Ministry of Health

National Implementation Guidelines for HIV and STI Programming Among Young Key Populations

SEPTEMBER 2018

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Foreword

Kenya released a Fast Track Plan to End HIV and AIDS Among Adolescents and Young People in 2015 to accelerate the HIV response to end new HIV infections, AIDS related deaths, and stigma and discrimination among adolescent and young people. The plan stresses the need to develop population-specific interventions for optimal results. There are young key populations (YKPs) that bear disproportionate burdens of HIV and are the m ost vulnerable, including young men who have sex with men (MSM), transgender youth, young people who inject drugs, and adolescent and young adult sex workers. Key populations have been identified as priority populations in the HIV response for Kenya since 2009. High prevalence of HIV among the key populations, high occurrence of new HIV among this group, and their high estimated numbers justify prioritization of this population.

While the effort in recent years have been to saturate coverage of the estimated key populations in the country, emerging evidence shows that key populations between the ages of 15-24 are not being optimally reached either by programmes for young people or those designed for adult key populations. This points towards a big gap in our HIV response as high priority and high risk young people are being missed from the response. While there are several structural and legal issues related to working with young key populations, Kenya has established an enabling policy environment for working with adolescents and young people and key populations.

These guidelines are yet another progressive step put forth by Kenya to address the HIV epidemic by focusing on a special population group which will potentially have a big impact on reducing new HIV infections in the country. As government, we have a duty to protect and fulfil the needs of young people. These guidelines will provide guidance to programme implementers, researchers, and community-based organisations to work with young key populations.

This is a critical area of intervention for us and I hope that these guidelines will be successful in accelerating the scale up of programme and research with this special population.

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Acknowledgement

The guidelines are very timely as the country has recently made a strong commitment towards accelerating its HIV prevention response focusing on adolescents, young people, and key populations. The writing team includes Helgar Musyoki, Parinita Bhattacharjee, George Victor Owino, and Serah Malaba.

The guidelines borrow heavily from research on young key populations conducted in Kenya and outside; and global guidance provided by the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS). Key research and assessment conducted recently in Kenya that helped in development of these guidelines include: i) research conducted by UNICEF and LVCT Health to understand the risks and vulnerability of young key populations; ii) transitions research conducted by University of Manitoba with support from the Canadian Institutes of Health Research (CIHR) among young women who sell sex in Mombasa to understand their risks; and iii) assessment conducted by University of Manitoba and the National AIDS & STI Control Programme (NASCOP) with support from the International AIDS Vaccine Initiative (IAVI) to understand how to design programmes and access research priorities for young women who sell sex and young men who have sex with men and iv) Polling Booth Survey conducted by NASCOP and University of Manitoba with support from Global Fund. We thank all the researchers and implementers involved in this research.

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Abbreviation

AIDS	Acquired immunodeficiency syndrome
APOC	Adolescent package of care
ART	Antiretroviral therapy
CDC	Centers for Disease Control and Prevention
CRC	Convention on the Rights of the Child
CIHR	Canadian Institutes of Health Research
DIC	Drop-in center
FSW	Female sex worker
HCW	Health care worker
HIV	Human immunodeficiency virus
IBBS	Integrated Bio Behavioural Survey
IEC	Information, education, and communication
IPC	Interpersonal communication
IAVI	International AIDS Vaccine Initiative
HTS	HIV testing service
KANCO	Kenya AIDS NGOs Consortium
KASF	Kenya AIDS Strategic Framework 2014/15 – 2018/19
KP	Key populations
MAT	Medically assisted therapy
MARA	Most at risk adolescents
M&E	Monitoring and evaluation
MoH	Ministry of Health
MSM	Men who have sex with men
NGO	Non-governmental organization
NASCOP	National AIDS & STI Control Programme
NACC	National AIDS Control Council
OST	Opioid Substitution Therapy
ORW	Outreach worker
PBS	Polling Booth Survey
PE	Peer educator
PEP	Post-exposure prophylaxis
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
SRHR	Sexual and reproductive health and rights
SOP	Standard operating procedure
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/ AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
YKP	Young key populations
YWSS	Young women who sell sex
YMSM	Young men who have sex with men
YPWID	Young people who inject drugs

Glossary

Definitions of some terms used in this guideline

Adolescents: Individuals between the ages of 10 and 19 years.

Assent: Affirmative agreement of a child.

Child: An individual who has not attained the age of 18 years [1].

Consent: Affirmative agreement of an individual who has reached the legal age.

Convention on the Rights of the Child (1989): The Convention on the Rights of the Child (CRC) is a global treaty guiding the protection of human rights for people under 18 years of age. One of its key principles is that the best interests of children should guide all actions concerning them (Article 3). The CRC guarantees their rights to non-discrimination (Article 2), life, survival, and development (Article 6), social security (Article 26), and an adequate standard of living (Article 27), among others. Article 24 stresses "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for treatment of illness and rehabilitation of health."

Throughout this document, age categories are used. It is acknowledged that the rate of physical and emotional maturation of young people varies widely within each category. The United Nations Convention on the Rights of the Child (CRC) recognizes the concept of evolving capacities of the child, stating in Article 5 that direction and guidance, provided by parents and others with responsibility for the child, must take into account the capacities of the child to exercise rights on his or her own behalf.

Emancipated minor: Status conferred upon persons who have not yet attained the age of legal competency as defined by state law, but who are entitled to treatment as if they had by virtue of assuming adult responsibilities, such as self-support, marriage, or procreation.

Female sex workers: Females, 18 years of age and above who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work is consensual sex between adults, can take many forms, and varies between and within communities. Sex work may vary in the degree to which it is formal or organised. Sex work is used in these guidelines when referring exclusively to adults aged 18 years or older.

Homosexuality: Refers to an enduring tendency to form emotional, romantic, and/or sexual attractions to people of the same sex. The term gay is sometimes used to refer to people with a homosexual orientation.

Homosexual sex or same sex relationship: Refers to sexual behaviour between people of the same sex, regardless of their sexual orientation.

Hotspots: These are 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.

Informed consent: This refers to the process by which a participant voluntarily confirms their willingness to participate in a study or a service, after having been informed of all aspects of the research study or service that are relevant to the subject's decision to participate.

Key populations: Defined groups who, due to specific higher-risk behaviours, are at increased risk of HIV, irrespective of epidemic type or local context. They often have legal and social issues related to their behaviours that increase their vulnerability to HIV. The three key populations identified in Kenya AIDS Strategic Framework 2014/15 – 2018/19 are female sex workers, men who have sex with men, and people who inject drugs. World Health Organization also includes transgender people and prisoners and others living in closed settings as key populations; however, in Kenya, these populations have not been identified as key populations as yet.

Mature minors: Those 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.

Men who have sex with men: In this document, men who have sex with men refers to all males of any age who engage in sexual and/or romantic relations with other males with or without the exchange of money or goods. In this document MSM or men who have sex with men is used in frequent references to males who are above 18 years.

People who inject drugs: Refers to people who inject non-medically sanctioned psychotropic (or psychoactive) substances. 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. This definition of injecting drug use does not include people who self-inject medicines for medical purposes, referred to as "therapeutic injection," nor individuals who self-inject non-psychotropic substances, such as steroids or other hormones, for body shaping or for improving athletic performance. In this document PWID or people who inject drugs refers to all males and females above the age of 18 years.

Research: Performing a methodical study in order to prove a hypothesis or answer a specific question. Research must be systematic and follow a series of steps and a rigid standard protocol.

Sexual exploitation of children: Includes exploitative use of children in prostitution, defined under Article 2 of the Optional Protocol to CRC on the sale of children, child prostitution, and child pornography as "the use of a child in sexual activities for remuneration or any other form of consideration."

Young key populations: Defined groups of adolescent and young people aged 18-24 years who, due to specific higher-risk behaviours are at higher risk of HIV. The three young key populations identified in Kenya are young women who sell sex, young men who have sex with men, and young people who inject drugs.

Young women who sell sex: This document refers to females, 15-24 years of age, including children 15-17 years who are sexually exploited and adults 18-24 years who are sex workers.

Young men who have sex with men: This document refers to males 15-24 years, including boys 15-17 years and men 18-24 years who have sex with other males.

Young people who inject drugs: This document refers to males and females 15-24 years of age who inject non-medically sanctioned psychotropic (or psychoactive) substances, including children 15-17 years and adults 18-24 years.

Young people: Individuals between the ages of 10 and 24 years.

Youth: The UN defines 'youth' as individuals between the ages of 15 and 24 years.

Executive Summary

These guidelines, developed by the National AIDS & STI Control Programme (NASCOP), Ministry of Health, Kenya, in response to Kenya's Fast Track Plan to End HIV and AIDS Among Adolescents and Young People, aims to inform the design and implementation of interventions with young key populations (YKP), 15-24 years, specifically young women who sell sex (YWSS), young men who have sex with men (YMSM) and young people who inject drugs (YPWID). While the Ministry of Health does have guidelines for programming with key populations (KP), they do not address issues specific to YKPs adequately. These guidelines fill that gap and aim to accelerate the HIV response to end new HIV infections among young key populations.

These guidelines have resulted from a process that includes research in Kenya and outside: review of global guidance for young key populations, consultations with young key populations and technical consultations with experts and stakeholders from civil society including community based organizations, development partners, national and county governments. The guidelines were endorsed by the national Key Population Technical Working Group.

The guidelines highlight that YKP experience more unprotected sex, sexually transmitted infections including HIV, unintended pregnancy, violence, mental health disorders, and substance use compared to older/ mature members of key populations and youth among the general population. YKP experience significant barriers to accessing care; coverage of services is low, largely because of stigma and discrimination experienced at both the health system and policy levels. The need to work with young key populations who are generally hard to reach and are missed by programmes meant for young people or for adult key populations is highlighted. Overlooking this group, on the other hand, creates a critical gap in HIV response and undermines the investments in the response that the country has already made.

The operational guidelines recommend evidence informed combination prevention approaches and defines specific interventions including research that are expected to accelerate achievement of the goal when implemented at scale.

Kenya has scaled up interventions for all KPs in the last few years very successfully. Based on learnings from scaling up key populations programme and understanding the needs, realities and aspirations of young key populations, the guidelines recommend an enhanced intervention package for young key populations. The guidelines do acknowledge that key populations below the age of 18 years are children and hence in the intervention package emphasize the need to interweave sexual, reproductive, health, and harm reduction services with other voluntary services, including housing, education, job skills training, mental health services, reunification with families, participation in research, legal services, and protection. The guidelines spell out the approaches of working with young key populations and service delivery mechanisms specially focusing on hotspots.

The guidelines also emphasize the need to involve young key populations at all levels of programme and policy design, implementation, and evaluation. It also recognizes the need to work on changing policies and laws that criminalizes behaviours and make access to services for young people very difficult.

