NATIONAL STRATEGY ON HIV AND AIDS & STI PROGRAMMING ALONG TRANSPORT CORRIDORS IN KENYA
As outlined in the Kenya National AIDS Strategic Plan III, addressing the continued concentrated HIV epidemic among key populations along transport corridors remains an epidemiological priority. Evidence has shown that HIV prevention activities along transport corridors in Kenya require increased coordination, harmonization and scale-up. Population movement is complex and dynamic, and the most effective way to protect the national population from HIV and AIDS is to identify and work with populations with an exceptionally high risk.

In response, the National AIDS Control Council (NACC), in collaboration with the National AIDS and STI Control Programme (NASCOP), with assistance from the International Organization for Migration (IOM), facilitated the process of developing a national strategy on HIV/STI programming along transport corridors.

This strategy aims to achieve corridor-wide scale up of cohesive combination prevention programming that responds to the immediate epidemiological and behavioral drivers of new infections and ensures the provision of HIV services to mobile and key populations along transport corridors. It is the wish of the National AIDS Control Council that all aspects of this strategy are thoroughly implemented in order to achieve HIV free corridors in Kenya and in return, reduce infections among the wider populations.

PROF. ALLOYS S. S. ORAGO, MBS
DIRECTOR, NATIONAL AIDS CONTROL COUNCIL
ACKNOWLEDGEMENTS

This National Strategy on HIV/STI Programming along Transport Corridors in Kenya is the result of determined efforts from many individuals and organizations and is a product of commitment and support from all partners, stakeholders and implementing agencies.

Specific acknowledgements to the Kenya National AIDS & STI Control Programme and the National AIDS Control Council for their cooperation and support, as well as the International Organization for Migration, for their technical assistance and invaluable support. We would also like to appreciate all members of the task force which include the Ministry of Transport, Kenya Long Distance Truck Drivers Union, Kenya Highways Authority (KENHA), North Star Alliance and Family Health International (FHI 360).

The Implementation of this strategy does recognize the fact that the transport corridor cuts across various counties within the country. Collaboration with the county governments will therefore be key to the success of the strategy.

Special thanks go to NASCOP’s Dr. George Githuka, MARPS Programme Manager and Helgar Musyoki, for providing strategic direction in development of this document, and to NACC’s Lilian Langat, MARPS Programme Officer and Steven Oyugi, Personal Assistant to the Director NACC and Programme Officer Regional Initiatives. Special appreciation to the consultants; Olum Gondi H., and team as well as Timothy Abuya for their tireless efforts and contribution to this entire process. We also thank the IOM Migration Health team: Paola Pace, Regional Health Programme Officer; Jason Theede, Regional Research Coordinator; Samah Elsir, HIV and Mobility Specialist and Vyona Ooro, Communications Officer.

DR. WILLIAM K. MAINA, OGW
HEAD, NASCOP
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<th>Acknowledgements</th>
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<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
</tr>
<tr>
<td>FSW</td>
<td>Female Sex Worker</td>
</tr>
<tr>
<td>EAC</td>
<td>East African Community</td>
</tr>
<tr>
<td>FHI360</td>
<td>Family Health International 360</td>
</tr>
<tr>
<td>FSW</td>
<td>Female Sex Worker</td>
</tr>
<tr>
<td>GLIA</td>
<td>Great Lakes Initiative on AIDS</td>
</tr>
<tr>
<td>HCT</td>
<td>HIV Counselling and Testing</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IDU</td>
<td>Injecting Drug User</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education and Communication</td>
</tr>
<tr>
<td>IOM</td>
<td>International Organization for Migration</td>
</tr>
<tr>
<td>KAIS</td>
<td>Kenya AIDS Indicator Survey</td>
</tr>
<tr>
<td>KDHS</td>
<td>Kenya Demographic Health Survey</td>
</tr>
<tr>
<td>KNASP</td>
<td>Kenya National AIDS Strategic Plan</td>
</tr>
<tr>
<td>LDTD</td>
<td>Long Distance Truck Driver</td>
</tr>
<tr>
<td>M &amp; E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MARP</td>
<td>Most At Risk Populations</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSM</td>
<td>Men having Sex with Men</td>
</tr>
<tr>
<td>NACC</td>
<td>National AIDS Control Council</td>
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<tr>
<td>NASCOP</td>
<td>National AIDS and STI Control Programme</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>PITC</td>
<td>Provider Initiated Testing and Counselling</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>SADC</td>
<td>Southern African Development Community</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TOR</td>
<td>Terms of Reference</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNJUPSA</td>
<td>United Nations Joint Programme on HIV and AIDS</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Programme</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</tbody>
</table>
1.1: Introduction

