



Ministry of Health

MARCH 2016

POLICY FOR THE PREVENTION OF HIV INFECTIONS AMONG KEY POPULATIONS IN KENYA





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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
CAJ	Commission on Administration of Justice
CBO	Community Based Organisation
CCM	County Co-ordinating Mechanism
CGPH	Centre for Global Public Health
COBPAR	Community Based Programme Activity Report
DPP	Director of Public Prosecutions
ETR	End Term Review
FBO	Faith Based Organisations
FIDU	Female Injecting Drug User
FSW	Female Sex Worker
GBV	Gender-Based Violence
GNSWP	Global Network of Sex Work Projects
HIV	Human Immuno-Deficiency Virus
HMIS	Health Management Information System
HCT	HIV Counseling and Testing
IDU	Injecting/Intravenous Drug User
IPOA	Independent Police Oversight Authority
KAIS	Kenya Aids Indicator Survey
KMTC	Kenya Medical Training College
KASF	Kenya AIDS Strategic Framework
LGBTI	Lesbian, Gay, Bi-sexual, Transgender, Intersex
MARP	Most-at-Risk Population
MIDU	Male Injecting Drug User
MSM	Men who have Sex with Men
MSW	Male Sex Worker
NACC	National Aids Control Council
NASCOP	National AIDS and STI Control Programme
NEP	Needle Exchange Programme
NGO	Non-Governmental Organisation
PEP	Post-exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Worker
VCT	Voluntary Counseling and Testing

DEFINITION OF KEY TERMS

Definitions used in this policy are aligned with current consensus definitions used in the Global Health Sector Strategy on HIV/AIDS 2011–2015 (1) and by the United Nations, as described in the Joint United Nations Programme on HIV/AIDS (UNAIDS) “Guidance note on HIV and sex work”(2) and other relevant World Health Organisation (WHO) and other United Nations documents.

Key populations: Groups who, due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviours that increase their vulnerability to HIV. This policy focuses on three key populations as stated in the Kenya AIDS Strategic Framework: (1) Sex workers (2) Men who have sex with men (2) People who inject drugs. The key populations are important to the dynamics of HIV transmission. They also are essential partners in an effective response to the epidemic.

Sex workers: Include female, male and transgender adults (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work is consensual sex between adults, can take many forms, and varies between and within countries and communities. Sex work also varies in the degree to which it is more or less “formal”, or organised. As defined in the Convention on the Rights of the Child (CRC), children and adolescents under the age of 18 who exchange sex for money, goods or favours

are “sexually exploited” and not defined as sex workers.

Men who have sex with men: All men who engage in sexual and/or romantic relations with other men. The words “men” and “sex” are interpreted differently in diverse cultures and societies and by the individuals involved. Therefore, the term encompasses the large variety of settings and contexts in which male-to-male sex takes place, regardless of multiple motivations for engaging in sex, self-determined sexual and gender identities, and various identifications with any particular community or social group.

People who inject drugs: People who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other injectable routes. People who self-inject medicines for medical purposes – referred to as “therapeutic injection” – are not included in this definition. The definition also does not include individuals who self-inject non-psychotropic substances, such as steroids or other hormones, for body shaping or improving athletic performance. While these guidelines focus on people who inject drugs because of their specific risk of HIV transmission due to the sharing of blood-contaminated injection equipment, much of this guidance is relevant also for people who inject other substances.

FOREWARD



One third (33%) of all new infections in Kenya occur among people from the Key Populations and their immediate partners according to the latest Kenya Modes of transmission analysis. In all counties and settings within Kenya, the Key Populations comprising of male and female sex

workers (SW), men who have sex with men (MSM) and people who inject drugs (PWID) are most vulnerable, experience the greatest burden of HIV and are currently underserved in terms of provision of essential HIV prevention, care and support services.

Despite the general decline in HIV prevalence currently standing at 5.6% among Kenyans aged 15-64 years according (KAIS 2012), the Key Populations remain highly burdened with HIV with prevalence ranging from 29.3% in Female sex workers, 18.2% in men who have sex with men to 18.7% amongst people who inject drugs.

According to the HIV prevention revolution roadmap, the key populations play a central role in the dynamics of HIV epidemics. It has become clear that people from key populations do not live in isolation as they can acquire and also transmit HIV to other general populations.

The Ministry of Health (MOH) is aware of the fact that despite the well acknowledged value

of scaling up comprehensive HIV services for key populations, monumental barriers still exist. Such barriers include social, legal, structural and other contextual factors that increase vulnerability of key population and obstruct access to HIV services. Some of these are brought about by punitive legislation and poor policing practices, stigma and discrimination, poverty and violence.

The Government of Kenya through the MOH, National AIDS Control Council (NACC) and National AIDS and STI Control Programme (NAS COP) is thus committed to championing a multi-sectoral approach in planning, developing and monitoring effective and efficient programmes for key populations that are relevant to our epidemiological context. This commitment is clearly stated in the Kenya AIDS Strategic Framework 2014/15 to 2018/19 (KASF). The policy for Prevention of HIV Infections among Key Populations in Kenya is therefore one of the strategic enablers for the HIV response in Kenya and will seek to accelerate rolling out of targeted, timely and evidence-based comprehensive prevention and care services for key populations.

This policy has been developed under the leadership of NACC through consultations with various stakeholders.

Dr. Nicholas Muraguri,
Principal Secretary,
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Finally, we cannot forget to thank the many CSOs working with the key populations who participated in numerous consultation and validation meetings and encouraged us to develop this policy.