A monitoring and evaluation plan is also drawn out which builds on existing systems and mechanism of data collection and analysis. A programme science approach addresses specific knowledge gaps and recommends a continuous effort to assess the approaches of programming, their successes, and challenges.

1. Introduction

Young people aged 10-24 years constitute one quarter of the world's population. In Kenya, AIDS remains the leading cause of death and morbidity among adolescents and young people. It is estimated that 16% of all people living with HIV in Kenya are adolescents and young people, and that approximately 29% of new HIV infections occur in this group. In the age group of 15-19 years, new HIV infections stand at 70% for women and 30% for men; in the age group of 20-24 years, at 62% for women and 38% for men. In 2015, Kenya launched a *Fast Track Plan to End HIV and AIDS among Adolescent and Young People* that identifies young people at high risk. The plan suggests geographical, population specific combination prevention interventions to reduce risk, new infections, and AIDS-related death among them [2].

Key populations (KPs) at higher risk of HIV in Kenya include female sex workers, men who have sex with men, and people who inject drugs.[1] Young people who belong to one or more KPs – or who engage in activities associated with them – are particularly vulnerable to HIV due to widespread stigma and discrimination, violence, power imbalances in relationships, alienation from family and friends, policies and laws that demean or criminalise their behaviours, and education and health care that ignore, reject or otherwise fail to provide the information and treatment they need to stay safe. These factors increase the risk of their engaging – willingly or otherwise – in high risk behaviours such as frequent unprotected sex and sharing drug injecting equipment. These same vulnerabilities exclude them from programmes for adult KPs.

The global response to HIV largely neglects young key populations. There is inadequate funding on research, HIV prevention, and treatment for them. HIV service providers are poorly equipped to serve young key populations and the staff of programmes for young people may lack the sensitivity skills and knowledge to work specifically with members of key populations. The specific needs of young people from key populations are neglected both by programmes designed for youth generally and by programmes for adults from key populations.

Governments have a legal obligation to respect, protect, and fulfill rights of young people to life, health, and development. The Kenya AIDS Strategic Framework (KASF) 2014/15-17/18, which is anchored in the Kenya HIV Prevention Revolution Road Map, promotes a location-population approach that addresses the heterogeneity of the HIV epidemic [3,4]. The KASF regards adolescents and young people as a priority population and recommends scale up of evidence-based combination HIV prevention and care interventions in response to growing evidence of increasing risk and vulnerability among them [7]. KASF also acknowledges that KPs have a high risk of HIV exposure and that a disproportionately high number of new HIV infections occur among them. In addition to KASF, the government of Kenya launched Kenya's Fast Track Plan to End HIV and AIDS Among Adolescents and Young People. The plan outlines services packages tailored to populations and age groups and prioritizes strategies that provide enabling environments and address structural challenges to the response focused on adolescents and young people. The plan acknowledges that while HIV can affect anyone, being orphaned or living without parental care, sexually exploited or in transactional sex work, living with HIV, experiencing violence, disabled, engaged in male to male sex and/or drug use can pose additional risks and increase a person's vulnerability. The plan advocates for investments to focus on expanding access to comprehensive HIV prevention and support services for adolescents and young people and recommends that strategies should be integrated and strengthened in the education, social protection, social welfare, and health sectors for this population.

These guidelines have been developed to operationalize the plan specific to key populations identified in Kenya's Fast Track Plan, namely girls exploited through selling sex (referred to as young women who sell sex in this document), young men who have sex with men, and young people who inject drugs. This document defines these three populations by their HIV risk and vulnerability and identifies optimal strategies that will prevent new infections among the populations.

1 Though WHO includes transgender populations and prisoners and others living in closed settings as key populations, in Kenya, these populations have not been identified as key populations as yet due to lack of local evidence of risk within these groups.

1.1 Framework and policies that guided development of the document

The legislative framework that guided the development of this document includes:

- The Constitution of Kenya 2010
- The HIV and AIDS Prevention and Control Act 2006
- The Children Act, 2001
- The Counter-Trafficking in Persons Act, 2010
- The Victim Protection Act, 2014
- The Sexual Offences Act, 2006
- The Penal Code, Cap 63
- The Narcotic and Psychotropic Substances Act, 1994
- United Nations Convention on the Rights of the Child (CRC)
- African Charter on the Rights and Welfare of the Child (ACRWC)

The policies and guidelines that guided the development of this document include:

- The Kenya AIDS Strategic Framework 2014/15-2018/19
- The Kenya HIV Prevention Revolution Road Map
- ESA commitment on comprehensive sexuality educations and sexual and reproductive health services for adolescents and young people, 2013
- The Adolescent and Youth Reproductive Health Policy, 2014
- National guidelines for management of sexual violence
- National Guidelines for HIV/STI Programming with Key Populations, NASCOP, 2014
- Policy for The Prevention of HIV Infections Among Key Populations in Kenya, NACC and NASCOP, 2016
- Respect, Protect, Fulfill: Best Practice Guidance for Conducting HIV Research with MSM in Rights Constraints Environment, amfAR, IAVI, JHU – CPHHR, 2015
- Guidelines for Conducting Adolescent HIV Sexual and Reproductive Health Research in Kenya, NASCOP, IAVI, LVCT Health, and KEMRI, 2015
- Kenya's Fast-Track Plan to End HIV and AIDS among Adolescents and Young People, NACC, September 2015.
- Kenya HIV Testing Service Guidelines, NASCOP, 2015
- National plan of action for protection of sexually exploited children
- National standard operating procedures for the management of sexual violence against children, 2018
- Child protection guidelines, Department of Children Services, 2011
- Framework for national child protection systems for Kenya, National Council for Children's Services, 2011

1.2 How these guidelines were developed

These guidelines were developed as a response to implement the *Kenya Fast-track Plan to End HIV and AIDS Among Adolescents and Young People, 2015*. Several consultations were organised with key stakeholders working with key populations during the period of 2015-2017. Research was commissioned with young key populations (young men who have sex with men, young women who sell sex, and young people who inject drugs) to understand their risk and vulnerabilities including their needs for programming during this period. Some studies covered all three sub populations while others studied either one or two of the mentioned groups. The key among them were conducted by University of Manitoba and NASCOP with support from CIHR among YWSS, LVCT Health with support from UNICEF among all three sub populations, University of Manitoba and NASCOP, with support IAVI among YWSS and YMSM and KANCO, with YPWID. To better understand the needs of young key populations, community consultations were organised with young MSM and young women who sell sex by a team of young facilitators from the KP community in 2017. NASCOP with technical support from University of Manitoba also conducted population based surveys using Polling Booth Survey method with young women who sell sex, young men who have sex with men and young people who inject drugs in 2017. This guideline draws heavily from this research and community consultations. Technical consultations have been conducted with experts from health, education, law, gender, and youth and key populations to develop a practical implementation guideline. The guidelines also researched and incorporated information from global guidance developed by WHO. NASCOP organised meetings with a team of technical experts to finalise the guidelines in 2017. Peer review was conducted by experts from WHO, Geneva, FHI360 and Desmond Tutu Foundation. The guidelines were validated by the Key Population National Technical Working Group in April 2018.

1.3 Population groups

These guidelines inform the design and implementation of interventions with young key populations in the age group of 15 – 24 years. The key populations include young women who sell sex, young men who have sex with men and young people who inject drugs. While young key populations above the age of 18 years are considered as adults, 15-17 years old young people are considered as minors. However, the 15-17 years old key populations, many of whom could have been surviving outside a family setting for years, managing day to day lives as de factor adults are termed as mature minors or emancipated minors in Kenya.

2. Background & Context

2.1 Young key populations in Kenya

It has been long established that female sex workers, men who have sex with men, and people who inject drugs are at higher risk of HIV exposure in Kenya. This is not only because of the risk factors (high number of partners, condom-less anal or vaginal sex, or sharing of needles) but also social and structural factors like violence, criminalisation, high levels of stigma, and discrimination, etc. An overarching need is the overall accessibility of reproductive health services for adolescents. Globally and in Kenya, there are limited studies with young key populations. Based on existing global literature review conducted by WHO, studies commissioned by NASCOP, experiences of KP programme implementers and as guided by *Kenya Fast-track Plan to End HIV and AIDS Among Adolescents and Young People, 2015,* it is clear that young key populations need special attention in the national HIV response.

2.1.1 Young women who sell sex

Young women who sell sex (YWSS) remain under-represented in research on HIV and sex work. As studies of sex workers rarely disaggregate outcomes by age due to ethical or legal concerns, there is a lack of accurate global estimates of young people, particularly of girls under 18, who sell sex. Transitions, a study conducted by University of Manitoba and NASCOP in collaboration with the Canadian Institutes of Health Research in Mombasa, Kenya, estimates that 52% of women who sell sex in the hotspots frequented by adult sex workers are below the age of 24 years. It also reveals that HIV prevalence is almost three times higher among YWSS than among other women engaged in casual or transactional sex at the same hotspots [5].

Young people sell sex for many reasons. Some of the reasons could be selecting sex work as an occupational choice to escape poverty, meet financial obligations, or support their families, and/or because gender inequality, discrimination, or bullying limited their access to education, and by extension, their earning capacity. Participants in the consultation conducted by United Nations Population Fund (UNFPA) in Kenya said that they had parental responsibilities for their siblings and would rather sell sex than beg in the street. Some young girls are also trafficked and coerced into sex work through exploitation. Their risk and vulnerability of young people who sell sex are linked to the frequency and location of selling sex, their power to negotiate condom use, susceptibility to violence, and dependence on alcohol and drugs [5-10]. The Transitions study conducted with YWSS in Kenya shows that rates of condom use at first sex is negligible [5]. Laws around consent and fear of being identified as engaging in a criminalised and stigmatised occupation pushes them further to the margins, where their access to health and safety information, comprehensive sexual and reproductive health services, and exposure to HIV programmes for KPs is significantly compromised [5-10]. UNFPA consultation participants in Kenya reported large unmet need for contraceptive commodities and education. The participants had experienced multiple pregnancies and all had terminated their pregnancies, usually by unsafe methods, with no post-abortion care [6].

The national behavioural assessment conducted by NASCOP in three sites in Kenya (Kisumu, Mombasa and Nairobi) with young women who sell sex reveal that though condom use with clients was high only 44% of the respondents used condoms with regular non-paying partners (lovers and husbands), 25% of the respondents had atleast one occasion in the last month when they had condom less sex and 26% could not find a condom when they needed it in the last month. 47% of the respondents experienced police violence and only 40% of them received post violence support. 18% respondents were already HIV positive (self- reported) but only 63% of them were enrolled to ART. Out of those enrolled in ART, 37% had missed their last appointment [10].