HIV and AIDS remains a major challenge in Kenya. Though prevalence has shown a relative decline since the beginning of the epidemic, by the end of 2011, HIV prevalence stood at 6.2% among those aged 15 and 49 (NACC and NASCOP 2012). Currently, more than 1.6 million people are living with HIV in the nation and women represent 59% of those infected. HIV incidence in Kenya is 0.5% with 104,173 newly infected in 2011.

According to the Modes of Transmission study (2008), an estimated 44% of new infections occur in long term relationships and casual sex contributes to 20.3% of new infections. At least one third of the new infections in Kenya are attributed to men who have sex with men (15%), injecting drug users (4%) and sex workers (14%) (See Figure 1). Truckers and sex workers, as well as members of the fishing community have rates higher than the national average (Kenya Demographic Health Survey 2008). These populations are considered drivers of the epidemic.

Figure: 1 Prevalence Rate for New Infections (NACC, 2008)

The Risk Environment

Sex workers, truckers, and other key populations are associated with transport corridors and also considered mobile populations. Transport corridors, defined as highways, waterways, and border points that come together in the transport of people and goods, are areas of high HIV prevalence and a primary risk environment for these key populations. High levels of transactional sex, multiple concurrent partnerships, low consistency of condom use, drug and alcohol use, among other factors increase vulnerability to HIV transmission. Other risk factors such as delays created by bureaucracy at truck stops and border crossings which generate a large number of overnight stays, the isolation associated with travelling away from a familiar source of life for truckers, and disposable income that creates a disparity between the truckers and the community act to further encourage the risk environment or “space of vulnerability.” Each increases the likelihood and availability of risky behaviours, namely the use of alcohol and other drugs and the propensity to sell and purchase sex (Morris and Ferguson 2006, Ferguson and Morris 2007, NACC and NASCOP 2012). Finally, though mobility alone is not a risk factor for HIV it acts to increase vulnerability to HIV transmission given these risk taking behaviours (Morris and Ferguson 2007).
1.2 Situational Analysis

Mobile populations face the severe challenge of accessing services at appropriate locations and times. Targeted HIV services for the transport corridors are poorly coordinated, inadequately resourced, operate under out-dated policies, and experience severe structural barriers such as; infrastructure, service availability and accessibility that limit the appropriate provision of services or inhibit proper access of the key population.

According to the Response Analysis study on Combination HIV Prevention Programming along the Northern Transport Corridor in Kenya (2010) supported by IOM and NACC, there were alarming gaps in the response to HIV and AIDS at the truck stops covered under the study. Funding restrictions, limited resources, commodity management, and targeted messaging for key populations served as gaps to achieving a standardized health care package along the corridors. Programmes also lacked an adequate monitoring and evaluation system and implementation framework where cultural, political, environmental and economic components of programming were ignored. Gaps also exist in mapping and the sustainability of programmes was not addressed. Finally, biological and behavioural aspects within the combination prevention model were not to scale neither were they coordinated. This suggests that HIV services offered along the transport corridors should be intensified to adopt a more combination approach for services.