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EXECUTIVE SUMMARY

Kenya has the third largest population of people living with HIV in sub-Saharan Africa. Its national HIV prevalence is the highest of any country outside of Southern Africa. The National HIV and AIDS Estimates Working group estimated that HIV prevalence rates among people aged 15-49 to be 6.0% in 2013. It is estimated that 1.4 million adult Kenyans were living with HIV in 2013.¹ The reduction in HIV in the country since KAIS I in 2007 can be attributed to many reasons, key among them being the efforts by the Government of Kenya, development partners and civil society organisations to combat the disease. The Government has over the years committed significant amounts of resources towards achieving “an HIV free society in Kenya”. This fight is spearheaded by National AIDS Control Council (NACC) and National AIDS and STI Control Project (NAS COP) under Ministry of Health.

In Kenya, the different key population sub groups that have been identified and considered to be at high risk of HIV infection include Female Sex Workers (FSW), Male Sex Workers (MSW), Men who Have Sex with Men (MSM) and People who Inject Drugs (PWID).² According to the Kenya HIV Prevention Responses and Modes of Transmission Analysis for the year 2009 by NACC, 14.1% of the new HIV infections were attributed to sex workers and clients; 15.2% were attributed to MSM and prisons; while 3.8% were attributed to PWID. All these add up to

33% of new infections which are attributable to key populations. Other evidences show that HIV prevalence and incidence among sex workers, MSM and PWID are 2-5 times higher than in the general population. A mapping conducted by NAS COP in 2012 shows high number of sex workers, MSM and PWID hence making a point that these populations cannot be ignored any longer.

However, due to perceived criminality, key population sub groups in Kenya are vulnerable to harassment, extortion and institutionalised stigma and discrimination, all of which impact negatively on their ability to access HIV services thus impeding the scaling up of programmes. This is not only a public health concern where poor coverage of this population with prevention and care programme can fuel the epidemic further but also a human rights violation especially when the Constitution provides all citizens with an equal right to access health care. This situation calls for a policy framework which provides the key populations and the programme implementers a facilitating environment to ensure that all key populations are reached by high quality programmes free of stigma, discrimination and violence.

The vision of this Policy is “a facilitating environment where all key populations in Kenya can access HIV prevention and treatment programmes and services”.

¹ Kenya HIV Estimates Report, MoH, 2014

² The Kenya National AIDS Strategic Plan III (KNASP), 2009/10 to 2012/13.

The overall objective of the policy is "to enhance access to HIV prevention and treatment programmes and services among key populations in Kenya". The specific objectives are **1) to facilitate the generation and synthesis of information on key populations for evidence based programming for key population; 2) to address barriers to scaling-up comprehensive key populations programming 3) to increase access to comprehensive services for key populations; and 4) to facilitate stakeholder coordination to harmonise the national and county level HIV response to key populations.**

The policy is human rights-based; it acknowledges the provisions of various relevant international human rights instruments which Kenya is a party to. These international human rights instruments form a part of the country's legal system by virtue of Article 2(6) of the Constitution of Kenya, which states that any treaty or convention ratified by Kenya shall form part of the law of Kenya. Additionally, the policy is in line with provisions of Article 43(1)(a) of the Constitution of Kenya which states that every citizen has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care; the provisions of the HIV and AIDS Prevention and Control Act, No. 14 of 2006, which among other things prohibits discrimination against persons living with HIV and controls research on HIV; and finally,

it also acknowledges Kenya's international obligations and commitments including the Millennium Development Goals and the Abuja Declaration, among others.

The Policy provides a broad framework within which all stakeholders, including Government ministries, departments and agencies (MDA), civil society organisations (CSO), faith based organisations (FBO) and development partners should work collaboratively towards the reduction of HIV infections among the key populations. It has also incorporated an implementation; coordination; and a monitoring and evaluation framework.

This Policy has been developed under the stewardship of NACC over a period of 20 months through a consultative and evidence based process that involved stakeholders from various MDAs, development partners, academic and research organisation, FBOs, CSOs, key populations' umbrella organisations and community representatives. These consultations were undertaken in order to gain the best possible input, experiences and guidance to the policy content and direction. The policy's guiding principles are based on human rights doctrines, global guidelines and best practices relating to dealing with HIV and AIDS among key populations including the evidence based approaches, combination prevention, non-discrimination, participation, co-ordination, partnership, and sustainability.

Chapter One

INTRODUCTION

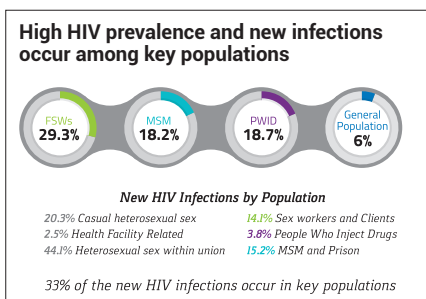
1.1 Background and Rationale

Kenya has the third largest population of people living with HIV in sub-Saharan Africa and the highest national HIV prevalence of any country outside of Southern Africa. The National HIV and AIDS Estimates Working group estimated HIV prevalence rate among people aged 15–49 to be 6.0% in 2013. It is estimated that 1.4 million adult Kenyan were living with HIV in 2013.³ Although the spectrum⁴ results show a continued decline of HIV prevalence among the adult population from late 1990s to 2008, the prevalence has since stabilised. Kenya's HIV epidemic is geographically diverse, ranging from a prevalence of 25.7% in Homa Bay County in Nyanza region to approximately 0.2% in Wajir County in North Eastern region of Kenya. These new estimates confirm a decline in HIV prevalence among both men and women at the national level. Prevalence remains higher among women at 7.6% compared to men at 5.6%. The reduction and stabilisation can be attributed to many reasons, key among them the efforts by the Government of Kenya, development partners and civil society organisations to combat the disease. Indeed, the Government has, over the years, committed huge amounts of resources towards achieving “an HIV free society in Kenya”. This fight is spearheaded by the National AIDS Control Council (NACC) and National AIDS and STI Control Project (NAS COP) under Ministry of Health. It is in recognition of their mandate and commitment to reduce new HIV infection as stated in the

Kenya AIDS Strategic Framework 2014/15 to 2018/19 (KASF) that this policy for the prevention of HIV infections among the key populations in Kenya has been developed.