Young women who sell sex

44% of respondents used condoms with regular non-paying partners (lovers and husbands)

25% of respondents had atleast one occasion in the last month when they had condom less sex

26% of respondents could not find a condom when they needed it in the last month

47% of the respondents experienced police violence of which **40%** of them received post violence support

18% respondents were already HIV positive (self-reported) but only **63%** of them were enrolled to ART

37% of respondents had missed their last appointment out of those enrolled in ART

The national behavioural assessment in three sites (Kisumu, Mombasa and Nairobi), 2017

Sexually exploited children and adolescents who sell sex

Many factors specific to children and adolescents aged 10-17 years contribute to their vulnerability to sexual exploitation. They include severe circumstances of initiation and involvement, such as physical force and lack of

control over their situation and finances, inability to negotiate safe sex, systemic reasons like legal and policy barriers to access sexual and reproductive health services, frequent contact with police, and lack of or inadequate youth friendly services. Fear of police harassment or being sent to government institutions often prevent sexually exploited children and adolescents who sell sex from accessing HIV services and drive them underground, becoming invisible, excluded, and more vulnerable.

The United Nations Convention on the Rights of Child (UNCRC) sets out four pillars of children's rights. These are Survival, Development, Protection, and Participation rights of children. These rights are echoed in the African Charter on the Rights and Welfare of the Child (ACRWC), the Constitution of Kenya, and domesticated through the Children Act 2001. The pillars are briefly explained: Survival (states that every child has the inherent right to life and ensure the maximum extent possible the survival and development of the child). This addresses the issues of the right to be born and be protected in all ways so as to live a healthy and conformable life, and the right to the highest standard of health, health services, and maintenance. Development right deals with access to quality education to develop a child's personality and ability; develop the child morally, spiritually, and physically. Protection deals with the right to protection from work that is dangerous or prevents a child from attending school or holistic development, and protection from all forms of abuse. Participation is a process of child development that provides an opportunity for children to be involved in decision making on matters that affect their lives and to express their views in accordance with their evolving activities. Child participation recognizes that children are not a passive, powerless target group, but rather capable communicators, who can effectively engage in activities within their communities.

The CRC clearly articulates that children younger than 18 have the right to the "enjoyment of the highest attainable standard of health" (article 24) and that the "best interests of the child should guide all actions for, with, on behalf of children." The above have been replicated in articles 43 and 53 respectively of the Constitution, 2010. Article 21(1) of the Constitution specifically provides that "it is a fundamental duty of the State and every State organ to observe, respect, protect, promote and fulfil the rights and fundamental freedoms in the Bill of Rights" The Committee on CRC has further interpreted obligations of governments – that people younger than 18 years have the right to participate in decisions that affect them, be free from HIV and discrimination, and that children who are sexually exploited should have access to comprehensive sexual and reproductive health and rights (SRHR) services. In addition, the Convention restricts protective and judicial interventions against children and adolescents. The objective of the HIV and AIDS Prevention and Control Act, 2006 is to provide the protection and promotion of public health and for the appropriate treatment, counseling, support and persons infected or at risk of HIV and AIDS infections. The Act specifically recognizes that mature minors and emancipated minors can seek access to HIV-related services without the need to seek prior consent from their parents and/or guardians. The evolving capacities of adolescents should thus be considered to determine the most appropriate interventions to support them.

2.1.2 Young men who have sex with men

Global data on the number of young men who have sex with men, their HIV risk, and the structural barriers to protective behaviours is not well defined, particularly in sub-Saharan Africa, but emerging data suggests that they have high risk and are vulnerable. Despite growing evidence about the implications of the structural and individual drivers of vulnerability, there is relatively little guidance for programmes specifically tailored to their needs. Chief among the challenges of reaching them with sexual health education and other services, and engaging them in research, is the criminalisation and stigma attached to same-sex relationships. Individually, they may be confused about their sexuality, not self-identify as gay or bisexual, or be wary of disclosing their sexual orientation to others, especially health care providers who they do not perceive as supportive. Abandonment, stigma, and violence meted by families force them to leave their homes and stay in risky environments without a support system. Risk and vulnerability is heightened by laws related to consent to services and participation in research, and among those who engage in sex work or unprotected anal sex, face violence, consume alcohol or drugs, or have inadequate access to information [6,7,9-11].

The national behavioural assessment conducted by NASCOP in three sites in Kenya (Kisumu, Mombasa and Nairobi) with young men who have sex with men reveal that only 85% of the respondents used condoms at last sex and only 77% used a lubricant in the last sex. 61% respondents sold sex for money with another man in the last one month. 26% of the respondents had at least one occasion in the last month when they had condomless sex and 14% could not find a condom when they needed it in the last month. 27% of the respondents experienced police violence and only 41% of those received post violence support. 20% respondents were already HIV positive (self-reported) but only 68% of them were enrolled to ART. Out of those enrolled in ART, 34% had missed their last appointment. [10]

Young men who have sex with men

85% of respondents used condoms at last sex

77% of respondents used a lubricant in the last sex

61% respondents sold sex for money with another man in the last one month

26% of the respondents had at least one occasion in the last month when they had condomless sex

14% of respondents could not find a condom when they needed it in the last month

27% of the respondents experienced police violence of which **41%** received post violence support

20% respondents were already HIV positive (self-reported) but only

68% of them were enrolled to ART

34% of the respondents had missed their last appointment out of those enrolled in ART

The national behavioural assessment in three sites (Kisumu, Mombasa and Nairobi), 2017

2.1.3 Young people who inject drugs

Similar to young women who sell sex and young men who have sex with men, current methods of gathering and reporting data make it impossible to calculate a reliable global estimate of the number of young people who inject drugs (YPWID). In Kenya, information on YPWID is limited except a few specific studies conducted by UNICEF, LVCT Health, and the Kenya AIDS NGO Consortium (KANCO). Harm-reduction services can serve as important mechanisms for data collection, but age restrictions placed upon them limit the amount of data the service providers can collect on young people. Though in Kenya, Opiod Substitution Therapy (OST) is also provided to PWIDs under 18 years at the discretion of the clinic doctor, there are very few who access these services due to fear and lack of knowledge about them. The criminalization of drug use through the narcotic drugs and psychotropic substances Act has resulted in limited access to healthcare services, which in turn has increased the risk and occurrence of HIV and hepatitis among injecting drug users.

Though not all drug users or those who inject drugs become dependent on drugs, there are many who do. For some young people, drug use is a part of adolescent experimentation and pleasure seeking. On the other hand, some identify negative experiences that spurred them to begin using – and eventually injecting – drugs: feelings of alienation, anger or emptiness, or difficulties with their families. In most cases there is a progression from smoking drugs to snorting them and then to injecting. Reasons for beginning to inject ranged from curiosity and the desire to get a more intense high, to a wish to use drugs more "efficiently" or to counteract the decreasing quality and potency of their drugs. The desire to belong to a group and participate in its activities is natural among young people, and it may be particularly strong for those whose social ties are otherwise precarious. Socializing with young people who inject drugs also normalizes and reinforces injecting behavior [7,12,13].

The frequency with which young people inject varies, and they may not have developed dependence or experienced adverse consequences for their health. For these reasons, many of them may not identify as a "person who injects drugs" or see themselves as needing any guidance. Female drug users are more vulnerable than their male counterparts as evidence from Kenya through Youth RISE consultations reveal that women drug users rely on their male partners to provide injecting equipment, and they frequently share syringes with their male partners [12].

The national behavioural assessment conducted by NASCOP in two sites in Kenya (Mombasa and Nairobi) with young people who inject drugs reveal that only 87% of the respondents injected narcotic drugs in the last month. 14% of the respondents shared needles in the last month and 29% did not get a new needle when they needed one in the last one month. 43% of the respondents experienced drug overdose. 53% of the respondents experienced police violence and only 56% of those received post violence support. 19% respondents were already HIV positive (self- reported) but only 65% of them were enrolled to ART. Out of those enrolled in ART, 73% had missed their last appointment. [10]

Young people who inject drugs

87% of the respondents injected narcotic drugs

43% of the respondents experienced drug overdose

19% respondents were already HIV positive (self-reported) but only…

14% of the respondents shared needles

53% of the respondents experienced police violence…

65% of them were enrolled to ART.

29% of the respondents do not get a new needle when they needed one

of which **56%** received post violence support

73% of those enrolled in ART, had missed their last appointment

The national behavioural assessment in two sites (Mombasa and Nairobi), 2017

Young key populations have overlapping vulnerabilities. Young people who inject drugs may consider homelessness or economic marginalization as more pressing concerns. Young women who sell sex and young men who have sex with men also abuse alcohol and drugs. People who inject drugs may have to sell sex to make money to buy drugs. In addition, unprotected sex, stigma, discrimination and violence, sex work, criminalisation of drug use, and laws related to consent to access services also act as barriers for the young key populations to access services.

2.2 Emerging needs of young key populations

The findings from the community consultations and evidence compiled from various studies shed light on several of their emerging needs. The main ones are described below.

The need to establish rapport and programming in spaces of risk and vulnerability

Most young KPs cruise, solicit, or use drugs at hotspots frequented by older/mature KPs. Yet according to the Transitions study, only 26% of YWSS at the hotspots are met by a KP programme, possibly because these hotspots are in small, local brew dens that are sometimes missed by mapping exercises conducted for programming. Young men who have sex with men (YMSM) tend to stay physically hidden from programmes because they seek partners via the phone or Internet, and go to cruising areas as they become more comfortable with their sexuality or when they meet other YMSM. Similarly, YPWID normally use drugs in sites where adults access drugs. The hotspots (physical and virtual) are very important sites to establish contact and rapport with young key populations and introduce them to interventions meant for them.

Need to prevent and respond to violence

YWSS are assaulted by clients, law enforcement officials, and older/mature sex workers with whom they share work space. The main perpetrators of violence against YMSM and YPWID are their families and law enforcement officials. The violence may be sexual, physical, verbal, emotional, or financial (such as not paying for sex or forcibly taking back payment). Access to justice is poor, as the young KPs are unaware of ways to seek assistance without exposing themselves to the risk of further harassment. The fear of violence and stigma force this population to go underground and become invisible.

Need to address stigma and discrimination

Judgmental attitudes, threats of eviction or public disclosure, stigma and discrimination, social isolation, and violence perpetrated by health care providers, clients, law enforcement officers, religious leaders, and their own families, combine to demotivate young KPs from availing health care services. The need for services that are stigma and discrimination free and respect and accept the young key population was expressed.