Among different programmes, overlaps related to operational hours, location and appropriateness of services existed, with the majority of organizations providing similar services within the same regions, lacking coordination between them. A few were found to be conducting joint implementation such as; APHIAplus and Family Health International (FHI 360) with the ROADS project.

For HIV control, certain key elements need to be addressed including: the need for updated bio-behavioural data such as size estimates and prevalence rates; the need for improved coordination amongst implementing partners; the development of a monitoring and evaluation framework and corresponding tools to help identify gaps; the need for increased advocacy, and the importance of more effective interventions within this population, elements of which have been recognized in the Kenya National AIDS Strategic Plan 2009/10- 2012/13 (KNASP III)².

²Spaces of vulnerability refer to a range of environments created by specific risk factors relating to a unique location. These factors, including the relationship dynamics between mobile and sedentary populations, involve the areas in which migrant and mobile populations live, work, pass through, or originate. They may include land, border posts, ports, truck stops, or hot spots along the transport corridor, construction sites, commercial farms, fishing communities, mines, migrant sending communities, detention centres and emergency settlements. (IOM & UAC, 2008)

²While, this strategy is based on the KNASP III, the evidence presented is sufficient to validate the need to focus programming on this population. Emerging evidence will be implemented in line with KNASP IV and any future policy developments.
1.3 Policy Analysis

As it relates to advocacy and policy, there is a gap in policy guidelines for key populations specifically along the transport corridors. Despite recognition of the need to address HIV and AIDS among the key populations in KNASP III, it is important to facilitate an enabling environment for HIV programming for these key mobile populations, who suffer from social and security vulnerabilities, and lack the applicable legal framework which undermines their access to appropriate health services; specifically keeping in mind FSW, whose activities are criminalized and stigmatized.

1.4 Key Populations

This strategy will address the mobile populations along transport corridors and other spaces of vulnerability. The primary beneficiaries will be truckers, sex workers, and men who have sex with men, along with the communities they interact with, such as; border officials, police officers and the general population.

1.4.1 Sex workers

Paid sex or sex work is an important factor in HIV transmission in Kenya. Sex work is defined as the “exchange of money for sex” and includes transactional sex, “the exchange of sex for food, clothing, or other resources” (KDHS 2008, Baral et al 2012). Research shows that sex workers have a high prevalence of HIV and Sexually Transmitted Infections (STIs). The HIV prevalence among (female) sex workers in Kenya is 29.3%; the highest in the world (Modes of Transmission 2008, Baral et al 2012, NASCOP 2012).

Along the transport corridor, sex workers engage in sex primarily through bars and lodging based trade. Poverty and lack of opportunity are compounded by factors including high frequency of multiple concurrent partners and inconsistency of condom use to create this risk environment and make them vulnerable to the transmission of HIV (ed. Mayer and Pizer 2009). Sexual violence, low levels of education, stigmatization, age of entrance into the profession, low health seeking behaviour, as well as general lack of health access also contribute to the risk environment. Migrant sex workers in particular are further marginalized by factors such as immigration status, lack of fluency in the local language, and cultural barriers that inhibit their ability to negotiate for safe sex and health seeking behaviours (IOM 2010). According to the IOM study prevalence among migrant female sex workers is also high at 23%. Overall, the interaction between the sex workers and their clients serves as a bridge of HIV transmission with the general population.

1.4.2 Long Distance Truck Drivers

Clientele of sex workers along the transport corridors vary according to location, but almost always include truckers; truck drivers as well as turn boys. Issues such as poor roads, insecurity, mechanical breakdowns,
police harassment, unsatisfactory relations with their employers, administrative delays at truck stops and border posts and long absences from home, are all factors which help to encourage the risk environment for truckers. Due to these challenges truckers tend to seek entertainment during stop-overs usually involving alcohol and multiple concurrent partnerships and the trading of sex with sex workers. Many sex workers in fact rely on truckers as consistent clients, because of their access to disposable income and regularity along the corridors.