The HIV in Kenya is characterised as a generalised epidemic among the adult population but more concentrated among key populations who are considered to be at a heightened risk of infection and transmission due to their sexual and social behaviours. The different key population sub groups that have been identified and considered at risk of HIV infection include Female Sex Workers (FSW), Male Sex Workers (MSW), Men who Have Sex with Men (MSM) and People who Inject Drugs (PWID).⁵

According to the Kenya HIV Prevention Responses and Modes of Transmission Analysis for the year 2009 by NACC, 14.1% of the new HIV infections were attributed to sex workers and clients; 15.2% were attributed to MSM and prisons; while 3.8% were attributed to injecting drug users. Therefore, 33% of the new infections are attributable to key populations in Kenya.

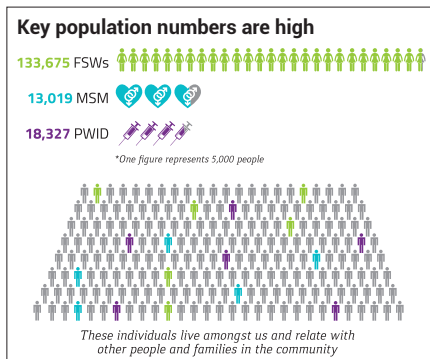


3 Kenya HIV Estimates Report, MoH, 2014

4 Estimation and Projection Package (EPP) and Spectrum software is recommended by the UNAIDS Reference Group on Estimates, Modeling and Projections

5 The Kenya National AIDS Strategic Plan III (KNASP), 2009/10 to 2012/13.

A mapping of key populations done by NASCOP (2012) revealed that these numbers were too high to ignore. The mapping estimates more than 133000 FSWs, 13000 MSM and 18000 PWID in Kenya. Due to public health reasons, it is important to reach these key population sub groups because they are not isolated from but are part of the general population. Indeed, they are connected by way of their sexual and drug injecting networks; sex workers through their clients; MSMs through their female partners; and PWID through their sexual partners.



Currently, though there are programmes that seek to reduce HIV transmission among the key populations in Kenya, the coverage gap is still high. However, the challenges associated with the implementation of these programmes can be attributed to the manner in which both the law and the public view the key populations and their behaviours. Due to perceived criminality of some of their behaviours, key population sub groups in Kenya are vulnerable to harassment, extortion and institutionalised stigma and discrimination which impact negatively on

their ability to access HIV services and this impedes the scaling up of programmes in government health systems as was established under the KNASP III ETR report.

The need for a policy framework to guide HIV response for the key populations' arose from the desire for an enabling environment that promote access to HIV services for the key populations and allows implementers to run programmes with key populations without fear of stigma, discrimination or violence. The policy has taken a public health approach. It has relied on the evidence available on the control and spread of HIV among the key population sub-groups to develop strategies and make recommendations that seek to improve prevention, treatment and care outcomes. It draws strength from the evidence that in an epidemic-hit country like Kenya, scaling up comprehensive key population interventions will be a game changer in the HIV response. Modelling conducted in Kenya has shown that when the community empowerment-based, comprehensive HIV prevention reaches coverage of 65% among sex workers, a total of 20,683 new infections among the adult population may be averted between 2012 and 2016⁶. This will also considerably reduce the burden on the HIV care programme for the country.

The policy is rights-based as it acknowledges the provisions of various relevant international human rights instruments to which Kenya is a party to. These international human rights instruments form a part of the country's legal system by virtue of Article 2(6) of the

Constitution of Kenya, which states that any treaty or convention ratified by Kenya shall form part of the law of Kenya. The policy is in line with provisions of Article 43(1)(a) of the Constitution of Kenya which states that every citizen has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care; the provisions of the HIV and AIDS Prevention and Control Act, No. 14 of 2006, which among other things prohibits discrimination against persons living with HIV and controls research on HIV; and finally, it also acknowledges Kenya's international obligations and commitments including the Millennium Development Goals and the Abuja Declaration, among others.

1.2 The Supporting Documents for the Policy

This policy has drawn from the draft Kenya Health Policy 2012-2030 that is currently being developed and which is based on principles of equity in the distribution of health services and interventions with a focus on inclusiveness. The draft health policy seeks to commit the country to the reduction of communicable diseases and putting interventions in place to support marginalized populations that are affected by communicable conditions. The policy seeks to build on and leverage on relevant strategy documents like the Kenya AIDS Strategic Framework (KASF) 2014/15 – 2018/19 and guidelines that have already been developed including the National Guidelines for HIV/STI Programmes for Sex Workers (Ministry of

Health, 2014); Standards for Peer-Education and Outreach Programmes for Sex Workers (Ministry of Public Health & Sanitation, 2010b); Standard Operating Procedures for Medically Assisted Therapy for People Who Use Drugs (PWUD) (Ministry of Health, 2013a); and Kenya National Guidelines for the Comprehensive Management of the Health Risks and Consequences of Drug Use (Ministry of Health, 2013b).

The Policy further acknowledges the need for a scaled up response to meet the HIV and AIDS prevention, care and needs of key populations; and a supportive framework and mechanism to enhance the clarity, commitment and coordination of all service provision among the key populations. Priority policy areas of focus include, strengthening the key population's evidence-base, addressing the structural and social constraints to effective programming, defining a comprehensive package of HIV prevention and care services for key population sub-groups, building the capacity of health and other service providers for key populations' friendly service delivery and building the capacity of key populations to participate in effective programme design and delivery.

