Ministry of Health

NATIONAL HIV & STI COMBINATION PREVENTION

COMMUNICATION STRATEGY

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Foreword

The Kenya Ministry of Health through NASCOP together with stakeholders has developed this National HIV& STI combination prevention communication strategy with the support of WHO to provide a framework for optimizing HIV&STI combination prevention programs through evidence driven social and behavioral communication approaches.

It is well designed to enhance demand, uptake and coverage of behavioral, biomedical and structural interventions to achieve desired health outcomes among priority populations and build systems to support scale up.

This HIV combination prevention communication strategy is addressing the gap that exists in integration of services for the maximum benefit of the client who may have different health issues that require time and money spent to access these services.

The intended audience for this document includes national and county health policy makers, development and implementing partnership coordinators and practitioners from government and non-governmental organizations private sector and academia that are responsible for funding planning implementation monitoring and evaluation of social behavioral communication for HIV&STI at national and decentralized levels.

Dr. Masasabi Wekesa
Ag Director General

Acknowledgment

This first edition of the National HIV and STI Combination Prevention Communication Strategy been developed through the collaborative efforts of many individuals and organizations.

I take this opportunity to acknowledge the Prevention unit at the Division of National AIDS and STI Control Program (NASCOP through the leadership of Dr. Catherine Ngugi (Head,) for their key role in coordinating the development of this strategy. Special thanks go to the World Health Organization (WHO) for their generous financial and technical support. Additionally, I salute the following organizations for their immense contribution and review of the document: The Ministry of Health (MOH) NASCOP, NACC, JHPIEGO-Jilinde, Clinton Health Access Initiative (CHAI), Kenya Red Cross (KRC) United Nations Children's Fund (UNICEF), Sex Workers Outreach Program (SWOP), Bell Consult, The HIV/STI Communications Subcommittee members , the County Governments of Nairobi, Laikipia, Nakuru, Mombasa, Siaya, Homa Bay and Kakamega and Centre For Behaviour Change and Communication (CBCC) for compiling the document.

To all of you, we say thank you!

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Abbreviations

ABYM	*Adolescent Boys and Young Men*
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immuno-Deficiency Syndrome
aPNS	Assisted Partner Notification Services
ART	Antiretroviral Therapy
BCC	Behavioural Change Communication
C4D	Communication for Development
CHMT	County Health Management Team
CITC	Client-Initiated HIV Testing and Counselling
CSO	Civil Society Organization
EBI	Evidence-Informed Behavioural Intervention
FWID	Females Who Inject Drugs
HIV	Human Immuno-Deficiency Virus
HIVST	HIV Self-Testing
HTS	HIV Testing Services
HW	Health care worker
IEC	Information, Education and Communication
IPC	Infection Prevention and Control
KAP	Knowledge, Attitudes and Practices
KASF	Kenya AIDS Strategic Framework
M&E	Monitoring and Evaluation
MSM	Men Who have Sex with Men
NASCOP	National AIDS and STI Control Programme
NGO	Non-Governmental Organization
NSP	Needle and Syringe Programme
PEP	Post-Exposure Prophylaxis
PITC	Provider-Initiated HIV Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
SBC	Social and Behavioural Change
SBC	Social and Behavioural Change Communication
SDGs	Sustainable Development Goals
STI	Sexually Transmitted Infections
SW	Sex Worker
TB	Tuberculosis
TfP	Treatment For Prevention
TG	Transgender
UN	United Nations
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
YKP	Young Key Populations
YFSW	Young Female Sex Workers
YMSM	Young Males who have Sex with Males
YPWID	Young People who Inject Drugs

1 About this Communication Strategy for HIV and STI Combination Prevention

This introductory section presents the rationale for this HIV and STI Combination Prevention Communication Strategy, in terms of why this document was needed, its vision, mission, intended users and how to use it. It also provides insight on the process for developing the strategy.

AIM: Despite significant investment in advocacy and behavioural change communication efforts to curb the spread of HIV in Kenya, it remains a major public health threat. Prior strategies were fragmented and executed in silos. This document offers a framework for optimizing HIV and STI combination prevention programs through evidence-driven social and behavioural communication approaches. A well-designed SBC strategy can concurrently enhance demand, uptake and coverage of behavioural, biomedical and structural interventions to achieve desired health outcomes among priority populations and build systems to support national scale up

This SBC strategy is informed by an analysis of Kenya's HIV and STI burden, the national response framework, the social, legal and policy environment, lessons from previous communication programmes and roll out of new HIV combination prevention interventions. Audience-specific SBC strategies are outlined to address barriers to behavioural, biomedical and structural interventions at multiple levels, with practical steps to strengthen coordination, implementation and M&E.

HOW TO USE: In addition to guiding the design of new SBC strategies or plans, this document may be used to complement, improve or evaluate ongoing national SBC initiatives for HIV and STI combination prevention interventions for identified priority groups, as per local needs. A sample SBC action plan is attached to show programmers how to create a simple but innovate approach using existing communication channels and materials for targeted primary, secondary and tertiary audiences.

USERS: The intended audience for this guide includes national and county health policymakers and development partners, HIV and STI prevention coordinators and practitioners from government and non-governmental organisations (NGOs), private sector and academia that are responsible for financing, planning, implementation, M&E of SBC for HIV and STIs at national and decentralised levels.

VISION: Our vision is one where all adult men and women including youth, vulnerable and key populations at all levels of Kenya's society are empowered to remove the threat of HIV and STI to public health, social and economic development. By applying sound social and behavioural communication strategies from policy to community level, at risk and affected individuals, families and networks are knowledgeable, motivated, skilled and engaged in national efforts for reversing the HIV and STI epidemic towards attaining zero new infections, zero AIDS-related deaths and zero stigma.

MISSION: To mobilize, engage and empower priority population groups and their core influencers at multiple levels, using diverse SBC approaches to reduce new HIV and STI infections, deaths and stigma.

DEVELOPMENT OF THIS DOCUMENT: A highly consultative process was used to develop this HIV and STI combination prevention communication strategy under the leadership of NASCOP with WHO Kenya technical and financial support. In addition to the Kenya AIDS Strategic Framework and Prevention Revolution Road Map, this document is informed by existing health sector policies, guidelines, behavioural change communication strategies and study reports such as KAIS, KDHS, bio-behavioural surveillance, and a WHO scoping mission of barriers to new interventions (e.g. PrEP, HIV self-testing). HIV and STI combination prevention and behavioural change practitioners from both government and non-governmental institutions participated in the review and validation of this document.

2 HIV Country Context

This section provides the foundational basis for this social and behavioural change communication (SBC) strategy for HIV and STI combination prevention, given the socio-demographic context, geographical disparities of the disease burden, and challenges with national HIV and STI response within the existing policy, legal and social environment.

2.1. Background

Kenya is a lower-middle-income country with the second largest population of 48.5 million in East Africa (KNBS 2009/2015 projection). Almost two thirds of the population is below 25 years of age, which puts great demands on health, education and employment sector. Despite generally high literacy levels (78%), inequalities persist (87% literacy for Nairobi versus 4% for Marsabit). Unemployment and poverty levels range from 40% and 45%, respectively, with women and youth significantly disadvantaged. While the 2010 Kenya Constitution defines health as a fundamental right for all citizens, less than 60% of the population reside within a 5-kilometre radius of a health facility. The estimated health facility density in 2016 was 2.2 to 2.3 per 10,000 population, and core health worker density (doctors, clinical officers, nurses and midwives) 9 per 10,000 population. However, health facility and core worker densities for rural counties are more than 4 times higher (KHSSIP 2013-2017). It is anticipated that the devolved health system will bring services closer to the people, by improving efficiency and accountability, thereby empowering all citizens to demand for health care and high quality of life, as proposed in Kenya's Vision 2030 country development blueprint.

2.2. HIV and AIDS Burden

Since the first HIV case was reported in 1984, Kenya's HIV epidemic has grown to 1,493,400 people living with HIV (PLHIV), 52,800 new infections and 28,200 AIDS-related deaths per year. While the 2018 Kenya HIV Estimates Report confirms over 50% decline in national HIV incidence from 0.32% in 2013 to 0.19% and adult HIV prevalence from 10.6% to 4.9% since 1996, geographic disparities persist. HIV incidence and prevalence range from 0.82% and 21%, respectively for Siaya to almost zero for Wajir County. Over half of PLHIV are in 8 HIV burdened counties, with 5 counties that have above average HIV prevalence contributing 43% of all new infections. Eight high HIV-incidence counties account for 61% of new infections among youth; with the 5 high prevalence counties contributing over 1,000 new infections among young people per county.

The 2018 Kenya HIV Estimates Report also confirms the high vulnerability of youth and females. Youth aged 15-24 years accounted for 13% of PLHIV, 39% of new infections and 12% of AIDS-related deaths. HIV prevalence for females is higher than of male counterparts (5.2% versus 4.5% for adults 15-49 years, and 2.6% versus 1.3% among 15-24 years). More than half of new HIV infections occur among adult women, one third among youth, with one in three among sexually active unmarried women. Finally, of estimated annual AIDS-related deaths, youth account for 5.3% (2,800) and children 8.1% (4,300).

Although key populations comprise less than 0.5% of Kenya's population, they contribute a third of all new infections, with HIV prevalence of 29.3% for female sex workers, 18.2% for men who have sex with men and 18.3% for people who inject drugs (KMOT 2008/9, IBBS 2010 and 2011 UNODC IDU Study). While FSW are distributed across the country, MSM and PWID are primarily in Nairobi, Kisumu and coastal region. Other groups with heightened HIV risk include; fisher-folk around lake region (26% prevalence, KEMRI 2015), long-distance truck drivers, prisoners and migrant populations.

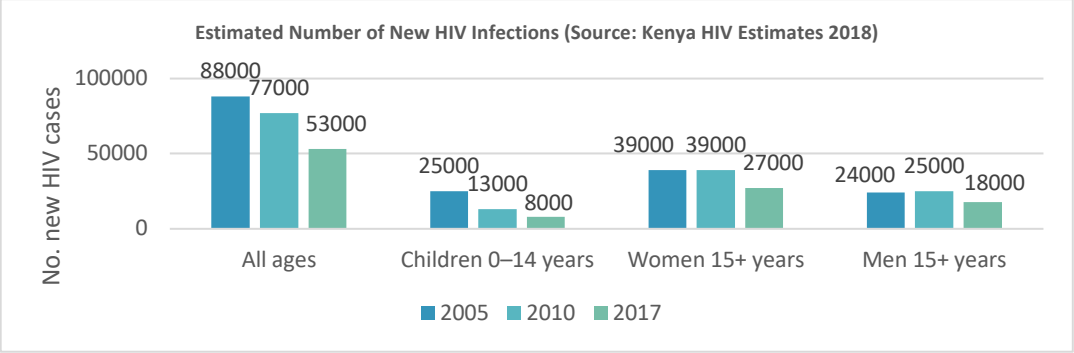
The tables below portray the county stratification by HIV incidence and prevalence.

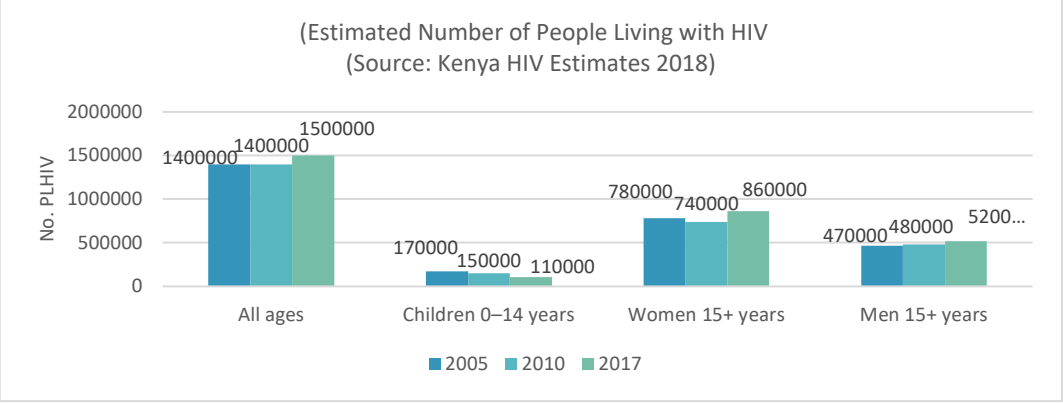
Table 1: County Distribution by HIV Incidence level (Source: Kenya HIV Estimates Report, 2018)

Incidence Level	*Incidence Range*	*Counties*
Hyper-endemic	Above 0.26%	Siaya, Homa Bay, Kisumu,
High	0.131% - 0.26%	Busia, Migori, Nairobi, Kiambu,
Medium	0.081% – 0.13%	Kakamega, Vihiga, Nyamira, Kisii, Nyandarua, Nyeri, Kirinyaga, Muranga, Tharaka Nthi, Machakos, Makueni, Kitui, Taita Taveta, Kilifi, Kwale, Lamu
Low	0.041% – 0.08%	Trans Nzoia, Bungoma, Uasin Gishu, Turkana, Kericho, Nakuru, Laikipia, Meru, Isiolo, Meru, Embu, Kajiado
Attained	Below 0.04%	West Pokot, Elgeyo Marakwet, Baringo, Nandi, Bomet, Narok. Samburu, Marsabit, Tana River, Garissa, Mandera, Wajir

Table 2: County Distribution by HIV prevalence level (Source: Kenya HIV Estimates Report, 2018)

Prevalence Level	*Prevalence Range*	*Counties*
Hyper-endemic	Above 11.1%	Siaya, Homa Bay, Kisumu, Migori
High	5.0% – 11.0%	Busia, Nairobi, Vihiga
Medium	2.1% – 4.9%	Kitui, Kakamega, Kisii, Trans Nzoia, Nyamira, Muranga, Makueni, Mombasa, Taita Taveta, Kiambu, Uasin Gishu, Murang'a, Kitui, Kajiado, Machakos, Kwale, Kilifi, Nyeri, Nyandarua, Nakuru, Tharaka Nthi, Isiolo, Bungoma, Turkana, Kirinyaga, Lamu, Kericho, Embu, Laikipia, Narok, Meru
Low	0.1% – 2%	Nandi, Bomet, Samburu, Elgeyo Marakwet, West Pokot, Marsabit, Baringo, Mandera, Wajir





In conclusion, Kenya has made substantial progress toward reducing the number of people infected with HIV, thereby averting a cumulative 635,500 AIDS-related deaths since 2004 (KARPR 2018). However, the decline in new infections is slow, due to multiple sexual partners, sero-discordancy, low condom use, and other factors. Halting and reversing the HIV epidemic demands for a dramatic shift in the national HIV response that prioritizes populations with high HIV risk and reduced access to services.

2.3. Burden of Sexually Transmitted Infections in Kenya

Sexually Transmitted Infections (STIs) are a major public health threat in Kenya with far-reaching health and socio-economic consequences due to their magnitude, substantial escalation of HIV acquisition and transmission, as well as adverse complications among sexually active men, women and their children (cervical cancer, infertility, congenital deformities, prematurity, blindness and death in newborn, etc.). While there is paucity of data on the incidence of STIs in Kenya, the trend is believed to mimic that of other developing countries. Rates of many STIs are highest among sexually active adolescents and young adults, with persons who initiate sex early during adolescence having substantially increased HIV risk. A cross-sectional study conducted among women aged 18-49 years attending a family planning clinic at Kenyatta National Hospital found 13% prevalence of Chlamydia trachomatis, with the highest prevalence (21%) among those aged 25-29 years. No case of Neisseria gonorrhoea was identified.[1] According to the 2014 Kenya Demographic and Health Survey (KDHS), 2% of respondents that ever had sex reported having an STI in the 12 months preceding the survey, while 6% of women and 2% of men reported of more recent STI or STI symptoms.[2] Women who are currently married or living with a partner had 6% prevalence of STI compared to 7% among those who are divorced, separated, or widowed, and 4% among women who had never been married.

Key populations, often referred to as high risk populations are disproportionately affected by STIs. A study by the National AIDS and STI Control Programme (NASCOP) among people who inject drugs (PWID) revealed higher STI prevalence than that of the general population: 4.2% had chlamydia, 1.7% syphilis 1.7% and 1.5% gonorrhoea. Females who inject drugs had significantly higher trichomoniasis and bacterial vaginitis prevalence (38.1%), compared to 10-28% STI prevalence among female sex workers, with slightly higher prevalence among HIV-infected sex workers. MSMs who sell sex had combined STI positivity of 5% for syphilis, gonorrhoea or chlamydia compared to 5.3% for MSMs who were not sex workers.

Finally, studies in Nairobi, Mombasa and Kisumu show that significantly higher HIV and STI risks among young key populations, i.e. sex workers, MSM and PWID aged below 25 years. Young female sex workers reportedly had thrice the HIV prevalence of older women engaging in casual and transaction sex at the same hotspot.[3]

[1] Maina AN, Kimani J & Anzala O (2016). Prevalence and risk factors of three curable sexually transmitted infections among women in Nairobi, Kenya. BMC Research Notes 20169:193. DOI: 10.1186/s13104-016-1990-x

[2] Kenya National Bureau of Statistics (2014). Kenya Demographic and Health Survey. Dhsprogram. com/publications/publication-fr308-dhs-final-reports.cfm

[3] Transitions Study Brief, NASCOP and University of Manitoba, 2017

Table 3: National HIV Estimates for 2017 (Source: 2018 HIV Estimates Projections)

INDICATOR	Adults and Children (all ages)	Children (0-14)	Adolescents (10-19)	Young People 15-24		Adults 15+	
				Male	Female	Male	Female
Estimated total population							
People living with HIV	**1,493,400 [1 300 000 - 1 800 000]**	105,200 [76 000 - 130 000]	105,200 (62,800 – 147,700)	184,719		**1,388,200 [1 200 000 - 1 600 000]**	
						523,600 [430 000 - 630 000]	864,600 [730 000 - 1 000 000]
HIV prevalence rate				1.3 [0.8 - 1.9]	2.6 [1.4 - 3.9]	**4.8 [4.0 - 5.8]**	
						3.5 [2.7 - 4.3]	**6.2** [5.0 - 7.4]
New HIV infections	**52 800 [31 000 - 86 000]**	8000 [4600 - 13 000]	8,200 (2,400 – 15,900)	17,667		44 789 [25 000 - 76 000]	
				5,200 (1,100 – 8,600)	12,500 (7,200 – 18,800)	17 600 [9800 - 31 000]	27 200 [16 000 - 46 000]
HIV incidence per 1000 population	**1.21 [0.70 - 2.00]**					**1.95 [1.10 - 3.28]**	
AIDS-related deaths	**28 200 [19 000 - 43 000]**	4300 [2500 - 6800]	2,100 (1,200 – 3,200)	2,830 (1,700 – 4,700)		23,900 [16 000 - 36 0 00]	
						13,800 [8700 - 21 000]	10 100 [6900 - 16 000]
Orphans due to AIDS (0-17)		**580 000 [450 000 - 740 000]**					
People living with HIV who are on ART	**1 121 938**	86 323				**1 035 615**	
						322 104	713 511
Percent of people living with HIV who are on ART	**75 [63 - 89]**	82 [60 - >95]				**75 [63 - 88]**	
						62 [51 - 74]	83 [69 - >95]
Percent on ART 12 months after starting	**90**	93				**90**	
People living with HIV who have suppressed viral loads	**940 000**						
Percent of people living with HIV who have suppressed viral loads	**63 [53 - 74]**						
Coverage pregnant women who receive ARV for PMTCT							**76 [58 - 92]**
Pregnant women needing ARV for PMTCT							69 000 [53 000 - 83 000]
Pregnant women who received ARV for PMTCT							53 067
HIV-exposed children who are uninfected		830 000 [600 000 - 1 000 000]					

2.4. Overview of National HIV and STI Strategic Framework and Policy Environment

The Kenya AIDS Strategic Framework (KASF) 2014/15-2018/19 provides strategic guidance on the national and decentralized multi-sectoral HIV response. Building on the successes of former strategic plans, it strives to address core drivers of the HIV epidemic through four strategic objectives, namely: reducing new HIV infections by 75%, AIDS-related mortality by 25%, HIV-related stigma and discrimination by 50% as well as increasing domestic financing for HIV response to 50%

KASF is backed by numerous policy frameworks such as the Kenya Health Policy 2014-2030, the Second Health Sector Medium Term Plan (MTP II), the Kenya Health Sector Strategic and Investment Plan (KHSSIP) and Kenya Vision 2030. The Universal Health Coverage (as part of the President's Big Four Development Agenda), has energized support for national scale up of HIV and AIDS prevention, treatment and care. Other policy documents facilitating KASF implementation include:

- Existing laws: Kenya HIV and AIDS Prevention and Control Act 2006, The Marriage Act 2014, The Sexual Offences Act 2006, The Children's Act 2011, The Victim Protection Act 2014, etc.
- Policy documents: 2016 Kenya HIV Prevention Policy for Key Populations, National Reproductive Health Policy, Adolescent and Youth Reproductive Health Policy 2014, Gender and Development Policy, The School Health Policy (2009), and Policy Guidelines for Sustaining VMMC in Kenya, 2018
- Strategic Plans: Kenya Fast Track Plan to End AIDS among Adolescents, Eastern and Southern Africa Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services.
- National Guidelines: 2018 Guidelines on Use of Antiretroviral Drugs for HIV Treatment and Prevention, 2015 Guidelines on HIV Testing Service, 2014 Guidelines for HIV/STI Programming with Key Populations, 2018 Guidelines for Prevention, Treatment and Control of STIs, Guidelines for Management of Sexual Violence, 2018 Guidelines for HIV & STI Programming among Young Key Populations, 2014 Guidelines for HIV Prevention & Management among People Who Use Drugs, etc.