1.4.3 Men having Sex with Men (MSM)
Research shows that MSM are not a homogeneous population and may be homosexual, gay, bisexual or transgender and, in fact, may not even self-identify as a member of any of those groups. The sexual networks of MSM and concomitant risk of HIV extend to the general population. The HIV prevalence among men who have sex with men in Kenya is 18%. Most interventions for sex workers target females (FSW), but it is important to recognize the growing trend of male sex workers and those MSM for which stigma is also high (NASCOP, 2012). A Bio-Behavioural Survey (BBS) study of key populations in Nairobi and Kisumu revealed that a majority of MSM (90%) had regular male partners, and that 40% in Nairobi and 67% in Kisumu engaged in sexual activity with paying sexual partners in the past two months. In all cases, consistency of condom use is low. MSM also reported having sexual relationships with women who pay them as well as those who are casual partners.

1.5 The Policy Environment
Enabling policy makes it possible for interventions to be effective by creating an environment that helps overcome potential barriers to implementation. The foundation of this strategy is derived from a pragmatic vision, realistic mission, and achievable objectives with a view of removing constraints that have hindered the development of effective HIV prevention. The strategy builds on KNASP III which aims at reducing the number of new HIV infections by using new, evidence-based approaches to HIV prevention.

1.6 Purpose of the Strategy
The Kenya National AIDS Strategic Plan 2009/10- 2012/13 (KNASP III) and the Kenya Modes of Transmission Study highlight the fact that a major gap exists in reaching mobile populations along transport corridors with effective HIV/STI prevention, treatment, care and support programmes. The purpose of this strategy is to provide a national framework within which HIV programming can be realized by various stakeholders providing HIV services along the transport corridors in Kenya.
The implementation of the objectives, proposed strategies and activities is guided by the Goal, Vision, Mission and Guiding Principles.

2.1 Goal
To provide a national framework that will guide delivery of HIV prevention, treatment, care and support services for mobile populations and communities along the transport corridors in Kenya through the HIV Combination Prevention approach.

2.2 Vision
HIV free transport corridors in Kenya.

2.3 Mission
To intensify and sustain access to innovative and tailored HIV/STI prevention, care, treatment and support services in transport corridors and spaces of vulnerability.

2.4 Guiding Principles
The strategy is developed within a framework of the following principles:
- Good governance
- Community engagement and empowerment
- Rights based and evidence informed
- Innovation and use of best practices
- Ownership and sustainability
2.5 Strategic Direction

The strategy is grounded on 5 strategic objectives to address gaps. They are as follows:

- HIV prevention interventions and approaches to mobile populations in Kenyan transport corridors is streamlined;
- Improved coordination and learning among stakeholders involved in prevention, care, support and treatment along transport corridors;
- Adequate and sustainable resources acquired for the implementation of this strategy;
- Improved availability and management of essential commodities;
- Enhanced generation and use of strategic information and evidence building for decision making and quality assurance.

2.5.1 Strategic Objective 1:

*HIV prevention interventions and approaches to mobile populations in Kenyan transport corridors is streamlined*

There are many organizations implementing prevention, care, treatment, and support services for HIV along the transport corridors. Effective HIV prevention requires a combination of behavioural, biomedical and structural interventions. This calls for the development of a comprehensive service package which will provide the standard package for implementing services at all levels in the highest quality.

**Strategies**

1. Develop a comprehensive HIV Combination Prevention package to address biomedical, behavioural, and structural interventions.