The policy, therefore, provides a broad framework within which all stakeholders, including MDAs, CSOs, FBOs, academic and research organisations and development partners will contribute to the reduction of HIV infections among the key populations. It has also infused an implementation, coordination, and a monitoring and evaluation framework.

Chapter Two

POLICY DIRECTIONS

2.1 Vision

The vision of this policy is to ensure “a facilitating environment where all key populations in Kenya can access HIV prevention and treatment programmes and services”

2.2 Overall Objective

The overall objective of this policy is “to enhance access to HIV prevention care and treatment programmes and services among key populations in Kenya”

2.3 Specific Objectives

The specific objectives of the policy are to:

- a. Facilitate the generation and synthesis of information on key population sub populations for evidence based key population programming.
- b. Address barriers to scaling-up comprehensive key populations programming.
- c. Increase access to scaled up and comprehensive services for key population.
- d. Facilitate stakeholders’ coordination to harmonise national and county level HIV response to key populations.

2.4 Guiding Principles of the Policy

The guiding principles that underlie this policy are based on global guidelines and best practices relating to dealing with HIV and AIDS among key populations.

2.4.1 Evidence-based Approaches

The HIV prevention interventions among key populations shall prioritize interventions that have been proven to be effective in scientific literature and identified as best practices. All decisions and actions at the level of planning or implementation shall be based on the most up-to-date information and best practices.

2.4.2 Combination Prevention

Effective prevention strategies are distinguished by not relying on any single intervention approach alone, but instead using a combination of behavioral, structural and biomedical interventions that are coordinated to achieve maximum effect. To this end, the Government shall ensure commitment in the actualisation of an effective and sustained prevention, treatment, care and support response with regard to HIV among key populations. A combination prevention intervention approach will work in Kenya by adopting a multi-sectoral approach.

2.4.3 Non-discrimination

Promotion, protection and respect of human rights including gender equality should always be integrated in HIV prevention programming for key populations. HIV prevention, treatment and support services shall be provided equitably to all persons in their communities, including key populations. All citizens have the right to access information and health services. There shall be comprehensive gender mainstreaming throughout HIV programmes that target key populations, including the collection and collation of gender disaggregated data. Emphasis shall be placed on gender equity and prevention of gender-based violence throughout the sub populations.

2.4.4 Participation

There shall be active and meaningful involvement of key populations, including people living with HIV, to ensure that the goal and objectives of this policy are realised. At all levels of HIV prevention planning, programming and implementation, the participation of the community and target groups shall be integral to achieve programme impact.

2.4.5 Co-ordination

Implementation and coordination of HIV prevention interventions among partners 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 package for key populations.

2.4.6 Partnership

All partners including public, private, NGOs, CBOs and civil societies shall be involved in design and implementation of HIV prevention programmes for key populations to maximize the coverage, scale and intensity of prevention services.

2.4.7 Sustainability

All HIV prevention programmes among key populations shall be designed based on long term goals that foster and maintain sustainability.

2.5 Process of Developing the Policy

This Policy has been developed under the stewardship of NACC over a period of 20 months through a consultative and evidence-based process that included stakeholders from various government ministries, department and agencies, development partners, faith-based organisations, civil society organisations, key populations' umbrella organisations and community representatives. This consultative approach was undertaken to gain the best possible input, experiences and guidance to the policy content and direction. It entailed a critical analysis of the HIV and AIDS-related risks and vulnerabilities among the key population sub-groups, which have informed and shaped the policy's objectives and priorities.

Chapter Three

**POLICY PROVISIONS ON KEY ISSUES
THAT EXPOSE KEY POPULATIONS IN
KENYA TO HIV INFECTIONS**

3.1 Policy Objective 1: Facilitate the generation and synthesis of information on key population sub-populations for evidence-based key populations programming

As already noted a large percentage of key population is exposed to (or) infected with HIV. There have been numerous efforts by Government agencies such as NACC, NASCOP and other stakeholders to generate relevant data to improve HIV programming for key populations in Kenya. However, there still exist huge gaps in evidence base particularly in the context of social and structural drivers of the HIV epidemic amongst the key populations⁷. This lack of information has led to among other things, limited understanding of the social determinants of health among the key population sub-populations.

Ethical concerns on the research targeting the key populations; particularly on the identification of knowledge gaps, involvement of key populations and utilization of the research findings were flagged out as major issues of concern in Kenya. Over the last three decades, several institutions have commissioned researches on HIV and AIDS among the different key population sub-groups without necessarily understanding the needs of the key population or the country. The challenge has been also in ensuring that these research findings and evidence are used in developing plans and programmes for key populations. The key population groups have felt marginalised and have raised concern in the recent past that they are often used as subjects rather than equal partners.

3.1.1 Policy Directions

To achieve the above, the Government will:

- (i) Integrate the Key Populations research priorities in the National research agenda and ensure that related findings are adequately disseminated and

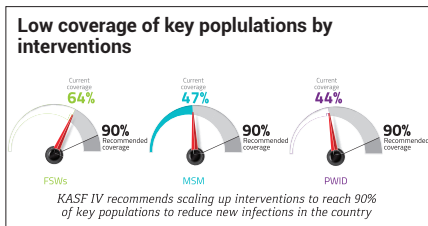
- included in the HIV research hub.
- (ii) Identify and determine the key information and evidence gaps for all key population sub-groups across all counties of Kenya.
- (iii) Strengthen the key population evidence base by conducting new research to supplement the information and evidence gaps identified.
- (iv) Strengthen incorporation of minimum standard package of gender and sub-population disaggregated national indicators and data collection tools for key population programmes.
- (v) Strengthen capacity of local Kenyan organisations especially key population-led organisations to design, conduct and use research findings.
- (vi) Build capacity of programme planners/policy makers to apply the existing and new information and evidence in planning programmes for key populations.
- (vii) Commit resources towards generation of new evidence, especially among key populations sub-groups and counties where evidence is poor and update existing evidence like mapping.
- (viii) Develop regular surveillance systems specially designed for key populations and include key population related indicators in existing data collection processes like KDHS, KAIS and HMIS.