Need for comprehensive sexual health education, and sexual and reproductive health services under one roof

Coverage for effective and comprehensive information and services for young key populations appears to be low. Young people in Kenya generally lack access to comprehensive sexuality and sexual health education, as all schools do not provide it. Contraceptive commodities are not freely available for those below 18 years and use of condoms for prevention of diseases or spacing/family planning is low. YWSS and young women who use drugs may have multiple unwanted pregnancies as they cannot access services. Abortion is illegal in Kenya and post-abortion care is only available in selected services. Programmes that do not offer comprehensive health services discourage young people from accessing these programmes as their needs

are not met in one place. KP clinics are preferred to government clinics for their shorter waiting times, friendlier service providers, and the relevance of advice and counselling offered. The young key populations expressed the need for a space/ service where they can get correct information and comprehensive services that address their needs.

Need for social and economic support

YMSM and YPWID are frequently abandoned by their families and evicted from their homes. Their earning potential may be restricted by limited education and skills. Many YWSS and YPWID are heads of households and frequently have dependents. Participants in the community consultations expressed a need for education and vocational training to facilitate supplementary or alternative livelihood support.

Need for support to cope with substance dependence

Young KPs exhibit a high rate of dependence on alcohol and drugs such as Cannabis sativa or bhang. YWSS may use alcohol and other drugs to lower their inhibitions while soliciting or because their work environments normalise substance use. This impacts their risk perception, making them more likely to face violence or engage in unprotected sex. YMSM may use drugs and alcohol to cope with the anxiety, fear, stigma, and discrimination that is intrinsic to their experience. The young PWID also expressed their need to access deaddiction services or medically assisted therapy (MAT) to support them to cope with the dependence.

Need for safe spaces and information to assess personal risk

Many young KPs do not undergo regular health check-ups because they do not perceive their risk. Lack of information can lead to fear of testing, or of testing positive, thereby delaying linkage to care and treatment. Young KPs who are evicted or abandoned lack safe spaces such as transition housing and secure homes. Awareness around condom and lubricant use is high, and both are accessible through peer outreach and drop-in centers (DICs). However, young KPs ability to negotiate condom use is impacted by violence, power imbalances in sexual relationships, which is common, or their partners' unwillingness. The young key populations expressed their need for safe spaces where they can meet other people, get information, relax, and feel safe. They also expressed the need for support to help them understand their risk but also address issues of guilt and low self-esteem.

Need for friendlier law and policy implementation

Kenya has had policy and legal frameworks that promote adolescent sexual and reproductive health, rights, and research since the mid-1990s. However, young key populations must still contend with a complex legal environment. Articles 21, 43(1) and 53(1) of the Constitution mandate that public service officers and state organs address the needs of vulnerable groups, protect every citizen's right to the highest attainable standard of health, and every child's right to basic nutrition, shelter and health care, respectively. Article 53(2) of the Constitution also stresses the importance of ensuring adherence to the best interest of the child principle in matters affecting them.

The Revised National Guidelines (2015) of the HIV Testing Services Policy lower the age of consent for HIV testing service (HTS) to 15 years [13]. The National Guidelines for Provision of Adolescent and Young Friendly Services (YFS) (2005), National Youth Policy (2007), AHRD Plan of Action (2007), National Adolescent and Young Sexual and Reproductive Health Policy (2015), and the Guidelines for Conducting Adolescent HIV Sexual and Reproductive Health Research in Kenya also provide a favourable policy environment [14]. The Ministry of Health has also developed an adolescent package of care (APOC) for adolescents and young people.

However, on the other hand, sex work and homosexual sex (anal sex, more generally) between consenting adults, possession and use of specific drugs is criminalised through national and county laws. Young key populations who are victims of violence are reluctant to approach the police for fear of extortion, sexual abuse, or arrest on the pretext that their behaviour is a 'public nuisance.' Service providers hesitate to provide services and commodities as this could be misconstrued as encouraging children to perform sexual acts or drug use as Kenya's Sexual Offences Act criminalises sexual offences with children and mandates their protection from harmful practices, sexual exploitation, and drug use. Furthermore, minors require parental consent to access sexual and reproductive health related services, and to participate in research. These factors hinder access to services, especially when an individual's medical issues require them to disclose the nature of their work or sexuality. The consultations clearly stated the need to review policies and laws that act as barriers to access to services for young key populations without compromising the fact that young people need protection.

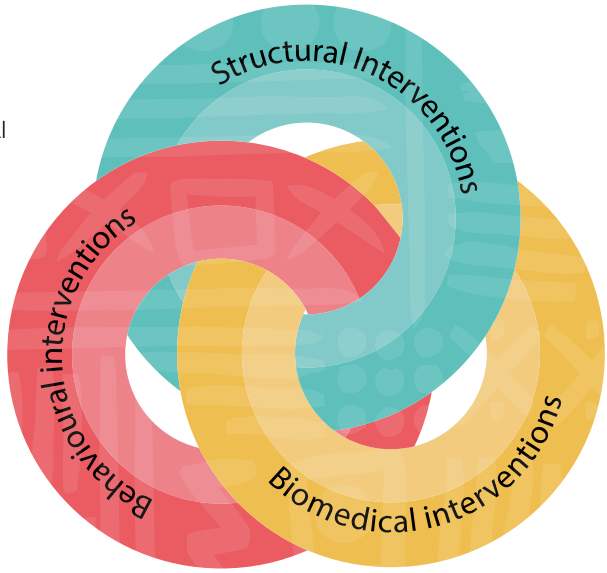
Need for research

YWSS, YMSM and YPWID are aware of research on HIV/STI prevention, testing, and treatment, and of provisions for self-testing kits, antiretrovirals (ARVs), and pre-exposure prophylaxis (PrEP). While research on women who sell sex has examined psychosocial issues, support, family planning, clients, and law enforcement, young men are less aware of research on their needs and risks. Yet, with the exception of the Transitions, Whispers, and MARA studies, very few research studies focus specifically on the youth. Some

women recounted negative experiences with studies for which they were asked to provide biological samples without being told what purpose they would fulfill. They welcome information on research studies from peer educators, programme staff, and researchers. Some young women and men know about biometrics and view them as a convenient way to connect to services confidentially. Some of the women expressed concerns that they would be labelled as sex workers for the rest of their lives if their biometric data was ever divulged. Besides these fears, the young key population expressed the need to conduct research that is relevant to their lives.

The interventions designed based on the needs of the young key populations and global guidance [6] will include:

Structural Interventions



- Shaping policy and creating enabling environment
- Provision of stigma-free services
- Access to education, skill-based job training, and social protection
- Access to social protection including social assistance, social security and health insurance
- Empowering the YKP community, including ownership and leadership including advisory boards
- Access to comprehensive violence prevention and response services
- Legal support to address rights violation including coercion and exploitation
- Economic empowerment

Behavioural interventions

- Hotspot-based young key population responsive peer education
- Comprehensive sexual and reproductive health, sexuality and harm reduction education and targeted information and education on HIV prevention, drug dependence and treatment
- Promotion, demonstration, and distribution of male and female condoms and water-based lubricants
- Risk and harm reduction counselling and skills building

Biomedical interventions

- Comprehensive condoms and lubricant programming
- Access to pre-exposure prophylaxis (PrEP)
- Access to post-exposure prophylaxis (PEP)
- Harm reduction for people who inject drugs though needle and syringe programmes and opioid substitute therapy
- Interventions to address harmful alcohol and/or drug use
- Access to nalaxone for overdose management
- HIV testing and counselling services
- Access to antiretroviral therapy (ART) and treatment
- Access to prevention of mother-to-child transmission
- Tuberculosis screening, diagnosis, and treatment or referral to treatment
- Hepatitis B and C prevention, screening, diagnosis, and treatment
- Mental health assessment, support and referral
- Sexually transmitted infection screening, diagnosis, and treatment
- Cervical and anal cancer screening
- Conception and pregnancy care including spacing and family planning services, post abortal care, and emergency contraception
- Linkage to voluntary medical male circumcision services
- Nutritional support
- Services to address poly drug use
- Services to manage neonatal abstinence syndrome
- Vaccination and treatment for hepatitis and human paillomavirus (HPV)
- Screening, diagnosis and treatment of anal warts

3. Objective & Principles

3.1 Objective of the document

This document operationalizes the recommendations provided in the Kenya's Fast Track Plan to End HIV and AIDS Among Adolescents and Young People for priority interventions for key populations.

The objectives of the document are as follows:

- To provide guidance on implementation of HIV prevention, testing, and treatment programmes and research with young key populations.
- To advocate to include young key populations in the HIV response.
- To accelerate and scale HIV prevention, testing, and treatment programmes and research among key populations.

3.2 Target audience

This document is intended for implementers, policy makers, programme managers, donors, and community-led organisations who wish to work with young key populations in Kenya.

3.3 Principles

1. Meaningful participation of young key populations

Young KPs have the right to have their voices heard. Young KPs have detailed knowledge of social, cultural, and institutional constraints that block their access to services and denies them their rights. Drawing from young KPs' wisdom and experiences and engaging them in a participatory process in all aspects of programme planning, implementation, evaluation and research can facilitate access to, acceptance, and uptake of health and other services. Meaningful participation means that KP members are able to: a) choose how they are represented and by whom; b) choose how they are engaged and involved in the process; c) choose whether to participate; and d) have an equal voice in how partnerships are formed and managed. This also means drawing upon and strengthening competencies and capacities of young KPs.

2. Beneficence and do no harm

Maximizing benefits for young KPs while minimizing risk of harm to the them is very important. Primary consideration to the best interest of the young KPs, especially those between 15-17 years should be given in the design and delivery of programmes. The service providers and researchers must consider the possible harm that any intervention and study might do and engage the young KPs to discuss their safety and security. Sufficient capacity should be strengthened amongst service providers and researchers to ensure that they understand this principle and apply rights-based approaches while interacting and working with young KPs.

3. Respect and non-discrimination

Services for, and research with young KPs should be non-coercive, respectful, and non-stigmatizing. Young KPs should be aware of their rights to confidentiality and any limits of confidentiality should be made clear. Promotion, protection, and respect of human rights including gender equality should be integrated in HIV prevention, testing, and treatment programming and research for young key populations. HIV prevention, testing, treatment, and support services shall be provided equitably to all irrespective of age, sexual orientation, and behaviours.

4. Addressing overlapping risks and vulnerability

While high rates of HIV infection among young key populations can be attributed to their risky behaviours, the social and structural factors cannot be ignored. While unprotected sex or sharing of needles are important risk factors, there is also evidence that young key populations are often more vulnerable than older/ mature KPs to the effects of discrimination, harassment, violence, social isolation, criminalisation, and self-stigmatisation. In addition, many young key populations also have overlapping multiple risks that need to be addressed in a comprehensive way.

