• Life skills training e.g. Stepping Stones: Creating Futures	• Promote Child Rights protection, GBV elimination programmes, Sexual and reproductive education at school • Social protection
	10-14 years	• HIV and sexual and reproductive health education clubs	• HTC, VMMC, PEP, Post rape care, HPV vaccines	• Life skills training e.g. Stepping Stones: Creating Futures	• Initiatives to keep girls in school, GBV elimination programmes, sexual and reproductive education at school, community mobilisation for legal action against sexual offenders
	15 – 19 years	• HIV & STI testing, sexual and reproductive health and HIV education, condom use	• HTC, VMMC, PEP, Post rape care, Emergency contraception, HPV vaccines	• Healthy Choices	• Conditional Economic Support-IMAGE • Reveiw requirement of parental consent for HIV testing of adolescents • Programmes to keep girls in school
	19 and above	• HTC, CHTC, self-test kits, condom use, VMMC	• PITC, Family Planning, VMMC, PEP, Post rape care, EC, HPV vaccines	• Evidence-based interventions (EBIs), • Alcohol reduction campaign • Promote risk reduction among HIV negative testers to stay negative • Positive health, dignity and prevention, • Promotion of condom use campaign	• Conditional Economic Support-IMAGE • Programmes to prevent Gender-Based Violence • Protection from cultural issues directly linked to HIV risk such as wife inheritance

MEDIUM INCIDENCE CLUSTER					
Bridging Populations					
Truck drivers, migrant, fishing communities		• Mobile HTC, sexual and reproductive health services, frequent and regular CHTC, condom use, VMMC	• ART – regardless of CD4 count, PEP, eMTCT	• Positive health dignity and prevention, condom use	• Enact maximum working hours policies • Economic empowerment –IMAGE
Priority Populations					
People Living with HIV		• Linkage to care • Adherence to treatment • eMTCT, Condom use	• ART as per guidelines, eMTCT	• Positive Health, Dignity and Prevention, condom use, Assisted partner disclosure, Universal access to HIV and sexual and reproductive health education	• Reduce stigma and misplaced discrimination by-laws
Discordant couples		• Linkage to care • Adherence to treatment • eMTCT, condom use • CHCT	• ART regardless of CD4 • PrEP, eMTCT, VMMC, FP	• Motivate negative, partner to stay negative through risk reduction	• Implement partner (s) notification for HIV testing
Young women at risk (15-24 years)		• HIV & STI testing and education, promote female condom use, Family Planning and Emergency contraception	• PrEP, PEP	• Healthy choices	• Programmes to keep girls in school • Conditional Economic Support-IMAGE • Conditional motivation for HIV negative to stay negative • Messages on intergenerational sex as risk factor
Sex workers		• Male and female condom use • Frequent and regular HTC, STI screening including anal and cervical cancer screening	• STI treatment • Treatment regardless of CD4 count, PrEP, PEP, eMTCT, HPV vaccines	• Campaigns and recognition to motivate those tested HIV negative to adopt risk reduction and stay negative • Positive health, dignity and prevention • Alcohol and substance abuse programmes	• 100% condom use policy • Recognition of negative status since previous HIV test • Promote human rights • Safe spaces • Conditional economic support-IMAGE • GBV prevention programmes • Health care providers and Police sensitivity trainings
Men who have Sex with Men		• Male condom use, lubricants • Frequent and regular HCT, STI, HPV screening and vaccines, Anal STI screening.	• STI treatment, ART – regardless of CD4 count, PrEP, PEP, eMTCT, HPV vaccines	• Campaigns to motivate those tested HIV negative to adopt risk reduction and stay negative • Positive Health, Dignity and Prevention • Reduction of number of partners • Alcohol and substance abuse programmes	• Human rights protection for MSM • Safe spaces/drop-in centres fo IDUs • Social support -M-powerment • Psycho social support mechanisms • GBV prevention programmes • Health care providers and police sensitivity trainings

MEDIUM INCIDENCE CLUSTER					
People Who Inject Drugs		• Peer education on HIV prevention comprehensive service package for PWID • Regular HTC, sexual and reproductive health care, TB and Hepatitis B & C screening • Sterile needle and syringe kits, Safe disposal of used injecting equipment, • Integrated ART and Medically Assisted Therapy	• STI screening and treatment, eMTCT, family planning • ART – regardless of CD4 count, PrEP, PEP, • Needle and syringe exchange programmes • Medically assisted therapy,TB treatment, vaccination for Hepatitis B and C	• Addiction counselling on alcohol and substance abuse • Safer injecting practices, • Reduction of sexual partners, • Positive Health, Dignity and Prevention • Motivate for HIV negative status • GBV prevention programmes	• Key Population policy review • Human rights protection of people who inject drugs, safe spaces/drop-in centres, legal aid • Psychosocial support mechanisms/mental health • Health care providers and police sensitivity trainings • Basic hygiene kits and child care support for females who use/inject drugs • Economic enhancement via vocational training and IGAs
Prison communities and other uniformed forces		• Frequent and regular HTC, STI screening	• HTC, STI, HPV screening, • STI treatment, ART – regardless of CD4 count, • PEP, • EMTCT	• Risk reduction for HIV negative testers • Positive Health, Dignity and prevention • EBI- e.g., START	• Psycho social support mechanisms for reintegration • Review of Prison policy on HIV prevention to include condom use, PrEP, Safe injecting needles, and conjugal visits

LOW INCIDENCE CLUSTER: *1% of new HIV infections occur in 10 of the 47 Counties*

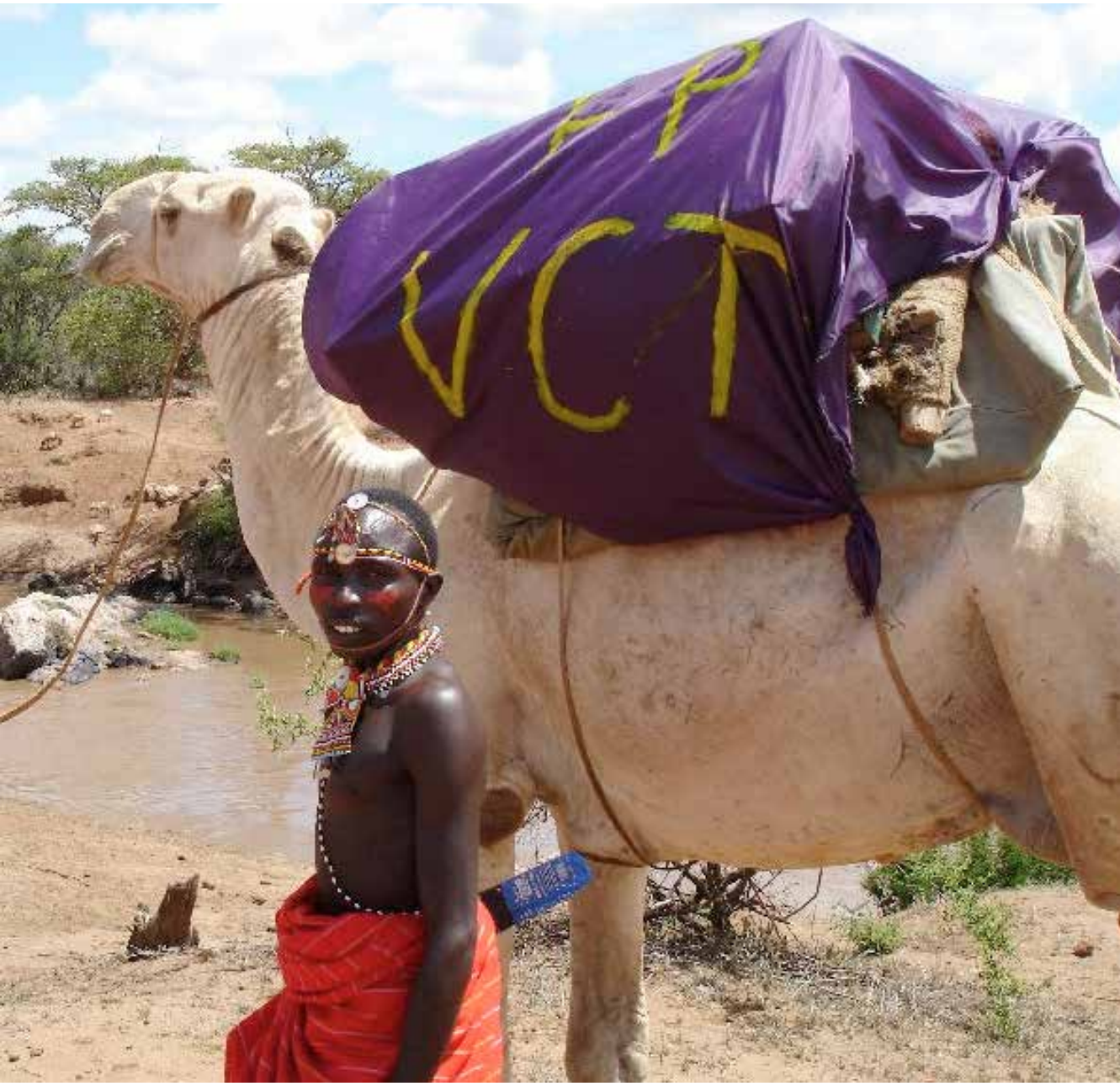


County	New HIV infections (total)
Kakamega	327
Bungoma	176
Mandera	154
Garissa	130
Busia	109
Marsabit	85
Vihiga	66
Lamu	49
Tana River	44
Wajir	20