3.2 Policy Objective 2: Address barriers to scaling-up comprehensive key populations programming

The Government of Kenya has developed national guidelines for HIV/STI Programmes for key populations. It is, therefore, important that the programmes are delivered to scale because presently only 64% of the mapped FSW, 47% of the mapped MSM and 44% of the mapped PWID are reached through programmes. Although there has been an extensive mapping exercise carried out for the key populations in Kenya, programming

⁷ KNASP III ETR (2014)

for them has been inadequate. According to the NASCOP data for 2014 (upto June 2014), even though there are an estimated 133,675 FSWs spread over 35 counties, only 30 counties have interventions. Out of 30 counties, only 18 counties have interventions to cover 100% or more of the estimated FSW. In the remaining 12 counties, programmes cover 50% or less of the estimated FSW. On further analysis, it is found that only four of the counties have contacted 100% of the contractual target for FSW. The story is similar for MSM and PWIDs.



To facilitate the substantial scale-up of services for key population sub-groups, what is needed is an overarching supportive policy framework that will provide clarity regarding expectations, human and resource commitments and coordination of all service provision to key populations. This framework will include recognition of the right to health of key populations and the social and structural determinants of their HIV and AIDS risks and vulnerabilities.

3.3.1 Policy Directions

To achieve this, the Government will:

- (i) Implement the Kenya AIDS Strategic Framework (KASF) to ensure 90% coverage and access to services for key populations' sub-groups at national and county level.
- (ii) Build the capacity of implementing partners and establish a technical support mechanism to meet the HIV prevention, care and support needs of key populations.
- (iii) Build capacity of implementing partners and provide them with funding to implement programmes for key populations.

- (iv) Develop learning sites to pilot new strategies and build capacity of implementing partners through hands-on practical training.
- (v) Conduct periodic programme reviews and outcome evaluation to assess progress towards achieving the strategic plan.
- (vi) The MOH and its lead agencies in HIV response will as a part of routine scoping, establish the commodity and infrastructure needs to deliver a comprehensive package of services to all sub-populations of the Key Populations.
- (vii) Work towards integrating services for key populations in mainstream health service delivery so as to enhance efficiency and sustainability. Models need to be tested and health worker attitudes need to change towards facilitating the needs of key populations.

3.3. Policy Objective 3: Increase access to scaled up and comprehensive services for key populations

It is widely acknowledged that key populations seeking prevention, care, treatment and support often face stigma, discrimination, physical and sexual violence, which takes different forms and manifestations. These have been identified as some of the key barriers to them receiving quality health and other services and thus inhibiting service provision. Added to fear of arrest, sex workers for example often lead a clandestine life, usually shifting regularly from place to place while their sexual negotiations are often hurried thereby making discussions about condom use marginal.⁸ MSMs often experience stigma and shame from society and health care providers, which pushes them to avoid seeking health care when in need. Victims of stigma, discrimination and violence are more likely to engage in

8 Okal J, et al (2009). *Social Context, Sexual Risk Perceptions and Stigma: HIV Vulnerability among Male Sex Workers in Mombasa, Kenya*. Culture, Health and Sexuality: An International Journal for Research, Intervention and Care.

unprotected sex and are less likely to seek health care or report STI symptoms. Sexual minorities, including MSM and transgender people are often subjected to violence due to phobia that exists in the society against MSM and transgender people.

Key populations also often report that they routinely experience violence and harassment. Male and female sex workers in particular are often subjected to physical and sexual abuse by clients, law enforcement officers and power brokers. SWs specifically are usually subjected to physical and emotional trauma by their clients while the police also subject them to harassment, threats, arrests, beatings, sexual coercion,⁹ loitering and extortion of money or sexual services.¹⁰ A national study conducted by NASCOP in 2014 found that 22% of the female sex workers reported being beaten and physically forced to have sexual intercourse in the past six months.¹¹ Some 44% of the FSW also reported being arrested or beaten by police and askaris in the last six months. In the same study, 17% MSM reported being beaten and physically forced to have sex in the last six months and 24% reported being arrested or beaten by police or askaris. Among the PWIDs, 57% of them reported being arrested or beaten by police or askaris in last six months. As a result of being criminalised and stigmatised, key populations do not seek protection or redress from the law. Research has established that violence against SWs is associated with unsafe sex thereby heightening the risk of contracting HIV.¹² In Mombasa, for example, 77% of FSWs surveyed in 2007 reported being physically abused or forced to have sex without a condom.¹³

Violence and unsafe environment are barriers to access to services for key populations

Provisions of Article 43(1)(a) of the constitution of Kenya states that every citizen has the right to the highest attainable standard of health. Even then key population experience high violence and harassment making the work environment unsafe



Sexual violence

22% FSWs 17% MSM 8% PWID



Unsafe work environment

44% FSWs 24% MSM 57% PWID

There are direct and indirect intersection of violence and HIV

Indirect: Fear and constant experience of violence leads to anxiety, depression, loss of self esteem and lower priority to health directly increase vulnerability to HIV

Direct: Rape, coercion to have sex without condoms or share needles can directly increase risk to HIV

Gender assumptions and inequalities also underpin risks and vulnerabilities that key populations in Kenya are exposed to. Indeed, feminized poverty is a key driver for many women who enter sex work. FSWs are forced into risky sex by clients and for which they are prepared to pay more.¹⁴ Little is known about MSWs but there is no doubt that people become MSWs because of financial incentives.¹⁵ With regard to drug use, FIDUs generally experience greater stigma than MIDUs and may engage in transactional sex to support their drug-taking. But it must be noted that drug addiction generally represents a descent into impoverishment with few, if any, social safety nets to help PWIDs and their partners.¹⁶

Currently, members of the key populations in Kenya are already stigmatised, and their need for HIV-related services adds another layer of stigma to their lives.¹⁷ This makes it very difficult for them to access services including the police and health care services. Thus, establishing stigma-free, confidential health care provision for all sub-groups is a core element of support to key populations. In this

8 Okal J, et al (2009). *Social Context, Sexual Risk Perceptions and Stigma: HIV Vulnerability among Male Sex Workers in Mombasa, Kenya*. Culture, Health and Sexuality: An International Journal for Research, Intervention and Care.