The 2015 Kenya Prevention Revolution Roadmap proposed radical shifts in HIV prevention paradigms to eliminate HIV by 2030. This requires intensified efforts in high disease burdened and epidemic hotspot areas, while maintaining coverage for other populations in order, as follows:

- From a national approach to geographical HIV incidence clusters approach
- From intervention driven to populations driven HIV responses
- From heavily biomedical dependent to a mixed combination prevention of biomedical, behavioural and structural interventions
- From a national approach to geographical (county clusters) approach
- From health sector driven to HIV prevention that is everyone's business

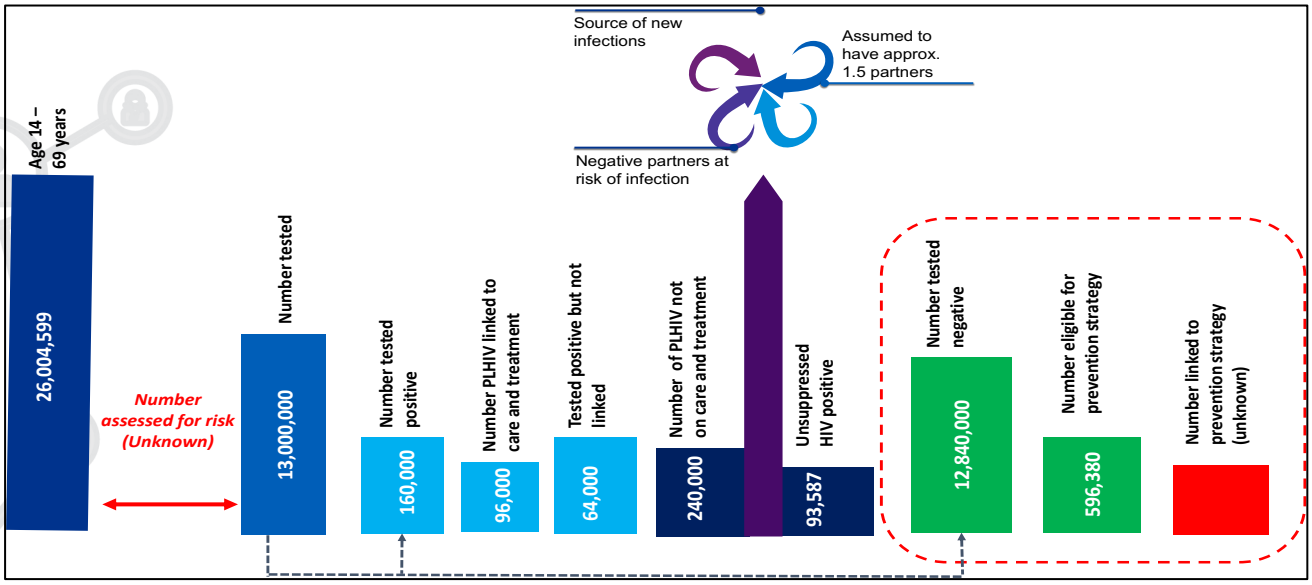
KASF is aligned with numerous international and regional policy and strategic frameworks that guide how to reach long term health goals. These include the Sustainable Development Goals (SDGs) and the UN Political Commitment to Ending the AIDS Epidemic by 2030. UNAIDS set the 90-90-90 targets for 2020 (i.e. 90% of people living with HIV know their HIV status, 90% of those diagnosed with HIV receive ART; and 90% of people on ART are virally suppressed). These targets were subsequently extended to 95-95-95 for 2030.

The 2018 Kenya AIDS Response Progress Report indicates that only 62% of people living with HIV in Kenya know their HIV status, 75% of those diagnosed are on ART, and 77% of these are virally suppressed. As observed for many countries globally, a key bottleneck to Kenya's achievement of the 90-90-90 targets is the low case-finding across sub-populations. This calls for more effective, innovative and appropriate testing strategies, tailored to the local epidemiology and with high and sustained ART coverage for identified PLHIV.

The figure below illustrates that of the 26 million adult population in Kenya, only half were tested for HIV, yielding 1.23% HIV positive. Of these, 40% were not linked to HIV treatment, thereby increasing the number of PLHIV not on treatment to 240,000. Over 57% of PLHIV had high viral load.

Of the 12,840,000 persons who tested HIV negative, about 5% were eligible for HIV prevention interventions such as VMMC, FP, PrEP, condoms, etc. However, there is no data on numbers reached.

Figure 1.1: Unmet Need for HIV Prevention Interventions



In 2018 NASCOP launched National Guidelines for Prevention, Management and Control of Sexually Transmitted Infections to address critical shortcomings in previous STI guidelines. The vision for renewed STI control efforts is in line with that of the World Health Organization which aims to have **Zero New STIs**, **Zero STI-related Complications and Deaths**, and **Zero Discrimination** in a world where everyone can freely and easily access STI prevention and treatment services, resulting in people able to live long and healthy lives (WHO, 2016b).

Key STIs are prioritized which need immediate action for control and that can be monitored comprise of:

- Neisseria gonorrhoea — because of the rising risk of untreatable gonorrhoea and co-infection with other STIs including Chlamydia trachomatis.
- Treponema pallidum — with elimination of congenital syphilis, which demands for screening and treatment of all pregnant women and control of syphilis in specific populations.
- Human papillomavirus — with emphasis on vaccination towards the elimination of cervical cancer and genital warts.

The 2018 National STI guidelines are also in line with the Global Health Sector Strategy on STIs which set ambitious targets of reducing by 90% the incidence of gonorrhoea and syphilis infections by 2030, reducing congenital syphilis cases to 50 cases per 100,000 live births in 80% of countries and sustaining 90% coverage of HPV vaccination.

3 HIV Combination Prevention Approach

This section articulates the Ministry of Health's HIV and STI Combination Prevention Approach for reaching the UNAIDS 90-90-90 targets and Global STI Strategy. In addition to presenting the core components of behavioural, biomedical and structural interventions, this section proposes communication goals based on a review of current progress, implementation strategies and identified barriers to service uptake.

> UNAIDS (2010) defines *combination HIV prevention* as follows:
> *"The strategic, simultaneous use of different classes of prevention activities (biomedical, behavioural, social/structural) that operate on multiple levels (individual, relationship, community, societal), to respond to the specific needs of particular audiences and modes of HIV transmission, and to make efficient use of resources through prioritizing, partnership, and engagement of affected communities" [20].*

The Ministry of Health, through the National AIDS and STI Control Programme (NASCOP), is committed to implementing evidence-based policies, strategies and innovations that can propel the country towards ending new HIV and STI infections, HIV and STI-related stigma and deaths by 2030. Given the complexity of Kenya's HIV and STI burden, substantive decline in incidence and deaths cannot be realised unless contextual factors that increase HIV and STI risks and vulnerability as well as barriers to health care access across counties, gender and priority groups (such as pregnant and breastfeeding women, discordant couples, adolescents and youth, key populations) are addressed.

NASCOP has adopted an integrated and evidence-informed high impact HIV and STI Combination Prevention approach to achieve KASF's ambitious vision of eliminating the impact of the AIDS and STIs. Prevention is most effective when delivered as a combination of ***behavioural***, ***biomedical*** and ***structural*** interventions that identify vulnerable populations to mitigate HIV and STI transmission at multiple points in the transmission cycle. Biomedical interventions which can reduce infectiousness of people with sexually transmitted infections (STI) and HIV may comprise of a mix of antiretroviral therapy (ART), pre-exposure prophylaxis (PrEP), STI treatment and needles and syringe programme for people who inject drugs (depending on the targeted population), while other HIV prevention strategies such as condom promotion and risk reduction counselling reduce HIV and STI susceptibility among the uninfected.

However, an aggressive roll-out of behavioural and biomedical interventions that merely focuses on set targets may overlook a clients' right to informed consent, increase the risk of intimate partner and gender-based violence and promote criminalization of HIV and STI-related risk behaviours, particularly among key populations. Rights-based structural interventions such as violence prevention and response or eliminating stigma and social exclusion are vital to assure uptake and effectiveness of HIV prevention. The table illustrates core components of NASCOP's recommended HIV and STI Combination Prevention service package whose efficacy is strongly backed by evidence.

Table 4: Essential HIV and STI Combination Prevention Interventions (Source: Kenya Prevention Revolution Road Map, & 2018 NASCOP website for KPs, National Implementation Guidelines for HIV and STI Programming among Young Key Populations)

BEHAVIOURAL	BIOMEDICAL	STRUCTURAL
Aim		
To reduce risky behaviours and sustain positive change as well as increase acceptability and demand for biomedical interventions	To influence biological systems via which the virus infects a new host, so as to block virus transmission, decrease infectiousness, or reduce risk of acquiring infection	To address social, economic, political, and environmental factors that affect individual or group HIV risk and vulnerability
Examples of core Interventions		
• Peer education • Targeted information, education, and communication -IEC • Promotion, demonstration, and distribution of male and female condoms and water-based lubricants • Risk assessment, risk-reduction counselling, and skills-building • Evidence-informed behavioural interventions (EBI) e.g. Sister-to-Sister	• ARV-related prevention (PEP, PrEP) • HIV testing and counselling • Assisted partner notification services • STI screening and treatment • HIV care and treatment • Elimination of mother to child transmission • TB screening and treatment • Voluntary medical male circumcision • Needles and syringe programme • Medically assisted therapy for PWID • Screening and management of hepatitis B • Cervical and anal cancer screening • Family planning sexual and reproductive health services	• Shaping policy & creating enabling environment • Access to education, life skills & social protection • Provision of stigma-free services • Empowering community, including ownership and leadership • Mitigate and manage sexual violence • Mitigate violation of human rights • Access to micro credit and other financial products

Given that different population groups across counties may have different HIV risks and vulnerabilities, the package of HIV Combination Prevention interventions may need to be tailored to the local context. The following table propose different intervention packages by sub-population group which can be adapted as per local needs and resources.

Table 5: Intervention packages by Sub-population

	BEHAVIOURAL	BIOMEDICAL	STRUCTURAL
Sero-discordant couples	IEC, Mentor mothers	HIVST, ART, STI, PrEP, aPNS, condoms, PMTCT, VMMC, FP, Cancer screening,	Shaping policy, violence prevention, provider training
Adolescent Girls & young women	EBIs, Life skills, IEC	HIVST, STI, PrEP, female condoms, ART FP and SRH, substance use, PMTCT	Shaping policy, stigma, YFS reduction, teacher training, youth empowerment, cash transfer, IGA
Sex Workers	Peer education, EBIs, Sister to Sister	HIVST, STI, PrEP, ART, female condoms, FP, SRH, substance use, cancer screening	Shaping policy, stigma reduction, empowerment, violence prevention & response, cash transfer
MSM	Peer-to-Peer, IEC	HIVST, STI, PrEP, aPNS, ART, condoms and lubricants, VMMC, Substance use, cancer screening	Shaping policy, stigma reduction, empowerment, violence prevention
PWID	Peer-to-Peer,	NSP, OST, HIVST, STI, PrEP, ART, TB/HIV, PMTCT Viral hepatitis, Mental health	Shaping policy, stigma reduction, empowerment, violence prevention & response

3.1. Situation Analysis on Coverage, Uptake and Outcomes of HIV and STI Combination Prevention

To address emerging HIV and STI Combination Prevention needs for targeted priority and key populations, NASCOP revised the national ART guidelines for same day treatment initiation of PLHIV with differentiated models of care, while launching ARV pre-exposure prophylaxis (PrEP), assisted partner notification services and scaling up adolescent and male-targeted HIV services. Innovative solutions to optimize case finding among general, key and priority populations were initiated using high-yield testing strategies such as partner notification services (aPNS), HIV self-testing, (HIVST), integrated ANC, HIV, TB and hepatitis screening as well as community-based and outreach, while strengthening linkage to treatment and retention.

The following table presents an overview of new and current HIV and STI combination prevention interventions in terms of purpose, implementation approach, strengths, bottlenecks, as well as suggested strategies and communication objectives for scale up.

Table 6: Review of new high impact evidence informed HIV and STI Combination Prevention interventions

INTERVENTION	*DESCRIPTION*
PrEP Pre-Exposure Prophylaxis	In May 2017, Kenya became 1st country in SSA to launch PrEP within the public health sector in order to attain 75% reduction in new infections by 2020 and zero new infections by 2030. National PrEP target for 2020 was 500,000 at risk persons in high HIV incidence/prevalence regions and/or whose behaviour or that of partners puts them at substantial risk of acquiring HIV. Over 900 PrEP sites were operational by 2018, with 53,291 persons having received PrEP at least once. Target Population: Discordant couples, key populations, AGYW, PBFW and men with multiple concurrent partners Strengths: Strong government leadership and partnership support, robust social marketing & communication campaign, cultivated wide acceptance by general & key populations; convenient; protects partner and decreases fear of HIV, empowers AGYW, FSW, victims of sexual and gender-based violence (SGBV), overcomes cultural restrictions, provided at no cost at CCCs and via purchase in private hospitals. PrEP roll out backed by 2016 National Guidelines for ARV treatment, National PrEP Guidelines 2017, PrEP Toolkit for HW & Non-clinical service providers, PrEP Youth Engagement, WHO Implementation Toolkit for PrEP, and Kenya AIDS Strategic Framework (KASF) 2013/14 -2018/19 Barriers: Misconceptions of PrEP – confusion between PEP & PrEP; promoting PrEP with condom implies low PrEP efficacy; Fear of PrEP side effects; short term use e.g. 7 days by FSW; low risk perception/optimism about PrEP Fear of follow up HTS; lifestyle, relationship barriers, stigma of ART intake, social norms; limited community support for PLHIV, health system constraints (few sites, staff shortage, HW attitude, low privacy, monthly drug refills, stock out) Strategies: Normalize PrEP, Male involvement, review PrEP guidelines, protocols, HIV education plus health worker curriculum, job aids, enhanced adherence counseling: Target Sites: integrate with existing services - For AGYW: ANC, SRH, HTS and schools; For PBFW: ANC, PMTCT and primary health care sites; For KPs: at DICES, For DC: HIV/ART and STI Clinics; improve HW knowledge and IPC skills; reduce lab cost; task shifting; uninterrupted supply of commodities **Communication goal**: Change attitude, reduce stigma, increase knowledge and self-efficacy for PrEP in target population • Increase HIV service demand quality by improving health worker IPC skills; • Ensure comprehensive knowledge regarding PrEP efficacy and address stigma to raise demand for PrEP as part of wider prevention package with sustained adherence to PrEP plus other prevention interventions to decrease HIV risk, including limiting number of sexual partners, consistent condom use, and curbing sexual violence risk.
aPNS assisted Partner Notification Services	Kenya initiated assisted Partner Notification Services (aPNS) to increase HIV positivity yield amidst declining positivity rates of routine HTS from 2.9% in 2015 to 1.4% (2018 Kenya AIDS Response Programme Report, NACC) and to break the HIV transmission chain by linking HIV negative persons to prevention interventions such as VMMC, PrEP, and condoms. Priority populations adolescents, PBFW, PWID and sexual and/or injecting partners of index clients and their children. Strengths: aPNS yields high positivity rate for HIV and HCV infected persons through tracing index clients Barriers: aPNS implementation is complex, with low acceptability among general and key populations due to perceived human rights violation (no confidentiality, increased IPV risk); relationship barriers and fear of repercussions deter HIV+ve disclosure to partner; community HIV stigma; health systems constraints; non-disclosure a violation of HIV Act

	Strategies: Normalize aPNS by integrating at all SDPs, improve provider interpersonal communication skills (IPC); link aPNS with HIVST, PrEP and ART; offer safe space for KPs; sensitize Community Advisory Boards; review legislation; hotline 1190; engage outreach workers
	Communication goal: Increase awareness and address misconceptions regarding aPNS among general and key population groups, reduce fear and resistance of index clients to partner disclosure, reduce stigma to increase HTS uptake/self-efficacy among contacted persons and linkage to prevention, care and treatment as needed. Improve service provider skills and self-confidence for quality aPNS implementation.
HIVST – HIV Self Testing	HIV Self-Testing (HIVST) rolled out in 2017 to address notable testing gap among men (67%) and youth (48%), low repeat testing among key populations, increase awareness of HIV status and linkage to prevention and treatment services as needed. NASCOP's goal was to reach the first 90 target by 2020. By 2018, 5698 aged 15-24 reached by HIVIST versus 13,936 aged 25+ years (56% tested were females) - Priority populations: hard to reach populations: especially men, key population (MSM and sex workers), AGYW, health workers, first time testers and those who need confirmatory retest. Strengths: HIVST widely accepted, convenient, resolves issues of stigma; offers privacy and self-control for AGYW, FSW, SGBV victims and Adolescent Boys and Young Men (ABYM); available at no cost at public health facilities. HIVST is backed by Kenya Guidelines on HIV Self-Testing, 2015-2019 National HTS Communication Strategy, HPACA Act and an HIVST Policy Guideline. Barriers: misconceptions, limited geographical coverage, no post-test follow up and linkage to care for HIV+ves – only 16% clients return; no disposal mechanism for used test kit; doubt saliva test results; stigma of HIVST: suspected HIV +ve; coercion to test by sex partner, employers; non-disclosure of HIV+ve status to partner; health system constraints (no verification of used kits; no community distribution; HW fear job replacement; non-reporting of test results; 18 month shelf life, regulatory requirements for HIVST kit; no QA for false HIV positive result). Strategies: Declassify HIVST kit for DICE distribution, reduce cost, minimize stock outs, safe kit disposal; post-HIVST follow up; integrate with SRH (ANC/FP), PrEP and ART; promote human-rights approach and repeat testing for KPs (quarterly/risk exposure); CSO and community engagement in roll out & follow up; Hotline for crisis management
	Communication goal: Expand knowledge, improve self-efficacy for HIVST and disclosure to partners Improve health workers IPC for pre and post-test counselling and linkage to HIV prevention, care and treatment for post-HIVST clients who report to the facility. Mentor known PLHA to champion stigma reduction efforts

NOTE: Above findings drawn from WHO scoping mission and a series of stakeholder workshops that included PLHIV, vulnerable and key populations.

Table 7: Implementation status of other HIV and STI Combination Prevention interventions

INTERVENTION	*DESCRIPTION*
eMTCT (Elimination of Mother to Child Transmission of HIV and Syphilis)	Eliminating mother-to-child transmission of HIV and syphilis remains a major component of Kenya's HIV response. An estimated 1.9 million women get pregnant each year, 1.1 m access ANC testing, 6.3% HIV infected, with 11.5% MTCT rate. Four-pronged eMTCT strategy recommends: HIV and syphilis prevention for women of child bearing age with RH services so that baby is a deliberate choice; prevent MTCT to HIV exposed infants by optimizing cARV- therapies; appropriate infant feeding practices with optimal ARV therapy for babies with breakthrough infections; optimizing mother and family wellbeing to enable long-term survival of child. (Kenya Framework for eMTCT transmission of HIV and Syphilis, 2016-2021) Strengths: Keeping Mothers Alive has highest level political support (First Lady), backed by eMTCT policy and integrated within 2018 National Guidelines for ART Barriers: low literacy/risk perception, fear of HIV test, distance, transport costs, threat of IPV, long queues, lack of privacy/space at clinic; home deliveries, non-disclosure, partner testing, knowledge gap on dual testing, and access to commodities, delay ANC initiation, HIV diagnosis and ART initiation for effective VL suppression prior to child birth thus increasing HIV transmission risk for HIV exposed infant. Other barriers: heavy workload, provider knowledge and attitude, stock out of test kits Strategies: In high-prevalence areas, repeat HIV and STI test for PBFW with initial HIV negative result around delivery and during breastfeeding when risk of HIV acquisition may be high with associated increased MTCT risk. Access to FP for all HIV positive women wishing delay, to space, or limit pregnancies as per individual needs and health situation. Sensitization on dual testing, supported partner disclosure, resource mobilization for more commodities for timely syphilis treatment, Family-centered appointment with drug pick up scheduling, viral load monitoring. For paediatric HIV case finding, promote routine HIV test for children with suspected HIV-related conditions (e.g. malnutrition or TB in high HIV burdened settings) or after index testing of HIV infected biological parent or sibling. Repeat HIV test for breastfeeding children upon weaning. Link with OVC services if needed
	Communication goal: Increase treatment literacy for PBFW living with HIV and infected with syphilis, improve health worker IPC skills to engage young and older PBFW, male involvement.