Garissa, Kenya © Shutterstock

LOW INCIDENCE CLUSTER					
1% of new HIV infections	Age group/ sex	Available Biomedical Interventions		Behavioural interventions	Structural interventions
		Community Settings	Facility Settings		
General Population					
	0 – 5 years	• Integration of HIV testing in immunisation programmes	• Infant circumcision • Paediatric ARV for all HIV positive children	• Exclusive breastfeeding for all up to 6 months	• Training of pre-school teachers and community health workers as agents of communication for infant HIV testing
	5 – 9 years	• Mobile HIV and sexual and Reproductive health education (clubs)	• VMMC	• Life skills training	• Sexual and reproductive education at school
	10-14 years	• Mobile HIV and sexual and reproductive health education clubs	• HTC, VMMC, PEP, Post rape care	• Life skills training	• Programmes to Keep girls in school, GBV prevention programmes, sexual and reproductive education at school • Messages on intergenerational sex
	15 – 19 years	• Mobile HIV & STI testing and education, condom use, • Family Planning and Emergency contraception	• HTC, VMMC, PEP, Post rape care, HPV	EBI-Healthy choices	• Review (adolescent) requirement of parental consent in HIV testing policy • Messages on intergenerational sex
	19 and above	• Mobile 6 month CHTC, condom use, VMMC, Family planning and emergency contraception	• Provider initiated testing and counselling, HTC, FP, VMMC, PEP, Post rape care, EC, HPV	• Campaigns on risk reduction for HIV negative testers • Condom use campaign	• Increase surveillance on incidence
Bridging Populations					
Truck drivers, migrants, fishing communities		• Mobile HTC • Frequent and regular CHTC, condom use, VMMC	• ART – regardless of CD4 count, eMTCT	• Positive health, dignity and prevention • Condom use, partner prevention	• Review policies on maximum working hours, mobile services
Priority Populations					
Discordant couples		• Linkage to care • Adherence to treatment • eMTCT, condom use, CHCT	• ART regardless of CD4 count, PrEP, eMTCT, VMMC, FP	• Positive health, dignity and prevention, partner prevention	• Implement partner (s) notification for HIV

LOW INCIDENCE CLUSTER					
Sex workers		• Male and female condom use • Frequent and regular HTC, STI screening including anal and cervical cancer screening	• STI treatment, • Treatment regardless of CD4 count, PrEP, PEP, eMTCT, HPV vaccines	• Campaigns and recognition to motivate those tested HIV negative to adopt risk reduction and stay negative • Positive health, dignity and prevention • Alcohol and substance abuse programmes	• 100% condom use policy • Recognition of negative status since previous HIV test • Promote human rights • Safe spaces • Conditional economic Support • GBV prevention programmes • Health care providers and police sensitivity trainings
Men who have Sex with Men		• Male condom use, lubricants • Frequent and regular HCT, STI, HPV screening and vaccines, Anal STI screening.	• STI treatment, ART – regardless of CD4 count, PrEP, PEP, EMTCT, HPV vaccines	• Campaigns to motivate those tested HIV negative to adopt risk reduction and stay negative • Positive health, dignity and prevention • Reduction of number of partners • Alcohol and substance abuse programmes	• Human rights protection of MSM • Safe spaces/drop-in centres • Social support -M-powerment • Psycho social support mechanisms • GBV prevention programmes • Health care providers and Police sensitivity trainings
People Who Inject Drugs		• Peer education on HIV prevention • Comprehensive service package for PWID. • Regular HTC, sexual and reproductive health care, TB and Hepatitis B & C screening • Sterile needle and syringe kits, Safe disposal of used injecting equipment, • Integrated ART and Medically Assisted Therapy	• STI screening and treatment, eMTCT, family planning • ART – regardless of CD4 count, PrEP, PEP, • Needle and syringe exchange programmes • Medically assisted therapy,TB treatment, Vaccination for Hepatitis B and C	• Addiction counselling on alcohol and substance abuse • Safer injecting practices, • Reduction of sexual partners, • Positive health, dignity and prevention • Motivate for HIV negative status • GBV prevention programmes	• Key Population policy review • Human rights protection for people who inject drugs, Safe spaces/drop-in centres, legal aid • Psychosocial support mechanisms/ Mental health • Health care providers and police sensitivity trainings • Basic hygiene kits and child care support for females who use/inject drugs • Economic enhancement via vocational training and IGAs
Prison communities and other uniformed forces		• Frequent and regular HTC, STI screening	• HTC, STI, HPV screening • STI treatment, ART – regardless of CD4 count • PEP • EMTCT	• Risk reduction for HIV negative testers • Positive health, dignity and prevention • EBI- e.g., START	• Psycho social support mechanisms for reintegration • Review of Prison policy on HIV prevention to include condom use, PrEP, Safe injecting needles, and conjugal visits



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5.0 Efficiency in Delivery

To achieve and sustain the goal of zero new HIV infections by 2030 will require greater efficiency in HIV programming and implementation. Approaches to maximize synergies and integration within the health system are recommended. They include strategies to increase and sustain knowledge of HIV status, address leaks in the retention cascade, strengthen linkages to reproductive health services, improve capacity and linkages between community and facility level interventions.

Towards 100% coverage of targeted populations

5.1 Increasing knowledge of HIV status and linkages to services

HTC is the point of entry for individualized HIV prevention care, and treatment. KAIS 2012 revealed that 53% of people living with HIV were unaware of their status. Knowledge of HIV status is crucial, as studies have shown that people living with HIV who start treatment early, when their immune systems are relatively healthy, dramatically reduce the risk of HIV transmission and the occurrence of opportunistic infections. The challenge now is to create a robust, seamless linkage and retention system so that the benefits of early prevention care and treatment can be realized.

1 Addressing leaks in the retention cascade: HIV Testing and Counseling Linkages

- ***Service providers:*** All HTC providers are obligated to ensure referral to appropriate post-test services. This includes care and treatment for all people living with HIV and links to HIV prevention programmes for all individuals identified to be at high risk
- ***Community:*** Community health strategies, including effective referrals involving community health extension workers (CHEWS), will prove vital in the Counties to Strengthen the link between facilities and communities.
- ***Integration:*** Leveraging intiatives with strong community and health facility linkages such as infant immunization programmes for coordinated care of children tested in community settings

2 Making HTC an entry point not only to care and treatment but also to combination HIV prevention and other health care services

- All persons who test HIV-positive should receive partner notification services while taking steps to safeguard the human rights and dignity of all clients
- Build capacity of health providers to identify individuals at high risk of HIV acquisition and link them to or deliver effective HIV prevention interventions
- Provide sexual partner and family HIV testing and counselling, adherence counselling, TB screening and treatment, family planning services, STI diagnosis and treatment, and cervical cancer screening within three months of diagnosis
- Positive Health Dignity and Prevention (PHDP); a rights-based approach that ensures all newly diagnosed people are linked and access treatment and care services
- Integrate violence counselling, as part of prevention and management of gender based violence

3 Delivering HTC that is prescriptive in nature rather than routine. HTC strategies or approaches to be applied determined by the populations and geographical settings

- Continue to scale up facility-based PITC by utilizing task shifting to identify new HIV infections and link PLHIV to care and treatment
- Implement VCT and other community HTC approaches to identify self-selecting individuals at high risk of HIV and for delivery of evidence based behavioural interventions
- Test and implement new approaches such as self-testing to scale up targeted re-testing for populations at high risk and to scale up knowledge of HIV among populations with high stigma
- Innovative strategies to scale up HTC services for hard-to-reach populations, individuals who have never been tested before and individuals who were previously tested but require re-testing to know their correct HIV status such as door-to-door testing, self-testing, adolescent testing and conditional peer club testing

4 Deliver HTC at scale

- Trained facility-based health providers must offer HTC routinely as part of the standard care to all patients

53% of HIV infected persons were unaware of their HIV status

(KAIS 2012)

5.2 Integration of HIV Prevention Programmes

- Expand access to combination prevention HIV interventions, especially in high HIV burden areas through existing health systems and routine health-care delivery mechanisms in order to reach the largest number of persons at-risk
- Integrating HIV interventions into health services such as immunization, Sexual and Reproductive Health or MNCH offers a unique opportunity to reach more women, children and families with a comprehensive package of effective interventions for HIV prevention, treatment and care
- HIV testing and counselling processes must be simplified and mainstreamed in all routine health services (including mental health, nutrition, STI screening, etc.), as an entry point for life-saving HIV prevention, treatment and care
- Cultivate high level support and commitment of County and sub-County governments to support integration of HIV services through annual work planning and budgets
- Capacity building and supervision of service providers at facility and community to deliver integrated health/HIV services to those in need and provide effective referrals and linkages.
- Community involvement to build consensus on essential package for integrated health/HIV services and preferred service delivery model
- Address underlying health systems bottlenecks
- Raise public awareness to increase demand and uptake of expanded package of health and HIV services.
- Ongoing monitoring and evaluation to identify and apply best practices in HIV service integration for scale up

