



**NATIONAL SYNDEMIC DISEASES
CONTROL COUNCIL**

Kenya's Multisectoral HIV Response for Adolescents and Young People 2015-2025

**Political
Commitment,
Youth Engagement
and Measurable
Impact**

Background

In 2015, Kenya reported a national HIV prevalence of 3.1% among youth aged 15–24 years, translating to an estimated 268 588 young people living with HIV. In addition, there are an estimated 35 000 new HIV infections and approximately 5000 AIDS-related deaths annually in this demographic. The burden was most pronounced in high-prevalence counties such as Homa Bay, Kisumu, Siaya, Migori and Nairobi, which collectively accounted for 43% of new infections among adolescents and young people. In response, a national Fast Track Plan under the global ‘All In’ campaign was developed by the National Syndemic Diseases Control Council (formerly the National AIDS Control Council). This plan focused on youth aged 10–24 years and set explicit targets: reduce new HIV infections among adolescents and young people by 40%; reduce AIDS related deaths in this cohort by 15%; and reduce stigma and discrimination by 25%. Early epidemic estimates in 2015 highlighted the concentrated burden among this cohort, with more than 26 000 new infections (approximately 43% of national new infections) and roughly 4300 AIDS-related deaths in this age group.

This case study describes Kenya’s HIV response aimed at adolescents and young people through the stewardship of the National Syndemic Diseases Control Council (NSDCC) over the last decade.

Adopting a measurable multisector approach to drive down new infections

The national response evolved through distinct but linked processes between 2015 and 2023. These were anchored by multisectoral stewardship and execution, localized service delivery linkages, peer-based mobilization and political accountability, all underpinned by shared indicators and a common measurement framework.

Political and policy accountability in 2015. The President of Kenya became the public face of the 'All In to End Adolescent AIDS initiative' (the 'All In' campaign), receiving biannual progress reports and anchoring multisectoral accountability at the highest level. Stewardship and governance were reorganized to create clear interministerial accountability across critical sectors to reach and mobilize adolescents and young people for HIV prevention, treatment retention and adherence scale-up. A national committee was co-chaired by the Principal Secretaries for Health and Education, supported by subnational multisectoral technical working groups.

Key policies facilitating engagement by adolescents and young people.

The legal age of consent for HIV testing, treatment and pre-exposure prophylaxis (PrEP) was maintained at 15 years in national guidelines, with exceptions for emancipated minors (e.g. married or pregnant adolescents and young people). This increased autonomy and coverage among at-risk adolescents. Despite inconsistencies between health guidelines and the HIV/AIDS Prevention and Control Act of 2006, confidentiality provisions under Kenyan law were reinforced, supporting trust and uptake among minors. This stance aligned with international human rights instruments such as the Convention on the Rights of the Child and the Maputo Protocol.

Multisectoral and stakeholder stewardship and execution

Ministry of Health AIDS control programme

The Ministry of Health, through NSDCC and NASCOP, focused on biomedical optimization for adolescents and young people, facilitating initiation of same day antiretroviral therapy (ART) using first-line dolutegravir-based regimens, supported by viral load monitoring every six months, as per national guidelines updated in 2022. Studies from high burden counties demonstrated viral suppression rates exceeding 90% at 12 months post-dolutegravir transition. However, adolescents—particularly those with pre-initiation non-suppression or lacking strong caregiver support—remained at higher risk of suboptimal outcomes, underscoring the importance of tailored adherence counselling and disclosure support. Peer support clubs, flexible clinic hours and the ‘Red Carpet Program’—which featured adolescent ‘VIP’ experiences, school health facility linkages and tailored psychosocial interventions—further improved three- and six-month retention in care from 66% and 54% to 90% and 99%, respectively, while supporting early ART initiation and viral suppression rates above 82% in programme facilities.

Ministry of Education

Programme design embedded HIV prevention within education and youth systems. The national curriculum review, led by the Kenya Institute of Curriculum Development, was leveraged to insert age appropriate HIV and sexual and reproductive health (SRH) content, and teacher guidance materials were developed and distributed. Data linking the lack of school transition to early pregnancies and localized HIV incidence were mined from the National Education Management Information System (NEMIS) to identify retention and transition indicators at subnational level for targeted interventions. This intervention was essential to strengthening school health facility linkages and increasing retention among school going adolescents.

County (subnational) leadership

County-level plans translated national targets into subnational action, supported by government and resources from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Annual county epidemic appraisals, prioritized in the Kenya AIDS Strategic Framework (KASF II, 2019-2025), enabled counties to identify points of vulnerability for young women and develop localized interventions. For example, outreach programmes targeted young men in the motorcycle taxi and fishing sector to promote condom use.