HTS (HIV Testing Services)	Despite AYP contributing 49% of new HIV infections annually, HTS uptake is low: 49.8% among 15-19 years (55.6% females vs. 44.7% males) compared to 80.7% among 20 to 24 year-old youth (91.6% females vs. 67.3% males). Of estimated 184,700 YLHIV only 69% know their HIV status. -2018 KARPR, NACC
	Strengths: National HTS guidelines recommend multiple testing strategies: PITC, VCT, family testing, HIV self-testing, retesting key populations and confirmatory testing of newly diagnosed PLHIV before treatment start. To increase adolescent uptake, HTS age of consent reduced to 15 years. Post-test referrals/linkages: HIV positive – same day ART, aPNS, family testing, TB screening. For HIV negative – risk reduction, PrEP, VMMC, condoms, FP, TB, PEP, etc.).
	Barriers: low HTS uptake among AYP and men; decreasing yield of HIV positives via routine HTS: of 142,704 tested in 2018, HIV+ve 1.63% (2,327), of whom 51.1% linked to HIV care and 1,138 started ART; also laboratory worker shortage
	Strategies optimize HTS via symptom or risk based and index testing: voluntary PNS/index testing, Integrate HTS with VMMC, STI, NCD screening, home based and workplace, outreach, Youth friendly/responsive services (YFS), DICES; extend operational hours, sexual network analysis,
	In high-prevalence areas, individuals engaging in unprotected sexual intercourse who have not been tested in the past 6 months may have high rates of HIV infection
	Communication goal: Increase knowledge and self-efficacy for regular HTS and linkage to prevention or treatment. Improve provider IPC skills to better engage with at-risk populations
STIs (Prevention, Screening, Diagnosis and Treatment of Sexually Transmitted Infections	Because STIs have far reaching physical, psychological and social consequences among infected adults, youth as well as children, Kenya's Ministry of Health revised its STI programme approach in 2018 as a response to the evolving STI/syndrome with increased HIV transmission risk and emerging STI drug resistance.
	Target Population: adult male and females including pregnant women, youth and key populations plus children
	Strengths: National Guidelines for STI Prevention, Treatment and Control launched in 2018 to curb STI spread and improve sexual and reproductive health.
	Barriers: low literacy, poverty, low income, threat of gender-based violence, alcohol and substance use, mental and physical disability, culture, age of consent
	Other barriers: restrictive laws & policies, lack of privacy, health worker attitude, stock out of STI commodities
	Strategies: Primary prevention for at-risk populations: pre-exposure vaccination (Human Papilloma Virus for AGYW, hepatitis B virus for uninfected, hepatitis A and B virus for MSM), condom promotion, risk reduction counselling. Secondary prevention: routine STI screening, for early diagnosis and treatment with partner notification and referral by index STI clients. Tertiary prevention: medical treatment to reduce complications and sequelae of untreated STIs.
	Other strategies: provider training, advocacy for public support and stigma reduction, targeted IEC campaigns to increase knowledge of STI prevention and service availability, integration,
	Communication goal: awareness-raising to build political support for sexual and reproductive health, reduce risky behaviours, improve STI screening, prevention and treatment adherence; improve provide IPC for youth and KPs
VMMC (Voluntary Medical Male Circumcision)	Based on reported VMMC rate 91% (KAIS 2012), the national program targets non-circumcising communities in Homa Bay, Kisumu, Migori, Siaya, Turkana, Busia, Kericho, Nairobi, Nandi and West Pokot. The 2nd VMMC strategy of 2014 aimed to reach 80% MC coverage among males aged 10-29 years in focus counties by 2019 combined with ART scale up. By 2018: 1.8 million reached cumulatively from non-circumcising region with almost 80% coverage in priority counties. -2018 KARPR, NACC and 2018 Kenya PEPFAR COP
	Strengths: VMMC policy in place, enabling environment, increased demand creation, static and mobile circumcision services, policy guidelines for sustaining medical male circumcision in Kenya,
	Barriers: limited domestic funding, overburdened community health volunteer for messaging, lower uptake by older men, cultural beliefs
	Strategies: demand creation via VMMC champions and market approach, integrate with other health services and community health strategy, improve reporting, promote early infant male circumcision, pre-service health worker training on VMMC, mobile and static VMMC services
	Communication goal: Increase knowledge of sexual health and self-efficacy for VMMC uptake and STI screening among traditionally non-circumcising men; Improve provider IPC skills for pre and post VMMC counselling
Condoms	Strengths: In 2016/17 8.25 million condoms distributed, enabling uptake by 92% of sex workers, 79% MSM and 75% of PWID. However, condom use for persons reporting multiple sex partners 44.5% for men versus 40% for women
	Barriers: lack of knowledge, low risk perception, weak negotiating power among AGYW, more pay for condomless sex
	Communication goal: Increase knowledge of dual prevention and promote consistent condom use
Nutrition	Kenya has continued providing nutrition assessment, counselling and support (NACS) plus therapeutic feeding for PLHIV with severe acute malnutrition (SAM), including Orphans and Vulnerable Children to increase school attendance.
	Strengths: National Nutrition and HIV guidelines, job aids, counselling cards and charts, Maternal, Infant and Young Child Nutrition (MIYCN) Policy developed targeting PLHIV, CLHIV.

	Issues: obese versus malnourished PLHIV at risk of NCDs and uptake of recommended IYCF
	Communication goal: Promotion of healthy nutrition practices with EID for mothers with HIV exposed infant; improve provider IPC and change attitude of community members toward ANC testing
Care and Treatment	Kenya has made significant progress on 90-90-90 cascade reaching 75% adults and 84% children with ART, 90% retained in care at 12 months, 77% virally suppressed. 45% PLHIV from 5 high burden counties (2018 KARPR, NACC). Strengths: Test and Start policy and 2018 ART guidelines updated for optimization of care and treatment via differentiated care approach, strengthening client escorted referrals, community-based adherence support, HIV treatment literacy via education curriculum, online platforms to disseminate HIV information and appointment reminders. 10 Viral Load and EID testing laboratories performing over 1 million VL tests per year. Positive Health, Dignity and Prevention (PHDP) interventions for PLHIV include risk reduction counselling, STI screening, FP counselling, adherence and retention interventions, partner testing, disclosure counselling and psychosocial support According to 2018 Kenya PEPFAR COP Report, in 2017, 85% adults, 64% adolescents and 65% children who had a Viral Load test were virally suppressed Barriers: overwhelming PLHIV needs (SGBV, STI, mental health, TB, NCD), concerns of DTG for adolescents; inadequate capacity for Test and Treat with holistic prevention, follow up and management of ADRs Strategies: Optimized ART regimens (DTG), Differentiated HIV care, community involvement and peer support to enhance adherence and retention, male friendly corners.
	Communication goal: Given the availability of life-saving ART, change knowledge, attitude and self-efficacy for testing and taking treatment. Improve provider IPC skills for rights-based, comprehensive and quality HIV prevention combination services delivery
Cervical Cancer screening	Evidence shows that women with HIV are four to five times more likely to develop persistent precancerous lesions and progress to cervical cancer, often with more aggressive forms and with higher mortality. (Source: 9WHO/International Agency for Research on Cancer: http://gco.iarc.fr/) Strategies: Screening for cervical cancer to all HIV infected women, beginning at high volume sites and subsequently scaled to all women receiving ART. VIA is a simple POC screening test for early case detection that may be conducted either onsite or through referral
	Communication goal: Given the benefits of early cancer detection and treatment, change knowledge, attitude and self-efficacy of all women including those living with HIV for routine cervical cancer screening. Improve provider IPC skills for delivery of rights-based, comprehensive and quality cervical cancer screening services
Key Populations Programme	NASCOP's Key Populations Programme adopted an HIV and STI Combination Prevention strategy to address prevailing HIV risks and vulnerability among key populations. In line with KASF 2014/15 to 2018/19, KP programme implements behavioural, biomedical and structural interventions to prevent new infections and ensure linkage to HIV treatment and care. Core interventions include awareness raising on HIV and prevention interventions, promotion/distribution of condoms and lubricants for sex workers and MSM, needles and syringes to PWID; HIV, STI, TB, hepatitis and drug use prevention and treatment; policy review and advocacy to mitigate violence, stigma, and discrimination against KPs. Strengths: National HIV Prevention Policy, Guidelines plus Communication Strategy for KP HIV/STI Programming, Implementation Guidelines for Young Key Populations. Senior MOH support with moderate partnerships evidenced by robust national KP Technical Working Group decentralized to high-KP burdened counties. Target Population: Primarily FSW, MSM, PWID including those with overlapping risks Strategies: Intensified focus on young key populations with child-protection measures in line with Kenya Fast-Track Plan to End HIV and AIDS among Adolescents and Young People; optimize ART uptake and retention of key populations living with HIV by strengthening linkage between drop in centres with ART centres, community involvement, peer support, KP surveillance and implementation science to determine what works. Barriers: low awareness and skills, distance, cost, poverty, gender disparity, restrictive laws, stigma, substance use, few KP responsive sites, provider attitudes,
	Communication Goal: Increase demand for HIV and STI Combination Prevention and treatment retention by eliminating stigma, discrimination, social exclusion and violence against key populations Improve provider IPC skills for delivery of rights-based comprehensive and quality HIV and STI Combination Prevention packages for KPs with particular attention to young KPs

Source: Programme Manager Presentations at SBC Strategy for HIV and STI Combination Prevention, June 2019

3.2. HIV and STI Combination Prevention Landscape for Priority Populations

Kenya is globally recognised for championing new prevention strategies and reaching over 1.5 million males in traditionally non-circumcising communities through Voluntary Medical Male Circumcision (VMMC) since 2013. In addition to scaling up HIV treatment for PLHIV as well as eliminating mother to child transmission, it is also recognized for expanding coverage of targeted HIV prevention interventions for key and vulnerable populations and initiating Pre-Exposure Prophylaxis (PrEP), HIV Self-Testing (HIVST) and assisted Partner Notification Services (aPNS) since 2017. To date notable progress is observed in reducing HIV incidence as well as meeting the global 90-90-90 targets, with 62% of estimated people living with HIV (PLHIV) in Kenya knowing their status, 75% of those in HIV care receiving ART, and 77% attaining viral suppression (2018 KARPR, NACC).

Below is a synthesis of the HIV and STI situation for four priority population groups in terms of demographic profile, disease burden, related risky behaviours, and barriers that hamper access targeted for HIV and STI Combination Prevention.

1. **Pregnant and breastfeeding women (PBFW)** who have substantial risk of HIV-related maternal mortality and mother to child transmission of HIV (MTCT) to infants.
2. **Discordant couples (DC)**: HIV-negative sexual partners of PLHIV have increased risk of HIV acquisition.
3. **Key populations (KP):** individuals whose elevated behavioural risk of HIV with discrimination and stigma impede access to health care services. This document focuses on Sex workers (SW), Men who have sex with men (MSM), People who inject drugs (PWID), as well as young key populations (YKP).
4. **Vulnerable populations**, for whom a range of factors make them less able to protect themselves against HIV. This document focuses on Adolescents and Young People (AYP) with special attention to Adolescent girls and young women (AGYW).

3.2.1. Pregnant and Breastfeeding Women (PBFW)

In Kenya HIV primarily affects persons of reproductive age, with women accounting for half of new infections and persons living with HIV. In 2017, about 69,500 women living with HIV in Kenya became pregnant, 12% (8,680) of whom were newly diagnosed with HIV.[4] Among almost 2 million women of reproductive age who were pregnant in 2017, only 57% accessed ANC testing for HIV, and 76% of HIV infected received ART for PMTCT, with only 11 counties achieving > 80% PMTCT coverage. To address the increased HIV risk during pregnancy and lactation, repeat testing for ANC clients was made a national policy. However, current rates for ANC repeat testing are unknown. In 2017, 11.5% on HIV exposed infants (HEI) were diagnosed with HIV through immunization screening, 8-12% of them in 4 high burdened counties.[5] Without treatment, the risk of mortality is high among HIV-infected children. While paediatric ART coverage is high, inferior NVP-based regimens and poor adherence compromise treatment outcomes. Key motivators for ANC attendance include desire for healthy baby, free ANC and delivery services, prior positive ANC and PMTCT outcomes, and material incentives (e.g. bednets, lesos).

[4] http://www.croiconference.org/sessions/most-breastfeeding-women-high-viral-load-are-still-undiagnosed-subsaharan-africa
[5] Ibid

Evidence shows a high prevalence of chlamydia infection (6.9%) among pregnant women in Sub-Saharan Africa, which is significantly higher (21.3%) for HIV positive pregnant women. Another study revealed that 20.8% of ANC clients in rural Kenya had a curable STI: 14.9% chlamydia, 19.3% bacterial vaginitis, 2.5% genital ulcers and 1% gonorrhoea.[6]

Reported risky behaviours among PBFW include: delayed ANC initiation with low completion of 4 ANC visits, non-disclosure of HIV positive status to partners, sub-optimal ART adherence for PMTCT, childbirth without skilled attendants, mixed infant feeding, poor care-giving practices, etc.

Population specific barriers: maternal age, low risk perception, denial of HIV status, distance/transport costs, long queues, family demands, religious restrictions, male control, threat of intimate partner violence, anticipated stigma, and preference for traditional birth attendants. Those who anticipate male partner stigma or violence are more than twice as likely to refuse antenatal HIV testing. Barriers at health system level: inconsistent volume of clients, space limitations, work load, poor provider knowledge and attitude, language barrier, test kit stock outs, poor design of MCH screening tools, unpalatable paediatric ARV formulations.

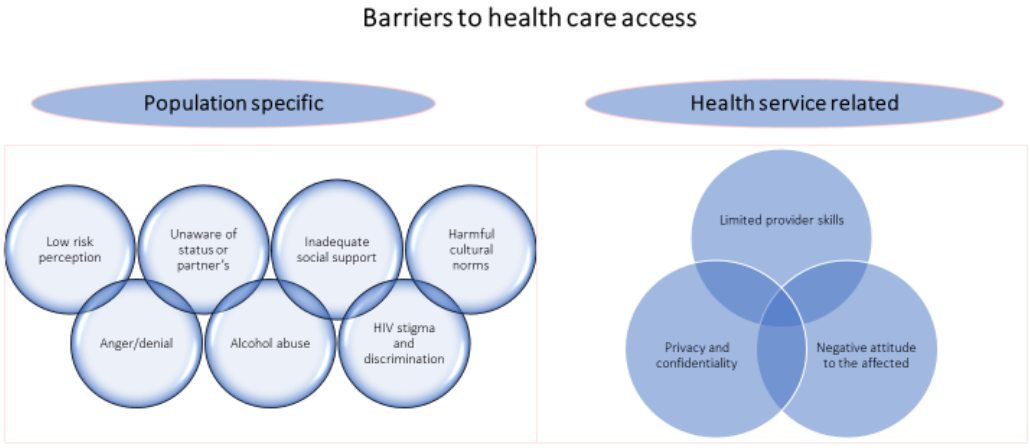
3.2.2. Discordant Couples (DC)

Definition: These are two persons in an ongoing sexual relationship where one partner is HIV infected and the other is not.

According to the 2009 Kenya Modes of Transmission Study, about 11% of all couples are living with HIV with 45% of adults living with HIV having a partner who is currently not infected. Of the estimated 350,000 discordant couples, 190,000 comprise of HIV-uninfected women with an HIV-infected man, while 160,000 are HIV-uninfected men with an HIV infected woman.[7] A multi-country Partners study of 4 sites in Kenya (Nairobi, Thika, Kisumu and Eldoret), revealed that two-thirds of HIV positive partners were women with median age of 33 years (versus 35 years for male partners) and 76% were married. Most couples had cohabited for a median 5 years with 30% reporting at least one unprotected sex act in previous month. Despite 76% of couples being married, 5% of men disclosed of sex with outside partner compared to less than 2% of women.[8]

Reported risky behaviours among discordant couples include: Multiple sex partners (higher in males at 5% versus 2% females), inconsistent condom use, mainly due to concurrent alcohol use, denial of sero-discordance, desire for children, and cultural beliefs (females cannot ask man to use condom).
NOTE: There is paucity of data on proportion of discordant couples reached with HIV services.

[6] 2018 National Guidelines for Prevention, Management and Control of Sexually Transmitted Infections, MOH
[7] Kenya Modes of Transmission Study, 2008/9
[8] Lingappa JR, Lambdin B, Bukusi EA, Ngure K, Kavuma L, Inambao M, et al. Regional differences in prevalence of HIV-1 discordance in Africa and enrollment of HIV-1 discordant couples into an HIV-1 prevention trial. PLoS One. 2008;3(1):e1411. Epub 2008/01/10



3.2.3. Adolescents and Young People (AYP)

Definition: Adolescents are persons aged 10-19 years while young people (YP) are persons aged 15-24 years. According to the 2009 Census, AYP account for one third of Kenya's population across urban and rural areas and slums. They include in school youth plus out of school youth in the streets, working, at entertainment spots, plus married and orphans (estimated 777,000 female OVC aged 10-17 years).

According to the 2018 Kenya HIV estimates, 49% of new HIV infections occur among Adolescents and Young People (AYP) who comprise 12% (184,700) of all PLHIV, majority in high HIV prevalence counties. Young women (YW) have twice the HIV prevalence (2.6%) of young men (YM) 1.3%, and despite high ART uptake, AIDs remains a major cause of death in AYP, with only 66% attaining viral suppression.[9] Despite 70% of YP having correct HIV knowledge, less than half know their HIV status. One out of five YP have sex before age 15, many with multiple partners without condoms, with substance use compounding risky behaviour. While two thirds of YW aged 15-24 years report condom use at first sex, 89% abandon condom use with partners of unknown status as trust sets in.[10]

The 2015 Kenya Fast Track Plan to End AIDS and Stigma among Adolescents and Young People reports disproportionate vulnerability to HIV and STI among adolescent girls and young women (AGYW) compared to male counterparts as follows: highest prevalence of sexually transmitted infections (STIs) among sexually active adolescents, 12% percent of girls aged 15-19 years have had sex at least once by age 15 years, with early sexual debut increasing risk of STIs. Low consistent condom use among AG with partners of discordant or unknown HIV (11% versus 43% for male counterparts). 44% of adolescents aged 15-19 years were unaware of family planning methods, and 1 out 4 Kenyan AG has already initiated child bearing, with high teenage pregnancy rates (26-27%) for Coastal and Nyanza regions respectively, thereby contributing to school drop-out, early marriage, abortion and dependency on sex partners. About 4.8% of adolescents aged 10 to 14 years disclosed history of alcohol use while 1.4% of adolescents in the same age group reported drug use. About a third of AG are raped by 18 years of age and 22% report their first sexual intercourse was forced. About half of adolescents aged 15-19 years do

[9] 2018 Kenya AIDS Response Progress Report, NACC
[10] Kenya PrEP Communications Landscape Analysis, McCann Global Health, January 2017

not know their HIV status, and HIV prevalence increases with age from 1.1% for 15 to 19-year-olds to 4.6% for YW aged 20-24 years and 7.9% among women 15-29 years old. Only 58% of adolescents living with HIV access ART.

A study of YW aged 18-24 years in Kisumu identified Herpes simplex virus type 2 (HSV-2) as the most prevalent STI (30.4%), followed by bacterial vaginosis 19.9%, yeast infection 10.6%, chlamydia 4.5%, and 0.6% for gonorrhoea and syphilis. Sexual debut before 18 years of age, HSV-2 sero-positivity, and low levels of education were associated with HIV infection.[11] A third of YW reported of rape by 18 years, and 43% had unwanted pregnancies for the following reasons: more biologically susceptible, unprotected sexual intercourse with multiple sexual partners of short duration with limited access to health care.[12]

Population-specific barriers to HIV information and services among AYP include: limited knowledge and access to HIV prevention information, scarcity of youth responsive services (only 7% coverage); bias toward abstinence versus other protective measures; youth sexuality education and condom use is controversial; poor health worker attitude, lack of confidentiality and long queues; limited youth involvement in policy making and community events; and restrictive policies.