Trained community health service providers should routinely offer HIV testing and counseling at every contact with the identified priority populations

5.3 Strengthening Community and Health Facility-level Linkages

Strong linkages between the community and health facility prevention intervention is key to successful implementation of this Road Map:

Community Level

- Peer education for various populations to serve as agents of change in accordance with national guidelines
- Capacity building on HIV prevention messages for key groups such as religious leaders, provincial administrators, councils of elders and political leaders as communication agents for change among peers and community members
- Capacity building of community health workers to deliver HIV services as a priority within the community strategy
- Equipping peer educators, community health workers and outreach workers with the minimum package of commodities to effectively deliver services
- Referral directory for health facilities and services for effective referral and linkage.
- Eliminate stigma, discrimination and violence against key populations and PLHIV
- Engaging key populations, people with disability and PLHIV to organise themselves within the community and champion against breaches of their human rights
- Meaningful engagement of priority populations, key populations, people with disabilities and PLHIV as key stakeholders in HIV prevention
- Sustained rapid results campaigns for scale up of all key interventions in the counties

Health Facility Level

- Decentralisation of HIV prevention, care and treatment services to all health facilities
- Strong linkage between health facilities and their catchment population through community health workers, peer educators and outreach workers
- Adequate infrastructure and staffing of health facilities in accordance with national norms and standards
- Sensitivity and service provider value assessment trainings to ensure good customer care services to key populations and people with disabilities with emphasis on stigma reduction and non-discrimination in the delivery of health services
- Develop and train health care workers on Standard Operating procedures for risk assessment and enhance health workers' occupational safety and health relating to HIV and TB
- Utilise data for decision making at facility, county and national levels
- HIV commodities security through proper management, forecasting and quantification and resource mobilisation and allocation

6.0 Leveraging: HIV Prevention is Everyone's Business

An effective revolution in the HIV prevention response will only be achieved when HIV prevention becomes everyone's business. Under this Road Map, Kenya will employ a three-pronged approach that includes a focused social movement that makes specific demands, triggers political will and accountability and catalyzes legal and structural reforms needed to 'get to zero' new HIV infections by 2030.

Kenya will leverage the power of the existing HIV movement such as networks of People Living with HIV, community service organisations, faith-based organizations, sexual and reproductive health service and rights-based movements. Other nationally and internationally recognised movements such as the women's movement, youth organisations, teachers' unions and social media will be engaged. Key groups are traditional and religious leaders to help lead the social movement, influence political will and promote legal reforms. Kenya will identify and deploy HIV prevention champions (such as governors, first ladies, youth leaders and religious leaders) at county and national level to help lead the movement.

6.1 Priority Legal and Structural Interventions

- Remove barriers (e.g. age limits) to access HIV and sexual and reproductive health education and services by 2015
- Implement gender-structural interventions e.g. financial incentives
- Integration of HIV prevention programmes across all sectors at county and national level by 2015
- Promote social rights and dignity for sex work, drug use and MSM and review by-laws that lead to stigma by 2020

6.2 Priority Political Actions

- Mobilize additional resources for HIV prevention at national and county levels
- Align national and county laws to promote access to HIV services and rights protection of priority populations (young girls, prisoners, MSM, sex workers, people who inject drugs) by 2015
- Proactively develop guidelines that facilitate efficient translation of research into policy (PrEP, Treatment for HIV Prevention, Microbicides) by 2015
- Lead from the front: Champion HIV Testing, HIV Prevention, and Adherence

1.2.3 Priority Demands of Social Movement

Demand for universal access to HIV prevention and sexual and reproductive health education and services
Demand for increased domestic funding of HIV responses to 80% by 2030
Demand investment of private sectors in HIV prevention
Demand availability of sufficient and high-quality male and female condom use (at least 30 condom use per person aged 13-70 per year with targeted branding) at accessible points for all priority populations
Develop guidelines that facilitate efficient translation of research into policy
Demand new prevention options for priority populations. Challenge social and cultural norms that increase HIV vulnerability
Roll out : • 'Stay negative' campaign by 2014 • 'Don't discriminate' campaign by 2014 • Access to prevention tools now • "Condom useise Now" campaign • Treatment for all by 2015

Making HIV Prevention Everyone's Business

King of condoms demonstrates condom use to H.E The First Lady Margaret Kenyatta (immediate right), Mombasa Governor Hassan Joho (behind king of condom) and Dr Segor (behind Joho) during World AIDS Day, 2013 *© PPS*

6.3 Leveraging Key Sectors

All sectors are important in the national HIV response. Based on data on the geography of new infection (clusters), drivers of the epidemic, populations highly affected, and the potential of various sectors to influence HIV prevention programmes, Kenya will prioritize HIV prevention partnerships with priority sectors. The matrix below outlines the specific roles of each sector in supporting the social movement for a prevention revolution that challenges norms, attitudes and beliefs, influences political will and encourages legal and structural reforms to achieve zero new HIV infections by 2030.

Sectors	Role in supporting Prevention Movement	Priority Roles in HIV Prevention
Transport (Private and Public)	Social movement	• All public transport vehicles and trucks have prevention messages. • All stations and termini have male and female condom use dispensers and information for accessing other HIV prevention services
	Political Will	• Associations conduct bi-annual testing campaigns
	Legal and structural reforms	• Non-discrimination policies on employment, health insurance and service are in place • Policies are in place on maximum working hours and maximum number of days absence from family and partners • Steps are taken to remove unnecessary delays within the transport chain, such as port and border clearance • Develop a framework to deliver combination prevention along road and other infrastructure constructions as provided by the law
Media (Private and Public)	Social movement	• Promote a bold and evidence-based prevention campaign that challenges norms, attitudes and beliefs • Spearhead the HIV prevention campaigns
	Political Will	• Watchdog on implementation – A score card will be implemented to motivate success, recognise good leadership and accelerate progress in prevention
	Legal and structural reforms	• Hold government accountable for protecting human rights in line with constitution
Mobile and Web Technology	Social movement	• Implement an HIV prevention platform (M-Prevention) for delivery of SMS campaign • Implement information and communication based referral and linkage systems • Implement an on-demand counselling dial-in service • Support national social media campaign on Facebook, Twitter and other emerging social platforms
	Political Will	• Invest at least 30% of social responsibility budget in HIV prevention campaign • Contribute to fund/awards for good leadership on HIV prevention
	Legal and structural reforms	• Facilitate anti-discrimination campaigns, GBV campaign; Human Rights (free SMS and platforms)
Education	Social movement	• KNUT/KUPPET to conduct an HIV and anti-stigma/anti-bullying campaign at schools • Support student unions to conduct the stay negative campaign • Support student/pupils clubs (6-18 years) to conduct reproductive health, sexuality and HIV education
		• KNAP (Kenya National Association of Parents) and School heads associations to rally parents to support HIV prevention efforts in the education system
	Political Will	• Ministry of Education to facilitate national campaign on STI, HIV and HPV testing at school and referral to combination prevention package

	Legal and structural reforms	• Revise the education policy on reproductive health to include HIV, sexuality, human rights and gender from first class in primary school • TSC to institute prevention campaign on sexual abuse and rape at school and surroundings
Micro-finance	Social movement	• Institute preferential loan package (IGA) for priority populations. • Implement a fund to keep young girls in school (scholarship)
	Political Will	• Invest at least 30% of social responsibility budget in HIV prevention campaign • Contribute to fund/awards for good leadership on HIV prevention.
	Legal and structural reforms	• Facilitate anti-discrimination campaigns, GBV campaign, human rights (messages)
Tourism and Hotel (including bars and lodgings)	Social movement	• Integrate HIV prevention messages and free condom use at all hotel facilities (reception, bars, toilets, rooms) and a system for referrals to PEP
	Political Will	• Champion legal protection for sex workers and protection against sexual abuse • Invest at least 30% of social responsibility budget in HIV prevention campaign • Contribute to fund/awards for good leadership on HIV prevention
	Legal and structural reforms	• Create safe spaces for sex workers and their clients, MSM and people who inject drugs within their establishments • Enforce 100% condom use
Political leadership	Social movement	• Mobilise communities and challenge social norms for HIV prevention • Lead in accessing HIV testing, prevention, care and treatment services and openly disclose HIV status to diminish social stigma
	Political Will	• High-level advocacy for sustained HIV prevention funding
	Legal and structural reforms	• Enact laws that promote social rights and dignity of key populations
Religious sector	Social movement	• Lead from the front in accessing HIV testing, prevention, care and treatment services • Promote non-stigmatising HIV discussions within places of worship
	Political Will	• Challenge faith healing among unscrupulous religious leaders • Facilitate implementation of evidence-based interventions that may challenge social and religious norms
	Legal and structural reforms	• Facilitate implementation of evidence-based HIV prevention interventions in faith-based school, tertiary education institutions and health facilities
Judiciary, law and order	Social movement	• Identify HIV prevention and human rights champions within the judiciary and uniformed forces
	Political Will	• Institute data collection and reporting mechanisms for GBV and HIV within judiciary and uniformed forces • Publish annual HIV and human rights abuse statistics in the country and counties
	Legal and structural reforms	• Training of judiciary and uniformed services to include HIV particularly for key populations • Sensitivity training for all in-service personnel • Reform HIV and AIDS policy to allow HIV prevention tools in prison