5. Co-ordinated multi-sectoral approach

Implementation and coordination of HIV prevention, testing, and treatment interventions including research for and with young key populations should include multiple sectors and shall be harmonized to avoid duplication of efforts and increase efficiency. Nationally recommended policy and programming guidelines shall be adhered to within the context of implementing the HIV prevention, testing, and treatment package for young key populations. Health and harm reduction services should be interwoven with services related to social protection, education, skill building, legal, housing, and so on. The programme will work with other programmes in different sectors leveraging the resources needed for a multi sectoral approach.

6. Universal Health Care

Universal health care (UHC) (also called universal health coverage, universal coverage, universal care or socialized health care) is a health care system that provides health care and financial protection to all citizens of a particular country. Kenya being a United Nations member state agreed to work toward universal health coverage by 2030.[5] One of the goals with universal healthcare is to create a system of protection which provides equality of opportunity for people to enjoy an attainable level of health. UHC is organized around providing a specified package of benefits to all members of a society with the end goal of providing financial risk protection, improved access to health services, and improved health outcomes. Young key population will be supported to ensure that they get access to the UHC and can access health services without incurring financial hardship.

1 **Meaningful participation of young key populations**
Young KPs have the right to have their voices heard.

2 **Beneficence and do no harm**
Maximizing benefits for young KPs while minimizing risk of harm to the them

3 **Respect and non-discrimination**
Services for, and research with young KPs should be non-coercive, respectful, and non-stigmatizing.

4 **Addressing overlapping risks and vulnerability**
While high rates of HIV infection among young key populations can be attributed to their risky behaviours, the social and structural factors cannot be ignored.

5 **Co-ordinated multi-sectoral approach**
Implementation and coordination of HIV prevention, testing, and treatment interventions including research should include multiple sectors and be harmonized.

6 **Universal Health Care**
Young key population will be supported to ensure that they get access to the UHC and can access health services without incurring financial hardship.

4. Delivering Services for Young Key Population

In the absence of extensive evidence on service delivery models for young key populations, specific programmes for young key populations, a combination of approaches can be borrowed from health programmes that have been considered effective for young people or for key populations in general. It is essential that services are designed keeping in mind the needs of the young key populations and takes into account their rights. Interventions need to be designed according to their age-specific behaviours, the complexities of their social and legal environment, and the epidemic setting.

4.1 Considerations regarding services for young key populations

- Acknowledging and building upon the young key populations' strengths, competencies, capacities, and particularly on their ability to articulate the services they need.
- Prioritising young KPs' best interests in design and delivery of all programmes and services. Children below 18 years who are sexually exploited have the right to be provided with human rights-based and evidence-informed services in accordance with the minimum intervention and due process principles of the CRC, including HIV and sexual and reproductive health services while being protected from criminal charges, law enforcement violence, and compulsory detention and 'rehabilitation.'
- Evidence and rights based efforts to be made to protect children from all forms of exploitation.
- Empowering key population communities as an essential component of service provision by involving them meaningfully in the planning, design, implementation, and evaluation of services and research.
- Ensuring that health, welfare, protection, education, and social protection programmes and services are integrated, linked and interwoven, with a strong system for referral and continuum of care in order to utilize the most comprehensive range of services to address the overlapping vulnerabilities of young key populations.
- Ensuring that there is sufficient capacity among health care workers, social workers and law enforcement officials to work with young key populations and apply rights-based approaches and evidence-informed practices.
- Partnering with community-led organisations of young key populations and KP networks, building upon their experience and credibility with young key populations.
- Building robust baselines, monitoring and evaluation mechanisms into programmes and research to boost quality and effectiveness. Developing a culture of learning, and encouraging willingness to modify programmes and improve research.

4.2 Intervention package

The intervention package for young key populations includes a combination of effective, acceptable, and scalable behavioural, structural, and biological interventions that are needed to prevent new HIV infections and ensure linkage and retention in HIV treatment and care [16,17]. Interventions in these packages should meaningfully involve beneficiaries in the design and implementation of the intervention, and take into account the context in which the intervention is being delivered to thoughtfully address issues of stigma and discrimination. An effective intervention package for young KPs must address their vulnerability and risk in equal measure to reduce risk, as well as address the circumstances that compel young people to take such risks. The strategies for young KPs should also address age-specific and overlapping risks.

Kenya's HIV prevention programme, based on the combination prevention approach described in the National Guidelines for HIV/STI Programming with Key Populations (2014) and Kenya's Fast Track Plan to End HIV and AIDS Among Adolescents and Young People (2015) details out the essential intervention package for young key populations. The efficacy of its components is supported by evidence and where evidence is lacking, it's guided by the needs of young KPs.

a. Structural intervention package[2] [18-21]

- Prevent and respond to violence by establishing violence response mechanism immediate support for physical, emotional, and sexual violence. Response services should include counselling and psychosocial support, health and safety support including shelter and accommodation arrangements for independent or group housing. The clinical management is guided by the national guidelines on the management of survivors of sexual violence and the attendant 2018 SOPs that detail management of child survivors. Provide information to young KPs on safety and security and sensitize law enforcement on key populations and their rights. Provide identity cards to young peer educators to protect them from police harassment and arrest.
- Provide information about rights through "know your rights" workshops specially tailored for each sub population and age specific, access to free and affordable legal services and justice specially to those who are coerced or trafficked.
- Sensitize the police and the criminal justice sector to prevent violence against young key populations and facilitate their access to justice in case of rights violations.
- Create safe spaces either as drop-in services, short-term shelters, or long-term housing. Special days could be organized in the existing DICs or existing friendly health care services for young key populations.
- Facilitate access to scholarships to remain in or return to school; job skills training or vocational training; livelihood development through savings and loans; assistance in accessing social services and state benefits.
- Conduct sessions with families, including counselling for parents and families to support and facilitate access to services where consent is needed and reunification when the young key populations desire so.
- Address social norms and stigma around sexuality, drug use, gender identity, and sex work by sensitizing and training key populations, peer educators, and health care providers, families, communities, and religious leaders.
- Empower young KPs for leadership and ownership by encouraging them to form support groups and become members of community-led groups.
- Provide services for children like child care, health care for children, creche etc.
- Advocate for supportive policies and laws.
- Sensitizing law enforcers on the need to treat KPs in a humane way that respects their rights when seeking to enforce the existing punitive laws.
- Coordinate to ensure that young YKP receive social protection offered by the Kenyan Government. Social protection include a) Provision: focusing on social assistance covering a broad range of actions including cash transfers, food aid, affordable health charges, child protection services, and responses to life-threatening emergencies b) Prevention: focusing on strengthening social security and health insurance schemes as well as services to support communities to prevent deprivation or destitution c) Promotion: seeking to strengthen interventions aimed at enhancing livelihoods and productivity, such as conditional cash transfers, public works programmes, food for work, micro and area-based schemes and d)Transformation: supporting the formulation of policies and the enactment of laws and regulations including the development of evidence-based programmes on social protection, the statutory minimum wage, maternity benefits, inheritance rights, anti-discrimination legislation, anti-stigma campaigns, anti-corruption legislation, policies on fee-free education, and regulations on safe classroom environments (to avoid exclusion of vulnerable children and girls).

2 For more details on the activities please refer to the a) National Guidelines for HIV/STI Programming with Key Populations, NASCOP 2014 http://www.icop.or.ke/wp-content/uploads/2016/10/KP-National-Guidelines-2014-NASCOP.pdf b) United Nations Population Fund, Global Forum on MSM & HIV, United Nations Development Programme, World Health Organization, United States Agency for International Development, World Bank. Implementing comprehensive HIV and STI programmes with men who have sex with men: practical guidance for collaborative interventions. New York (NY): United Nations Population Fund; 2015. https://www.unfpa.org/sites/default/files/pub-pdf/MSMIT_for_Web.pdf c) United Nations Office on Drugs and Crime, International Network of People Who Use Drugs, Joint United Nations Programme on HIV/AIDS, United Nations Development Programme, United Nations Population Fund, World Health Organization, et al. Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions. Vienna: United Nations Office on 317 Drugs and Crime; 2017. http://www.unaids.org/sites/default/files/media_asset/2017_HIV-HCV-programmes-people-who-inject-drugs_en.pdf d) World Health Organization, United Nations Population Fund, Joint United Nations Programme on HIV/AIDS, Global Network of Sex Work Projects, World Bank, United Nations Development Programme. Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions. Geneva: World 327 Health Organization; 2013. http://www.nswp.org/sites/nswp.org/files/SWIT_en_UNDP%20logo.pdf

b. Behavioural intervention package[3] [18-21]

- Conduct hotspot-based peer outreach involving young KPs as peer educators in physical and virtual hotspots/venues frequented by them. Peer outreach workers should be paid for their work as prescribed in the national guidelines and trained in microplanning appropriately. Younger peer educators can be also paired with older/mature peers for guidance and training to handle difficult situations where feasible and acceptable. They should also receive higher intensity of supervision and support. Young peer educators can also do outreach through SMS text messaging and through private chats with members of their social and peer networks. Young MSM value continued online contact as a way to establish a trusting relationship with project staff while maintaining a degree of anonymity. This relationship enables facilitating access to other services.
- Provide information and education about reproductive and sexual health; sexuality, the risks of unsafe sexual behaviours, and prevention strategies and services through targeted interpersonal communication (IPC).
- Provide information on harm reduction, drug dependence, rehabilitation, detox and treatment, poly drug use and overdose management
- Build skills to remain HIV negative. Information could be disseminated online, via mobile, and through one-to-one, face-to-face communication. Conduct special campaigns designed and led by young KPs showcasing inspiring stories of change through various forums, film viewings, festivals, World AIDS Day, and anti-drug events that can be organised within a wider context of social events. Non HIV related content like personal grooming, topical news, and parenting skills could be included to effectively engage young KPs.
- Promote, demonstrate, and distribute male and female condoms and condom compatible lubricants; needles, and syringes; skills building on negotiating condom use with a variety of partners.
- Provide risk assessment, risk reduction, and psychosocial support counselling in community and clinical settings, and with peer Fsupport groups. Counselling should address risks and benefits, skills building, support for disclosure of sexuality or sex work or drug use (where applicable), and mental health issues such as self-esteem, confidence, anxiety, and depression.
- Engage the young key populations in other evidence based interventions like Positive Health Dignity and Prevention (PHDP) or Stepping Stones.