Additional barriers that hamper AGYW access to HIV services include: misconceptions, low risk perception and skills to negotiate relationships, poverty, weak job/IGA opportunities, gender inequality, plus negative attitude to adolescent sexual and reproductive health (ASRH) & other health systems constraints lead to early sexual debut, unwanted pregnancies and early marriage. Fear of stigma and intimate partner violence makes it difficult to disclose their status.

3.2.4. Key Populations (KP)

Definition: These populations have significantly higher risk of acquiring and transmitting HIV infection due to their work and practices. They comprise of the following:

- **Men Who Have Sex with Men (MSM):** These are men who have sex with other men, regardless of whether they have sex with women or identity associated with being gay, bisexual or transgender. It includes those who exchange sex acts for cash or material gain.
- **Female Sex Workers (FSW):** Females who exchange sex acts for cash or material items that would otherwise not be extended to them by their sex partners.
- **People Who Inject Drugs (PWID)**: Persons who inject drugs for nontherapeutic purposes, irrespective of the type of drug injected.

NASCOP's mapping of key populations across Kenya in 2013 determined an estimated 133,675 FSW, 13,019 MSM, and 18,327 PWID. At least half of FSW and MSM are married, while majority of PWID are single and 25% of MSM have heterosexual partners as a cover-up. FSW are highly mobile, frequenting bar, clubs, street, brothels, hotels, massage parlours, bus stops, etc. while PWID socialize in dens close to drug sources. Most FSW and at least half of PWID attained only primary education versus more educated MSM.

[11] JKUAT Abstracts of Postgraduate Thesis: Sexually Transmitted Infections and the Associated Risk Factors among Young Women Aged 18-24 Years in Kisumu City, Kenya accessed 20/9/2019: http://journals.jkuat.ac.ke/index.php/pgthesis_abs/article/view/412/0

[12] Kenya National Guidelines for the Prevention, Management and Control of Sexually Transmitted Infections, NASCOP 2018

Although key populations represent less than 2% of Kenya's population, they account for 33% of new HIV infections (15.2% attributable to male to male sex in the community and prisons, 14% to sex workers and clients and 3.8% to injecting drug use).[13] Whereas HIV prevalence for adults 15-49 years is 4.9%, it is 29.3% among FSW, 18.2% among MSM, and 18.3% among PWID (with 44.5% prevalence among FWID - females who inject drugs versus 16.0% for males).[14] There are disparities in key populations' HIV prevalence across counties, with highest prevalence in Nairobi, coastal and lake regions. NASCOP's 3rd Polling Booth Survey of 2017 that recruited 4393 FSW, 1645 MSM and 1131 PWID confirmed over 90% of all key populations accessed HIV testing services and 26% FSWs, 17% MSM and 20% PWID reportedly had HIV infection. However, only 73% of FSW, 63% MSM and 68% PWID were on ART.[15] While the PBS 2017 revealed 48% FSW, 20% MSM, and 44% PWID were victims of police brutality, it also reported sexual violence among 23% FSW, 14% MSM, and 20% PWI). However, young key populations aged 15-24 years are more prone to violence, particularly young PWID (53%) and 47% of young FSW (YFSW) versus 27% young MSM (YMSM). Due to fear of persecution, only 1 MSM and 1 FSW filed complaints of discrimination with HIV Tribunal in 2016-17 with YKP reporting limited post-violence support (40% YFSW, 41% YMSM and 56% YPWID).[16]

Evidence shows that key populations are disproportionately affected by STIs with 22.2% HCV infection among PWID (compared to <1% for the general population), 4.2% chlamydia, 1.7% syphilis and 1.5% gonorrhoea. Females who inject drugs have 38.1% prevalence of trichomoniasis and bacterial vaginitis (Tun et al., 2015). A surveillance study of Nairobi female sex workers (FSW) revealed a 10-28% prevalence of trichomoniasis, bacterial vaginitis, and candidiasis, with slightly higher STI rates among HIV infected FSW. STI Positivity tests for among MSMs who sell sex was 15% higher, with 5.6% rectal gonorrhea and 3.5% chlamydia compared to 5.3% positivity for one or more STIs for MSM who were not sex workers, 5.0% rectal gonorrhoea and 4.3% chlamydia. Other common STIs among MSM include genital warts, oropharyngeal STIs (chlamydia and gonorrhea).[17]

Reported risky behaviours among key populations include early sexual and drug use debut below age 15, poly-drug use (heroin, cannabis, alcohol and khat), multiple sex partners, transactional sex, inconsistent condom use, and anal sex. A study of 657 young key populations (YKP) aged 15-24 years from Nairobi, Mombasa and Kisumu revealed only 44% used condoms with regular non-paying partners, while 25% had unprotected sex at least once in previous month. Among young MSM (YMSM), 61% were paid for sex with a male partner in the past month, 26% had unprotected anal sex, 85% used condoms and 77% used lubricant at last anal sex. [18]

According to 2017 NASCOP programme data, at least 2 out of 3 key populations were reached with targeted interventions in 2017, (slightly higher for FSW), with at least 60% tested for HIV and know their status, and at least 68% were on ART (PBS, 2017). Among young key populations aged 15-24 years who accessed HIV testing services, 18% of YFSW, 20% YMSM and 19% of YPWID were HIV-infected. Of these, 63% YFSW, 65% YPWID and 68% YMSM were on ART.

Despite distributing about 330 condoms/person/year to MSM and FSW, reported condom use with non-regular partner or person of unknown HIV status was variable: FSW (92% versus 65% for MSM).

[13] Kenya Modes of Transmission Study, 2009
[14] Population Council, IBBS 2011; UNODC 2012 Report of Rapid Situation Assessment of HIV among IDUs
[15] Third National Behavioural Assessment of Key Populations in Kenya: Polling Booth Survey Report, 2018, NASCOP
[16] Ibid
[17] National Implementation Guidelines for HIV and STI Programming Among Young Key Populations, 2018, NASCOP
[18] Ibid

Similarly while 189 needles and syringes were distributed per PWID per year, 88% PWID using sterile needle at last injection, needle sharing reportedly increased in Nairobi from 9% to 21% (PBS, 2017).

Population-specific barriers hampering service access for key populations include: limited knowledge, poor risk perception and health seeking behaviour, concurrent substance use, restrictive laws fuelling stigma and discrimination, health system constraints (operational hours, long waiting time, negative provider attitude with limited knowledge and skills, inadequate safe space to access services, limited essential commodities), and fear of prosecution. Other factors that exacerbate FSW and FWID vulnerability to HIV and gender-based violence: poverty, low self-efficacy and relationship dynamics.

3.2.5. Cross cutting Barriers Reducing Uptake of HIV and STI Combination Prevention across Priority Populations

The situational analysis in the previous section confirms that despite Kenya's dramatic decline in HIV prevalence, incidence and AIDS-related deaths since 2011, the HIV epidemic remains unstable across counties, gender and sub-population groups. Below is a summary of key barriers compromising the HIV and STI response among the priority population, at health system, community and policy levels which need to be considered when designing a social and behavioural change communication strategy:

Low Literacy: due to low level of education, limited language skills, social position or disability may limit people's understanding of basic facts about HIV and benefits of interventions, particularly among some AGYW, PBFW or key populations, thereby reducing their risk perceptions and uptake of HTS, PMTCT or other preventive measures or treatment options. This issue may be more pronounced in rural areas.

Cultural beliefs and attitudes: traditional and religious values and practices within the local social environment can influence how some preventive HIV interventions are perceived by the community and thereby limit their reach among targeted at-risk populations such as AGYW and key populations. For example, discussing sex with children may be taboo, while mass distribution of condoms, lubricants, needles and syringes for PWID may be opposed by religious leaders and community elders.

Weak political will can slow the adoption and implementation of high-impact HIV prevention interventions for key populations (KPs) and youth. Newly appointed politicians or those vying renewal of office may bow to pressure to halt an intervention such as promoting health rights of sex workers

Personal biases: People in influential positions such as local chiefs, or even a mother-in-law may have personal biases that influence how well they relate and communicate with clients and family members. These biases may be due to differences in education, socio-economic status, ethnicity, geographic isolation, etc. Provider bias may decrease client uptake or compliance in evidence-based interventions e.g. ART for PMTCT or PrEP, and partner disclosure for aPNS, etc.

Legal and policy environment: Because sex work, same sex relations and drug use are criminalized in Kenya, key populations remain highly stigmatised and marginalized at all levels. E.g. The Narcotics and Psychotropic Act outlaws possession of sterile needles and syringes for personal use. Until these laws are reviewed, health interventions can only be accessed discretely for fear of retribution.

Stigma and discrimination: stigma associated with being HIV-infected or a key population may limit one's access to health information and services. Others face double stigma for having multiple risks e.g. MSM who injects drugs and is living with HIV or being a migrant sex worker from another country may fear to access life-saving ARVs due to fear of judgement, lack of confidentiality.

Poor social support or network: limited or lack of family or peer support can compromise ANC attendance, ART adherence and self-disclosure and partner tracing for HTS and linkage to care.

Violence against vulnerable and key populations: Despite existence of supportive laws and policies, discrimination and violence against key populations and AGYW prevails. This is due to weak enforcement of protective regulations for human rights violations.

Chronic health systems constraints such as: health worker shortage, negative attitude, long queues, travel costs and stigma, inequitable distribution of ART sites and health workforce, with bias to urban areas and higher cadres. Inadequate dissemination and use of human-rights based health policies and guidelines, limited provider training, supervision, support and motivation; provider stigma of PEP and of working with KPs and PLHIV; insufficient political will for adoption of KEPH-defined HIV and AIDS

services across counties, weak community engagement in HIV response, inequitable distribution and coordination of CSOs, stock outs of essential commodities: test kits, ARVs, IPC materials.

Below is a summary of common challenges cutting across all key primary populations with regard to HIV and STI Combination Prevention as determined at one of the consultative meeting for developing this document. Stakeholders deliberated on potential barriers affecting each priority group through group discussions. The range of barriers for each population group may need to be reviewed periodically as they are likely to evolve by geographical location or time.

Table 8: Common Risk Factors to be Addressed Through HIV and STI Combination Prevention by population

	Common Barriers to HIV Services Uptake	PBFW	DC	AYP	MSM	FSW	PWID
Individual Causes of Vulnerability							
i.	Biological	√	√	√	√	√	
ii.	Low literacy	√	√	√	√	√	√
iii.	Early sexual debut	√	√	√		√	
iv.	Multiple sexual partnerships	√	√	√	√	√	√
v.	Low HIV risk perception	√	√	√	√	√	√
vi.	Inconsistent condom use	√	√	√	√	√	√
vii.	Fear of HIV test	√	√	√	√	√	√
viii.	Economic dependency	√	√	√	√	√	√
ix.	Poor health seeking behaviour	√	√	√	√		√
x.	Risky drug-use related practices	√		√	√	√	√
xi.	Fear of self-disclosure	√	√	√	√	√	√
xii.	Low self-esteem	√		√	√		√
xiii.	Misconceptions about HIV	√	√	√	√	√	
Health Systems Barriers							
i.	Distance and cost of services	√	√	√	√	√	√
ii.	Limited provider skills	√	√	√	√	√	√
iii.	Negative health worker attitude	√	√	√	√	√	√
iv.	Lack of privacy & confidentiality	√	√	√	√	√	√
v.	Health worker shortage	√	√	√	√	√	√
vi.	Stock outs of essential commodities				√	√	√
vii.	Inadequate service package	√	√	√	√	√	√
Structural Barriers							
i.	Restrictive policies and legislation	√	√	√	√	√	√
ii.	Violence	√	√	√	√	√	√
iii.	Harmful social norms	√	√	√	√	√	
iv.	Stigma and discrimination	√	√	√	√	√	√
v.	Gender inequalities	√	√	√		√	√
vi.	Poor family/community support		√		√	√	√
vii.	Low involvement in decision making	√		√	√		√
viii.	Inadequate legal/social protection		√		√	√	√

4 SBC strategy purpose, objectives and guiding Principles

Social and Behaviour Change (SBC) is the systematic application of interactive, theory-based, and research driven processes and strategies to address social and gender norm change and behaviour change at the individual, community, and social levels, including cross cutting use of strategic communication. (FHI360 C-Modules).

This section provides the SBC strategy overall goal, objectives and guiding principles.

4.1. Overall Goal and Objectives

Overall Goal: To promote uptake, utilization and demand for HIV and STI Combination Prevention services for sustained social and behaviour change to contribute towards the elimination of new HIV and STI infections, stigma and discrimination in Kenya by 2030.

Broad Objectives:

1. To foster an enabling policy and social environment for universal access to HIV and STI Combination Prevention services among general and key populations.
2. To increase knowledge and awareness of HIV and STI Combination Prevention services among general and key populations.
3. To strengthen the capacity of service providers for delivery of responsive HIV and STI Combination Prevention services
4. To accelerate demand for and utilization of HIV and STI Combination Prevention services among general and key populations.

4.2. SBC Guiding Principles

Implementation of this SBC communication strategy is based on the following principles:

- ***Human rights-based:*** All communication will be respectful of rights of beneficiaries without causing any harm such as stigma and discrimination.
- ***Results-oriented***: Effective communication will entail correctly answering the question; 'what do we want to achieve with a given communication activity or intervention?'
- ***Evidence-based***: All communication will take into consideration existing research in answering the 'what', 'why', 'where', 'when' and 'how' questions. In addition to pre-testing, messages will be post-tested and periodically reviewed and updated if new evidence emerges.
- ***Audience-centred***: All communicators are expected to adapt the communication interventions to local context and language, and respond to changing needs and preferences of the target group.
- ***Participatory***: This implies involvement of concerned national, county and local stakeholders as well as peer educators and social workers and beneficiaries in all stages of communication planning, message development, implementation, monitoring and evaluation.
- ***Multi*-pronged approach**: A mix of behavioural communication interventions will be implemented simultaneously targeting different levels of influence and depending on resource availability. Efforts will be made to build on success of prior interventions.
- ***Sustainability and ownership:*** SBC strategies will be steered by the national and county leadership through the county health management team and integrated within county health programme initiatives.

4.3. Guidelines for the implementation of the SBC HIV and STI combination prevention communication strategy

This section proposes guidance and key principles on effective implementation of this strategy.

- **Multiple levels of influence**: the SBC approaches and solutions should be implemented at multiple levels to influence change at individual, interpersonal, organizational and policy levels.
- **Mixed combination prevention**: The SBC solutions, tools and packages of messages should address barriers to uptake of mixed HIV and STI combination prevention that includes biomedical, behavioural and structural interventions.
- **HIV incidence clusters and geographical approach**: this is critical in guiding implementation decisions at different levels. The intensity and dosage including investment of SBC implementation should vary based on the incidence levels. More resources should be invested in the high and medium clusters.
- **Tailored SBC implementation**: Roll out of evidence-based HIV and STI Combination Prevention SBC interventions should be based on local epidemiological context, prevailing HIV risks and vulnerabilities as well as geographical coverage.
- **Integrated package of HIV and STI Combination Prevention messages**: A toolkit should be developed with a set of relevant integrated print and audio-visual messages for the core interventions targeting the primary, secondary and tertiary audience. The integrated toolkit may contain;
    I. Advocacy kit for policy and decision makers containing documentaries, brochures, presentations, media briefs.
    II. A capacity building kit for service providers containing training manuals, job aids, counselling guides, standard operating procedures, algorithms
    III. An SBC kit for the primary audience and their influencers containing posters, brochures, radio spots, TV spots, documentaries, community mobilization guides,
    IV. Publicity kit for program promotional purposes containing banners, fliers, promotional materials like T-shirts, caps, water bottles, folders, calendars, key holders, lesos, etc.
- **Integrated and systematic HIV and STI Combination Prevention SBC programming**: The implementation should adhere to a systematic process of implementation for sustained results. The process should go beyond messaging to providing a full range of SBC strategies that will support people to individually and collectively act.
- **Research driven:** the HIV and STI Combination Prevention SBC should always start with a comprehensive understanding of the situation to generate data across priority audiences on social and behavioural determinants and underlying contextual factors that that increase HIV risk and vulnerability as well as obstruct access to services across counties, gender and sub-populations. This may include knowledge, awareness, risk perceptions, current practices, attitudes, beliefs, motivations, norms, and skills.
- **Human Centred Design approach and Co-creation:** Design and development of the HIV and STI Combination Prevention branded campaign, messages, materials and solutions for the priority audiences using the human centred design and co-creation process with priority audiences
- This roll out will be phased to ensure maximum behavioural communication intensity. Initial focus will be on capacity building and local planning in all high-burden counties.
    I. services and interpersonal communication skills.

- **Phase 3:** *SBC for Priority populations:* Implementation of multi-level and multiple approaches using relevant and appropriate channels. These are Interpersonal communication channels including peer to peer approaches, EBIs, counselling, life skills and all face to face approaches with smaller groups like meetings and trainings. Mass media channels such as TV, Radio, Social media and community media including community dialogue, **Phased SBC approach**: This strategy proposes to implement intensified, multi-level social and behavioural communication strategies in all high-burden counties, while supporting targeted strategies in medium-burden counties over the next 5 years through a phased approach.

    I. **Phase 1:** *Development of the Integrated package of HIV and STI Combination Prevention messages*. This package has the Advocacy kit, Capacity building kit, SBC kit publicity **kit.**

    II. **Phase 2:** *Capacity strengthening for providers***:** through implementation of Provider Behaviour change and communication aimed at reducing provider bias by addressing perceptions, norms and motivations hindering uptake of services, Capacity strengthening on service delivery for HIV and STI Combination Prevention integrated community mobilization, events, and edutainment

    III. **Phase 4:** *Advocacy for policy and decision makers*: Advocacy aimed at improving financial, political and social commitments through social mobilization for collective responsibility, partnerships and alliances, partnerships and collaboration with NACC and other line ministries and sectors (Education, Social protection, Youth and gender)

    IV. **Phase 4**: Monitoring, Evaluation, Re-planning

5. Priority Target Audience for HIV and STI Combination Prevention

This section looks at prevailing behaviours of priority target populations groups and barriers to HIV and STI combination prevention uptake context that is informed by the paradigm shift from intervention to populations driven HIV responses as proposed in the Prevention Revolution Roadmap to Vision 2030. The target population groups addressed are the following:

- **Primary audience**: Mostly affected at the core of the problem. These are the discordant couples, key populations, and vulnerable populations specifically focussing on Adolescents and Young People (AYP) with special attention to Adolescent girls and young women (AGYW), Pregnant and breastfeeding women (PBFW) and general population
- **Secondary audience**: People directly influencing the behaviour of the primary priority audience. These are people at the interpersonal and organizational level including partners, peers, family, networks, support groups, employers, religious leaders, health providers, teachers and employers.
- **Tertiary audience**: People indirectly affecting the priority audience such as policy and decision makers at national and county levels, enforcement agencies, legislators, and implementing organizations.

The table below gives a summary of the common priority primary, secondary and tertiary audience

Figure 1: Priority Audience Analysis

Primary audience ***(Directly affected)***	• Sero-discordant couples • People living with HIV • Adolescent and Youth Population • Adolescent girls and young women • Key populations (FSWs, PWIDs, MSMs) • Pregnant and breastfeeding women
Secondary audience ***(Directly influencing)***	• Spouses/partners • Health care workers (HCWs) • Community and religious leaders • Parents & other close family members • Friends and peers • Employers • Social workers • Drop-in-centre personnel • Community health volunteers • General population
Tertiary audience ***(Indirectly influencing)***	• Policy and decision makers at various levels • Line Government ministries and departments • Private sector organizations • Media Local administrators (chiefs etc.) • Civil society organizations, including CSO, FBOs, CBOs and NGOs

6. SBC approaches and channels for HIV and STI Combination Prevention

This section highlights the specific strategies, tactics and channels that will be used to reach out to the target audience for this strategy. Figure 2 gives a brief presentation of the strategies and a description of each is provided below.