9 Okal J, et al (2011). *Sexual and Physical Violence against Female Sex Workers in Kenya: a Qualitative Enquiry*.

10 Okal J, et al (2009). *Op cit*.

11 National Polling Booth Study among key population in Kenya, NASCOP 2014

12 UNAIDS (2009). *UNAIDS Guidance Note on HIV and Sex Work*.

13 Tenang S, et al (2007). *Concurrent Sexual and Substance use Risk Behaviours among Female Sex Workers in Kenya's Coast Province*. Journal of Social Aspects of HIV/AIDS.

14 Vaginal or anal sex without a condom.

15 Okal, J et al (2009). *Social Context, Sexual Risk Perceptions and Stigma: HIV Vulnerability Among Male Sex Workers in Mombasa Kenya*. Culture, Health and Sexuality Vol. 11.

16 International HIV/AIDS Alliance (2010). *HIV and Drug Use: Community Responses to Injecting Drug Use and HIV*.

17 UNAIDS, *Reducing HIV Stigma and Discrimination: A Critical Part of National AIDS Programmes*. 2007.

regard, the provision of human rights and HIV training for health care workers has been shown to reduce stigma and discrimination in health care settings.¹⁸ While such training is essential, other strategies such as the adoption and implementation of national and facility-level policies would assist to support the provision of healthcare that is free of stigma and discrimination. These should be supported by the routine measurement of stigma and discrimination in health care facilities.¹⁹

3.2.1 Policy Directions

To achieve this, the Government will:

- (i) Develop national guidelines and comprehensive package of services (biological, behavioural and structural) for population sub-groups.
- (ii) Infuse key population issues into existing HIV and AIDS laws, policies and guidelines.
- (iii) Develop a violence prevention and response system in programmes to address violence and discrimination against key populations.
- (iv) Undertake awareness raising and advocacy with key political, religious, community and media influencers.
- (v) Sensitise all law enforcement agencies on the need for an enabling environment for implementing a HIV prevention programme among key populations.

3.4 Policy Objective 4: Facilitate stakeholders' coordination to harmonise national and county level HIV response to key populations.

The KNASP III ETR identified weak coordination mechanism at both national and decentralised levels as one of the challenges and recommended the improvement of the same in order to reduce the spread of

AIDS among the key populations. This is important because the complex nature of the issues affecting the various key population sub-groups imperatively demands a well-co-ordinated and functionally coherent framework where all the relevant agencies (government and non-governmental) work in concert to deliver the necessary comprehensive package of services to the key populations at both national and county government levels. In the past, HIV programme responses that target the sub-populations have been disjointed thereby leading to duplication of efforts and failure to capture large groups of the sub-populations.

The implementation of this policy will require a multi-sectoral approach similar to the approach suggested in KASF IV, meaning the process will not be left to just one ministry, department or agency. The policy takes cognisance of the governance and service delivery structures that the Constitution of Kenya has devolved including the health service delivery which is now a shared responsibility between the national Government and the county governments. The successful delivery of this policy will, therefore, be dependent on the good co-ordination and complementarity of functions between the two levels of governance.

The policy also acknowledges other partnerships at the national and sub national level that are crucial and must be upheld to remove the barriers that various key population sub-groups face so as to facilitate their access to health services and enjoyment of their human rights. Therefore, this policy shall encourage NACC and NASCOP to promote and support regional, national and local partnerships through structured framework of engagement for harmonised key populations' targeted interventions as stated in KASF IV.

17 UNAIDS, *Reducing HIV Stigma and Discrimination: A Critical Part of National AIDS Programmes*. 2007.

18 UNAIDS. *We can remove punitive laws, policies, practices and discrimination that block effective responses to HIV*. 2012.

19 Aparna Jain and Laura Nyblade.

3.4.1 Policy Directions

1. Role of the Ministry of Health

The 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.

a) Role of the National AIDS Control Council

As the Government lead agency accountable for the results of HIV response and responsible for policy, coordination, monitoring and evaluation and reporting NACC shall;

- (i) Undertake dissemination and advocacy of the policy at the national and county levels.
- (ii) Provide technical leadership and coordination at the county level including:
 - Stigma, discrimination and violence reduction.
 - Initiating process of re-alignment to the existing legal environment.
- (iii) Undertake resource mobilisation to support HIV policy locally and internationally including rolling out of key population programmes.
- (iv) Ensure coordination of implementation of the policy at all levels (national and county).
- (v) Coordinate key populations targeted researches as part of research coordination mandate focusing on all the sub-groups.
- (vi) Constitute a working group to continuously review the inherent risks and structural barriers to key population programming and service uptake, and institute appropriate mitigation strategies to ensure sustained conducive environment for

programming nationally and in the counties.