Partnerships

The DREAMS Partnership, launched nationally in 2016 across high burden counties and urban informal settlements, delivered a layered package of biomedical (HIV testing, PrEP), behavioural (risk reduction, condom promotion) and structural (schooling subsidies, financial capability, social asset building) interventions to adolescent girls and young women and their peer networks. Evaluations in Nairobi and Siaya reported higher uptake of HIV testing, improved school retention, increased social support and self-efficacy and modest reductions in unprotected sex and number of sexual partners among adolescent girls and young women.

Early implementation revealed persistent programmatic weaknesses, including fragmented interventions across donors and implementing partners that were invisible to county and national committees. In 2017, NSDCC conducted a stakeholder mapping exercise and deliberately aligned Global Fund, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and government investments to reduce duplication at the subnational level and allow counties to operationalize a minimum adolescent prevention package tailored to local epidemiology (Fig. 1).

Donor engagement raised critical questions:

- Do available investments translate to programmatic success for Kenyan citizens?
- Are young people, rather than projects, the priority?
- Can resources be used more effectively to support county governments?
- Can efficiency and effectiveness be increased?
- Can competition be reduced in favour of joint work?
- Are stakeholders willing to be accountable at both county and national levels?



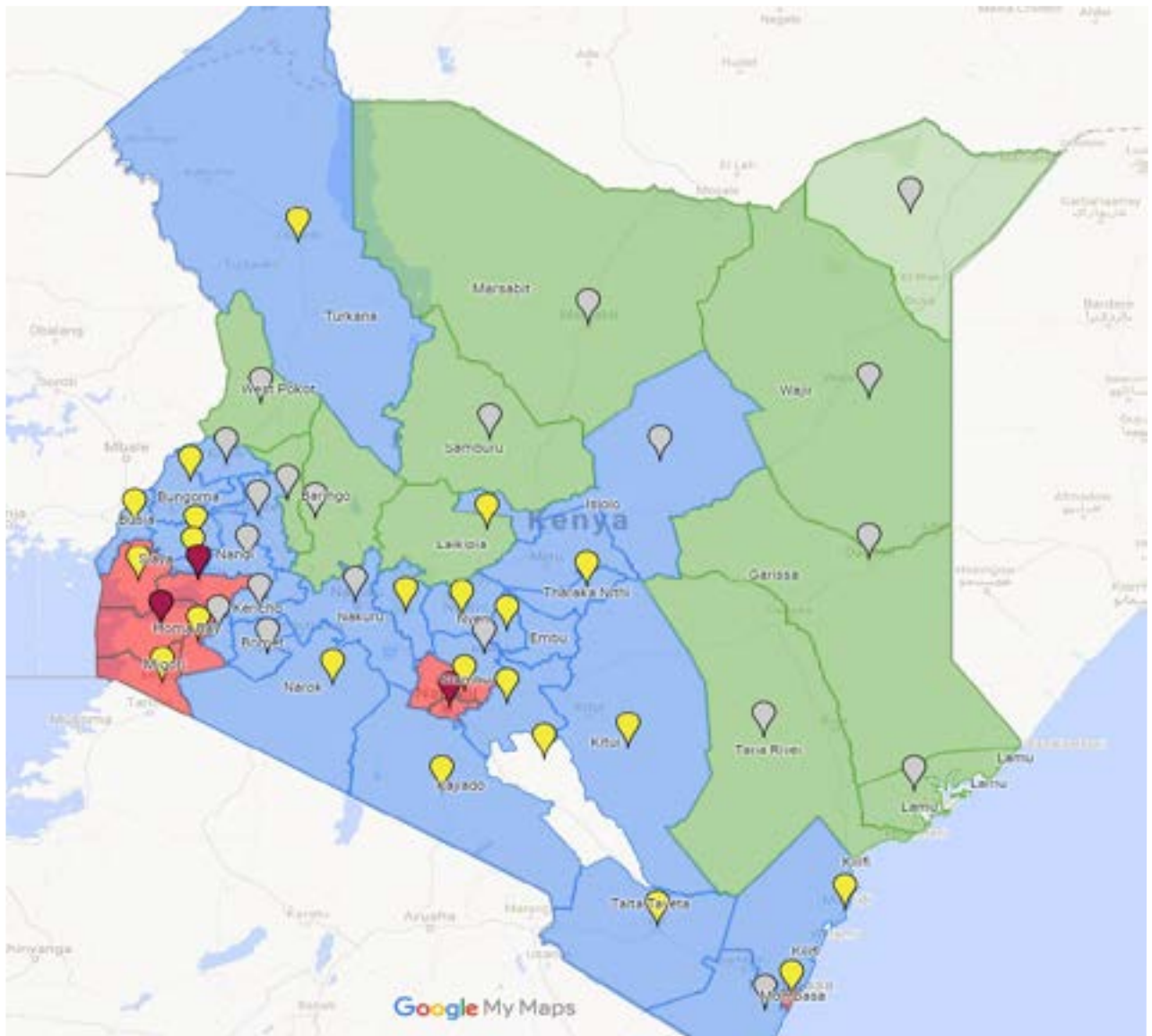
Youth community networks

The NSDCC provided mentorship and accepted learning from young people. The Maisha Youth Network brought together youth groups and individuals as champions, expanding to counties across the country. *Sauti Skika* (“Hear Our Voice”), a subcommunity under NEPHAK comprising young people living with HIV, focused on peer support for testing, linkage to care, psychosocial support and treatment literacy, using the Operational Triple Zero platform to ensure zero missed appointments, zero missed drugs, and zero missed viral load tests.