Figure 2: SBC approached for this strategy

6.1. SBC Approaches

Five broad SBC strategies will be used for HIV and STI Combination Prevention to target all the priority populations and influencers. These are:

i. Social and behaviour change communication: aimed at reducing risky behaviours and sustain positive change as well as increase acceptability and demand for biomedical interventions.
ii. Social change to shift norms, address perceptions, values, gender and socio-cultural practices hindering uptake of HIV and STI Combination Prevention.
iii. Social and community mobilization: For collective responsibility, partnerships, and alliances
iv. Capacity strengthening: To improve skills, self-efficacy and access to services. Capacity building for health workers is aimed at influencing biological systems via which the virus infects a new host, so as to block virus transmission, decrease infectiousness, or reduce risk of acquiring infection.
v. Advocacy: For enabling environment aimed at addressing social, economic, political, and environmental factors that affect individual or group HIV/STI risk and vulnerability.

6.2. SBC Channels

i. The channels that are applicable and crosscutting that will be implemented targeting the priority audience and their direct influencers at the interpersonal and community level are as follows;

- Interpersonal communication channels including peer to peer approaches, risk-reduction counselling, and skills-building, Evidence-informed Behavioural Interventions (EBI) e.g. Sister-to-Sister, and all face to face approaches with smaller groups like meetings and trainings.
- Mass media channels: print, TV, radio, online through mobile networks and social media-
- Community media: community dialogue, community mobilization, events, and edutainment.

- Target IEC materials and sustained brand campaign including job aids, guidelines and SOPs for service providers
- Training for healthcare providers on HIV and STI Combination Prevention package and interventions.
  - Provider behaviour change and communication using multiple approaches including mentorship, coaching, role modelling, relevant media, online, and mobile technology innovations.
  - Advocacy meetings including; stakeholder sensitization meetings, targeted high level one on one meetings, workshops, conferences, symposiums, workshops, breakfast meetings for policy and decision makers
  - Partnerships and collaboration with NACC and other line ministries and sectors (Education, Social protection, Youth and Gender).

The following table provides a summary of above mentioned social and behaviour change communication channels, by pros and cons and resource needs.

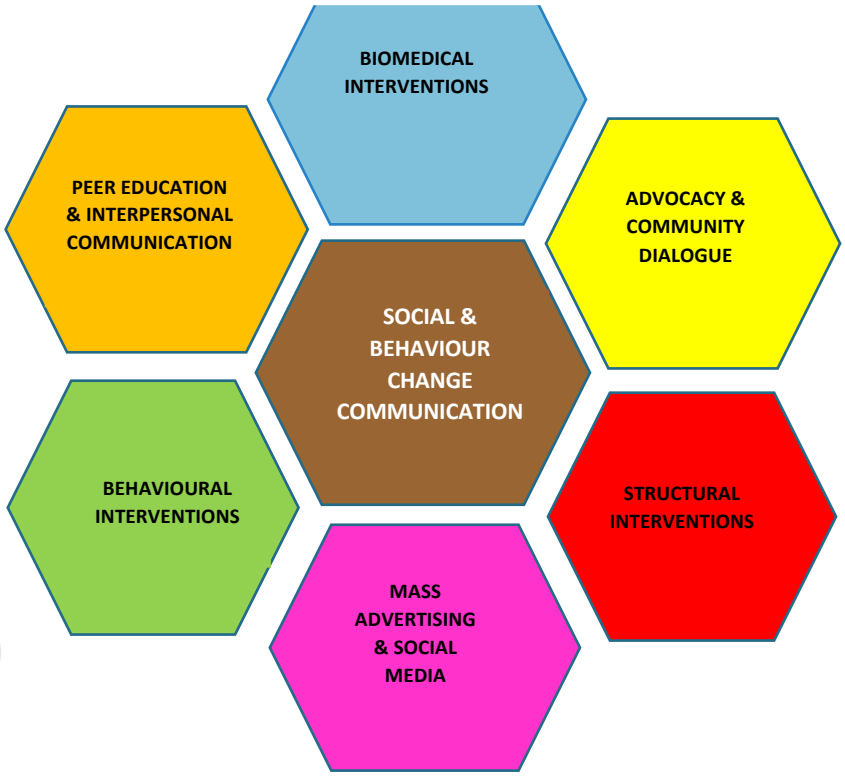
Table 9: Types of channels, pros and cons

Channel/ Method	*Message Complexity*	*Reach*	*Advantages*	*Disadvantages*	*Resource Needs*
Mass Advertising	Blunt and direct	Wide but not targeted	Can quickly reach large number of people	Targeting difficult, short term impact, expensive	High goods and services costs, specialist marketing skills
Printed Information materials	From blunt & direct to detailed and explanatory	Depends on distribution network	Detailed discussion of topic possible	Need expert consensus and input, requires time and professional skills	High goods and services costs, time intensive
Outreach	From blunt & direct to nuanced & holistic	Limited but targeted	Targeted effort, potential for participation	Needs high level of ongoing support	Low goods and services costs, time intensive, local knowledge required
Community dialogue	Nuanced & holistic	Small, but with flow effect	Can create long term flow on effects, can be done quickly	Unpredictable outcomes	Low goods and services costs, local knowledge required
Interpersonal communication	From detailed & explanatory to nuanced & holistic	Small but targeted	Flexible, targeted, high individual impact	High level of structural support needed	Low goods and services costs, trained staff, supervision and support
Peer education	Nuanced & holistic	Limited but targeted	Flexible, high individual impact	Difficult to define short-term outcomes	Low goods and services costs, time intensive
Online and new media communication	All levels of complexity	Wide and targeted	Flexible, fast	High level of technical skills and marketing knowledge needed, volatile, short-lived	Medium costs, active maintenance needed
Training	From detailed & explanatory to nuanced & holistic	Small but targeted	Flexible, targeted, high individual impact	High level of structural support needed	Medium goods and services costs, trained staff, supervision and support
Advocacy meetings	Nuanced & holistic	Small, but with flow effect	Can create long term flow on effects, can be done quickly	Unpredictable outcomes	Low goods and services costs, local knowledge required

A 2016 multi-country study on *Evaluating the Evidence Historical Interventions Having Reduced HIV Incidence* revealed that for Kenya changes in sexual risk behaviour (e.g. increased condom use and decrease in higher risk sex) was the major contributor (and to a much lesser extent ART), that had averted approximately 4,107,000 infections between 1980-2015. An important takeaway from these results was that ART had marginal impact on prevalence trends but that it has yet to be fully optimized.[19]

The following figure gives the entire HIV epidemic and the response may be integrated with social and behavioural change communication

*Figure 4: HIV and STIs begin and end with behaviour **change**.*
Everything else is in between!



[19] *World Bank Group; UNAIDS; World Health Organization; The Global Fund; UNFPA; Imperial College London. 2016. Evaluating the Evidence for Historical Interventions Having Reduced HIV Incidence: A Retrospective Programmatic Mapping Modelling Analysis - Synopsis Report 2016. World Bank, Washington, DC. © World Bank. https://openknowledge.worldbank.org/handle/10986/25763 License: CC BY 3.0 IGO*

6.3. SBC strategy for the primary audience

Table 10: Summary strategy for the primary audience

Primary audience /priority population	*Individual level:* Discordant couples, Adolescent and Youth Population, Adolescent Girls and Young Women and Key Populations (FSWs, PWIDs, MSMs), Pregnant and Breastfeeding women *Interpersonal level:* Partners, peers, family, networks, support groups, employers, religious leaders
Desired behaviour for the priority audience	*Knowledge and awareness* • Increase comprehensive knowledge on HIV/STI prevention and address misconceptions • Promote use and benefit of HIV and STI Combination Prevention interventions • Improved knowledge on where to get HIV and STI Combination Prevention services *Social norms, values and motivations affecting uptake of HIV and STI Combination Prevention package and interventions* • Decrease of harmful socio-cultural and gender norms and practices promoting HIV/STI transmission • Improved attitudes, beliefs, and self-efficacy for HIV and STI Combination Prevention package • Improved risk perception *Skills, access and current practices to improve uptake of HIV and STI Combination Prevention package and interventions* • Seek regular HIV and STI Combination Prevention services • Adopt safer sexual practices • Initiate and adhere to recommended HIV/STI care and treatment • Maintain current positive and safer practices and sustain new practices • Change risky practices and help populations move from initiation to maintenance
SBC objectives	• Increase knowledge and awareness on HIV/STI prevention, availability of HIV and STI Combination Prevention package and interventions • Increased demand for and utilization of services among priority audiences • Address misperceptions, gender and socio-cultural norms and practices that hinder the uptake of HIV and STI Combination Prevention services. • Enhance skills, access and self-efficacy to improve uptake of HIV and STI Combination Prevention package and interventions
SBC strategies	• Behaviour change communication aimed at changing social conditions and individual behaviour • Social change to shift norms, address perceptions, gender and socio-cultural practices • Social & community mobilization for collective responsibility, partnerships, alliances • Community capacity strengthening (parents, peers, • Peer groups, treatment buddy, reducing stigma, discrimination and violence in schools, support fare for clinic visits
HIV incidence clusters	• The intensity and dosage of SBC interventions will be tailored and aligned to HIV incidence clusters.
Channels	• Interpersonal communication channels including peer to peer approaches, risk-reduction counselling, and skills-building, Evidence-informed behavioural interventions (EBI) e.g. Sister-to-Sister, and all face to face approaches with smaller groups like meetings and trainings • Mass media channels: TV, Radio, Social media • Community media: community dialogue, community mobilization, events, edutainment
SBC tools and materials	• Branded HIV and STI Combination Prevention campaign • HIV and STI Combination Prevention print and audio-visual materials for priority audience including posters, charts, dialogue guides, TV, Radio spots, outdoor materials, promotional materials

6.4. SBC strategy for secondary audience

Table 11: Summary SBC strategy for healthcare providers

Priority service delivery/secondary audience	*Facility and community-based Health workers and other service providers,*
Desired behaviour for the Healthcare providers	*Knowledge and awareness* • Comprehensive knowledge and information on HIV and STI Combination Prevention package and interventions • Understanding the HIV related risks and health rights of priority populations • Social norms, values and motivations affecting uptake of HIV and STI Combination Prevention package and interventions • Reduced provider bias in providing HIV and STI Combination Prevention package and interventions • Provide user responsive services and treat clients with dignity, without discrimination nor prejudice against youth and KPs • Skills, access and current practices to improve uptake of HIV and STI Combination Prevention package and interventions • Provide integrated services for HIV and STI Combination Prevention
SBC objectives for Healthcare providers	• Increased knowledge and awareness on HIV and STI Combination Prevention package and interventions to improve utilization of services among priority audiences • Shift norms by addressing perceptions, gender and socio-cultural norms and practices that hinder the uptake of HIV and STI Combination Prevention services • Improved interpersonal communication skills and self-efficacy to enhance uptake of HIV and STI Combination Prevention package and interventions
SBC strategies for Healthcare providers	• Provider behaviour change and communication aimed at reducing provider bias by addressing perceptions, norms and motivations hindering uptake of services • Capacity strengthening on service delivery for HIV and STI Combination Prevention integrated services • Capacity strengthening on interpersonal communication skills
Channels for Healthcare providers	• Training for healthcare providers on HIV and STI Combination Prevention package and interventions • Provider behaviour change and communication using multiple approaches including mentorship, coaching, role modelling, relevant media, online, mobile technology innovations
SBC tools and materials for Healthcare providers	• Branded HIV and STI Combination Prevention campaign for health providers • HIV and STI Combination Prevention print and audio-visual materials for health providers including posters, job aids, charts, dialogue guides, guidelines, protocols and Standard Operating Procedures, outdoor materials, promotional materials • Training manuals for TOTs and participants

6.5. SBC strategy for tertiary audience

Table 12: Summary SBC strategy for policy and decision makers

Policy and decision makers	*Policy and decision makers at all levels, enforcement agencies, legislators, implementing organizations*
Desired behaviour for policy and decision makers	• Knowledge and information on HIV and STI Combination Prevention package and interventions • Understanding the HIV-related risks and health rights of youth and KPs • Support increased budget allocation for HIV and STI Combination Prevention packages and interventions • Ensure an enabling policy environment for integrated service delivery for Combination Prevention. • Supportive policies and laws for stigma-free delivery of HIV and STI Combination Prevention for KPs and other minority groups • Support programmes and efforts to reduce power inequalities in society
SBC objectives for policy and decision makers	• Increase knowledge and awareness on HIV and STI Combination Prevention package and interventions for policy and decision makers • Sustained advocacy for resource allocation and commitments for HIV and STI Combination Prevention packages and interventions • Sustained advocacy for review and development of relevant policies that provide an enabling environment for the provision of integrated HIV and STI Combination Prevention services.
SBC strategies for policy and decision makers	• Advocacy aimed at improving financial, political and social commitments • Social mobilization for collective responsibility, partnerships and alliances • Partnerships and collaboration with NACC and other line ministries and sectors (Education, Social protection, Youth and Gender) • Implementation research to generate evidence for use in advocacy
Channels for policy and decision makers	• Advocacy meetings including; stakeholder sensitization meetings, targeted high level one on one meetings, workshops, breakfast meetings • Partnerships and collaboration with NACC and other line ministries and sectors (Education, Social protection, Youth and Gender) • Conferences, symposiums and workshops
SBC tools and materials for policy and decision makers	• Advocacy package with fact sheets, policy briefs, presentations, reports, talking points, documentaries with success stories • Media brief package and information kits

7. Audience-Specific Behaviour Analysis for HIV and STI Combination Prevention

This section gives detailed audience specific behaviour analysis which includes the following; the specific audience, current behaviour, desired behaviour, key barriers, SBC objectives and SBC approaches. *Table 13* presents the behaviour analysis for the *primary audience* which includes: Sero discordant Couples, People Living with HIV (PLHIV), Men who have sex with men (MSM), Female sex workers (FSW), People who inject drugs (PWID), Adolescents and Young People (AYP), Adolescent Girls & Young Women (AGYW). This is followed by *Table 14* which gives the behaviour analysis for the *secondary audience* including; Partners and spouses, General Population, Healthcare Workers (HCW) and thereafter *Table 15* which presents the behaviour analysis for the *tertiary audience* including; Religious Leaders, Social, Political and Administrative Leadership

7.1. Primary audience behaviour analysis

Table 13:primary audience behavior analysis

Population	Current Behaviour	Desired Behaviour	Key Barriers	SBC objectives	SBC approach
PRIMARY AUDIENCES					
Sero-Discordant Couples (SDCs)	• Engaging in unprotected sex with a spouse while trying to conceive. • Some have multiple sexual partners with low condom use. • Substance use and IPV. • Knowledge gap and Poor health care seeking	• SDCs Know and access HIV and STI Combination Prevention package and interventions • Seek regular HTS for uninfected partner including HIVST & link to treatment on change of status • Seek support for disclosure of status • Adhere to PrEP or ART once started • Adopt safer sexual practices • Seek services for eMTCT • STI screening & treatment • Avoid substance use • SDCs know and access Screening and support for IPV	• Fear of discrimination and stigma from family & society • Do not know each other's status • Limited knowledge on availability, use of combination prevention services & products • Anger depression and/or denial from the uninfected partner • Inadequate counselling services to support safe partner notification • Delay or non-disclosure for fear of violence from partner and community • Poor access to services • Myths & misconception • Alcohol and substance use	• Increase SDCs knowledge and understanding of benefits of HIV and STI Combination Prevention package and interventions • Increase SDCs knowledge on HIV prevention and risk-reduction • Increase knowledge on benefits and use of PrEP, Condoms, HTS, and other services at available service delivery points • Increase knowledge on benefit and practice of adherence to ARV and PrEP • Increase knowledge on benefits of PMTCT and maintenance of desirable behaviour • Increase knowledge on IPV and substance use and support services available	• Targeted interpersonal communication (IPC) programmes in community e.g. counselling & dialogue, Peer to peer groups • Community media and mobilization and support via networks and CSOs • Targeted broadcast and social media campaigns • Targeted Information Education and Communication materials • Male engagement approaches
People Living with HIV (PLHIV)	Engage in unprotected sex with partner/spouse who may not know status. Some have multiple concurrent partners. Not disclosing status for fear of SGBV	• PLHIV Know and access HIV and STI Combination Prevention package and interventions • Early ART initiation, nutrition support to maintain viral suppression to achieve Undetectable=Untransmissible • Seek help on safe ways of disclosure to improve PSS • Use multi-protective devices e.g. condoms consistently alongside other measures to protect partner(s) • Observe adherence once started on ARVs • Access PMTCT, STI screening, etc.	• Inadequate knowledge on availability, utilization and source of combination prevention services and products • Denial of sero-status • Stock-outs of HIV commodities • Cost of PrEP or lack thereof for their partners • Poor psychosocial support for safe partner notification • Delay or non-disclosure for fear of violence from partner and community • Perceived hostile care providers and victim-blaming • Incompatible religious teachings • Fear of discrimination and stigma from family and society	• Increase PLHIVs knowledge and understanding of available HIV and STI Combination Prevention and PHDP (Positive Health, Dignity and Prevention) interventions • Raise awareness on benefits of taking ARVs and adherence to ARVs on viral load suppression (U=U) • Increase knowledge and benefits of safe conception methods	• Targeted interpersonal communication programmes at household and community level • Peer education and role modelling • Using peer support groups and community media and outreach • Education and support through available networks and community-based organization

Men who have sex with men (MSM)	They have concurrent sexual partners and also engage in heterosexual relationships. They have both vaginal and anal sex. Drug abuse and alcohol misuse is common as a coping strategy for stigma	• MSMs Know and access HIV and STI Combination Prevention package and interventions • Get tested to know status (voluntary, HIVST, or PITC) • Adhere to PrEP or ART once started • Use condoms and lubricants consistently with all partners • Seek mental Health Services • Reduce Alcohol and substance abuse	• Criminalization of lifestyle in Kenya • Feel discriminated and discouraged by health providers' negative attitude • Rejection and isolation by family and society • Lack safe spaces to access services • Misconception that anal sex is safe • Non-disclosure for fear of violence from partner and community • Effects of drug abuse & alcohol misuse (impaired reasoning) • • Lack of negotiation skills for condom use	• Increase MSMs knowledge and understanding of benefits of HIV and STI Combination Prevention package and interventions • Increase MSMs knowledge and benefits of HTS & link to prevention services • Increase MSMs knowledge on benefits of accessing DICs or other safe spaces for available services • Increase MSMs risk perception and promote use of PrEP consistently (adherence) among the uninfected who use)	• Peer education programmes • Education and support through available networks and community-based organization • Interpersonal outreach programmes • Build their capacity with condom use negotiation skills • Targeted Evidence Based Interventions • Ambassadors/champions as role models • Social media • Online sites
Female sex workers (FSW)	Early sex work debut. Have multiple sexual partners and engage in anal or unprotected sex to earn more. Some use vaginal wash or shower after unprotected sex. Self-treatment or traditional healers to avoid going to HCWs. Less frequent condom use with regular clients. Drug & alcohol abuse to cope.	• FSWs Know and access HIV and STI Combination Prevention package and interventions • Get tested to know status (voluntary, HIVST, or PITC) • Multi-protective devices e.g. Consistent condom use with clients and regular partners; FP, PreP • Early ART initiation & adherence for HIV infected • Routine STI screening & treatment • Seek mental Health Services	• Criminalization of sex work in Kenya • Negative health worker attitude • Rejection/isolation by family and society • Self-treatment or consulting local healers • Monthly dose pick up is challenging • Lack of negotiation skills for condom use • Inadequate knowledge on use/source of available services and products for combination prevention • Non-disclosure for fear of community and IPV • Work odd hours and lack safe spaces to access services • Misconception about not using condoms with PrEP; vaginal wash or shower after unprotected sex • Effects of drug abuse & alcohol misuse (impaired reasoning)	• Increase FSWs knowledge and understanding of benefits of HIV and STI Combination Prevention package and interventions • Increase FSWs knowledge, benefits and access to HTS, PrEP, HIVST, Condoms & link to prevention services	• Targeted Interpersonal communication channels – EBIs, • Community media, dialogue, drop in centres, outreaches • Ambassadors/champions as role models • Outreach via user responsive health facilities and other safe spaces
People who inject drugs (PWID)	Early drug use debut Share needles and engage in unprotected sex with multiple partners. Females also engage in anal sex and receive money in exchange for sex. Not seeking services from HCWs	• PWIDs Know and access HIV and STI Combination Prevention package and interventions • Get tested to know status (voluntary, HIVST or PITC) • Reduce harmful and risky behaviours (unprotected sex, multiple partners, needle and syringe re-use or sharing) • Seek regular health services for reviews • Early ART initiation & adherence for HIV-infected	• Criminalization of injecting drugs makes them hard to reach as they hide in dens or are incarcerated. • Rejection/isolation by family and society • Misplaced priorities due to multiple problems (preoccupied with remaining high; have to choose between addiction and care) • Some are also sex workers • Limited access to health care for those in prison • Effects of drug abuse & alcohol misuse (impaired reasoning)	• Increase PWIDs knowledge and understanding on benefits of HIV and STI Combination Prevention package and interventions • Increase PWIDs knowledge and understanding of benefits of HIV prevention, HTS & link to prevention services, PrEP for the uninfected, Condom use and accessing facilities and available services	• Targeted interventions via Outreach and at drop-in centres • Targeted Interpersonal communication channels – dialogue, counselling, • Outreaches through friendly health facilities and other safe spaces • Appropriate harm reduction strategies