- (vii) Undertake advocacy initiatives targeting political, cultural and religious leaders.

b) Role of the National AIDS and STI Control Programme

In implementing this policy, NASCOP shall:

- (i) Provide leadership in the rolling out of targeted behavioural and clinical interventions for key populations in line with global and national guidelines.
- (ii) Prioritise key population programmes based on mapping and size estimation
- (iii) Develop/adapt and review guidelines and standards for service delivery packages to all key populations.
- (iv) Convene the National Technical Working Group for Key Populations
- (v) Support the counties to scale up or initiate key population programmes
- (vi) Provide technical support to programmes to improve their quality
- (vii) Develop learning sites and support in building capacity of implementers

b) i) Role of the National Technical Working Group for Key Populations

The NTWG will provide technical leadership to consolidate HIV prevention interventions among key populations from a fragmented approach towards a target-based, well-coordinated and comprehensive population-based approach. This NTWG membership will be drawn from managers of HIV prevention programmes, technical leads from multi lateral and bilateral development partners, private sector, research community, people living with HIV and civil society organisations dealing with key population sub-groups. The role of the NTWG for Key Populations will be:

- (i) To provide coordination and leadership of HIV prevention programmes targeting key populations sub groups.
- (ii) To provide leadership and coordination of resource mobilisation efforts to address the programme needs.
- (iii) To promote linkages between different HIV prevention interventions and services implemented by partners.
- (iv) To provide leadership of prevention forums.
- (v) To establish strong links with County Technical Working Groups for necessary technical support.

c) Role of County Governments

As proposed in the KASF IV, it would be necessary to devolve the national structures for key populations to the county level for more effective programming and grassroots outreach. To this end, there will be need to:

- (i) Develop structures like Key Population Technical Working Group at county level to lead the KP programmes
- (ii) Support the partners in developing an enabling environment for key population programmes in the county
- (iii) Build the capacity of the county governments
- (iv) Assess key population programmes and make plans to address gaps
- (v) Take ownership to scale up the KP programme and ensuring services are accessible to KPs without fear, stigma, discrimination or violence

d) Role of other Government Agencies

The Government will incorporate other relevant government agencies such as KEMSA, NACADA, KEMRI, IPOA, and Office of the Attorney General and Department of Justice so as to create an enabling environment for participation and collaboration with NACC and NASCOP on issues relating to key populations.

e) Role of Development Partners

The development partners will work with NACC and NASCOP within the established framework and national guidelines to ensure effective coordination. These partners include intergovernmental development partners/ international development partners/funding agencies; national development partners; community based and international partners/ Faith Based Organisations at national and county levels.

ANNEXURE: IMPLEMENTATION FRAMEWORK

1. Facilitate the generation and synthesis of information on sub-populations for evidence-based key populations programming

Strategy	Output	Activities	Responsible
1.1 Strengthen the key population evidence base	Key information gaps, identified and determined	<ul style="list-style-type: none"> ■ Review existing data/evidence for all key population sub-groups. ■ Investigate the existing data from a county, gender, and sub-population lens. ■ Revalidate the existing evidence-using peer review mechanisms. ■ Create a database for all key populations programming and research. ■ Establish an inter-agency forum for periodic key populations data synthesis, collation and dissemination. 	<ul style="list-style-type: none"> ■ Ministry of Health ■ NACC and NASCOP (National)/ County government (County level), ■ National technical working group representation from key population alliance ■ Key populations/ HMIS/ COBPAR/Public and private sector reporting system ■ Institutions of higher learning ■ Research institutions
	New research/ evidence generated to address evidence gaps	<ul style="list-style-type: none"> ■ Strengthen the role and capacity of the NTWG to include research. ■ Identify and support a key population research agenda. ■ Develop and adopt standard national indicators and tools for key population research. ■ Conduct population-based mapping and research to address identified gaps and establish emerging trends. ■ Regularly update mapping to establish the denominator for key population baseline. ■ Conduct research on structural issues like violence, gender norms, impact of law. ■ Commit resources to conduct research to address the gaps in information/evidence related to sub population and geography. 	
	Agency of key populations to lead and implement research strengthened	<ul style="list-style-type: none"> ■ Build capacities of key population led organisations in research skills. ■ Collaborate/build partnerships with key population organisation in research. ■ Include key populations representation in research committees/programmes/as co-investigators/co-authors. ■ Disseminate and revalidate findings of studies with key population sub-groups. ■ Establish a key populations young investigators programme. ■ Organise structured learning events for key populations, like conferences. 	
1.2 Research-to-Practice Strategy Plan Elaborated	Application of research in key populations programming strengthened	<ul style="list-style-type: none"> ■ Build capacity of implementers and researchers to conduct applied research. ■ Conduct implementation science-based research. ■ Review programming on an annual basis to ensure alignment with new evidence. ■ Isolate and nationalise evidence based interventions for key populations. ■ Establish a national performance framework for key populations programming to track progress. ■ Establish mechanism to also receive feedback from the key population community (end users) on access and quality of programmes. 	