The Maisha County League leveraged the power of football to mobilize young people through a nationwide campaign for young women and men to “Kick Out HIV Stigma”. This initiative resulted in one million young people tested in targeted geographical areas, with a 68% linkage to care.

The National Youth Fund was used to mobilize and resource youth engagement activities, and youth networks were contracted to deliver peer-to-peer outreach, HIV education and targeted mobilization for testing and linkage to SRH services. One partner extended their One2One platform as a free hotline and digital platform for adolescents and youth to access SRH and HIV information.

Figure 1. Mapping of implementing partners for adolescents and young people with counties.






Partners Implementing in County

-  No implementing Partners
-  1-3 implementing Partners
-  > 5 implementing Partners

- KES 7.2 billion funding
- Represents only subset of all implementation partners

15-24yr HIV Incidence

-  Low Incidence Counties
-  Medium Incidence Counties
-  High Incidence Counties

<http://nacc.or.ke/ayp-implementation/>



National AIDS Control Council

Data strategy and evidence use

In 2016, Kenya pioneered the granulation of national estimates to subnational levels and developed burden, incidence and treatment estimates for adolescents and young people. A multisectoral team triangulated these estimates with Ministry of Education data from NEMIS, Violence Against Children surveys and routine family planning, SRH and gender-based violence (GBV) databases, producing a granular risk profile that enhanced targeting. HIV reporting tools were revised to capture age-specific data (HIV testing services for adolescents and youth) to inform programming.

Regular evaluations and stocktaking meetings assessed progress. By 2019, higher new infections among young people converged with higher ANC visits, increased GBV data and lower school transition rates in the same geographical locations. This convergence resulted in the development of a Commitment Plan to End the Triple Threat—linking HIV, unintended pregnancy and sexual and gender-based violence.

Constraints and challenges

HIV prevention interventions lacked a defined package of services, creating challenges for tracking progress. COVID-19 constrained localized interventions and increased reliance on peer networks; pandemic disruptions exposed weaknesses in service continuity and highlighted the need for more decentralized delivery models. Although domestic resources existed in other sectors, HIV financing largely remained siloed, limiting flexible reallocation to cross-sectoral interventions.

Impact and lessons

National estimates show sustained declines in new HIV infections and AIDS-related deaths among adolescents and young people over the 2015–2024 period. Reported national modelled values indicate an 82% decline in new infections (from about 35 776 in 2015 to an estimated 6362 by 2024) and a 50% reduction in AIDS-related deaths (from 3853 in 2015 to 1974 in 2024). These reductions reflect cumulative programme effects across prevention, testing and linkage interventions.

The NSDCC convening role enabled cross-sector resource mobilization and coordinated action at national and county levels. Domestic resource mobilization through the National Youth Fund and leveraging of non-health sector budgets (education, transport) created new channels for service delivery and information dissemination at scale without establishing parallel structures.

Multisector interventions directly linked to HIV services and continuously monitored with defined indicators and data sources, with reporting lines to high-level technical and policy decision-makers, were essential for sustained action. Data-driven targeting and localization through mining education and administrative datasets (NEMIS), triangulating health and non-health indicators (family planning, SRH and GBV) and conducting annual reviews facilitated ongoing programme refinement.

Perhaps the most impactful strategy was the meaningful youth engagement where young people designed programmes backed by domestic resources. Their contribution of increased uptake of condoms, HIV testing, linkage to care and retention were evident.

Conclusion

A key lesson from Kenya's HIV response for adolescents and young people is that sustained progress is possible even in the context of declining official development assistance, provided that government stewardship is strong, multisectoral and data-driven. The Kenyan experience demonstrates that political leadership at the highest level, combined with institutionalized accountability mechanisms, can mobilize domestic resources and align non-health sectors—such as education, youth and transport—to deliver HIV prevention and care at scale. The case study underscores that in an era of constrained donor financing, governments must prioritize the integration of HIV services into broader health, education and social protection agendas, while ensuring that youth engagement and localized data use remain central. This approach not only sustains epidemic control but also strengthens resilience against external, positioning domestic stewardship as the cornerstone of future HIV response.



Developed by the HIV
Multisector Leadership Forum.
A community of practice of
National AIDS Coordinating
Authorities Director Generals
of the Global HIV Prevention
Coalition countries. With
support from from the Global
HIV prevention Coalition
secretariat. With the technical
support of Yemaya Health
Advisory.