		• Seek mental Health Services			
Adolescents and Young People (AYP)	Early sexual debut with condoms used at first encounter followed by decline. Engage in inter-generational relationships in exchange for money or other material goods. Use alcohol & other drugs that impair reasoning & decision making. Not seeking HTS or other prevention services & infected not on ART	• AYPs Know and access HIV and STI Combination Prevention package and interventions • Get tested to know your status to get prevention and treatment services • Abstain as appropriate • Reduce the number of multiple and concurrent partners • Adopt multi-protective devices e.g. Consistent condom use, with PrEP, FP, etc. if sexually active • Early ART initiation & adherence for those already infected • Regular STI screening & treatment	• Abstinence-only education at expense of other interventions with conflicting messaging on condom use • Inadequate knowledge on availability, utilization and source of the combination prevention services and products • Fear of discrimination and stigma from family and society • Only half Know their HIV status • Condoms not accessible to most adolescents and youth • Lack negotiation skills for condom use • High cost of female condom and general lack knowledge on use • Lack safe spaces to access youth responsive services • Less than 10% health facilities in Kenya can be considered youth-friendly	• Increase AYPs knowledge and understanding on benefits of HIV and STI Combination Prevention package and interventions • Create awareness on the benefits of counselling and testing in accessing appropriate services for prevention, treatment or protecting others who are uninfected	• Mass media – Radio, TV, • Mobile technology & Social media • Outreaches to Schools and colleges • Community media, edutainment
Adolescent Girls & Young Women (AGYW)	Start having sex early, get married early and engaging in unprotected sex leading to unwanted pregnancies. Not seeking HTS and other prevention services	• AGYW Know and access HIV and STI Combination Prevention package and interventions • Get tested to know status • Abstain from and/or be faithful as appropriate • Practice safe sex if sexually active • Adopt multi-protective devices e.g. condoms, PrEP, FP, etc. • Early ART initiation & adherence for those already infected • STI screening & treatment • Disclose HIV positive status to partner	• Some not in control of their decision-making • Lack safe spaces to access services that are responsive to young people's needs • Fear discrimination & stigma from family and society • Don't know her status & only half know correct ways of preventing sexual transmission • More concerned about unintended pregnancy • Inadequate information on HIV. Have never seen sickly PLHIV therefore they do not view it as a threat • Receives conflicting messages from various sources; peers, church, elders • Misconceptions due to low level or lack of education • Lack negotiation skills for condom use with partners • Non-disclosure for fear of IPV and community (SGBV) • Peer pressure to engage in high risk sexual & other behaviour • Lack of social support and role models	• Increase AYPs knowledge and understanding on benefits of HIV and STI Combination Prevention package and interventions • Create awareness on the benefits of counselling and testing in accessing appropriate services for prevention, treatment or protecting others who are uninfected	• Mass media – Radio, TV, • Mobile technology & Social media • Outreaches to Schools and colleges • Community media, edutainment

Pregnant and breastfeeding women (PBFW)	Engage unprotected sex. Not seeking HTS and other prevention services, not seeking services from HCW, delay in starting ANC visits,	• Access HIV and STI Combination Prevention package and interventions • Seek regular HTS and link to timely treatment • Seek eMTCT services & repeat HTS during pregnancy & breastfeeding period • Practice safe sex if sexually active and STI screening • Adhere to ART once started for those already infected • Disclose positive status to partners	• Unaware of status of partner's HIV status • Lack of or inadequate knowledge about HIV and STI transmission and prevention methods • Limited resources to provide support • Secondary stigma and fear of knowing status • Lack of social support • Non-disclosure for fear of IPV and community (SGBV) • Some not in control of their decision-making • Inadequate information on HIV and STI.	• Increase eMTCT knowledge and understanding on benefits of HIV and STI Combination Prevention package and interventions • Create awareness on the benefits of counselling and testing in accessing appropriate timely services for prevention, treatment or protecting others who are uninfected	• Targeted Interpersonal communication channels – dialogue, counselling, • Mass media – Radio, TV, • Community media, edutainment • Peer education and role modelling • Using peer support groups and community media and outreach • Education and support through available networks and community-based organization, IEC

7.2. Secondary audience behaviour analysis

Table 14: Behaviour analysis for the secondary audience

SECONDARY AUDIENCES

	Current Behaviour	Desired Behaviour	Key Barriers	SBC objectives	SBC approach
Population Partners and spouses	Engage in unprotected sex with the priority populations whose status they may or may not know. Not seeking testing and other preventive services. May blame the victims and exhibit SGBV tendencies	• Peers and spouses know and access HIV and STI Combination Prevention package and interventions • Provide support to partner to enable and reinforce prevention care seeking for improved uptake and adherence • Avoid victim blame and violence towards partner • Get tested to know status to get prevention and treatment services where necessary	• Unaware of status of partner's HIV status • Lack of or inadequate knowledge about HIV/AIDS transmission and prevention methods • Lack of engagement or targeting • Feeling of betrayal by affected partner/spouse • Limited resources and lacks motivation to provide support • Secondary stigma and fear of knowing status • Strained relationship with uncooperative partner • Worries about getting infected and suffers secondary stigma for living with or interacting with PLHIV or other KPs • Poor communication skills cultural sensitivity of topic (taboo) • Feeling of entitlement due to culturally patrilineal society	• Increase peers and spouses knowledge and understanding on benefits of HIV and STI Combination Prevention package and interventions • Increase knowledge and create understanding on benefits of providing partner support and engaging in dialogue • Promote couple counselling	• Targeted interpersonal communication (IPC) programmes in community e.g. counselling & dialogue, Peer to peer groups • Community media and mobilization and support via networks and CSOs • Targeted mass media campaigns • Targeted Information Education and Communication materials • Male engagement approaches • Male engagement approaches
General Population	Condom use is low and inconsistent. Male adults have concurrent multiple female partners and may also be having sex with men. Men are also not seeking HTS. Women go for testing and obtain available preventive services	• General population know and access HIV and STI Combination Prevention package and interventions • Get tested to know status to get linked to prevention and treatment services • Seek help on safe ways of disclosure • Consistently use condoms alongside other prevention measures if sexually active • Observe adherence once on any prevention medication like PrEP or on ARVs for treatment if infected • Abstain and/or be faithful as appropriate	• Inadequate knowledge on availability, utilization and source of the combination prevention services and products • Fear of discrimination and stigma from family and society • Do not know their status with only half the adults having tested • Conflicting messaging on condom use and concurrent promotion of abstinence • Condoms not accessible in the rural areas • Lack negotiation skills for condom use • Cost of female condom and general lack of knowledge on correct use	• Increase general populations' knowledge and understanding on benefits of HIV and STI Combination Prevention package and interventions	• Mass media (TV, Radio, Social media)

Healthcare Workers (HCW)	Have difficulty interacting with vulnerable and minority groups such as KPs and AYP discriminating and showing bias. Create a hostile environment that keeps the groups away. Not seeking HTS and other services	• HCWs Know and provide HIV and STI Combination Prevention package and interventions • Provide integrated services for HIV and STI Combination Prevention • Provide friendly services and treat clients with dignity, without discrimination or favour, including youth and KPs • Show a positive attitude towards HIV and STI Combination Prevention	• Inadequate training on comprehensive management of HIV and dealing with KPs e.g. LGBTQ, MSM (lack skills, experience & treatment guidelines) • Personal biases towards minority and vulnerable populations (adolescents & KPs) • Poor work conditions that are demanding, stressful & emotionally challenging • Lack space for confidential SRH care • Strained patient-provider relationship • Ethical dilemma of non-disclosure issues • Worries about HIV infection and Opportunistic infections e.g. TB, Hepatitis B • Secondary stigma for serving PLHIV and KPs • Unclear/unsupportive legal environment e.g. HTS laws and fear of court cases. • Challenging work environment such as political approaches in technical issues.	• Increase HCWs Knowledge and understanding of benefits on HIV and STI Combination Prevention package and interventions • Create understanding on benefits of providing integrated services for HIV and STI Combination Prevention • Provide friendly services and treat clients with dignity, without discrimination or favour, including youth and KPs • Train on interpersonal communication and attitude change • Build capacity on HIV and STI Combination Prevention package and interventions service delivery	• Training, targeted workshops & CMEs • Online CMEs-Through tele-conferencing e.g. NASCOP ECHO hubs Professional and association meetings and conferences • Guidelines, policies and IEC materials e.g. job aids for quick reference, Protocols & SOPs

7.3. Tertiary audience behaviour analysis

TARGET AUDIENCE	CURRENT BEHAVIOUR	DESIRED BEHAVIOUR	KEY BARRIERS	SBC OBJECTIVES	SBC APPROACH
RELIGIOUS LEADERS	Currently providing services selectively guided by religious teaching. Tendency to isolate minority and vulnerable priority groups resulting in discrimination and stigma due to personal biases.	• Religious leaders Know and access HIV and STI Combination Prevention package and interventions • Provide friendly counselling services and treat clients with dignity without discrimination or favour, including youth and minority group • Get tested to know status and be a role model • Use interactive sessions as opportunities to educate the congregants and create awareness about HIV and STI Combination Prevention • Actively advocate for and support desirable behaviour change	• Limited skills and experience in discussing sexual health on HIV prevention with KPs such as LGBTQ, MSM as well as the youth who are vulnerable • Lack of or inadequate information and knowledge about HIV and STI Combination Prevention • Conflict of some prevention interventions with religious beliefs • Personal biases towards minority and vulnerable groups (Adolescents, Youth, MSMs, FSWs & PWIDs) • Religious organizational constitutions or rules that hinder HIV and STI Combination Prevention e.g. condom use.	• Increase religious leaders' knowledge and understanding of benefits on HIV and STI Combination Prevention package and interventions including risk-reduction strategies for hard-to-reach minority groups without discrimination • Build the capacity of Religious leaders on communication skills to deliver individualized and humane approach to counselling • Provide education and advocate for HIV and STI Combination Prevention in their places of influence	• Capacity building and strengthening • Training the clergy with an updated module for religious leaders on HIV and STI Combination Prevention • Sensitization on the legislation against stigma and discrimination • Mentorship programmes and role modelling • Participation in TWGs on HIV and STI Combination Prevention meetings
SOCIAL, POLITICAL AND ADMINISTRATIVE LEADERSHIP	Work is currently highly segmented along programme lines. Financial support has been minimal from GoK due to long term donor support	• Policy and decision makers know and access HIV and STI Combination Prevention package and interventions • Get tested to know status and be a role model champion • Support financial allocation and facilitation for HIV and STI Combination Prevention services. • Ensure a policy environment that enforces integration of services for Prevention combination. • Develop policies and laws that support programmes that provide information, education, procedures and enforcement for non-discrimination of minority groups • Support programmes and efforts to reduce power inequalities in society	• Lack of engagement • Lack of or inadequate information and knowledge on HIV • Sensitive topic and cultural diversity • Personal biases towards minority and vulnerable groups • Available laws criminalize and discriminate against behaviours underlying HIV • An attitude towards HIV being a donor project • Unsupportive law especially cap 24 HAPCA • NAAC and NASCOP not in harmony leading to policies that are in conflict with program interventions	• Increase opinion leaders knowledge & understanding of benefits on HIV and STI combination prevention and advocate for more resources, increased availability and access to services and products • Advocate for the review of laws e.g. HAPCA • Achieve harmony between NAAC and NASCOP towards development of policies. Advocate for partnership strengthening to promote harmony among stakeholders (coordination)	• Advocacy meetings including; stakeholder sensitization meetings, targeted high level one on one meetings, workshops, breakfast meetings • Partnerships and collaboration with NACC and other line ministries and sectors (Education, Social protection, Youth and Gender) • Conferences, symposiums and workshops

8. Roles and responsibilities of the Coordination and management structure

This HIV and STI Combination Prevention SBC strategy will be anchored within current existing structures at the National and County levels. Key agencies responsible for the implementation include NASCOP and NACC, the Community Strategy and the Health Promotion Unit within the Ministry of Health. A Joint STI HIV and STI Combination Prevention SBC Technical Working Group (TWG) may be formed at both National and County levels to coordinate the proposed SBC efforts. TWG representatives may be from: NASCOP, NACC and CSOs concerned with core HIV and STI Combination Prevention interventions such as: HTS, PrEP, STI, PMTCT, ART, Key populations, Health Promotion, M&E, and Commodities. It is highly recommended that the coordination is strengthened at the National level and County clusters with high incidence 0.4-2.98% (9 counties) and medium incidence 0.13-0.38% (28 Counties). The formation of the coordination structures may be optional for low incidence (0.07 – 0.01%) counties.

National level Joint HIV and STI Combination Prevention SBC Technical Working Group

- Providing strategic guidance for coordinated design, management and evaluation of HIV and STI Combination Prevention SBC strategies and work plans at national and county levels.
- Advocating for national and county government support to ensure availability of financial, material and human resources to implement and prioritize HIV and STI Combination Prevention SBC interventions as outlined in this document.
- Commissioning regular technical reviews of national and county SBC strategies based on routine programme monitoring, evaluation and research to demonstrate their contribution towards national and global HIV programme goals and targets.
- Acting as a reference point for HIV and STI Combination Prevention SBC related strategies and initiatives.
- SBC program monitoring and evaluation.
- Close monitoring of broader communication and media processes and trends to ensure that HIV and STI Combination Prevention SBC reports keep pace with evolving HIV context.

County level Joint HIV and STI Combination Prevention SBC Technical Working Group

- Establishment and coordination of the County level TWG.
- Develop and implement County specific HIV and STI Combination Prevention SBC work plans.
- Integrate HIV and STI Combination Prevention SBC plans into CIDPs.
- Advocating for county government support to ensure availability of financial, material and human resources to implement and prioritize HIV and STI Combination Prevention SBC interventions.
- Acting as a reference point for HIV and STI Combination Prevention SBC related strategies and initiatives at County level.
- SBC program implementation, monitoring and evaluation.

Members of the National HIV and STI Combination Prevention Communication Sub-Committee TWG

The HIV and STI Combination Prevention Communication Subcommittee at national level would report to the Prevention Committee of Experts TWG in NASCOP.

The proposed members are:

- Head of Prevention Unit at NASCOP (Chair)
- Head of Communication at NASCOP (Secretary)
- Representative of Communication from NACC
- Chairs of communication committee in prevention sections/programs (VMMC, HTS, PrEP, KP, AYP, PMTCT, ART, STI)
- Representatives of communications office from Division of Health Promotion and Communication
- Representatives from Division of Community Health
- Communication officers of implementing partners dealing with prevention programs
- 2 representatives from Civil society organisations (CSOs)that promote prevention activities.
- 1 representative from the Kenya red cross communication department.
- 1 representative from county governments forwarded by Council of Governors.
- Representative(s) from Line Ministries; Education, Social services, (any other ministry can be co-opted as matters arise)
- Representatives from donor agencies

Members of the County Combined prevention communication Sub Committee TWG

The HIV and STI combination prevention communication subcommittee would report to the prevention committee at county level.

The proposed members are:

- County Aid & STI coordinator CASCO (Chair)
- County NACC focal person (Secretary)
- Representatives of communications office from Department of Health Promotion and Communication
- County Community Health strategy coordinator
- HIV prevention focal persons (VMMC, ART, HTS, PrEP, KP, AYP, PMTCT, STI, County Pharmacist)
- Communication officers of implementing partners dealing with prevention programs
- A representative from Civil society organisations (CSOs) that promote prevention activities.
- 1 Sub-CASCO on rotational basis.
- Representative(s) from Line Ministries; Education, Social services, (any other ministry can be co-opted as matters arise)

9. Monitoring & Evaluation for HIV and STI Combination Prevention SBC

A structured performance framework is needed from initiation of the SBC Strategy for the national HIV and STI Combination Prevention programme to facilitate baseline assessments and monitoring of programme outcomes among targeted audiences and to determine how well-set objectives are achieved.

The Table below defines some sample outputs, outcomes and impact indicators that illustrate the pathway of change for SBC outputs of HIV and STI Combination Prevention interventions. Users may select and adapt any mix of indicators, depending on their programme context and priority information needs.

Table 15: Suggested indicators for monitoring pathway of change following implementation of HIV and STI Combination Prevention Interventions

	INTERVENTIONS	OUTPUT	OUTCOME	IMPACT
BEHAVIOURAL	Peer education Targeted information, education, and communication Promotion, demonstration, and distribution of male and female condoms and water-based lubricants Risk assessment, risk-reduction counselling, and skills-building Evidence-informed behavioural interventions (EBI)	No. of materials developed/ distributed No. of individuals trained No. of activities conducted No. of persons reached with EBIs (LSE, IEC)	% persons with comprehensive HIV knowledge % men and women who had 2+ partners in the past 12 months % females age 15-24 who report unintended pregnancy of current pregnancy or most recent births (teen pregnancy) % reporting condom use at last sexual encounter with partner of unknown status	
BIOMEDICAL	HIV testing and counselling ARV-related prevention HIV care and treatment including eMTCT STI prevention, screening, and treatment Medically assisted therapy for PWID Needles and syringe programme TB screening and referral to treatment IPC compliance in health care settings	No. of service delivery points No. of commodities distributed No. of service providers trained No. of persons receiving services No. of persons-initiated PrEP or ART	% PLHIV who know their status % PLHIV retained in treatment % consistent use of ART for prevention % virally suppressed % persons using PEP % persons completing TB treatment % sites offering services % women giving birth to HIV negative babies % linkage to care % treated STI cases	No. new HIV infections No. AIDS-related deaths % young people who had sex before age 15 No. of cases of stigma and discrimination No. cases of sexual or occupational exposure associated with HIV transmission
STRUCTURAL	Shaping policy and creating enabling environments Reducing stigma and discrimination Empowering the community, including ownership and leadership Violence prevention and response Health systems strengthening	No. of policy documents developed or reviewed No. of events conducts No. of persons reached (cash transfer, LSE, education subsidies) No. of reported GBV cases	% government resource allocation for HIV % persons who experienced physical or sexual violence in the past 12 months % people who have an independent source of income by sex and age % OVCs on social protection programs Rate of school retention and dropouts Change in social norms	

9.1. Data Sources for HIV and STI Combination Prevention SBC Strategy

There are numerous potential sources of indicator data for SBC monitoring and evaluation. The following M&E systems are in place for consideration by national and county HIV prevention stakeholders.

Table 16: Data sources for HIV and STI Combination Prevention SBC strategy

DATA SOUCRCE	KEY INFORMATION CAPTURED	RESPONSIBLE ENTITY
HIV Modelling	HIV Estimate data generated through EPP/Spectrum	NACC
DHIS (HMIS)	Biomedical service delivery statistics collected from the health facilities	NASCOP
Country HIV Information Hub	Data on proportion of funds allocated by the county for HIV and AIDS and on county level HIV related activities	NACC
Kenya Demographic and Health Survey	Population based indicators on risky behaviours of sexually active adolescents and young people e.g. condom use at last sexual encounter with partner of unknown status and teenage pregnancy	KNBS
Kenya AIDS Indicator Survey	Data on the number of HIV positive adolescents and children who know their HIV status and treatment access	NASCOP
Education Sector Management Information System	School enrolment, teenage pregnancies, bursary support to OVC	Ministry of Education
Cash Transfer Information Management System	Number of children who benefit from cash transfer and other social protections initiatives	Ministry of Labour and Social Security (Children Department)
KNASA	Proportion of funds allocated for HIV and AIDS activities for the county, national and sectors	NACC
Partner Reports (narrative, DATIM, etc.)	Additional data on SBC activities including advocacy meetings, capacity building initiatives and media campaigns and outcomes	Implementing partner

To reduce the burden of documentation and reporting for identified indicators there is need to maximize use of existing data sources and minimize the frequency of routine reporting where possible. Introduction of additional routine and non-routine data collection methods (e.g. program activity reports or surveys) may depend on available resources and capacities. Baseline and endline targets may vary for different geographical locations.