2. Define a minimum service package.

---

4 Combination prevention programmes are: “Rights-based, evidence-informed, and community-owned programmes that use a mix of biomedical, behavioural, and structural interventions, prioritized to meet the current HIV prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections. Well-designed combination prevention programmes are carefully tailored to national and local needs and conditions; focus resources on the mix of programmatic and policy actions required to address both immediate risks and underlying vulnerability; and they are thoughtfully planned and managed to operate synergistically and consistently on multiple levels (e.g. individual, relationship, community, society) and over an adequate period of time. They mobilize community, private sector, government and global resources in a collective undertaking; require and benefit from enhanced partnership and coordination; and they incorporate mechanisms for learning, capacity building and flexibility to permit continual improvement and adaptation to the changing environment (UNAIDS Prevention Reference Group, 2009).
2.5.2 Strategic Objective 2:

**Improved coordination and learning among stakeholders involved in prevention, care, support and treatment along transport corridors**

The coordination mechanism of the stakeholders’ prevention, treatment, care and support services along the transport corridors in Kenya must be strengthened. Strong leadership and capacity building of implementing partners along the transport corridor are necessary for enhanced coordination of HIV response. Strengthening linkages, networks and collaboration amongst stakeholders at all levels is also an essential component of response. Programming for key populations will be through the national technical working group for MARP in consultation with the national steering committee for MARP, the transport corridors task force and the devolved government structures. This objective will address issues related to coordination at implementing partner level, as well as referral and linkages among these partners.

The implementation of this strategy will be based on the outlined service delivery models by the government, NGOs and CBOs, public private partnerships and other regional networks. The location of the services will be guided by mapping exercises for mobile populations (size estimates, hot spots) as per existing regulations by various regulatory governmental agencies and regional bodies. All implementation will be coordinated through the technical working group and the devolved government systems.
The implementation framework will be guided by the following principles:

A. How - Service Delivery Models
   - Type (Integrated, stand alone, mobile)
   - Location of service (determined by the community)
   - Population to be serviced
   - Time variations of people to be serviced
   - Community proposal on service delivery model

B. Who - Who delivers services
   - Government
   - Non-Government Organization
   - Community Based Organization
   - Public Private Partnership
   - Regional Networks (East African Community [EAC], etc.)

C. Where – Where will services be located
   - Accessibility
   - Security Issues
   - KENHA
   - City Council Approval
   - Community Proposals
   - Existing Infrastructure

2.5.3 Strategic Objective 3:

*Adequate and sustainable resources acquired for the implementation of this strategy*

Resources for this programme are to be obtained from state resource allocations, stakeholders currently involved in HIV programming, the private sector, as well as the support provided by international organizations and other private public partnerships. For sustainability, it is necessary to engage potential partners and government on resource mobilization. The programme will engage in active resource mapping and advocacy for the resources to ensure sustainability. Resources should focus on programmes that provide the highest impact interventions.

2.5.4 Strategic Objective 4:

*Improved availability and management of essential commodities.*

It is necessary that this strategy will advocate for inclusion and provision of appropriate commodities and supplies, as well as forecasting and quantification of various HIV commodities into local health facilities along the transport corridor.

This strategy will also aim to strengthen commodity supply chain management through enhancing coordination of different mechanisms in place that include; government, supply chain management unit, private sector, mechanisms supported by other agencies.
2.5.5 Strategic Objective 5:

Enhanced generation and use of strategic information and evidence building for decision making and quality assurance

This strategy will focus on utilization of real time data generated through surveys, situational analysis, rapid assessments, programme data, and other data sources. This will be achieved through improvement of the design and management of national and regional responses to HIV and AIDS through the generation of and easy access to strategic information along the transport corridors. The process will complement regular national HIV and AIDS surveillance systems and population based surveys as well as emphasize the need for surveys among MARP, including their size estimation and mapping. It will also call for analysis of existing behavioural and biological data to obtain more in-depth understanding of HIV and AIDS dynamics among MARP along the transport corridor. Results from studies and information gathered will be disseminated and further used for design making and policy development.

This objective will focus on development and use of standardized monitoring and evaluation tools for data collection, analysis, and dissemination of the program data. Set standards will be maintained and improved for all programme components and processes. Standards for service delivery may include:
### RESULTS MATRIX

### STRATEGIC OBJECTIVES
*(The Kenya Strategic plan on HIV Combination Prevention Along Transport Corridors in Kenya)*

#### Strategic Objective 1:
*

**HIV prevention interventions and approaches to mobile populations in Kenyan transport corridors is streamlined.**

Indicator of achievement: HIV combination prevention model adopted (agreed on and implemented) by at least 90% of all stakeholders involved in HIV programming along the Kenyan transport corridors.