3 For more details on the activities please refer to the a) National guidelines for HIV/ STI Programming with key populations, NASCOP 2014 http://www.icop.or.ke/wp-content/uploads/2016/10/KP-National-Guidelines-2014-NASCOP.pdf b) United Nations Population Fund, Global Forum on MSM & HIV, United Nations Development Programme, World Health Organization, United States Agency for International Development, World Bank. Implementing comprehensive HIV and STI programmes with men who have sex with men: practical guidance for collaborative interventions. New York (NY): United Nations Population Fund; 2015. https://www.unfpa.org/sites/default/files/pub-pdf/MSMIT_for_Web.pdf c) United Nations Office on Drugs and Crime, International Network of People Who Use Drugs, Joint United Nations Programme on HIV/AIDS, United Nations Development Programme, United Nations Population Fund, World Health Organization, et al. Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions. Vienna: United Nations Office on 317 Drugs and Crime; 2017. http://www.unaids.org/sites/default/files/media_asset/2017_HIV-HCV-programmes-people-who-inject-drugs_en.pdf d) World Health Organization, United Nations Population Fund, Joint United Nations Programme on HIV/AIDS, Global Network of Sex Work Projects, World Bank, United Nations Development Programme. Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions. Geneva: World 327 Health Organization; 2013. http://www.nswp.org/sites/nswp.org/files/SWIT_en_UNDP%20logo.pdf

c. Biomedical intervention package[4] [18-21]

- Provide HIV prevention services including condoms with condom-compatible lubricants, PreP; support for adherence and retesting, and PEP. The emphasis should be on remaining HIV negative.
- Offer harm reduction services through needle and syringe programmes, opioid substitution therapy (MAT in Kenya), detox services and access to naloxone for emergency management of suspected opioid overdose for those who are dependent on opioids.
- Provide voluntary HIV testing and counselling in hotspots and clinical settings, with linkages to prevention, treatment, and care services; counselling about the potential benefits and risks of disclosing HIV status; support to determine when, how, and to whom to disclose. Oral self-testing could also be considered for this population.Link up or offer PrEP to those who test negative and eligible.
- Offer HIV treatment, care, and management, with antiretroviral therapy and services for prevention of mother-to-child transmission. Community-based approaches that involve training health care workers to understand the needs of these groups and barriers to uptake could improve treatment adherence and retention in care.
- Provide services for prevention and management of co-infections and co-morbidities, such as prevention, screening, and treatment of tuberculosis and hepatitis B and C.
- Provide sexual and reproductive health services, such as screening, diagnosis, and treatment of STIs; vaccination for hepatitis and human papillomavirus (HPV); contraception, pre-conception, antenatal care, skilled birth, postnatal care, post-abortion services; screening for cervical and anal cancer.
- Offer voluntary male medical circumcision for men in linkage with services providing VMMC services
- Nutritional support specially for PWID and HIV positive KPs
- Provide services to manage neonatal abstinence syndrome through training of existing service providers
- Conduct routine screening and management of mental health disorders, and provide evidence-based programmes for those who abuse drugs and alcohol.
- Train the health care providers to address their beliefs and values that can adversely affect their reporting practices specially related to child/ adolescent sexual abuse. Training should challenge stigma, cultural taboos related to sexual abuse, beliefs and attitudes perpetrating gender inequality and blaming victims and disapproval of consensual sexual activity between adolescents. Train health care providers on guiding principles for reporting child/ adolescent sexual abuse and whether, when, to whom and how to report.
- Establish process and system of record keeping and information sharing that ensure that information is kept confidential and relevant information is shared with persons who need to know.

4 For more details on the activities please refer to the a) National guidelines for HIV/ STI Programming with key populations, NASCOP 2014 http://www.icop.or.ke/wp-content/uploads/2016/10/KP-National-Guidelines-2014-NASCOP.pdf b) World Health Organization. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update. Geneva: World Health Organization; 2016. http://apps.who.int/iris/bitstream/10665/246200/1/9789241511124-eng.pdf?ua=1

4.3 Programme delivery

- *Reaching members of the target groups* by mapping venues that may be overlooked by KP programmes, such as local brew dens and bars without rooms. Technology such as internet-based outreach may be used to find networks of YMSM.
- *Sensitising the community and key stakeholders* in the community specially near the hotspots, drop in centres and facilities to help them understand the need to work with young key populations. Using evidence to help the community understand the risks and vulnerability of young key populations and sensitizing them to the package of services provided to YKP through the project should be done to create an enabling environment. The need for child protection and harm/ risk reduction services for YKP should be explained.
- *Providing information and services through young peer-based initiatives* with peer educators who are well trained, supported, mentored, and given paid opportunities to reach out to communities and act as role models. Information may be shared on social media whenever possible. Ensure that young peer educators understand and are supported to mitigate any security risks associated with their work (e.g. violence against young gay men for being vocal advocates for their community, etc.). Support from older/mature Peer educators can be taken where needed.
- *Offering community-based, decentralised services for HIV prevention, testing, and treatment* using differentiated approaches for mobile outreach to hotspots, and to reach those who do not sell sex regularly or use the internet to make contact with clients and partners. Differentiating approaches to reach those young KP who do not identify with gay community or sex workers and those who do.
- *Ensuring that services are free and engaging, and locations are private, and easy to reach* so that they feel safe, involved, and supported in their life decisions. Timing should be convenient for young key populations. Information may be shared on social and other media preferred by YKPs.
- *Integrating services into other service spaces such as DICs,* which can become one-stop shops for comprehensive services. Formal linkages must be established with services that cannot be provided through KP programmes including development of a referral directory.
- *Providing forums where older/mature and younger KPs can interact,* build solidarity, and share information on safety and work skills. Support groups co-led by older/mature and younger KP members can be one such forum. Mature/ older Kps can provide mentorship where feasible and acceptable.
- *Adopting innovative ways to mobilise young KPs,* involve them in planning and service delivery, and ensure that research activities are appropriate, acceptable, and relevant to them.
- *Providing adequate outreach and clinical staff*, trained to appreciate the importance of being non-coercive, respectful, and non-stigmatising. Staff must understand and be able to communicate that records will be maintained within the limits of confidentiality. They must also be trained on the overlapping risks of KPs, such as sex work and drug use. Finally, they must be aware of the agencies that have been sensitised to the needs of YKPs so that they can make appropriate referrals to only institutions that will not further discriminate against or harm them.
- *Sensitising service providers* on the lowering of the age of consent for HTS to 15 years. They must also be trained to offer the adolescent package of care developed by the Ministry of Health. They must also have an understanding of what should occur if they interact with an individual seeking services who is below the age of 15 years.
- *Providing developmentally appropriate information and education* for young KPs 15-17 years old, focusing on education, job skills, and social protection. Offering risk-reduction services effectively with the best interests of the individual. Addressing childhood trauma through mental health care.
- *Counselling families*, where appropriate and as requested, to facilitate access to services and participation in research. Developing or strengthening protection and welfare services that help parents/guardians to fulfill their responsibilities to effectively protect, care for, and support young KPs. Support groups for families have created family support for YMSM and YPWID in various contexts.
- *Facilitating reintegration* of young KPs (15-17 years) with their families if in their individual best interests or desired by YKP, or provide other appropriate living arrangements and care options.
- *Training and supporting law enforcement officers (police, lawyers)* who understand the legal issues that young KPs face and particularly minors or those below the age of consent.

- *Building the capacities of human rights defenders and crisis management committees* to advocate for the rights of young KPs.
- *Facilitating meaningful community engagement* in research with community ownership of protocol development for research studies on microbicides, long acting PrEP, and preventative and therapeutic HIV vaccines from the beginning.
- *Developing learning sites or model projects* which can provide learnings and innovation for scaling up interventions with YKP should be prioritized.

Criteria to include in the Young Key Population Programme

The inclusion and exclusion criteria to register/ enrol a person into a young key population programme would be:

Inclusion Criteria: All boys or men and girls or women between the age of 15 – 24 years who engage in high risk activity (solicit, cruise, meet sexual partners or use drugs) at the hot spot voluntarily. They may be included in the programme either through programme contact at the community or contact at the facility. They may self-identify themselves as sex workers, men who have sex with men or people who inject drugs or just describe their risk activity.

Exclusion criteria: a) All boys and girls who are below the age of 15th years b) All boys and girls who are below the age of 18 and report sexual exploitation or coercion c) All boys and men or girls and women between the age of 15 to 24 years who report coercion into risk activity.

Practical applications

Following practical ways can provide guidance to implementers to work with young key populations.

1. **Do not turn away any KP met at the community or facility.** At a minimum, it is always possible to provide accurate information. While programmes may not enroll a person based on the exclusion criteria, everyone should be provided information and linked to appropriate services whether it is child protection or harm/ risk reduction.

2. **Know and follow the Kenyan laws.** If the client accessing information, commodities and services is identified as a *mature minor* then provide appropriate services as per their needs. If the client reports sexual exploitation or coercion, assess their risk factors and follow the national guidance as per the Children Act (2001), the Sexual Offences Act (2006), Counter Trafficking in Persons Act, (2010), Victim Protection Act (2014) and/ or any other relevant law and link them to social protection or legal protection (child protection unit in case of a minor below 18 years). If the client (even above 18 years) reports exploitation, abuse or coercion, take consent from client and link them with appropriate agency (could be the child protection unit within the Kenya police service or to social protection).

3. **Know and follow local requirements and mechanisms for mandatory reporting.** However, maintain a focus on "first, do no harm" throughout the decision-making process. A service provider is required to report someone under 18 who says they have been exploited, that provider must disclose this to a client before asking age and/or risks. If a client is identified as a mature minor and is selling sex in their free will then the package of services can be provided under the HIV and AIDS Prevention and Control Act 2006. Pursuant to the Victim Protection Act (2014), any person charged with the duty of assisting victims shall undertake a preliminary assessment of every victim and file a report on the victim, within twenty-four hours of report of the offence, providing details of the case, including the alleged offender, any other action taken by the victim prior to reporting the case.

4. **Create networks of service providers who can meet the needs of all young people, including minors and those who are not members of key populations.** Programmes for key populations are unlikely to have all the resources that minors need -- for example, support to finish school or find shelter. Know and establish partnership with child protection officer in the area or the chief's or create alliances with other partners and programs that can meet the additional needs of minors like the USAID funded programme for orphan and vulnerable children (OVC). Ensure that all the organizations you plan to refer to are sensitized and able to meet the needs of minors who sell sex, who are involved in same-sex sexual relationships, who are transgender, or who inject drugs. At the same time, ensure that KP project staff are prepared to provide the necessary support to referred minors, including follow up to ensure their safety and security.

In order to simplify the process of determining the appropriate response to a Young Key Populations seeking services a flow chart to help guide interactions with a new client has been developed. A new client can be either met for the first time in the community or hotspot by the peer educator or at the facility by the facility team. Depending on where a YKP is met, these flow charts can guide the process of interaction and provision of services.