The following table presents a sample M&E Framework for monitoring and evaluating impact, outcomes and outputs of a mix of behavioural, biomedical and structural of an HIV and STI Combination Prevention SBC strategy.

Table 17: Suggested Indicators for monitoring the pathway of change across SBC objectives for HIV and STI Combination Prevention - consider as main M&E add Strategy

SBC Objective	INPUT/PROCESS	OUTPUT	OUTCOME	IMPACT
Enabling Environment for HIV and STI Combination Prevention	Counties with designated SBC TWG	SBC activities: meetings and workshops	Increased number of partners for SBC	Increased domestic funding
	No. of County stakeholder meetings	Policies and laws reviewed and updated	Policy and legislative change	
	Counties with SBC meetings and workshops	No. of policy makers sensitized	Expanded public and private dialogue and debate	
Reducing Stigma and Discrimination	Counties with legal framework to protect human rights	Counties that enforce legislation against stigma and discrimination	% people expressing accepting attitudes towards PLHA	Reduced stigma n discrimination
	% counties providing training and support for legal aid, etc.	No. of persons sensitized on health and human rights	% employers with non-discriminatory workplace policies and practices	
	No. of community engagement events	No. of opinion leaders reached	Increased decision-making role for people disadvantaged by HIV	
	No. trained on violence prevention & response	No. of persons received GBV services	No. of reported GBV cases	
Increasing knowledge and awareness	No. of IEC materials distributed	Use of media: no. generated/produced, distributed	% persons aware/know signs, prevention, free access	Decreased HIV incidence
	No. of outreach events	No. of persons reached with IEC	No. of persons who know their HIV status	
	No. of outreach workers	Increased accuracy of information exchange	% reporting condom use at last sex	
Improved quality of HIV combination provider communication	No. of SDP providing user responsive HIV and STI Combination Prevention services	No. of new and revisit clients	Increased treatment adherence	Improved quality of life Decreased AIDS-related mortality
	% counties with codes of ethics and conduct for health workers	Demand for services	% target population coverage of HIV and STI Combination Prevention (PrEP, IPT, ART for PMTCT, VMMC, etc.)	
	No. of service providers trained on interpersonal communication for HIV and STI Combination Prevention	No. of clients who adhere to treatment	Viral suppression	
	No. of commodities distributed for HIV and STI Combination Prevention SBC	Stock outs in past 3 months		

Table 18: Suggested M & E Framework for SBC for HIV and STI Combination Prevention

	INDICATOR	DATA SOURCE	FREQUENCY	BASELINE (2019)	ENDLINE (2024)
REDUCE NEW INFECTIONS, DEATHS & STIGMA	No. of new HIV infections	Spectrum	Annually		
	No. of AIDS-related deaths	Spectrum	Annually		
	% young people who had sex before age 15	KDHS	Five yearly		
	No. of cases of stigma and discrimination	Stigma Index	Annually		
INCREASE AWARENESS	% PLHIV who know their status	KAIS	Five yearly		
	% persons with comprehensive HIV knowledge	KAIS	Five yearly		
	No. of IEC materials developed/ distributed	Program reports	Quarterly		
	No. of individuals trained	Program reports	Quarterly		
	No. of activities conducted	Program reports	Quarterly		
	No. of persons reached with EBIs (LSE, IEC)	DHIS	Quarterly		
IMPROVED SELF-EFFICACY	% young people who had 2+ partners in the past 12 months	KDHS	Five yearly		
	% females age 15-49 who report unintended pregnancy of current pregnancy or most recent births (teen pregnancy)	KDSH	Five yearly		
	% reporting condom use at last sexual encounter with partner of unknown status	KDHS	Five yearly		
	No. of teenage pregnancies reported	Education Sector Report	Annually		
IMPROVE QUALITY OF HIV AND	% PLHIV retained in treatment	DHIS	Quarterly		
	% continued ART for prevention	DHIS	Quarterly		

	% virally suppressed	DHIS	Quarterly		
	No. of service provision points	DHIS	Quarterly		
	No. of commodities distributed	LMIS	Quarterly		
	No. of service providers trained	Health facility survey	Every 2-3 years		
	No. of persons receiving services	DHIS	Quarterly		
	No. of persons initiated on PrEP or ART	DHIS	Quarterly		
ENABLING POLICY ENVIRONMENT	No. of policy documents developed or reviewed	Program reports	Annually		
	No. of advocacy events conducted	Program reports	Quarterly		
	No. of persons reached (cash transfer, LSE, education subsidies)	Dept of Youth Affairs & Social Welfare	Quarterly		
	Annual school dropout rates	Education sector MIS	Annually		
	No. reported GBV cases	DHIS	Quarterly		
	No. of teenage pregnancies	Education sector MIS	Annually		
	% young people accessing economic opportunities	COBPAR	Annually		

9.2. M&E Performance Framework for SBC Strategy

Indicators for monitoring and evaluating SBC for HIV and STI Combination Prevention may be organized across 4 levels of M&E as follows:

- Output (O): these reflect the efforts made by the program to influence the intended audience e.g. activities, products or services developed by the program. They may include: number of individuals trained, or community-level sessions conducted.
- Reach and Coverage (RC): the percentage or number, of the intended population that received, participated in, benefited from or exposed to the program activities.
    - Coverage primarily refers to the number of eligible people "covered" by a program or received services.
    - Reach refers to the percentage of the population who benefitted from or were exposed to a program; requires structured interviews or surveys.
- Intermediate Outcome (IO): are "behavioural predictors" or antecedents of behaviour.
    - At the individual level, intermediate outcomes may include factors such as knowledge, attitudes, intention, self-efficacy, and so forth.
    - At the community level, they may include leadership and participation. Measures of intermediate outcomes require some type of structured interview.
- Behavioural Outcomes (BO): are the specific actions. These outcomes refer to actual measurable changes in behaviour that are ideally taken by an intended audience (e.g., the use of HIVST). Positive behavioural outcomes such as taking ART for eMTCT may ultimately lead to improved maternal and child health outcomes. They are generally measured through structured interviews or surveys. Indirect methods such as clinic attendance records or product sales can serve as proxies for behaviour.

SBC Indicators may also address multiple levels of influence as summarized below:

- Individual: monitoring change at the individual level may include indicators that measure recall of messages, knowledge, self-efficacy, intention, behaviour, perceived social norms, and attitudes.
- Community: monitoring of community mobilization efforts typically fall at the community level. These include indicators about participation in community events and the role of community leaders.
- Health service (HS) delivery: monitor the behaviour of health service delivery teams in terms of their use of SBC materials.
- Policy and environment: monitor political will, policy changes, national coalition-building, and resource allocation that create opportunities for communities and individuals to live healthy lives.

Table 19: M & E Performance Framework for SBC Strategy for HIV and STI Combination Prevention

OBJECTIVE	SBC STRATEGY	INDICATOR	DISAGGREGATION	FREQUENCY	BASELINE	ENDLINE	DATA SOURCE
ENABLING POLICY ENVIRONMENT FOR HIV AND STI COMBINATION PREVENTION SBC	Support of HIV and STI Combination Prevention collaboration and coordination (O, Policy)	No. of meetings that foster technical HIV and STI Combination Prevention coordination and collaboration between country partners	None	Annually	0		Program reports
	Development of National HIV and STI Combination Prevention communication strategy for national capacity strengthening about HIV and STI Combination Prevention (IO, Policy)	National HIV and STI Combination Prevention communication strategy approved by the ministry	None	1st Year	0		Program reports
	Launch and dissemination of HIV and STI Combination Prevention communication strategy (O, Policy)	HIV and STI Combination Prevention Communication strategy launched and disseminated		1st Year	0		Program reports
		No. copies of HIV and STI Combination Prevention Communication strategy disseminated	By geographical location				
		No. of stakeholders who attended the launch and dissemination	By level of government and partners				
	Policy advocacy and sensitization about HIV and STI Combination Prevention (IO, Policy)	No. of policy advocacy and sensitization forums held about HIV and STI Combination Prevention	By level of government and partners	Annually			Program reports
	Reach of HIV and STI Combination Prevention advocacy (RC, Policy)	No. of decision makers reached with HIV and STI Combination Prevention advocacy activities	By type of intervention, decision maker (e.g., politician, health facility administrator, religious leader)	Annually	0		Program reports
INCREASED KNOWLEDGE AND AWARENESS OF HIV AND STI COMBINATION PREVENTION	Development of HIV and STI Combination Prevention communication materials (O, HS)	No. of communication materials developed for HIV and STI Combination Prevention in last 12 months		Annually	0		Program reports
	Dissemination of HIV and STI Combination Prevention communication materials (O, HS)	No. of HIV and STI Combination Prevention communication materials disseminated in the last 12 months		Annually	0		Program reports
	Dissemination of HIV and STI Combination Prevention mass media messages (O, Community)	No. of HIV and STI Combination Prevention messages that were aired on television or radio in the last 12 months	By type of intervention, geographical coverage	Annually			Program reports
		% HIV and STI Combination Prevention broadcasts aired at the requested time	By type of intervention, geographical coverage	Annually			Program reports
	Implementation of SBC HIV and STI Combination Prevention interventions (O HS)	No. of SBC interventions implemented in the last 12 months	By type of intervention, geographical coverage	Annually			Program reports

	Community-level HIV and STI Combination Prevention activities (O, Com)	No. of community-level activities for HIV and STI Combination Prevention conducted in in the last 12 months	By type of intervention, geographical coverage	Annually			Program reports
	HIV and STI Combination Prevention messages, campaigns, or communication initiatives (RC, Individual)	No. of intended audience who recall hearing or seeing a specific HIV and STI Combination Prevention message/campaign/ communication initiative*in the last 12 months	By type of audience, age, sex	Annually			Program reports
	HIV and STI Combination Prevention messages, campaigns, or communication initiatives (RC, Individual)	No. of HIV and STI Combination Prevention messages campaign/communication conducted in the last 12 months	By type of intervention, geographical coverage	Annually			Program reports
	Coverage of HIV and STI Combination Prevention mass media messages (RC)	Estimated No. of intended audience in program areas reached by HIV and STI Combination Prevention mass media	By type of audience, age, sex	Annually			Program reports
	Knowledge of HIV and STI Combination Prevention interventions (IO, Individual)	% intended audience with comprehensive knowledge of HIV and STI Combination Prevention interventions	By type of audience, age, sex	3-5 years			Population survey
IMPROVING QUALITY OF HIV AND STI COMBINATION PREVENTION SBC	HIV and STI Combination Prevention provider training (O, HS)	No. of service providers trained on HIV and STI Combination Prevention interpersonal communication	By type of intervention, provider (community- or facility-based), sexual orientation	Annually			Program reports
	Dissemination of HIV and STI Combination Prevention communication materials to service providers (RC HS)	No. of service providers who received HIV and STI Combination Prevention communication materials	By geographic area, type of intervention, provider (community- vs. facility-based), type of materials (e.g., print, billboard, mobile application)	Annually			Program reports
	Provider use of HIV and STI Combination Prevention communication materials (BO, HS)	% HIV and STI Combination Prevention service providers reporting use of HIV and STI Combination Prevention communication materials in past 12 months	By geographic area, type of intervention, provider (community- or facility-based)	Annually			Program reports
	Provider-client communication about HIV and STI Combination Prevention (IO, Individual)	No. of individuals who were informed of other HIV and STI Combination Prevention interventions besides their preferred interventions, among those who visited an HIV and STI Combination Prevention provider in the past 12 months	By geographic area, type of intervention, age category, current marital status, parity	Annually			Program reports
	Provider-client communication about HIV and STI Combination Prevention (IO, Individual)	No. of individuals who were informed of potential side effects of any type of HIV and STI Combination Prevention interventions during their visit, among those who visited an HIV and STI Combination Prevention provider in the past 12 months	By geographic area, type of intervention, sex, age category, current marital status, parity	Annually			Program reports
	Attitudes towards HIV and STI Combination Prevention providers (IO, Individual)	No. of intended audience members with favorable attitudes towards HIV and STI Combination Prevention services	By geographic area, type of intervention, sex, age category, current marital status, parity	3-5 years			Population survey

	Reach of information from provider (RC, Individual)	% intended audience who reported that they received HIV and STI Combination Prevention information from a facility- or community-based health provider in the last 12 months (or a specified reference period) *	By geographic area, intervention, sex, age category, current marital status, parity, community, or facility source	3-5 years			Population survey
	Satisfaction with HIV and STI Combination Prevention provider (IO, Community)	% individuals who would refer others to their HIV and STI Combination Prevention provider, among those who have sought HIV and STI Combination Prevention services in last 12 months	By geographic area, type of intervention, age category, current marital status, parity, HIV and STI Combination Prevention interventions	Every 2 years			Client satisfaction survey
	Satisfaction with HIV and STI Combination Prevention services (BO, Community)	% individuals currently using at least one HIV and STI Combination Prevention intervention, reporting they adopted interventions by choice	By geographic area, type of intervention, age category, current marital status, parity, HIV and STI Combination Prevention interventions	Annually			Client satisfaction survey
INCREASED SELF-EFFICACY FOR HIV AND STI COMBINATION PREVENTION	Normative beliefs about HIV and STI Combination Prevention (IO, Community)	% intended audience who believe that their spouse/partner would approve of them using HIV and STI Combination Prevention intervention	By geographic area, type of intervention, sex, age category, current marital status, parity	Annually			Client satisfaction survey
	Normative beliefs about HIV and STI Combination Prevention (IO, Community)	% intended audience who believe that their spouse/partner would approve of them using condoms to space pregnancy* (clarify)	By geographic area, type of intervention, sex, age category, current marital status, parity	Annually			Client satisfaction survey
	Partner communication about HIV and STI Combination Prevention (IO, Community)	% intended audience who discussed HIV and STI Combination Prevention with their spouse/partner in the last 12 months % intended audience think their spouse/partner values their opinion on whether to use HIV and STI Combination Prevention*	By geographic area, type of intervention, sex, age category, current marital status, level of education, employment status	Annually			Client satisfaction survey
	Partner communication about HIV and STI Combination Prevention (BO, Community)	% individuals of the intended audience who talked about HIV and STI Combination Prevention with their spouse/partner in the last 12 months (or a specified reference period) *	By geographic area, type of intervention, sex, age category, parity	3-5 years			Population survey
	Interpersonal communication about HIV and STI Combination Prevention (BO, Community)	% individuals of intended audience who talked about HIV and STI Combination Prevention with others (friends, relatives, community) in the last 12 months (or a specified reference period) *	By geographic area, type of intervention, sex, age category, current marital status, parity, which "other" they talked to	3-5 years			Population survey
	Interpersonal communication about HIV and STI Combination Prevention (BO, Community)	% intended audience that has encouraged others (friends, relatives, community) to use HIV and STI Combination Prevention in the last 12 months (or a specified reference period) *	By geographic area, type of intervention, sex, age category, category of persons they encouraged	3-5 years			Population survey

	Interpersonal communication about HIV and STI Combination Prevention (BO, Community)	% individuals who have talked about HIV and STI Combination Prevention with a provider in the last 12 months[20]	By geographic area, type of intervention, sex, age category, parity, type of HIV and STI Combination Prevention user (e.g., non-user versus user),	3-5 years			Population survey
	Intention to use HIV and STI Combination Prevention (IO, Individual)	% non-users among targeted audience who intend to adopt HIV and STI Combination Prevention in the next three months	By geographic area, type of intervention, sex, age category, current marital status, parity, type of HIV and STI Combination Prevention interventions	3-5 years			Population survey
	Intention to continue to use HIV and STI Combination Prevention (IO, Individual)	% modern HIV and STI Combination Prevention users who intend to continue using a modern HIV and STI Combination Prevention intervention in the next 3 months	By geographic area, type of intervention, sex, age category, current marital status, parity, type of HIV and STI Combination Prevention interventions	Annually			
	Injunctive norms about HIV and STI Combination Prevention (IO, Individual)	% intended audience who believe that most people in their community approve of people like them using HIV and STI Combination Prevention*	By geographic area, type of intervention, sex, age category, current marital status, parity	Annually			
	Attitudes towards HIV and STI Combination Prevention (IO, Individual)	% intended audience with favorable attitudes towards HIV and STI Combination Prevention*(survey question should explain what favourable means)	By geographic area, type of intervention, sex, age category, current marital status, parity	Annually			
	Use of HIV and STI Combination Prevention interventions (BO, Community)	% individuals using (or whose partner is using) an HIV and STI Combination Prevention intervention	By type of intervention	Annually			
	Participation in community-level HIV and STI Combination Prevention activities (RC)	No. community members participating in community-level activities for HIV and STI Combination Prevention in the last six months	By geographic area, intervention, sex, age category, activity type (e.g., community dialogues, support groups, commodity distribution, household visits, mobile clinics)	Annually			

[20] Need for a baseline survey

SAMPLE IMPLEMENTATION PLAN FOR SBC FOR HIV AND STI COMBINATION PREVENTION

GOAL	PROMOTE UPTAKE, UTILIZATION AND DEMAND FOR HIV AND STI COMBINATION PREVENTION INTERVENTION FOR SUSTAINED SOCIAL AND BEHAVIOUR CHANGE AND CONTRIBUTE TOWARD THE ELIMINATION OF NEW INFECTIONS, STIGMA AND DISCRIMINATION IN KENYA BY 2030			
TARGET AUDIENCE (Primary/Secondary)	INCREASING AWARENESS & SELF-EFFICACY	IMPROVING PROVIDER CAPACITY FOR QUALITY OF SERVICES	INCREASING DEMAND FOR AND UTILIZATION FOR SERVICES	ENABLING POLICY AND SOCIAL ENVIRONMENT
PREGNANT & BREASTFEEDING WOMEN (PBFW)	• Targeted interpersonal communication (IPC) programmes in community e.g. counselling & dialogue, Peer to peer groups like mother support groups • Community media and mobilization and support via networks and CSOs • Targeted mass media campaigns • Targeted Information Education and Communication materials • Male engage: ment approaches • Social media Online sites • Mass media – Radio, TV, • Mobile technology & Social media • Community media, edutainment. •	• Training, targeted workshops & CMEs • Online CMEs-Through tele-conferencing e.g. NASCOP ECHO hubs Professional and association meetings and conferences • Provide care and treatment guidelines, and IEC materials e.g. job aids for quick reference, Protocols & SOP • Train HCW on how to report to DHIS and M&E • Develop indicators for Syphilis reporting to DHIS2	• Peer education programs • Education and support through available networks and community-based organization • Distribute IEC materials or posters with information on congenital syphilis • Ambassadors/champions as role models. • Community media, dialogue, drop in centres, outreaches • Mobile technology & Social media • Outreaches to Schools and colleges • Community media, edutainment • Advocacy meetings including; stakeholder sensitization meetings, targeted high level one on one meetings, workshops, breakfast meetings • Include Dual kits and drugs in the national distribution system •	• Develop a training package • Develop rapid advice/policy brief on combination prevention for HIV/Syphilis • Sensitization on the legislation against stigma and discrimination • Mentorship programs and role modelling • Participation in TWGs on HIV and STI Combination Prevention meetings • •Partnerships and collaboration with NACC and other line ministries and sectors (Education, Social protection, Youth and Gender) • Conferences, symposiums and workshops. • Increasing uptake of rapid dual HIV/Syphilis point care testing in ANC • Timely access to Syphilis screening at ANC. • Conducting Support supervision to HCW. • Ensuring a constant supply of reagents and test kits • Sensitization of health care workers on the importance of proper reporting of quality, timely data to avoid the reporting gaps. • Put strategies in place to ensure universal and equitable antenatal care (ANC) services that include syphilis testing and treatment at no cost to pregnant women. • Conducting best practice -sharing forums
DISCORDANT COUPLES (DC)	• Conducting outreaches to mobilize and sensitize the community on HIV and STI Combination Prevention • Conduct Mass and Social media Campaigns • Develop & distribute IEC Materials • Conduct targeted community messaging during Community Action and Dialogue days (Chief Barazas)	• Conduct targeted health talks in the health facilities e.g. couple counselling and testing, HIV and STI Combination Prevention strategy • Train and sensitize the healthcare workers on interpersonal communication and adherence to professional ethics Train and supervise health workers on professionalism and confidentiality	• Distribution of HIV prevention Commodities such as PrEP, HTS. • Target setting and quantification of HIV Prevention related commodities • Conduct training for HCW on combined HIV prevention strategies, data management	• Training or sensitization on HIV advocacy and rights targeting stakeholders and partners • Conducting meetings and workshops with partners and local leaders e.g. CBO dealing with health • Conduct sensitization on legislation against stigma and discrimination
ADOLESCENTS & YOUNG PEOPLE (AYP)	• Conduct Mass media awareness through Radio, TV and campaigns • Conduct Community media, and edutainment for mobilization and support via networks and CSOs • Targeted IEC via Mobile technology & Social media, • Conduct Outreach to Schools and colleges.	• Conduct Training to HCWs and teachers on APOC and Youth friendly services. • Conduct targeted workshops & CMEs to HCWs, teachers & clergy. • Provide Online CMEs-Through tele-conferencing e.g. NASCOP ECHO hubs Professional and association meetings and conferences	• Conduct Mass media awareness through Radio, TV, campaigns • Develop and provide IEC materials e.g. pamphlets, posters, flip charts. • Conduct Targeted interpersonal communication (IPC) programmes in community e.g. counselling & dialogue, Peer to peer groups.	• Develop Guidelines, policies and IEC materials e.g. job aids for quick reference, Protocols & SOPs • Develop Male engagement approaches and policies geared to AYP and AYGW on HIV and SRH issues • Conduct Capacity building, strengthening clergy with updated module for religious leaders on HIV and STI Combination Prevention