2. Address barriers to scaling-up comprehensive key populations programming

Strategy	Output	Activities	Responsible
2.1 Structural and intervention barriers identified and reduced	Relevant legislation aligned to the Constitution	<ul style="list-style-type: none"> ■ Analysis of existing laws (including City Council/County laws) and recommendation to relevant government bodies for alignment with the constitutional rights. ■ Engagement with relevant bodies such as law reform, health organisations to pursue this alignment. ■ Undertake a national audit of existing HIV and AIDS policies and guidelines and advocate for inclusion of key populations related issues. ■ Assist individuals in filing cases at the HIV Equity Tribunal. 	<ul style="list-style-type: none"> ■ National Level <ul style="list-style-type: none"> – Ministry of Health, Judiciary, Ministry of Interior ■ Coordination, Ministry of Devolution and Planning, ■ Ministry of Youth ■ Gender and Sports, NGECC, ■ Development Partners and CSOs including the national umbrella organisation for key populations ■ FBOs ■ County Level <ul style="list-style-type: none"> – County government - County ■ Secretary of Health, county umbrella organisations for key populations, sub-county health management teams, county FBO teams, Regional NGOs.
2.2 National standards for stigma, discrimination and violence free programmes developed	Comprehensive national package and operational guidelines for key populations with equal emphasis on behavioural, biological and structural interventions for key population subgroup defined and developed	<ul style="list-style-type: none"> ■ Consult with key population community and other stakeholders to identify key barriers to a good programme. ■ Develop a comprehensive package and operational guidelines for key population programming addressing biological, behavioural and structural issues. ■ Make available the legal services for key population to facilitate and support them to report cases of violence and discrimination. ■ Disseminate the guidelines at the country level. ■ Build capacity of programme managers and implementers at national and county levels on implementation of this package. ■ Build capacity of service providers in the public sector on the guidelines and provision of stigma free services for key populations through sensitivity training. ■ Build capacity of key population lead organisations on the guidelines and redress mechanism when services are not provided according to the guidelines. ■ Define programme reach and service delivery targets for key population sub-groups and counties for the plan. ■ Establish a mechanism to monitor interventions and services provision points for quality control. 	
2.3 Advocacy to key community, religious and political leaders, media and law enforcement	Key community, religious, and political leaders sensitised. Key media personnel sensitised Law enforcement agencies engaged and involved	<ul style="list-style-type: none"> ■ Conduct education and sensitisation workshops with religious leaders, community leaders and political leaders on key population issues. ■ Involve these leaders in development of guidelines and policies related to key populations. ■ Develop champions and key spokespersons from this community to speak in support of key population programmes. ■ Conduct sensitisation workshops with editors ■ Support the Kenya Media Council to develop a code of conduct for key populations reporting on sub-groups. ■ Train selected journalists on good reporting and support them to collect positive stories on key populations. ■ Conduct media analysis to understand trends in media reporting on key populations. ■ Sensitise the high ranking officials in law enforcement on the issue of key populations and need for programming. ■ Involve the law enforcers in inter-agency coordination framework. ■ Engage and advocate with IPOA, DPP, CAJ to target police through specific interventions. 	

3. Access to scaled-up services and comprehensive key population HIV and AIDS programming increased.

Strategy	Output	Activities	Responsible
3.1 Strategic plan for key population program scale up developed and implemented	A budgeted strategic plan developed	<ul style="list-style-type: none"> ■ Meaningfully include key population sub-groups and their issues in KASF IV planning and implementation. ■ Use evidence in programme gaps to implement KASF with special emphasis on 90% coverage of key populations through stigma free high quality programmes and services. ■ Develop national guidelines for key population programming with equal emphasis on gender and sub-populations. ■ Allocate resources for scaling-up key population programmes to plan for 100% coverage 	<ul style="list-style-type: none"> ■ National Level – MOH, Key population organisations, development partners, Treasury, Ministry of Labour, ■ County Level – County government, County umbrella organisations, County Commissioners
	Strategic plan implemented to ensure 100% coverage and access at national and county level	<ul style="list-style-type: none"> ■ Allocate resources and programmes in counties and for populations which are not fully covered. ■ Establish a system of technical support that helps implementing partners and services to provide quality services to targeted populations. ■ Build capacity of implementers and service providers in comprehensive programme guidelines and expectations. ■ Establish a standard monitoring mechanisms to monitor quality and coverage at county and national level. ■ Conduct annual outcome studies to monitor access to services by key populations and monitor expected behaviour change. 	
	Learning sites developed to build capacity of implementers	<ul style="list-style-type: none"> ■ Identify sites to implement comprehensive programming for key populations as per the guidelines ■ Develop curriculum to enhance capacities to roll on hands on practical learning in the sites. ■ Host learning sessions for implementers and service providers to build capacity. ■ Monitor the outcomes in the site, both for programmes and learning sessions. 	
3.2 Community led interventions scaled up	Key population organisations are provided capacity and funds	<ul style="list-style-type: none"> ■ Conduct capacity needs assessments of the key population led organisations. ■ Develop curricula and plans for capacity building at various levels e.g. individuals/ leadership and institutional. ■ Build capacity of key population leadership for them to lead their own research and interventions. ■ Fund programmes implemented by key populations community organization. 	

4. Facilitate stakeholders' coordination to harmonise national and county level HIV response to key populations.

Strategy	Output	Activities	Responsible
4.1 Intra & inter-government collaboration as well as between government and all stakeholders at national and county level improved	Inter-agency team set up to oversee the coordination and implementation of the policy	<ul style="list-style-type: none"> ■ Stipulate terms of reference and role of inter-agency team. ■ Advocate with other departments, stakeholders and key population organisations to nominate members to the group. ■ Disseminate information on the inter-agency team, working relationships defined among the stakeholders ■ Monitor working of the inter agency team or NITWG 	<ul style="list-style-type: none"> ■ National Level - MOH, Treasury, Key population organisation, FBOs, CSOs, Development Partners, NGEC, Ministry of Devolution and Planning ■ County Level-County Health Management Team, County Umbrella key population organisation, FBOs, CBOs, Regional NGOs
4.2 Optimal utilisation and allocation of key population funding strengthened	Cost-effective interventions for key population programming and research funded.	<ul style="list-style-type: none"> ■ Identify human resource needs and funding gaps at national and county level. ■ Strengthen public-private partnerships. ■ Create a database on all human and financial programming. 	
4.3 Mechanism to prioritise funding and track results developed	Joint monitoring framework and system for coordination is developed and implemented	<ul style="list-style-type: none"> ■ Analyse key population specific indicators to guide and prioritise funding. ■ Develop accountability and financing mechanisms for key population programmes. 	



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