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7.0 Revolutionising HIV Research and Development

7.1 Accelerating Innovation While Reducing Access and Delivery Gap

Research in Kenya adheres to national laws, guidelines and international ethical standards, assisted by UNAIDS/AVAC Good Participatory Practices, guided by effective and representative institutional review boards. NACC's Kenya HIV and AIDS Research Coordination Committee (KARSCOM), oversees all HIV-related human research, coordinating the efforts of research institutions, development partners, and medical centres. The committee mobilises resources for HIV-related research and disseminates important research findings to stakeholders throughout the country.

Despite Kenya's outstanding record of leadership in HIV research and development breakthroughs, the following research gaps persist:

Gap 1 **Delayed translation of research findings into policy and practices:** The gap between scientific discovery and integration of findings into the Kenyan national health system is unacceptable. For instance, there are still no national PrEP or Treatment for HIV Prevention guidelines, although many uncoordinated demonstration projects are on-going.

Gap 2 **Uncoordinated research and development programmes:** No research information and knowledge management hub synthesises HIV epidemiologic trends to inform prevention programming and priority prevention research. There are multiple institutions conducting similar research projects, with limited cross-learning and and a lack of connection to the current health care system.

Gap 3 **Unclear post-trial access and intellectual property agreements:** Guidelines on post-trial access and intellectual property for proven efficacious technologies have not been clearly defined.

Gap 4 **Disjointed research for prevention:** There is limited integration of biomedical, behavioural and structural interventions in clinical trials and demonstration projects. This makes if difficult to ensure that programmes are implemented in a manner that effectively leverages important prevention synergies.

Gap 5 **Uncoordinated public engagement for research and development:** Community and stakeholder engagement and formative research are often vertical (product-specific or organisation-specific), with minimal country or County coordination to create maximum public engagement and support for HIV research.

Gap 6 **Vertical health research and development:** HIV research and development has not harnessed synergies across other areas of health research, such as tuberulosis malaria, sexual and reproductive health and non-communicable diseases. Lack of coordination among organisations and funders conducting trials and demonstration projects of different biomedical products impedes cross-learning.

Gap 7 **Minimal translation of innovation to commercialisation:** Public-Private partnerships for health product development and access have yet to be harnessed at country and regional level to ensure that research is linked to manufacturing and commercialisation of innovation.

Gap 8 **Limited involvement and recognition of local scientists:** In basic research, protocol designs and implementation science. Limited capacity of Ethics and Regulatory Board.

Gap 9 **Lack of national HIV research and development priority and inadequate funding:** Kenya's national funding of health research and development is still below the funding targets for health research and development of 2-5% in the Algiers, Bamako and other regional declarations of commitment. The failure to adhere to pledges on health research and development funding is consistent with the country's broader failure to achieve the Abuja Declaration target of ensuring that 15% of national budget is allocated to health. These failures limit the potential for optimising the existing state-of-the-art research infrastructure and scientists for home-grown research on health.

This Road Map recommends a revolution in Kenya's approach to HIV-related research and development. Specifically, it provides for immediate action to:

1 **Expedite demonstration and delivery of current proven biomedical interventions** (PrEP, Treatment for HIV Prevention, VMMC) while answering key **behavioural and structural questions pertaining to combination prevention**. Demonstration projects should be integrated in the existing health system (public, NGO, private) and context to ensure accuracy of findings and data for effective decision-making.

2 **Prioritize research and development of additional prevention tools** (e.g., microbicides, preventive vaccines, cures and therapeutic vaccines) **and research to improve delivery and regimens of proven tools** (e.g., condom use, PrEP and Treatment for HIV Prevention)

3 **Ensure proactive development of policies and agreements** on intellectual proprety and post-trial access in order to accelerate access to, delivery and manufacturing of products found to be efficacious.

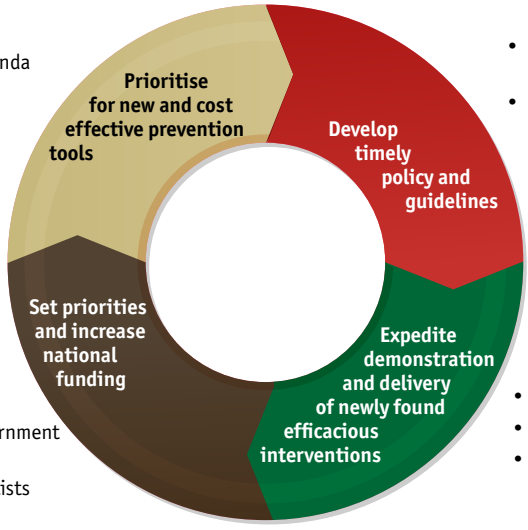
4 **Increase funding for health research and development to 2% of the national budget** to build capacity for home-grown pre-clinical and clinical research as well as manufacturing of HIV products with potential of cost-effectively eradicating AIDS in Kenya.

5 **Prioritize translational and operational research** that can inform practice.

Preparing a tranquilizer-type substance for injection with a safe injection kit.
© Sean Kimmons/IRIN

This Road Map calls for the following actions on key biomedical, socio-behavioural and structural Research and Development priorities:

- Coordinated and synergistic agenda
- Participatory agenda setting
- Unified hub for information and knowledge management



- Unified advocacy, policy and stakeholder engagement
- In synch with epidemic realities and rights-based

- Country owned and led
- Long-term commitment of Government and partners
- Capacity building for local scientists

- Access policies
- Safeguarding Intellectual Property
- Manufacturing plans

Biomedical HIV research and development priorities

- Determine the combination and intensity of prevention strategies that most effectively and efficiently reduce HIV incidence
- Conduct demonstration projects on new non-surgical male circumcision devices.
- Conduct demonstration projects of vaginal microbicidal gel and participate in efficacy trials of vaginal ring and multi-purpose prevention technologies (for HIV, pregnancy and other STIs)
- Participate in clinical trials on less adherence dependent PrEP and Treatment for HIV Prevention (e.g. long acting injectables)
- Participate in early trials of cure and therapeutic vaccine
- Interaction of HIV and geriatric diseases among older persons

Structural Priorities

- Strengthen capacity of Regulatory and Ethics Committees to establish a central database of research projects, strengthen mechanisms of communication with all existing regulatory bodies and oversee evolving clinical trials and demonstration project design and implementation
- Develop and harmonise mechanisms for a coordinated national and County-level policy, advocacy, communication and stakeholders engagement for HIV research agenda
- Ensure equitable participation of priority populations (young girls, discordant couples, MSM, people who inject drugs, sex workers) in clinical trials and demonstration projects
- Harmonise country and county data system (research hub) for continuous monitoring of impact and cost of newly introduced prevention options to inform service delivery and guidelines
- Increase funding allocations for health research by local and national governments.
- Develop mechanisms to align research funding to local priorities

Socio-behavioural Research Priorities

- Conduct analysis of granularity of drivers of new HIV infections and priority populations in the medium -incidence Cluster Counties where the epidemic is mixed, i.e. generalised and concentrated
- Conduct studies on risk perceptions, facilitators of adherence and retention in treatment for HIV prevention, PrEP and microbicides programmes
- Demonstrate community and population impact of combination prevention on incidence for the high-incidence and medium-incidence cluster counties
- Integrate gender, gender-based violence and sexuality analysis (including biomarkers of prevention, side effects, and interactions with other sexual and reproductive health products) in all demonstration projects and clinical trials
- Conduct studies to understand social and behavioural factors that affect use of existing preventive services (e.g., condoms, PEP) as well as new prevention tools (e.g.,PrEP , treatment as prevention) with end users
- Operational research and implementation science to identify barriers to service uptake for PWID, in order to improve the efficiency and effectiveness of OST/MAT and NSP
- Ensure social readiness, acceptability and guidelines for participation of young girls/boys, MSM, people who inject drugs, and children in the next generation of trials
- Establish the impact of alcohol and drug use on HIV transmission and prevention
- Study psychosocial issues affecting discordant couples and HIV prevention
- Understand sexual networks and their impact on HIV transmission and prevention

8.0 Coordination and Management

Implementation of this Road Map will require political leadership and accountability. Counties in different clusters will require different levels of effort to achieve their targets.