**Goal:** To contribute to the reduction of HIV infection rates in Kenya.

**Expected Outcome:** Reduction in HIV infection rates along transport corridors in Kenya.

<table>
<thead>
<tr>
<th>Outputs (expected results)</th>
<th>Output Indicators</th>
<th>Key activities</th>
</tr>
</thead>
</table>
| Stakeholders ideas, opinions and buy in on HIV prevention models for mobile and other key populations is acquired | No. of stakeholder consultative meetings held  
No. and type of stakeholders involved  
No. of stakeholders agreeing to the need to standardize service package (buy in) | Stakeholder consultative meetings  
Capacity building (training and mentoring) on standard HIV service package for mobile and key populations  
Awareness creation and information sharing  
Enforcement and compliance monitoring |
| Standardized minimum service package developed and disseminated                          | Availability of the published document  
-No. of stakeholders reached with dissemination efforts                               |                                                                                                          |
| Stakeholders have full understanding and are using the standardized service delivery model | No. of stakeholders correctly using standardized service package                  |                                                                                                          |
Strategic Objective 2:

*Improved coordination and learning among stakeholders involved in prevention, care, support and treatment along transport corridors.*

Indicator(s) of achievement: no. of stakeholders demonstrating activity coordination (target=60%); no. of stakeholders active in coordination meetings/activities (target=90%).

**Goal:** To contribute to the reduction of HIV infection rates in Kenya.

**Expected Outcome:** Reduction in HIV infection rates along transport corridors in Kenya.

<table>
<thead>
<tr>
<th>Outputs</th>
<th>Output Indicators</th>
<th>Key activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination forums established at national and local levels</td>
<td>No. of coordination forums/networks formed and active (target = at least one in each program area and one at national level; meets at minimum twice a year)</td>
<td>-Formation of inter-stakeholders fora/linkages/network</td>
</tr>
<tr>
<td>Management and governance structures of organizations implementing programs is strengthened</td>
<td>No. of agencies benefiting from capacity strengthening initiatives (target = at least 60% of organizations needing capacity enhancement benefit)</td>
<td>-Training and mentoring of programs so as to strengthen them to effectively coordinate with others</td>
</tr>
</tbody>
</table>
**Strategic Objective 3:**

*Adequate and sustainable resources acquired for the implementation of this strategy.*

Indicator(s) of achievement: Evidence of funding commitments for the strategy period made by government, NGOs, international organizations and donor community (Evidence=signed memoranda), evidence of availability or commitment to provide non-financial support.

**Goal:** To contribute to the reduction of HIV infection rates in Kenya.

**Expected Outcome:** Contribute to the reduction in HIV infection rates along transport corridors in Kenya.

<table>
<thead>
<tr>
<th>Outputs</th>
<th>Output Indicators</th>
<th>Key activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding availed or committed for the strategy period implementation</td>
<td>Portion of estimated cost of implementing strategy that has been funded or committed (target = 70%)</td>
<td>Strategy dissemination through all possible channels &amp; methods (promotion)</td>
</tr>
<tr>
<td>Commitment for the provision of non-financial resources (skills, materials)</td>
<td>No. of thematic areas with a firm commitment for material support or technical support (target = all thematic area has at least an agency or organization committing to provide support)</td>
<td>Development of a resource mobilization plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Meetings with key ministries (medical services, MoPHS, special programs) to discuss funding from government</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Meetings with donors- bilateral, multilateral, private foundations, private sector, international organizations, United nations, etc.</td>
</tr>
</tbody>
</table>
Strategic Objective 4:

*Improved availability and management of essential commodities.*

Indicator(s) of achievement: # of months with full supply of essential commodities (target=12 months, 0 stock outs).