Scenario 1: The new client is met at the community/ hotspot

YKP is met by a Peer Educator at the hotspots

Build rapport with the potential client and seek consent if the client would like to receive information and/or services

Provide education and commodities as needed

Screen for eligibility for registration in the programme

Client CANNOT be registered (based on exclusion criteria)

Refer to relevant social protection or/and legal services or projects for OVC

Document

Follow up

Client CAN be registered (based on inclusion criteria)

Screen for violence

No

Yes

Provide medical, psycho social, legal support as per guidelines at the community/hotspot

Refer to clinic

Document

Follow up at the community/hotspot

Scenario 2: The new client is met at the facility

Clinical care for children who have been sexually abused should be guided by obligations to protect, prevent, and respond to all forms of violence against children. These guiding principles specified in the Kenyan Children Act, Victims Protection Act and the Sexual Offence Act are aligned to the four international guiding principles of the Convention on the Rights of Children: Non-Discrimination; Best Interest of the Child; Survival and Development; and Participation. Health care providers need to be aware of these standards and apply them as guiding principles in providing care to children and adolescents who have been sexually abused [22].

The SOP on management of sexual violence against children, 2018 [22] states that consideration for obtaining consent/assent for the history and examination of a child survivor who is presented or presents self at a health facility may be determined by the age of the child and/or his/her capacity to understand the procedures that are likely to take place during the continuum of care. The guidelines further presuppose that there exists a caregiver and thereby states that depending on the child's age, assent/consent shall be taken as follows [22]:

- 0-5 years: obtain informed written consent from a non-offending caregiver
- 6-11 years: obtain oral assent from the child AND written consent from a non-offending caregiver
- 12-14 years: obtain written assent from the child AND/OR written consent from a non-offending caregiver OR written consent from an emancipated minor
- 15-18 years – obtain written consent from the child

Safety, privacy and confidentiality are also paramount during the course of all processes of management of the minor. By virtue of the principles of nondiscrimination and the best interest of the child, the above standards can be imputed to apply to instances where young key populations present for services in health facilities. Where the service provider establishes that the minor presenting in the facility is a victim of violence and exploitation and taking into account the child's security and safety needs, the same ought to be reported to the relevant authorities in line with the provisions of the framework for the national child protection systems in Kenya that seeks to promote the well-being of children through prevention of violence and exploitation, ensuring that in case it happens, prompt and coordinated action is taken to prevent further occurrence.

Whether health care providers have to comply with a legal or policy requirement, or are guided by an ethical duty to report known or suspected cases of child or adolescent sexual abuse, they should balance the need to take into account the best interests of that child or adolescent and their evolving capacity to make autonomous decisions. These actions include the following [23]:

- Assessing the implications of reporting for the health and safety of that child or adolescent and taking steps to promote their safety; there may be situations in which it may not be in the best interests of the child to report the abuse.
- Protecting the privacy of the child or adolescent (for example, in dealing with the media).
- Taking steps to promote the child or adolescent's health by providing immediate medical care and first-line support.
- Providing information to that child or adolescent (before interviewing or taking the history from them), and to their non-offending caregivers, on: a) the obligations to report the situation; b) the limits of confidentiality; c) what information will be reported and to whom; and d) what may happen next, practically and legally.
- Documenting the reporting and maintaining confidentiality of the documented information with extra precautions where the perpetrator is a caregiver who could access the child's or adolescent's file.
- In cases where the sexual abuse has been committed by another child or adolescent, referring them to appropriate health or other (e.g. welfare or social) services as needed.

4.4 Considerations for law and policy change, research and funding

4.4.1 Supportive policies

The national programme, county governments, and its advocacy partners need to work towards developing supporting laws and policies for young people including key populations. Working towards amending the HIV Prevention and Control Act, penal code, and the Narcotics and Psychotropic Substances Act to include the issue of providing services and enabling research and with mature or emancipated minors and barriers due to criminalisation of sex work, same sex relationships, and drug use, review of public order laws that interfere with health promotion efforts is necessary. Further implementation and enforcement of the Constitution and anti-discrimination and protective laws to eliminate stigma, discrimination, social exclusion, and violence against young key populations based on actual or presumed behaviours and HIV status should be ensured.

In the context of children, the laws must be upheld and administrative, social, and educational measures to protect children from all forms of harms including sexual exploitation, illicit use of narcotic drugs, and other substances as stipulated in the CRC and defined in the relevant international treaties. Article 53(2) of the constitution and sec 4(2) of the Children Act, 2001 stress the importance of giving paramount and primary consideration to the best interest of the child in all actions concerning a child. This should be the overarching principle for any provider working with young key populations. In any matters of procedure affecting a child, the child should be accorded an opportunity to express his opinion, and that opinion shall be taken into account as may be appropriate, considering the child's age and degree of maturity [24]. The HIV Prevention and Control Act, 2006 expressly recognizes the rights and ability of mature minors to consent directly when seeking HIV-related services, thereby dispensing with the strict requirement to seek the consent of the parent or legal guardian [25][5].

Where there is a mandatory reporting obligation on the part of the service provider like in cases of child sexual exploitation and abuse, the reporting should be in line with the framework for national child protection systems, the Victim Protection Act, the Sexual Offences Act, the Counter Trafficking in Persons Act, where applicable, and the National Standard Operating Procedures for Management of Child Survivors of Sexual Violence, 2018. The health care provider must, however, obtain assent or consent from the child or adolescent and/or caregiver as appropriate, prior sharing of information depending on the minor's evolving capacities. Respect for the affected child survivor's right to confidentiality must be taken into account throughout the reporting, referral process, and access of services to ensure no harm is done to the child or the family. The child victims also ought to participate in the decision-making process regarding referral and access to services. The safety and protection of the survivor and his/her family must be ensured at all times and in all stages of reporting and /or referral. It is important for the service provider to assess the implications of reporting to the health and safety of the child or adolescent and take steps to promote their safety. There may be situations in which it may not be in the best interests of the child to report the abuse.

Law enforcement procedures need to be changed so that confiscation of condoms or needles as evidence of sex work or same sex relationships, violence and harassment against young key populations by application of public order laws can be prevented.

There is also a strong and emergent evidence base that law enforcement-based interventions targeting adolescents aged 10-17 who sell sex or use drugs result in affirmative harm to the very same adolescents they are intended to protect. Despite that, a child protection framework is frequently applied in many counties to justify arrest-based interventions without reference to international human rights law governing the administration of juvenile justice, child protection, and the right to health. This calls for situating child-protective interventions firmly within international and national law and guidance governing the right to health, and regulating juvenile justice and child welfare interventions according to principles of minimum intervention, last resort, due process, and proportionality [15].

4.4.2 Strategic information and research

The Kenya Key Populations Programme adopts a Programme Science approach which is defined as the systematic application of theoretical and empirical scientific knowledge to improve the design, implementation, and evaluation of public health programmes. Programme Science provides a framework that applies science to programming to ensure appropriate focus on correct geographic areas, high-priority groups, right mix of interventions, optimal delivery mechanisms and options, real-time monitoring, and tactical and strategic adaptations. Involvement of communities, YKP in this context, in design, implementation, and dissemination of programmes and science is a key element. In the context of YKP, the programme will conduct research and surveillance to map and estimate population sizes, demographics, and epidemiology with disaggregation of behavioural data and HIV, STI, and viral hepatitis prevalence by age group and sex. The programme will also research to understand which approaches work best for this population, including those with overlapping vulnerabilities. The programme will evaluate effectiveness of programmes addressing young key populations. Ensuring involvement of young key populations in the research activities in a safe and ethical manner should be undertaken. The research topics will be identified by young key populations and implementers and will be conducted in the context of implementation within programming, thus embedding science and programmes.

4.4.3 Funding

Advocacy to increase funding for research, implementation, and scale up of evidence-informed initiatives addressing young key populations should be strengthened. There should be dedicated funds available for child protection and prevention against sexual exploitation including human trafficking for programmes that target young key populations and address overlapping vulnerabilities.

5 Section (14) (1), HIV Prevention and Control Act, 2006 states that "provided that any child who is pregnant, married, a parent or is engaged in behaviour which puts him or her at risk of contracting HIV may, in writing directly consent to a HIV test".

5. Programme Management

5.1 Planning for key population programme implementation

Mapping and size estimation will be used to inform the scope and scale of the young key populations program. NASCOP is leading a size estimation exercise with support from CDC and other partners. This exercise is being done with the involvement of key populations, implementing agencies and county governments at the local level. This exercise will include mapping and estimating young key populations in all the hotspots at the county level. Consequently, key populations mapping data collected at the local level (which will include data on YKP) will be appropriately analyzed at national, county, and sub-county levels and will be used as denominators to monitor coverage of the population and advocate for resources to saturate coverage. Implementation of interventions targeting young key populations will be hotspot based where young people self-identify as key populations. The interventions could be expansion of existing key population programmes or a new programme specifically for young KP. The interventions will be multisectoral involving sectors beyond health like the Ministry of Labour, Ministry of Gender, Ministry of Education, Ministry of Interior and so on. The interventions will fully utilize existing infrastructure and services that are considered appropriate and effective, and facilitate improved coverage and access.

5.2 Coordination mechanism

The Ministry of Health (MOH) has the overall mandate to provide quality, accessible, and affordable health care in Kenya and shall be responsible for strengthening its agencies responsible for HIV to enhance service delivery to key populations.

Role of the National AIDS Control Council (NACC)

As the Government-led agency accountable for the results of HIV response and responsible for policy, advocacy, coordination, monitoring, evaluation, and reporting, NACC shall:

- Undertake dissemination and advocacy of the guidelines at the national and county levels.
- Provide technical leadership and coordination at the national and county level including:
    - Review of policy and legislation to create an enabling environment for implementation of programmes with young key populations.
    - Undertake resource mobilization to saturate coverage of young key populations through quality programming.
    - Facilitate the multi-sectoral response needed for young key populations.
- Ensure coordination of implementation of the plan at all levels (national and county) and with other departments such as Interior, home, criminal justice, or education.
- Coordinate young key populations targeted research as part of research coordination mandate focusing on all the sub-groups.
- Continuously review the inherent risks and structural barriers to young key population programming and service uptake, and institute appropriate mitigation strategies to ensure a sustained conducive environment.
- Advocate for review and support development of policies to enable effective programming for YKP.

The role of National AIDS and STI Control Programme (NASCOP)

NASCOP, through the key populations programme will spearhead the implementation of interventions for young key populations. Specifically, NASCOP will:

- Develop guidelines to implement programs with young key populations.
- Provide guidance on overall implementation of young key populations programs.
- Form a sub-committee for young key populations with the National Key Population Technical Working Group (KPTWG).
- Coordinate implementation and ensure efforts are not duplicated.
- Provide technical support, capacity building, and mentorship to counties, funders, and implementing partners.
- Conduct on-site support to enable quality assurance and quality improvement.

The role of County Health Management Teams

The County Health Management Team has the overall responsibility of overseeing HIV service delivery for young key populations. This function also entails:

- Establishment of a functional and all-inclusive county level key populations technical working group including membership from young key populations.
- Assign funders and implementers geographical areas of operation within the respective county, as guided by the epidemiology and estimates of young key populations in the county.
- Allocate resources, including humans, commodities, infrastructure, among others for complementary resourcing of interventions targeting young key populations.
- Mobilize resources for implementation of interventions targeting young key populations.
- Supervise implementation of key population programmes including consolidating data for decision making.