The structures for the implementation of Kenya National AIDS Strategic Frameworks and Plans will guide the rollout of this Road Map. The oversight and coordination of its implementation will be provided at different levels as follows:

8.1 Leadership of HIV Prevention at the National Level

The National HIV Prevention Steering Committee

The National HIV Prevention Steering Committee will exert leadership, mobilise resources and ensure accountability towards achieving the targets of this Road Map. The NACC Director will chair the steering committee, which will consist of: The chairperson of the prevention technical working group, Senior-level representatives from key national government institutions, Development partners, Civil society organisations, PLHIV networks, Organizations and networks of key populations, people with disabilities and other key stakeholders, including but not limited to the education sector, researchers, pharmaceutical industry, business community (employers and workers), informal sector, justice and legal sector, media, information and communications sector, transport sector, microfinance, tourism and hotel industry, labour sector and the religious sector.

The steering committee members will be accountable for designing, implementing and reporting on progress regarding their sector's targets as identified in section 5.1 of the Road Map.

The National HIV Prevention Technical Working Group

The Head of the National AIDS and STI Control Programme will chair the national HIV prevention technical working group, which will provide technical leadership to consolidate HIV prevention interventions, from the current fragmented approach towards a target-based, well-coordinated and comprehensive population-based approach. Membership of the technical working group will be drawn from managers of HIV prevention programmes, technical leads from multi/bi-lateral, development partners, private sector and research community. The technical working group will establish and manage a HIV prevention research and knowledge management hub. It will work in consultation and in line with the County Technical HIV Working Group (CTWG).

8.2 Leadership of HIV Prevention Programmes at the Counties

County HIV Prevention Steering Committee

In each County, the County Executive Committee Member for Health will chair the County HIV prevention Steering Committee. The County Steering Committee will exert leadership, mobilise resources, ensure compliance with HIV national policies and guidelines, and promote accountability towards achieving the County targets. The Steering Committee will be responsible for integrating HIV in the broader county health plans and for leveraging all other key sectors for HIV prevention. The membership will consist of the CTWG, senior-level representatives from County government departments, development partners, civil society organisations, PLHIV networks, key populations, people with disabilities and other key stakeholders, including, but not limited to the sectors of education, research, pharmaceutical industry, business community, informal sector labour, legal, media, information and communications technology, transport, microfinance, tourism and hotel industry and the religious sector.

County HIV Prevention Technical Working Group

Chaired by the County Chief Officer for Health, the CTWG will provide technical leadership to consolidate HIV prevention interventions and to ensure a well-coordinated and comprehensive population-based approach. The CTWG membership will be drawn from County AIDS coordinators and the chairpersons of the sub-County health management teams, technical leaders from implementing partners, heads of preventive and promotive services, private sector, and research community. The CTWG will establish and manage a County HIV prevention research and knowledge management hub. The CTWG will work in consultation and in line with the national technical working group.

Sub-County Health Management Teams

The Sub-County Health Management Teams will integrate HIV prevention in all sub-County health plans. They will oversee implementation of the recommended HIV prevention combination packages for their clusters at facility and community levels, and will ensure appropriate geographic and population prioritization based on evidence from the granularity studies of the epidemic. Through stakeholder engagement, sub-County health management teams will work to ensure that HIV prevention is everyone's business at the community and household levels.

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9.0 Forecasting and Tracking Progress on HIV Prevention

Achieving the desired prevention revolution in Kenya will require innovation in monitoring and evaluation of the identified combination package at country, county and target population levels. The impact of recommended evidence-based biomedical, behavioural, and structural interventions will be regularly evaluated against specific outcomes. Monitoring will also be required to ensure that implementation of the prevention revolution accords with the principles of this Road Map.

Implementation of this Prevention Revolution Road Map will require vigilance to new and re-emergent challenges. For instance, successful implementation of the HIV prevention revolution may result in changes in epidemiologic and behavioural patterns. New cohorts of at-risk populations will emerge as today's children and young people transit into adolescence and adulthood. Unforeseen social or environmental changes may influence risk behaviour or the accessibility of prevention services. These and other potential changes will require adaptations in the HIV response, such as flexible planning processes, adjusted strategies for monitoring and evaluation, new or different combinations of interventions, and modified approaches to geographic and population prioritization. It is critical to anticipate and monitor performance in the three clusters and populations to ensure timely introduction of needed adaptations. A County score card will be implemented to motivate success, recognise strong leadership and accelerate progress towards preventing new HIV infections.

9.1 Forecasting

Outcome Indicators

	Indicator	Baseline	Target 2015	Target 2020	Target 2025	Target 2030
1	Reduced HIV incidence among adults	88,620 *(NASCOP/ NACC 2013)*	45,500	22,750	13,650	<1,000
2	Reduced HIV incidence among children	12,940 *(NASCOP/ NACC 2013)*	3,000	1,950	1,300	<200
3	Key populations contribution to new HIV infections (MSM, SW, PWID)	33% *(KMoT 2008)*	25%	15%	10%	5%
4	Reduction of percentage of PLHIV who report experiencing HIV related stigma	TBD 2013	25%	50%	75%	100%
5	Proportion of HIV budget allocated to prevention	20% *(KNASA 2013)*	35%	45%	50%	50%

Routine Monitoring

Throughout the implementation, process indicators will be documented, measured and evaluated through:

- Health Management Information System (HMIS)
- Programmes (PMTCT, HTC, VMMC, FP, Early Infant Diagnosis, EBIs) dash boards
- Community-based Health Information System (CBHIS)
- Logistics Management Information System (LMIS – commodities ordering, supply and utilisation information from health facilities)
- Kenya HIV and AIDS Research Coordinating Mechanism (KARSCOM) database on HIV research and demonstration projects

Outcome indicators will be documented, measured and evaluated through:

- Paper-based cohort monitoring
- Sentinel cohort monitoring
- Population-based surveys (KAIS, KDHS, etc.)

Revolutionary Shifts in Monitoring and Evaluation of HIV Prevention

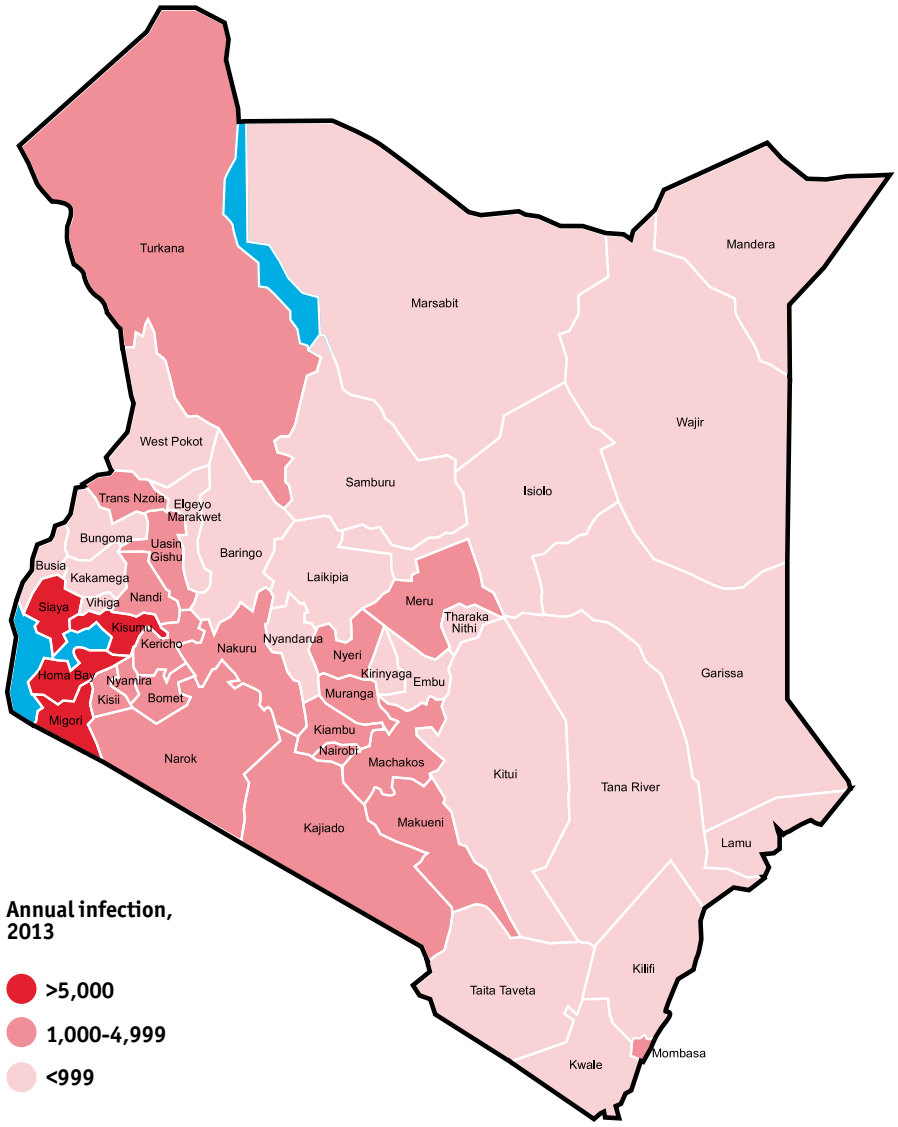
The HIV prevention revolution proposes paradigm shifts in monitoring and evaluation of HIV prevention in Kenya:

- Incidence data to be estimated by county clusters and HIV epidemiological populations
- Prioritize monitoring of outcomes over monitoring of processes
- Better surveillance in low incidence cluster
- Use of new technologies (GIS and viral load monitoring)

Appendix 1: Examples of Evidence Based Behavioural (EBI) and Structural Interventions

EBI and structural interventions	Target population	Key characteristics of the intervention
Family Matters Programme (FMP)	• Parents of Children aged 9-12 yrs	FMP an EBI targeting parents of pre-adolescents 9 to 12 years to equip them with skills they need to influence the sexual risk behaviours of their adolescent children
Healthy Choices I and Healthy Choices II	• Sexually active youth • Non-sexually active youth • Youth Living with HIV	• Healthy choices is a group intervention targeting children aged 10-13 years old for HC I and 14-17 year old for HC II. The interventions entails 8 sessions focusing on decision making, sex communication, negotiation and refusal skills with the aim of delaying sexual debut, promoting safer sex practice, HIV and STI risk reduction and condom use
EBAN Programme	• Discordant couples	• This interventions consists of eight two-hour sessions of small groups (3-5 couples) delivered over 8 weeks, as well as sessions for individual couples led by skilled male and female facilitators • EBAN aims to train couples on assertive communication skills, discuss triggers that make negotiating safe sex challenging and emphasize partner involvement in safer sex
Sister to Sister Programme	• Young women	• Sister-to-Sister, delivered by female health care workers and peer educators, is for women ages 18-45 years in groups of 3 to 5. The intervention aims to eliminate or reduce risk behaviours and prevent HIV and STI infections through increasing self-efficacy and condom use negotiation
Shuga	• Youth out of school	• A multi-media behaviour change communication intervention, Shuga targets youth between 15-24 years with the following key themes: • Sexual concurrency, correct and consistent condom use, sexual agency, personal risk perception, reduction of stigma and discrimination towards PLHIV, transactional sex, GBV and parent/child communication • Shuga is a 10-session intervention (150 minutes per session) in groups of a maximum of 20 participants delivered by facilitators, preferably a male and female within the age group of 18-29 years • Shuga utilises a combination of brainstorming, guest speakers, small group discussions and homework assignments
RESPECT	• Key populations, indiv PWIDals at highest risk	• RESPECT is an individual intervention delivered by trained HTC providers in 2 sessions with a focus on reduction of risk behaviour. The first session is delivered during the initial HIV testing and counselling session. and the second is offered during a scheduled follow-up counselling session
START	• Prisoners	• START is an indiv PWIDal-level, multi-session intervention for young men aged 18-29 years being released from a correctional facility and returning to the community. START focuses on increasing clients' awareness of their HIV, STI and Hepatitis risk behaviours after release and providing them with tools and resources to reduce their risk
IMAGE Study	• Young women and girls, women of reproductive age	• IMAGES utilises micro-finance institution systems of on-going contact with women, integrating economic empowerment with HIV and GBV training and service delivery. An evaluation in South Africa and showed significant HIV risk reduction and reduced GBV.. The intervention takes up to 1 year and consists of ten 2 hour sessions of up to 25 women
Conditional Cash Transfers study	• Young women and girls	• This is a structural intervention that targets young women and girls and their families. It involves provision of financial incentives to recipients who abide by stipulated conditions, such as remaining in school and reducing sexual risk behaviour
Cash Transfer Study	• Children affected by HIV/AIDS	• Cash and in- kind food and health care to meet the immediate needs of HIV/AIDS orphans. Reducing the vulnerability of these children potentially reducestheir vulnerability to HIV infection (UNICEF Malawi)
Stepping Stones: Creating Futures (HEARD)	• Young people over age 18 living in informal settlements	• Combined structural and behavioural intervention. Life skills training to decrease gender inequalities and increase livelihood security thereby reducing IPV and HIV risk

ESTIMATED NEW HIV INFECTIONS AMONG ADULTS (15+) BY COUNTY 2013



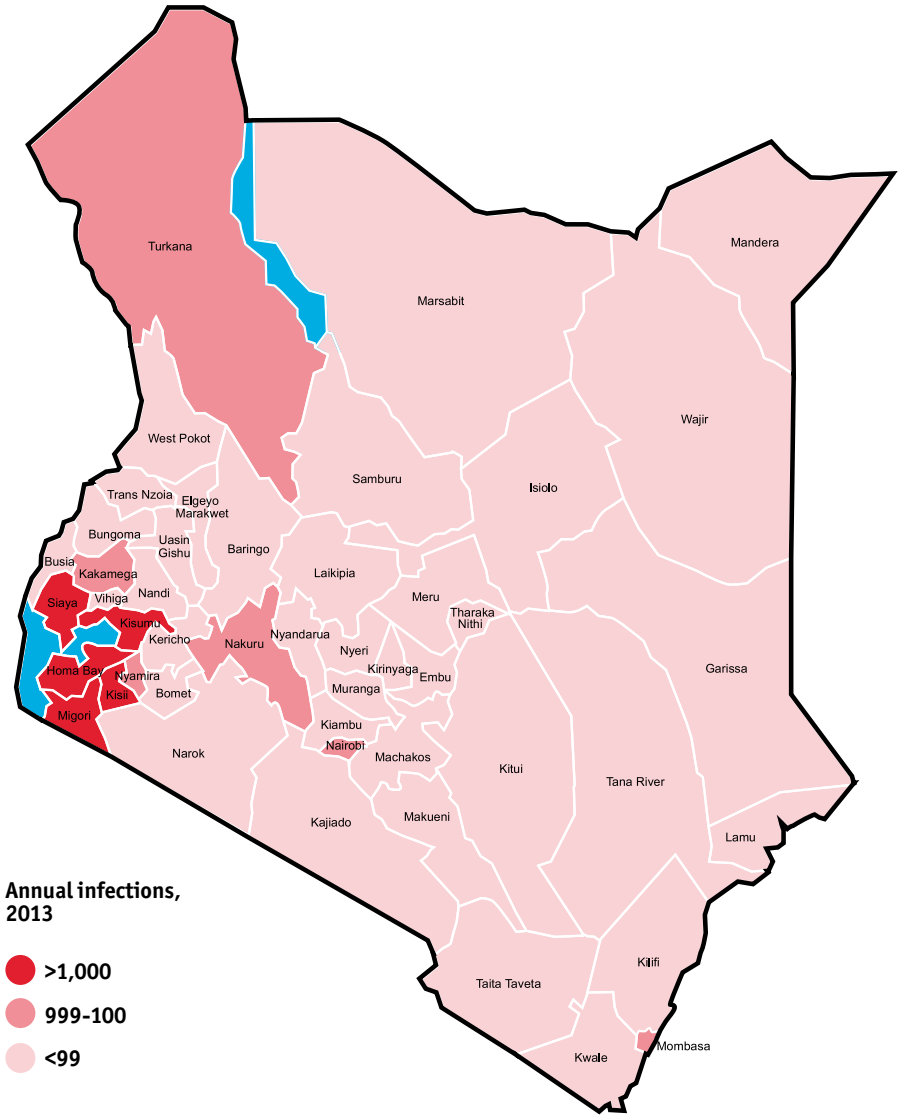
Counties	New HIV infections
Homa Bay	12,279
Kisumu	10,349
Siaya	9,869
Migori	6,786
Kisii	4,891
Nakuru	4,127
Nairobi	3,098
Turkana	2,997
Kiambu	2,931
Nyamira	2,052
Muranga	1,984
Uasin Gishu	1,921

Counties	New HIV infections
Bomet	1,875
Trans Nzoia	1,867
Narok	1,806
Mombasa	1,609
Kajiado	1,545
Machakos	1,463
Nyeri	1,307
Nandi	1,253
Kericho	1,214
Makueni	1,193
Meru	1,090
Kitui	988

Counties	New HIV infections
Nyandarua	899
Kilifi	821
Kirinyaga	795
Baringo	707
Laikipia	692
Kwale	623
West Pokot	576
Embu	518
Samburu	461
Tharaka	410
Elgeyo Marakwet	400
Taita Taveta	330

Counties	New HIV infections
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**