**Goal:** To contribute to the reduction of HIV infection rates in Kenya

**Expected Outcome:** Contribute to the reduction in HIV infection rates along transport corridors in Kenya.

<table>
<thead>
<tr>
<th>Outputs</th>
<th>Output Indicators</th>
<th>Key activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential commodities are consistently available at all times of the year (12 month supply)</td>
<td>No. of months with full supply of commodities (target 12 months in a year)</td>
<td>Supply chain analysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advocacy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Capacity building of all actors involved in the supply chain (from source to point of use)</td>
</tr>
<tr>
<td>Minimised losses of commodities</td>
<td>% reduction in number of cases of commodities loss, damage, theft or other kind of loss</td>
<td>Enforcement of appropriate legislations that are in place</td>
</tr>
</tbody>
</table>
Strategic Objective 5:

Enhanced generation and use of strategic information and evidence building for decision making and quality improvement.

Indicator(s) of achievement: number of different types of data captured and filed consistently; evidence of data being captured (data reports); number of research activities completed and disseminated (surveys, assessments, surveillance, experiments etc.).

Goal: To contribute to the reduction of HIV infection rates in Kenya.

Expected Outcome: Reduction in HIV infection rates along transport corridors in Kenya.

<table>
<thead>
<tr>
<th>Outputs</th>
<th>Output Indicators</th>
<th>Key activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality and timely data is gathered, processed and disseminated</td>
<td>Presence of quality tools, software or protocol for data capture, processing and dissemination</td>
<td>Procurement or development of appropriate software, forms, databases depending on the need</td>
</tr>
<tr>
<td>Evidence (not assumptions) is increasingly used to make decisions and guide program planning and development</td>
<td>Evidence of data or research findings being used to make decisions and/or influence policy and practice</td>
<td>Capacity building to stakeholders on how to use to collect or analyse or disseminate data</td>
</tr>
<tr>
<td>All actors have capacity to generate and disseminate strategic information</td>
<td>Dissemination of satisfactory quality and timely data as required</td>
<td>Research activities to inform policy and practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Data review sessions to enhance adoption of and use of data for policy and program decision making</td>
</tr>
</tbody>
</table>

5 Quality used here to mean that it is able to produce expected results.
Section III: Implementation Framework

Implementation of a strategy essentially involves translating strategic thought into strategic action. Implementation of the HIV Prevention strategy will depend upon teamwork, supporting organizational structure, creating strategy awareness and putting in place a well-defined coordination framework backed by strong leadership at all levels of the implementing institutions. It has been observed that many effectively formulated strategies fail because they are not successfully implemented.

3.1 Institutional Structure

In order to efficiently and effectively implement the strategy, NASCOP will put in place strengthened structures, systems, resources and physical infrastructure. Consequently, within the Organization Development (OD), process several thematic areas including organization issues, systems and accountability, human resources, and physical infrastructure have been identified and formulated for strategic growth / expansion.

3.2 Partnerships

Partnerships are the foundation of this strategy, this will be ensured through fostering of strong and vital links with all partners which will translate to stronger capacities for action, including thorough sustainable coalitions that accelerate progress towards implementation of this strategy. NACC will be the overall coordinating agency that will guide the implementation of this strategy as aligned in the National Aids Strategic Planner.

3.3 Management and Coordination

NACC will provide the overall guidance on policy issues related to programming along the transport corridors. NASCOP will coordinate implementation of this strategy and will be responsible for health services delivery at national, county and sub county level.