GOAL	PROMOTE UPTAKE, UTILIZATION AND DEMAND FOR HIV AND STI COMBINATION PREVENTION INTERVENTION FOR SUSTAINED SOCIAL AND BEHAVIOUR CHANGE AND CONTRIBUTE TOWARD THE ELIMINATION OF NEW INFECTIONS, STIGMA AND DISCRIMINATION IN KENYA BY 2030			
TARGET AUDIENCE (Primary/Secondary)	INCREASING AWARENESS & SELF-EFFICACY	IMPROVING PROVIDER CAPACITY FOR QUALITY OF SERVICES	INCREASING DEMAND FOR AND UTILIZATION FOR SERVICES	ENABLING POLICY AND SOCIAL ENVIRONMENT
	• Develop IEC materials e.g. pamphlets, posters, flip charts. • Conduct Targeted interpersonal communication (IPC) programmes in community e.g. counselling & dialogue, Peer to peer groups.	• Develop IEC materials e.g. job aids for HCWs and teachers. • Conduct TWGs meetings on HIV and STI Combination Prevention. • Conduct Conferences, symposiums and workshops.		• Conduct sensitization on legislation against stigma and discrimination • Conduct Advocacy meetings including; stakeholder sensitization meetings, targeted high level one on one meetings, workshops, breakfast meetings • Conduct Partnerships and collaboration with NACC and other line ministries and sectors (Education, Social protection, Youth and Gender). • Conduct advocacy to local administration and political environment on AYP, AYGW -HIV /STI / ASRH issues on combined prevention strategies.
KEY POPULATIONS (KP) • SEX WORKERS • MEN WHO HAVE SEX WITH MEN • PEOPLE WHO USE DRUGS	• Develop IEC Materials • Produce the IEC materials • Conduct outreach events at hotpots and safe spaces • KPs contacted weekly • Disseminate and distribute IEC Materials • Plan for refresher trainings immediately after the training	• Conduct training to service providers on HIV and STI Combination Prevention • Train peer educators on HIV and STI Combination Prevention • Peer ratio in hotspots maintained at 1:30-40 • Develop IEC materials including guidelines and SOPs • Plan for refresher trainings • Capacity building initiatives (CMEs, OJT, support supervisions, coaching, mentorship and whole site orientation of facility) • Conduct KP sensitivity training • Optimize technology for data capturing, analysis and use	• Provide individual and group counseling sessions • Ambassadors/ champions engaged as role models • Use of social media (dating sites) to share messages • Formation of KP support groups • Implementation of interventions that are co-developed with the users and evidence based. • Strengthen referral and follow up strategy	• Strengthen violence response by implementers • Improve knowledge and attitudes of law enforcement (police, administrative officers,) • Sensitization of policy makers (MPs), County assemblies • Sensitization of the community opinion leaders, gatekeepers, community advisory boards •
Healthcare Providers	• Conduct sensitization meetings for healthcare providers for increasing HCWs Knowledge and understanding of benefits on HIV and STI Combination Prevention package and interventions	• Training, targeted workshops & CMEs • Online CMEs-Through tele-conferencing e.g. NASCOP ECHO hubs Professional and association meetings and conferences • Guidelines, policies and IEC materials e.g. job aids for quick reference, Protocols & SOPs	• Counsel clients on HIV and STI Combination prevention interventions to improve demand and utilization for services	• Conduct sensitization meetings on revised HIV and STI Combination prevention guidelines and policies

SAMPLE M&E PLAN FOR SBC FOR HIV AND STI COMBINATION PREVENTION

OVERALL GOAL	PROMOTE UPTAKE, UTILIZATION AND DEMAND FOR HIV AND STI COMBINATION PREVENTION INTERVENTION FOR SUSTAINED SOCIAL AND BEHAVIOUR CHANGE AND CONTRIBUTE TOWARD THE ELIMINATION OF NEW INFECTIONS, STIGMA AND DISCRIMINATION IN KENYA BY 2030			**Suggested Impact Indicators** (by population, location, gender) • Unmet demand for HIV and STI Combination Prevention • HIV prevalence and incidence • Stigma index
SBC OBJECTIVES	**INCREASING AWARENESS & SELF-EFFICACY**	**IMPROVING PROVIDER CAPACITY FOR QUALITY OF SERVICES**	**INCREASING DEMAND FOR AND UTILIZATION FOR SERVICES**	**ENABLING POLICY AND SOCIAL ENVIRONMENT**
PREGNANT & BREASTFEEDING WOMEN (PBFW)	People with comprehensive knowledge of HIV People who recall hearing or seeing messages in past 12 months People who believe that their spouse/partner would approve of then using intervention	People reached with activities Individuals who have talked about a prevention intervention with a provider in past 12 months	PBFW who were tested/re-tested for HIV and STI and received their results People who intend to use intervention in next 3 months PBFW who initiated ART for PMTCT	Spousal consent for married women to access SRH services Mandatory HIV testing for marriage Persons who experienced physical or sexual violence from a male intimate partner in the past 12 months
DISCORDANT COUPLES (DC)	Estimated people reached by mass media People who received IEC materials People with comprehensive HIV knowledge People with favorable attitude toward HIV services People participating in support group People who believe their partner values their opinion whether to use an intervention	Individuals who were informed of potential side effects of any type of intervention People living with HIV who reported of stigma and discrimination in health setting People living with HIV who reported a health worker told others about their HIV status without their consent	People who initiated/received PrEP PLHIV retained on ART PLHIV tested for VL every 6 months PLHIV who attained viral suppression People currently using at least one intervention by choice Individuals whose partner is using an intervention	Women & men aged 15-49 years who express discriminatory attitudes toward PLHIV Persons sensitized on health and human rights People expressing accepting attitude toward PLHIV People who believe most people in their community approve of people like them using an intervention Employers with non-discriminatory workplace policies
ADOLESCENTS & YOUNG PEOPLE (AYP)	AYP who received IEC materials Estimated people reached by mass media AYP contacted by peer educators AYP with comprehensive knowledge of HIV prevention Individuals who discussed prevention intervention with partner in past 12 months Non-users who intend to adopt intervention	People who reported receiving information from a provider in past 12 months AYP living with HIV who reported a health worker told others about their HIV status without their consent AYP who would refer others to their provider among those who visited a provider in the past 12 months	AYP reporting adoption of HIV intervention People who initiate/adhere to PrEP or ART AYW who report unintended pregnancy AYP who were tested for HIV and received their results	Adolescents sensitized on child rights Reported cases of stigma against AYP Reported cases of violence against AYP Parental consent for adolescent to access HIV testing AYP reached with cash transfer YP participating in community level advocacy events in past 6 months YW who have an independent source of income
KEY POPULATIONS (KP) ● **SEX WORKERS** ● **MEN WHO HAVE SEX WITH MEN** ● **PEOPLE WHO USE DRUGS**	KPs who received IEC materials Estimated people reached by mass media KPs contacted by peer educators KPs with knowledge of HIV prevention package KPs with comprehensive knowledge about HIV	KPs who reported a health worker told others about their identity without their consent KPs denied health services because of their risk behaviours in past 12 months KP who would refer others to provider of those who visited a provider in the past 12 months Individuals who were informed of other interventions besides their preferred intervention among those who visited a provider in past 12 months	People currently using at least one intervention by choice KPs who initiated PrEP or ART PrEP users who intend to continue using intervention for next 3 months KPs who received GBV services KPs screened for STI every quarter, diagnosed and completed treatment KPs who took HIV test every quarter Female KPs using FP/spacing methods	Reported cases of stigma and discrimination Women & men aged 15-49 years who express discriminatory attitudes toward key populations Any stigmatization or punitive regulation of sex work Criminalization of sex work, Criminalization of same-sex acts Criminalization of drug use or possession for personal use Criminalization of transgender people People expressing accepting attitude toward KPs
HEALTH WORKERS	Providers who received IEC materials	Providers trained (on interpersonal communication for prevention intervention; violence prevention and response) Providers who report use of communication materials in past 12 months	Providers currently using at least one HIV prevention intervention by choice AYP who were tested for HIV and received their results	Counties with code of conduct and ethics for health workers

Operational Definitions/Glossary

Advocacy: this refers to processes or activities that aim to directly or indirectly influence decisions within the political, economic or social systems and institutions to support and implement actions that contribute to the realization of the desired behavioural outcomes.

Audience: refers to a group to which information/communication is targeted to and includes primary, secondary and tertiary audience.

Behaviour Change Communication (BCC): refers to the strategic use of communication, both mass media and interpersonal channels, to promote positive behavioural outcomes. It is based on formative research of the target groups' barriers and facilitators to adopting new practices or changing their current behaviours.

Behaviour: this is the outward manifestation of an individual's internal response to a situation. The response (an action or change in action) is derived through an individual's decision-making process, which may be automatic or deliberate (Kahneman 2011), and shaped by economic, psychological, or social mechanisms (Pawson and Tilley, 1997; Pawson, 2006; Pawson; 2013).

Communication serves as the backdrop to activities that intend to change behaviour. This element encompasses the channels or means through which behaviourally informed messages are conveyed to the target audience**.**

Behaviour change activities target or support specific choices and behaviours that are directly linked to a desired outcome. Behaviour change (or desired outcomes) can be observed in their changes as increasing, decreasing, being enhanced, improving, or being maintained (Morra-Imas and Rist 2009).

Social and Behaviour Change Communication: this is an interactive process of using communication to change behaviours by positively influencing knowledge, attitudes and social norms.

Condom Programming: a means of ensuring that sexually active persons at risk of HIV are motivated to use condoms, have access to quality condoms, and can use them consistently and correctly.

Differentiated service delivery model: refers to the process of simplifying and adapting HIV services across the care and treatment cascade to reflect the preferences and expectations of various groups of people living with HIV while reducing unnecessary burdens on the health system. All stable ART patients at treatment sites should be given six months of ART and six-month clinical consultations. All ART sites should regularly identify stable patients eligible for differentiated service delivery models, and develop and implement fast track ART refills for stable patients. PEPFAR estimates 60-80% of ART clients may be eligible for 6-month interval visits, i.e. their viral load is suppressed, and they don't have any co-existing medical condition requiring frequent medical follow-up. Patients visiting after 6 months for clinical review or drug refills should be screened for Opportunistic Infections, particularly TB.

Ecological Model: refers to is a theory-based framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviours of individuals and identifying leverage points for changing these behaviours.

Evidence-Informed Behavioural Interventions (EBIs): Interventions that have been proven effective through outcome evaluations and are likely to be effective in changing target behavior if implemented with integrity.

HIV and STI Combination Prevention: the strategic, simultaneous use of different classes of prevention activities (biomedical, behavioural, social/structural) that operate on multiple levels (individual, relationship, community, societal), to respond to the specific needs of particular audiences and modes of HIV and STI transmission, and to make efficient use of resources through prioritizing, partnership, and engagement of affected communities.

Behavioural interventions: provide information, motivation, education, and skills-building to help individuals or groups to reduce risky behaviours and sustain this positive change. Various communication channels may be used to change sexual behaviour (e.g. mass media, community-outreach, interpersonal communication) to disseminate messages designed to encourage people to reduce risky behaviours and promote protective behaviours (e.g. correct and consistent condom use, or never sharing injecting equipment). Delivered singly or as part of a comprehensive package, behavioural interventions also strive to increase the acceptability and demand for biomedical interventions.

Biomedical interventions: are those that directly influence the biological systems through which the virus infects a new host, so as to block virus transmission (e.g. male and female condoms), decrease infectiousness (e.g. antiretroviral therapy [ART] in prevention), or reduce risk of acquiring infection (e.g. voluntary medical male circumcision and STI management). They may be delivered at the health facility or community level with an established referral system.

Structural interventions: address social, economic, political, and environmental factors that affect individual or group HIV risk and vulnerability. They typically involve at least one of the following: Effecting policy or legal changes; Challenging harmful social norms; Catalyzing social and political change; and Empowering communities and groups. These approaches must be implemented in combination with behavioural and biomedical approaches and should be based on scientifically derived evidence and wisdom and ownership of communities.

HIV Testing: comprises of many strategies which include the following:

- **Index testing:** this is a form of HIV testing in which a person diagnosed with HIV serves as an "index patient" to identify family members, partners, and other individuals at higher risk of being HIV positive who are then proactively offered HIV testing services as a result of their association with the index patient. In addition to partner notification services, index testing also includes testing services for biological children and the parents of young children**.** Index testing generally has higher yields than other testing modalities and may also enable outreach to individuals unlikely to seek testing services on their own, especially younger men.
- **HIV Self Testing (HIVST):** is a process whereby an individual collects his or her own specimen (oral fluid or blood), performs an HIV rapid diagnostic test and interprets the result, often in a private setting, either alone or with assistance of a provider or someone he or she trusts, in a setting of their choice.
- **Client-Initiated HIV Testing and Counselling (CITC):** refers to a situation in which individuals, couples, or groups actively seek and undergo HIV testing and counselling at a site where these services are provided. Client-initiated HTC puts emphasis on tailored risk assessment and counselling.
- **Provider-Initiated HIV Testing and Counselling (PITC)** in health facilities is a model of HIV testing and counselling in which the healthcare provider offers and recommends HIV testing to patients as a standard component of medical care. Since post-test counselling is limited during PITC, service providers may need to refer key populations to further counselling services depending on individual needs. PITC comprises 3 testing strategies:
    - Diagnostic testing is the testing of patients who present with signs or symptoms suggestive of HIV.
    - Targeted testing is testing of subpopulations of increased risk as identified by behavioral, clinical, or demographic characteristics, or a combination of these such as STI clients, alcohol abuse, or high burdened areas.
    - Universal screening is testing of all patients presenting for medical attention regardless of presenting complaint (Health Research and Education Trust 2009). Diagnostic or strategically targeted, risk-based testing are recommended where ART coverage is over 70% and should yield at least 10% positivity.

Hotspots: Geographical locations where some members of key population groups may meet, cruse, solicit sexual partners, have sex, or inject drugs. These can be streets, clubs, bars, abandoned buildings, and so on.

Information, Education and Communication: this is a communication strategy for influencing behaviour which emphasizes information and education and combines strategies, approaches, and methods that enable individuals, families, groups, organizations, and communities to play active roles in achieving, protecting, and sustaining their own health.

Key populations: are defined groups who, due to specific higher-risk behaviours, are at increased risk of human immunodeficiency virus (HIV) irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviours that increase their vulnerability to HIV.

- **Female Sex Worker**: Female who engages in sex work and exchange sex acts for something of value including cash or material items that would otherwise not be extended to them by their sex partners. It is important to note that sex work is consensual sex between a sex worker and a client who gives something of value in exchange for sex.
- **Sex workers:** include female, male and transgender adults (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally.
- **Men who have sex with men:** refers to all men who engage in sexual and/or romantic relations with other men. Men who have sex with men in Kenya also reflect a range of sexual and gender identities while many also have sex with women. It should be noted that not all males who have sex with men identify themselves as homosexuals or even as men.
- **People who inject drugs:** refers to people who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine type stimulants, cocaine, hypno-sedatives, and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous, or other injectable routes.
- **Transgender:** is an umbrella term for people whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth; it includes people who are transsexual, transgender, or otherwise gender non-conforming. Transgender people may self-identify as transgender, female, male, trans-woman or trans-man, trans-sexual, or one of many other transgender identities, depending on their culture. They may express their genders in a variety of masculine, feminine, and/or androgynous ways.

Mass Media: refers to channels of communication that involve transmitting information to large numbers of people.

Mature Minors: Individuals who are 15 years of age or older, living apart from their parents or guardian, with or without their consent for any duration, and managing their own financial affairs, regardless of the source of income.

Media: refers to channels of communication through which people receive information.

Needle and Syringe Programme (NSP): is the distribution of free or low-cost sterile injecting equipment to people who inject to facilitate the use of clean needles and syringes in order to reduce the number of injections with used needles and syringes. NSP may also offer basic health care and address other specific issues that commonly affect people who inject drugs, such as risk reduction counselling, wound care and overdose prevention.

New ARV Regimen: Dolutegravir (DTG)-containing regimens are the preferred first-line ART due to superior efficacy, more rapid viral suppression, improved tolerability, and higher threshold for resistance compared to efavirenz (EFV)-containing regimens. The fixed dose combination (FDC) of tenofovir disoproxil fumarate/lamivudine/dolutegravir (TLD) is now available at a cost affordable to low- and middle-income countries.

Partner notification services (PNS): Trained providers ask people diagnosed with HIV about their sexual and/ or drug injecting partners, and then, if the HIV-positive client agrees, offers these partner(s) HIV testing services. Partner notification is provided using passive or assisted approaches.

Assisted Partner Notification Services (aPNS): Trained providers help HIV-positive clients disclose their status to their partner(s) and/or they help the clients provide information enabling a provider to anonymously disclose to a partner that they may have been exposed to HIV and should seek HIV testing services. Types of assisted partner notification include contract referral, provider referral, dual referral, and anonymous client notification services.

Peer education is based on the reality that many people make changes not only based on what they know, but on the opinions and actions of their close, trusted peers. Peer educators can communicate and understand in a way that the best-intentioned non-peers can't and can serve as role models for change. Note that peer education is not exclusively for school-based programs, but has been used in a wide range of contexts with a diversity of populations, including street youth, factory workers, sex workers, drug users, prisoners, etc.

Peer: A person who shares almost the same characteristics with another, such as age, social status, sexual orientation etc., e.g. adolescent girls in a village of the same social status and educational level.

Polling booth survey: is a group interview method whereby participants give their responses through a ballot box. In this method, the individual responses are anonymous and unlinked (i.e. an individual respondent is not linked to the response). This anonymity assures respondents of confidentiality, encouraging them to accurately disclose sensitive personal information.

Pre-Exposure Prophylaxis (PrEP): is an HIV prevention method where an HIV negative person at high risk of HIV infection takes daily oral ART medication to prevent HIV infection. Best used in combination with other HIV prevention strategies e.g. condoms.

Sexual violence: is defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's and men's sexuality using coercion, threats of harm, or physical force by any person, regardless of relationship to the victim, in any setting, including but not limited to home and work.

Social marketing: the adaptation of commercial marketing and sales concepts and techniques for attainment of social goals. It seeks to make health-related information, products, and services easily available and affordable to low-income populations and those at risk while at the same time promoting the adoption of healthier behaviour.

Social norms: refer to the perceptions people hold about how socially acceptable particular behaviours are in their respective community or other social group. What is considered socially acceptable may result from a group's cultural or religious beliefs, or their concept of what is fair. Additionally, when determining whether to adopt new practices or change their behaviours, people often are concerned with how they will look compared to others and whether this will result in them being shamed or ridiculed or being celebrated or congratulated.

Standard media: includes the use of television, radio, newspapers, posters and billboards, and leaflets to deliver behaviour change messages.

Vulnerable Populations: are people for whom a range of factors makes them less able to protect themselves against HIV, such as:

- **Adolescent girls and young women (AGYW):** Adolescents are 10-19 years of age, while young people are aged 15-24 years
- **Sero-discordant couples**: Sexual partners of People Living with HIV (PLHIV) are at risk of acquiring HIV.
- **Migrant and itinerant workers** who may face multiple challenges in the context of prolonged absence from home, leading to the concurrent sexual relationships and limited health care access. Fisher folk, miners, textile workers, and long-distance truckers are examples of groups who may be vulnerable in the context of their work.
- **Youth friendly services**: health services that are accessible, acceptable, equitable, appropriate, and effective and critical to supporting adherence and retention

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