ESTIMATED NEW HIV INFECTIONS AMONG CHILDREN (0-14) BY COUNTY 2013



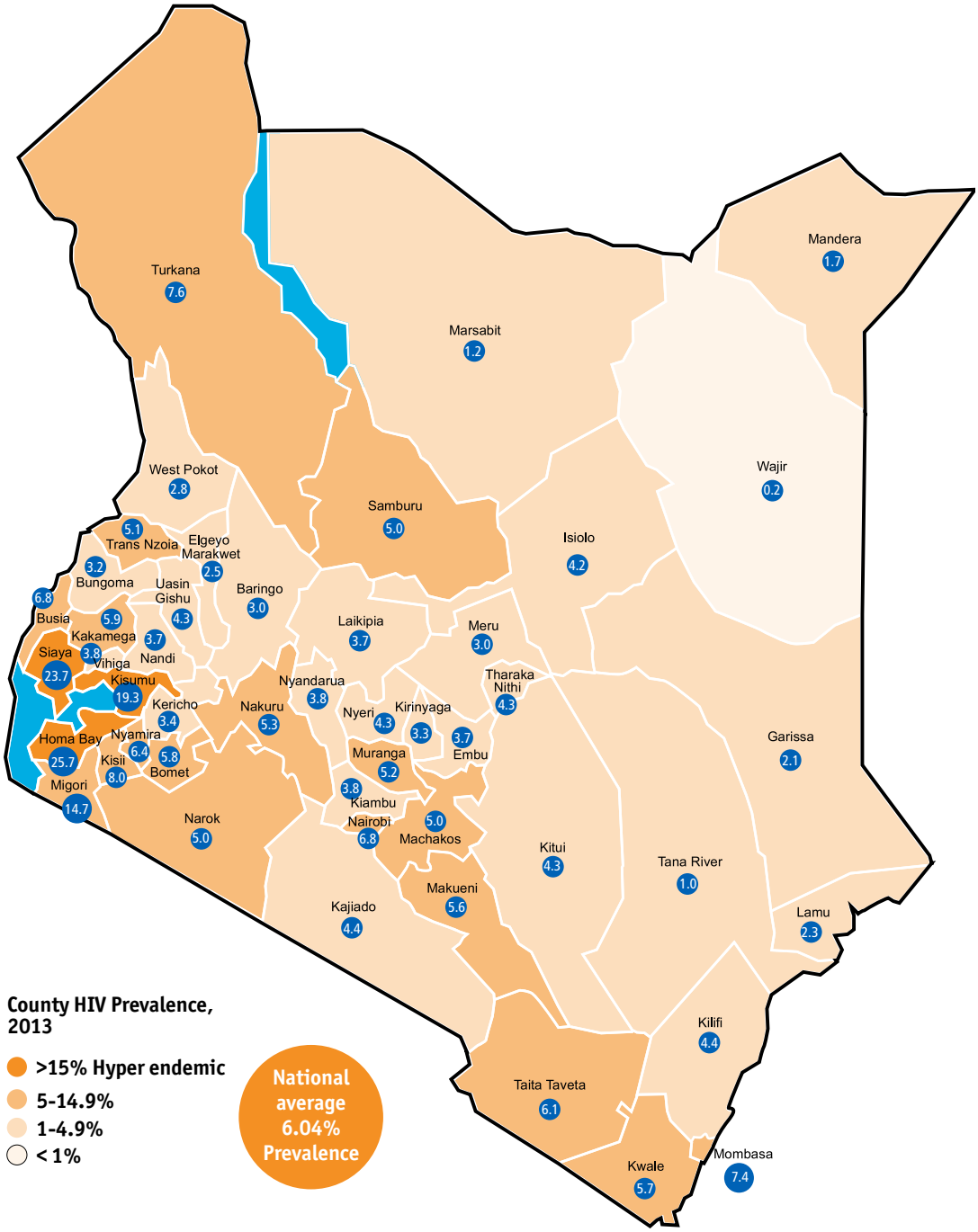
County	New Infections
Homa Bay	2,700
Kisumu	2,276
Migori	1,492
Siaya	2,170
Kisii	1,075
Nyamira	451
Nairobi	313
Nakuru	197
Kakamega	172
Mombasa	169
Turkana	143
Kiambu	95

County	New Infections
Bungoma	93
Uasin Gishu	92
Trans Nzoia	89
Bomet	89
Narok	86
Kilifi	86
Machakos	79
Kajiado	74
Kwale	65
Makueni	64
Muranga	64
Nandi	60

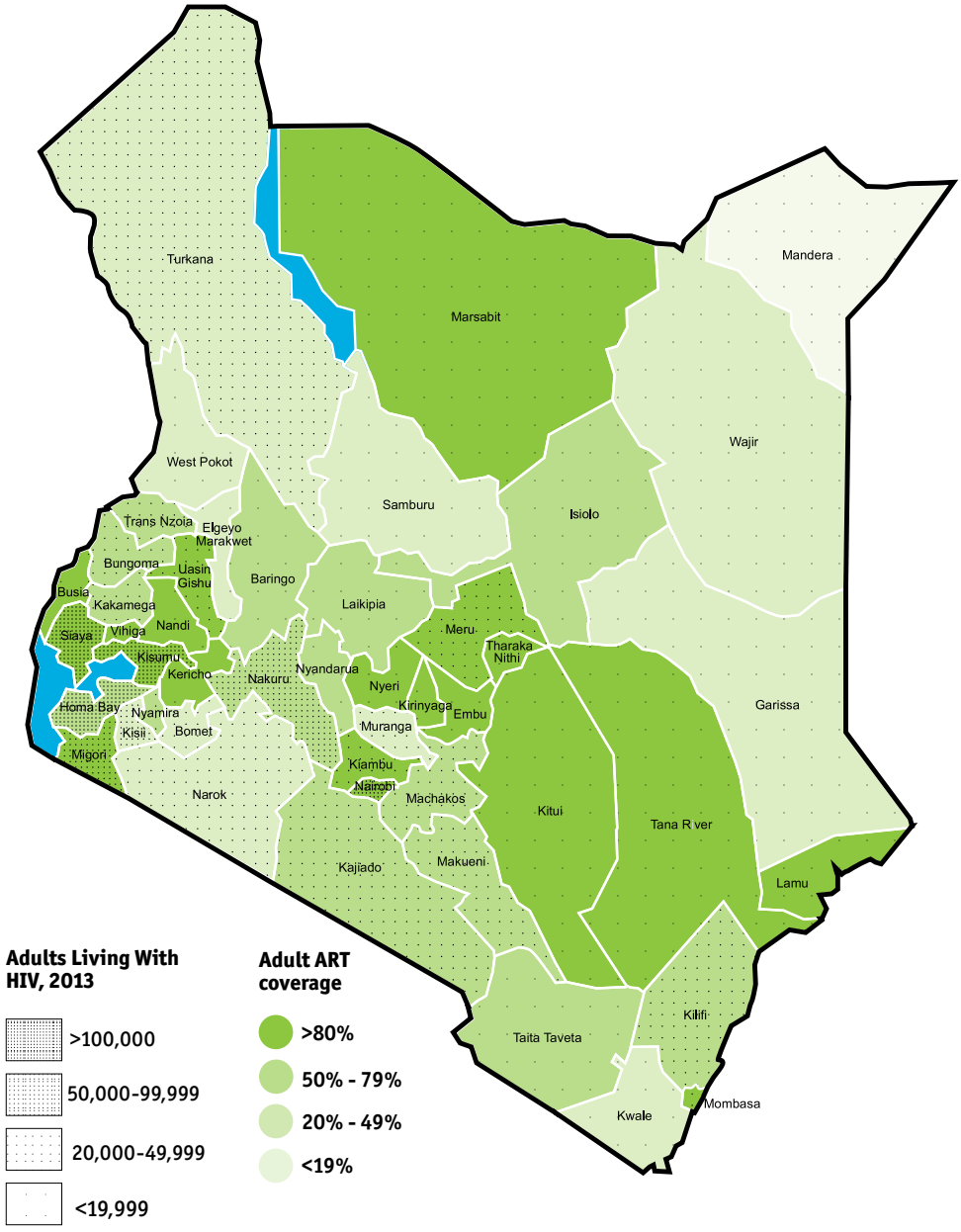
County	New Infections
Meru	59
Kericho	58
Busia	57
Kitui	53
Nyeri	42
Vihiga	35
Taita Taveta	35
Baringo	34
Laikipia	33
Nyandarua	29
Embu	28
West Pokot	27

County	New Infections
Kirinyaga	26
Samburu	22
Tharaka	22
Elgeyo Marakwet	19
Mandera	17
Garissa	14
Isiolo	8
Lamu	5
Tana River	4
Marsabit	4
Wajir	2
Kenya	**12,826**

ESTIMATED ADULT HIV PREVALENCE BY COUNTY



TOTAL # ADULTS LIVING WITH HIV BY COUNTY AND % ART COVERAGE FOR THOSE IN NEED (CD4 350)



County	ART Covearage	HIV+ Adults
Mandera	4%	3,928
Turkana	20%	39,043
Samburu	24%	6,001
Wajir	26%	307
West Pokot	29%	7,515
Kwale	31%	18,459
Bomet	38%	24,389
Elgeyo Marakwet	38%	5,208
Narok	38%	23,504
Muranga	45%	28,721
Garissa*	48%	3,262
Kisii	48%	55,970