3.4 Service Delivery

Service delivery will be rolled out in accordance to the principles outlined in the sex workers’ service delivery guidelines. This includes:
1. Provision of appropriate services
2. Accessible services
3. Acceptable services
4. Affordable services

3.5 Communication

This strategy seeks to give guidance to improve communication between all programmes:
1. Inter- Agency communication
2. Facility
3. Nation-wide
4. Community

Communications will also address issues of packaging messages, the media, annual reports and dissemination of research findings.
3.6 Advocacy
Advocacy will provide an enabling environment for this strategy at county and sub county level. The key agents for advocacy will be; Civil Society Organizations, Community Based Organizations, Key Populations Associations, MARPs, as well as other formal and informal associations.

The strategy will help to advocate both regionally and locally for the following:
1. Service delivery and uptake
2. Resource mobilization
3. Community buy-in and engagement
4. Political buy-in
5. Policy Briefs
6. The use of media to advocate

3.7 Human Resources
This will provide adequate numbers of trained personnel to provide biomedical and Behavioral Interventions. It will comprise of:
1. Personnel: Health care professionals, community health workers, outreach workers and peer educators.
2. Capacity Building: This will be achieved by training, exchange programmes and mentorship programmes.
3. Community leaders: For this to be achieved it will require partnerships with county government leaders especially county health coordinators.

3.8 Financing
The programme should engage in active resource mobilization from the government and the private sector and other development partners to ensure sustainability. Advocacy efforts under the strategic period should be made to encourage government and the private sector to increase resources for programming in this sector. These activities will be generated through the national steering committee.

The issue of income generation activities must be addressed at the sector to increase resources for programming in this sector. These activities will be generated through the national steering committee. The issue of income generation activities must be addressed at the national steering committee and the Technical Working Group. This strategy will encourage other stakeholders and implementers to mobilize resources for interventions.

3.9 Commodities
This strategy will ensure that commodities are provided through the government systems and other mechanisms and made available for use by these populations along the transport corridors. Commodities required for the minimum package comprises of: STI screening and treatment; TB screening and referral for treatment; HIV care and treatment; reproductive health services; emergency contraception and post exposure prophylaxis.
3.10 Monitoring, Evaluation and Reporting
A committee will be formed that will provide leadership in ensuring effective NASCOP monitoring and evaluation comprising of senior officers from relevant divisions/sections, and will be chaired by the Head of HIV Prevention of NASCOP. The prevention section will provide day-to-day coordination ensuring efficiency in monitoring and evaluation activities. Regular meetings will be held to discuss the strategy implementation. The M&E Committee will hold meetings once every quarter where progress towards achievement of the various strategic objectives will be evaluated. The committee will focus on the effectiveness of new and existing approaches, implementation status, challenges encountered and possible remedies.

Data can be collected through secondary sources, field visits, supervision missions, workshops, exchange visits, sample surveys and in-depth investigation. In order to guarantee efficient repository of generated information, NASCOP will maintain databases that capture the information needed for M&E Databases. An annual report will be prepared to describe actions taken towards achieving specific outcomes of the strategic plan. Annual Review Report: At the end of every calendar or financial year, annual progress report will be prepared that objectively highlights key achievements against set targets (both physical progress and financial status), constraining factors, lessons learnt and recommendations on the way forward.

Finally, a mid-term and a terminal evaluation of the HIV Strategy are foreseen during the plan period. The evaluation will entail the following: measuring actual performance against target levels and establishing variances, if any; identifying the causal factors for the variance; and identifying and recommending appropriate remedial measures including a review of the objectives and/or strategies. The Monitoring and Evaluation committee will ensure these two important evaluations are carried out.

3.11 Programme Scale-up
With programme scale up, regional coordination with neighbouring countries is an essential move in taking this strategy to the next level. It allows for further coordination of services within the Central Transport Corridor and major highways concentrated in East Africa. This strategy is embedded on KNASP III and will take into cognizance the emergence of new evidence and strategic direction provided by national or regional strategies and policies.

3.12 Dissemination
NASCOP and NACC will put in place a dissemination strategy to ensure that reports are widely disseminated to influence effective programme management and policy making. Forums like meetings, review workshops, retreats, and seminars will be organized annually for stakeholders to share the findings and recommendations of the reports.