The role of implementing partners

Implementers of young key populations interventions shall:

- Provide services in line with these guidelines.
- Work with NASCOP and the county by collaborating at national and county key populations technical working groups.
- Conduct biannual validation of hotspots.
- Submit complete and timely reports on indicators for young key populations using the predefined reporting framework and timeline.
- Set up and operationalize programme implementation teams including monitoring and evaluation systems as guided by NASCOP.
- Share experiences of implementation of programmes with young key populations.
- Contribute towards documentation or best practices.
- Adhere to ethical principles, guidelines, and best practices when conducting research.

The programme management structure at the implementing partners is similar to the structure for any key population programmes as described in the national guidelines. However, considering the need of the YKP, the following changes should be made:

1. Peer ratio: The peer educator to KP ratio should be maintained at 1: 30-40 KP considering the intensity of the work. Peer educators should be paid as per national guidelines.
2. Professional counsellor: a professional counsellor/psychologist should be hired considering the mental health needs of the YKP. The counsellor should also be trained on issues related to sexuality, drug use, and sex work. Counsellor should also focus on working with families and children of the YKPs. This position is in addition to an HTC counsellor that is already part of the management structure.
3. Advocacy officer: an additional advocacy officer should be hired to take care of the structural interventions including linkage of the YKP with social schemes, enrollment in schools, or vocational skills and other skills and income generating activities.

National Steering Committee

Under the leadership of NACC, a National Steering Committee (NSC) is in place to fast track the HIV response among adolescents and young people. The committee provides overall guidance on policy, legal, and operational matters of the fast track plan, on which the interventions for young key populations is hinged. The NSC and the Key Populations Technical Working Group will work in a complementary manner to address policy, implementation, research, monitoring, and evaluation to ensure the highest quality of young key populations programming. As per the fast track plan, the NSC's mandate includes:

- Oversight and lead in the HIV response for adolescents and young people.
- Coordinate and oversee various stakeholder initiatives targeting HIV among adolescents and young people.
- Develop road map for the implementation of the fast track plan.
- Monitor the progress of the fast track plan.
- Coordinate existing resources targeting adolescents and young people.
- Receive quarterly reports from various stakeholders.

National Key Populations Technical Working Group

Kenya already has a robust Key Populations Technical Working Group (KPTWG) led by NASCOP, which leads the HIV response among key populations. This KPTWG will continue to provide technical oversight and advise the implementation of young key population strategy. A sub-committee will be set up within the KPTWG for young KPs to discuss specifically issues related to young KPs. This sub-committee may invite few other invitees to include members from multiple sectors. The mandate of the sub-committee will be:

- Identify and coordinate a harmonized approach to young key populations programming.
- Identify resource requirements and facilitate resource mobilization for 90% coverage of estimated young key populations.
- Identify and address relevant implementation issues such as referrals, young KP friendly service provision.
- Provide advice to funders and implementers.
- Provide feedback and insight on programme effectiveness.

Membership

Members will be drawn from relevant government line ministries, development partners, private sector, civil society organizations, and the young key populations.

Frequency of meetings

Meetings shall be held quarterly at the NASCOP offices and chaired by the Key Populations Manager. Special meetings shall be held on need basis.

County Key Populations Technical Working Group

All counties are expected to have Key Populations TWG at the county level similar to the one at the national level to advise and technically lead the KP programming in the counties. These county KPTWGs will also support programme design and implementation with young key populations. The county KPTWGs will be expanded to include young key populations and other members (on invitation) to ensure that the multi-sectoral response can be catered to.

5.3 Monitoring and evaluation

Monitoring and evaluation of the young key populations programme will build on the existing Country M&E Framework for the Period 2014/15-2018/19. As such, key monitoring and evaluation systems in use for the HIV response include the District Health Information System (DHIS), Kenya Population-based HIV Impact Assessment (KENPHIA), HIV modeling, Stigma Index Survey, Integrated Bio Behavioural Survey (IBBS), and Polling Booth Survey (PBS) (especially for key populations). The following broad guidance is provided for the monitoring and evaluation of young key populations programmes:

- Population size, demographics, and epidemiology, with disaggregation of behavioral data and bio markers and HIV, STI, and viral hepatitis prevalence by age group and sex will be collected at commencement of the programme to enable evaluation of programme effectiveness in the future. Kenya used programmatic mapping and estimation methods to map and estimate

population sizes at hotspot, county, and national levels. Polling booth surveys are conducted annually to gather behavioural data and integrated bios. Behavioural surveys are done every 4-5 years to collect incidence and prevalence data. Routine monitoring data also provide evidence and information that help in assessment of the programme and future planning.

- A programme logic model that will be collaboratively developed with all stakeholders will guide implementation.
- Data will be reported on a monthly basis through DHIS – Key Populations module.
- DHIS data will be analyzed periodically to enable a review of performance.
- Annual polling booth surveys will be conducted.
- Integrated Bio Behavioural Survey will be conducted every five years.
- Standardized data collection tools for key populations will be used to capture data and service delivery level; these shall be summarized in MOH731B and submitted to the program's specific Sub County Health and Records Officer by the 5th of every month.
- Young key populations will be involved in research activities on an ethical and safe approach in line with the national policy for research with adolescent and young people.

Logic Framework for Programming with Young Key Populations

Requited Inputs

Funds
Personnel
Facilities
Equipment
Commodities

Well defined package of services:

Structural
- Safe spaces
- Legal and policy intervention
- Violence prevention and response
- Education and skill building
- Family interventions

Behavioural
- Peer education
- Hotspot based interventions
- Condom distribution and negotiation skills
- Harm reduction interventions
- Risk reduction counselling

Biomedical
- HIV testing
- PrEP, PEP, and condoms and lubricant
- Linkage to ART
- STI treatment
- De-addiction services
- Reproductive health services
- PMTCT
- Treatment of hepatitis

Outputs

- No. of reported cases of violence
- No. of reported cases addressed by the team
- No. of YKP received scholarship/ skill building training
- No. of YKP received legal support
- No. of YKPs reach by services by type of services and type of KP
- No. of YKPs reached by peer educators
- No. of YKPs received condoms/lubes/ needles as per need
- No. of YKPs received risk reduction counselling
- No. of YKP received HIV testing services
- No. of YKP initiated on PrEP and retained
- No. of HIV positive YKP initiated and retained on ART
- No. of HIV positive YKP on ART, virally supressed
- No. No. of YKP received deaddiction services
- No. of YKP received reproductive health services
- No. of YKP on MAT

Outcome indicators

- percentage of estimated
- percentage of YKP reached by programmes
- percentage of YKP used condoms at last sex
- percentage of YKP used new needle-syringe at last injecting episode
- percentage of YKP tested for HIV
- percentage of HIV positive YKP on ART
- percentage of YKP who experienced violence
- percentage of YKP on PrEP
- percentage of YKP on MAT
- percentage of YKP rejoined/continued education or skills training

Impact

- Reduction in new HIV infection among YKP
- Reduction in AIDS-related deaths among YKP
- Reduction in violence, stigma, and discrimination among YKP

*Indicators shown here are illustrative. Please see the annexure for detailed set of monitoring indicators.

The key output and outcome monitoring indicators are:

Programme Objectives	Output Indicators	Outcome Indicators
• To reduce the incidence of violence, stigma, and discrimination against YKPs	• # of the YKPs sensitised on gender, rights, and violence • # of programmes for YKP with a operational violence response system • # of reported cases of violence (by type) by YKP • # of reported violence cases addressed within 24 hours • # of police and other law enforcement sensitised on KP issues • # of the health care workers sensitized on needs of YKPs	• Reduction in incidence of violence and discrimination by perpetrator (partners, clients, police, health care workers) • Increase in violence response by implementers • Improvement in knowledge and attitude among law enforcement and health care workers
• To reduce vulnerability of YKPs to violence, addictions, and diseases	• # of YKPs accessing available social schemes • # of families of YKP sensitised (YMSM and YPWID) • # of YKPs accessing livelihood options	• Increase in proportion of YKPs accessing social schemes • Increase in proportion of YKPs who received family support • Increase in proportion of YKPs who improved skills and engaged in viable livelihood options
• To increase coverage and regular outreach to young KPs in the hotspots (physical and virtual)	• # of newly mapped hotspots (physical and virtual) with interventions for YKP • Peer ratio in the hotspots are maintained at 1: 30-40 • # of newly registered YKPs • # of registered KPs contacted every month	• Increase in coverage of YKP • Increase in peer outreach and education of YKP • Increase in knowledge on risk and prevention
• To increase correct and consistent use of HIV prevention methods (condoms and PrEP) young KPs	• # of YKP received condoms and lubes as per their need • # of YKP received sessions on condom negotiation • # of YKP received psycho social counselling sessions • # of YKP 40% became members of support groups • # of YKPs initiated on PrEP • # of YKP initiated on PrEP adhere to PrEP for 6 months • # of YKP received PEP within 72 hours of an HIV exposure	• Increase in condom use at last sex with different partners among YKP • Increase in availability of condoms and lubricants for YKP • Increase in condom negotiation among YKP • Increase in risk perception among YKP • Increase in proportion of eligible YKP initiated and retained on PrEP • Increase in proportion of YKP on PEP completing the course
• To improve health seeking behaviour related to HIV testing, STI treatment, and reproductive health among YKPs	• # of YKP registered in the clinics • # of YKP visited the clinic every quarter • # of YKP who took HIV test every quarter • # of YKP who screened for STI every quarter, diagnosed and treated. • # of YKP provided RCH services • # of YKP visited the DIC every quarter	• Increase in proportion of YKP undertaking HIV testing services (ever and last 3 months) among YKPs • Decrease incidence of STI among YKP • Increase in proportion of YKP completing treatment of STI • Increase in proportion of TKP (females) undertaking family planning/spacing methods • Increase in proportion of YKP visiting clinic/ DIC • Increase in proportion of YKP participating in DIC events
• To improve initiation and adherence to ART among YKPs who are HIV positive	• # of HIV positive YKPs enrolled in ART • # of YKP enrolled in ART contacted/followed up every month • # of YKP enrolled in ART became members of support group • # of HIV positive tested for viral load every six months • # of HIV positive YKP attained viral suppression	• Increase in proportion of HIV positive YKP enrolled in ART • Increase in proportion of YKP enrolled in ART retained/adhered to ART • Increase in proportion of YKP enrolled in ART and virally suppressed

All data will be disaggregated by age and KP type – i.e., by YSW, YMSM, YPWID

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