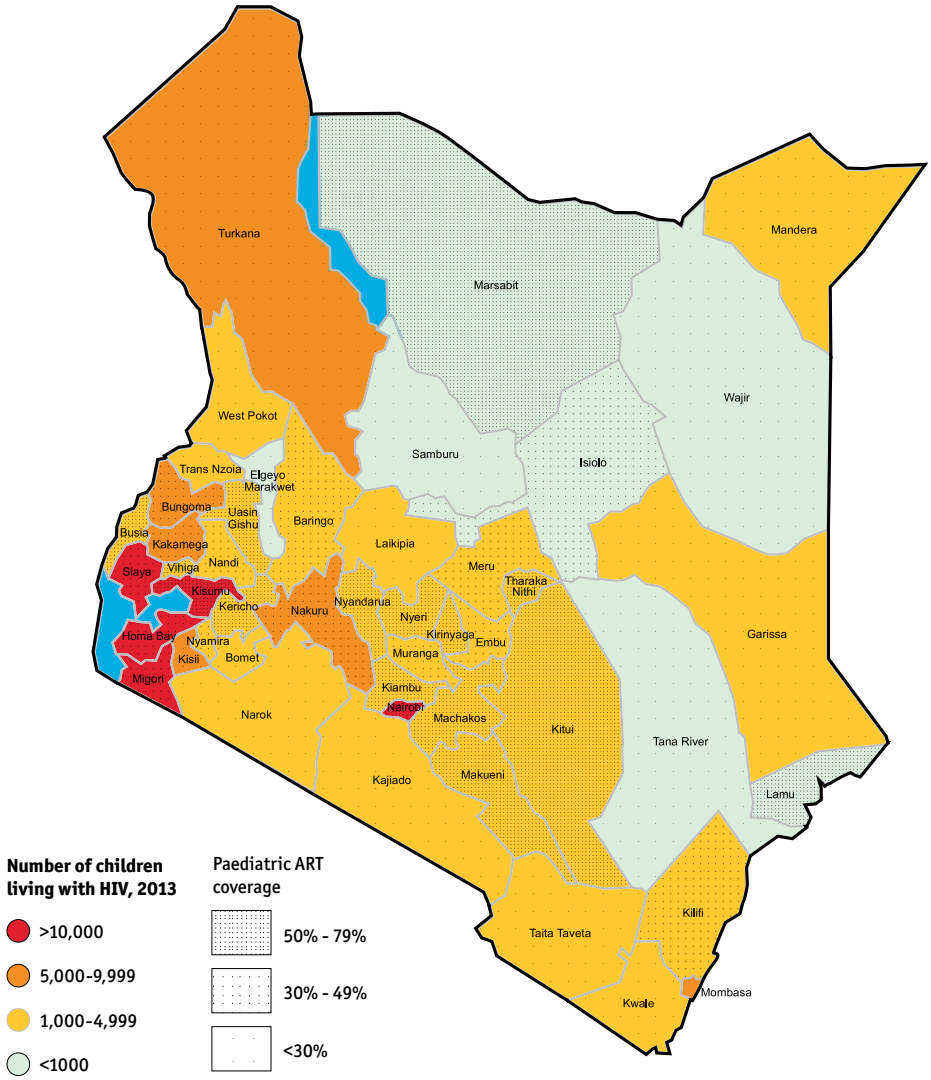
County	ART Covearage	HIV+ Adults
Taita Taveta	52%	9,781
Baringo	53%	9,194
Kajiado	53%	20,080
Laikipia	54%	8,963
Trans Nzoia	56%	24,323
Nyamira	58%	23,493
Isiolo	60%	2,822
Nakuru	62%	53,713
Bungoma	64%	26,093
Kakamega	66%	48,533
Homa Bay	70%	140,629
Kilifi	71%	24,413

County	ART Covearage	HIV+ Adults
Machakos	74%	27,063
Makueni	76%	22,110
Nyandarua	77%	12,950
Meru	82%	20,238
Nandi	82%	16,281
Siaya	82%	112,962
Marsabit	86%	1,480
Kitui	88%	18,328
Migori	89%	77,650
Kirinyaga	91%	11,458
Nairobi	92%	102,828
Embu	93%	9,641

County	ART Covearage	HIV+ Adults
Lamu	95%	1,263
Tharaka	95%	7,603
Tana River	97%	1,161
Vihiga	97%	9,853
Mombasa	98%	47,751
Nyeri	99%	18,923
Kiambu	102%	42,425
Kisumu	104%	118,538
Kericho	120%	15,846
Uasin Gishu	144%	25,021
Busia	183%	16,065
Kenya	**66%**	**1,345,785**

Disclaimer: Counties with over 100% coverage include clients from neighbouring counties

ESTIMATED NUMBER OF CHILDREN (0-14 YEARS) LIVING WITH HIV & PAEDIATRIC ART COVERAGE BY COUNTY



Counties	ART coverage	HIV+ Children
Mandera	3%	1,271
Wajir	4%	163
Samburu	9%	883
Garissa	10%	1,075
Narok	12%	3,456
Bomet	16%	3,589
Kwale	16%	2,659
West Pokot	16%	1,103
Laikipia	17%	1,324
Elgeyo Marakwet	17%	765
Kajiado	18%	2,956
Kisii	19%	7,715
Turkana	19%	5,736
Taita Taveta	20%	1,409
Tana River	26%	172
Trans Nzoia	29%	3,574

Counties	ART coverage	HIV+ Children
Nakuru	30%	7,898
Isiolo	30%	427
Bungoma	32%	5,086
Muranga	32%	2,881
Kakamega	33%	9,452
Baringo	36%	1,353
Migori	37%	10,705
Nyamira	38%	3,238
Nandi	39%	2,397
Mombasa	41%	6,870
Homa Bay	42%	19,370
Siaya	43%	15,568
Kilifi	44%	3,507
Meru	48%	3,082
Embu	49%	1,465
Kericho	51%	2,324

Counties	ART coverage	HIV+ Children
Kisumu	54%	16,326
Machakos	54%	4,135
Vihiga	57%	1,929
Marsabit	57%	229
Makueni	61%	3,372
Lamu	61%	187
Nyandarua	63%	1,305
Kitui	64%	2,792
Tharaka	65%	1,160
Kiambu	66%	4,256
Nyeri	68%	1,897
Kirinyaga	68%	1,154
Uasin Gishu	73%	3,677
Nairobi	74%	12,894
Busia	75%	3,138

HIGH INCIDENCE CLUSTER

65% of new HIV infections	Cumulative County data	Priority populations
Homa Bay, Kisumu, Siaya, Migori, Kisii, Nakuru, Turkana, Nyamira, Bomet	• HIV incidence: > 0.4% • No of PLHIV: 674,947 • Cluster population: 9,572,409	• General populations • People Living With HIV • Discordant couples • Youth (especially young women) • Sex workers • MSM and transgender • PWIDs • Fisherfolks

MEDIUM INCIDENCE CLUSTER

34% of new HIV infections	Cumulative County data	Priority populations
Trans Nzoia, Narok, Samburu, Kajiado, Uasin Gishu, Muranga, Nyeri, Nandi, Kiambu, Laikipia, Kericho, Nyandarua, Mombasa, Makueni, Machakos, Baringo, Kirinyaga, West Pokot, Isiolo, Elgeyo Marakwet, Kitui, Tharaka, Taita Taveta, Kwale, Embu, Nairobi, Meru, Kilifi	• HIV incidence: 0.1 - <0.39% • No of PLHIV: 801,213 • Cluster population: 25,356,108	• People Living With HIV • Discordant couples • Youth (especially young women) • Sex workers • MSM and transgender • County specific bridging populations

LOW INCIDENCE CLUSTER

1% of new HIV infections	Cumulative County data	Priority populations (County-driven epidemiologic assessment and response)
Lamu, Garissa, Marsabit, Mandera, Tana River, Busia, Kakamega, Vihiga, Bungoma, Wajir	• HIV incidence: <0.01% • No of PLHIV: 123,291 • Cluster population: 6,864,045	• County specific bridging populations • Mobile populations • Refugees

AIDS response in Kenya, a multi-sectoral effort

The National HIV Prevention Summit, 2013, Safari Park Hotel, Nairobi

HIV Prevention Revolution and Combination Prevention

Right to left: ***Wycliffe Obwiri (EGPAF) Revolution in Behavioural Interventions, Dr Nelly Mugo (KEMRI) Revolution in Biomedical Interventions, Dr Nduku Kilonzo (LVCT) Revolution in Structural Interventions, Dr Kipruto Chesang (CDC), Dr Emmy Chesire (NACC), H.E Nathif Jama Adam (Governor, Garissa)***

Expert Panel Discussion: Cross Cutting Issues in HIV Prevention

Right to left: ***Moderator:*** *Louis Otieno* ***Panellists:*** *Dr George Githuka (NASCOP), H.E Cyprian Awiti (Governor, Homa Bay), Regina Ombam (NACC), Fredrick Nyaga (MenKen) and Dr Peter Cherutich (NASCOP*

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Notes

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