SOUTH TO SOUTH LEARNING NETWORK

The HIV Prevention Interchange

The Journey Towards Establishing a Prioritized HIV Program for Transgender People

A Case Study from Kenya

BRIEF OVERVIEW OF KENYA'S HIV CONTEXT

Kenya, jointly with Mozambique and Uganda, has the third-largest HIV epidemic in the world. Kenya's HIV epidemic is driven by sexual transmission and is generalized, meaning that it affects all sections of the population including children, young people, adults, women and men. Based on the Kenya Population-based HIV Impact Assessment preliminary report (KENPHIA, 2018), the prevalence of HIV among adults in Kenya was 4.9% in 2018. This translates to approximately 1.3 million adults living with HIV in Kenya. HIV prevalence was twice as high among women at 6.6% compared to men at 3.1%. HIV prevalence among children was 0.7% which translates to approximately 139,000 children living with HIV in Kenya.

In recent decades, **Kenya has been a huge prevention success story in the region**. Kenya was one of the first countries to scale up voluntary medical male circumcision (VMMC) and programs for key populations. They were also one of the first African counties to approve the use and scale-up of PrEP. Kenya has continued to see a decline in HIV incidence among adults aged 15-49 from 3.2% in 2013 to 1.2% in 2019 (HIV estimates 2020, NACC).

OVERVIEW OF KENYA'S KEY POPULATION EPIDEMIC AND RESPONSE

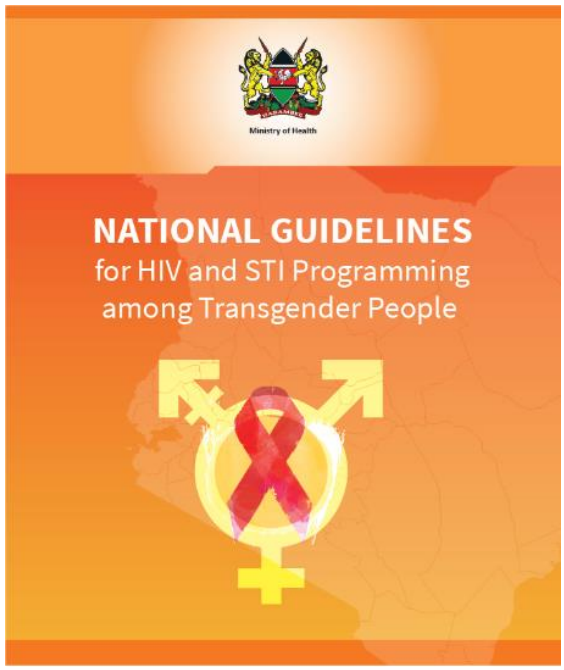
Key populations in Kenya contribute approximately **one third of all new HIV infections** in the country (MOT, 2009). Prevalence among key population groups is disproportionately higher than the general population, ranging from 29.3% among female sex workers (FSW), to 18.2% among men who have sex with men (MSM) and 18.3% among people who inject drugs (PWID). A recent national mapping and population size estimation exercise estimated 167,940 [129,271-206,609] FSW, 40,725 [30,880-50,569] MSM, 16,063 [12,426-19,691] PWID and 4,305 [2,826-5,783] transgender people in Kenya (KPSE 1 report, NASCOP 2019).

The National AIDS and STI Control Programme (NASCOP) and the National AIDS Control Council (NACC) within the Ministry of Health, lead the KP program in Kenya. The program aims to reach a high proportion of key populations and ensure that they have access to a combination of targeted behavioral, biomedical, and structural interventions. The KP program has been scaled up in Kenya with funding support from PEPFAR, the Global Fund and the Government of Kenya. Currently, the KP program in Kenya reaches over 90% of estimated FSW, MSM and PWID; however, **the current program for transgender people is still sub-optimal and further efforts are being made in the country to scale it up**.

DESCRIPTION OF THE PROGRAM INNOVATION

In 2016, with support from the LINKAGES project funded by USAID, Kenya conducted a gender analysis with transgender people – documenting the nexus between gender and HIV among transgender people in the country (LINKAGES 2016). HIV incidence among transgender women in Kenya is 20.6 per 100 person-years, compared to 5.1 per 100 person-years among men who have sex with men exclusively (Kimani et al, 2019). Transgender people in Kenya have also been found to experience elevated levels of violence, stigma and discrimination, according to a study conducted by a transgender-led organization. These findings have been substantiated through several consultations over the past few years, with transgender people, by transgender people.

A growing base of evidence, coupled with feedback from numerous consultations, ultimately led to the development of a collective advocacy agenda and a constituency of transgender people in Kenya who prioritized health and HIV as a key issue affecting the community. These developments catalyzed the need to urgently prioritize transgender people in the national HIV prevention response.



This case study shares the journey and efforts of the national Key Population Program towards including transgender people as a key population group and introducing population-specific HIV prevention programs in the country.

KEY STEPS TOWARDS INITIATING A TRANSGENDER HIV PREVENTION PROGRAM

Step 1 | Conduct a population size estimation: In 2018, Kenya's KP program for the first time conducted a **size estimation study which included mapping and estimating the number of transgender people in key population hotspots.** The study estimated 4,305 transgender people in FSW and MSM hotspots across 34 counties in Kenya. This evidence assisted the national KP program advocate for **tailored HIV prevention interventions to specifically address the needs of transgender people**. This evidence also facilitated the inclusion of Transgender-led Organizations as key stakeholders within the Key Population Technical Working Groups at national and county level. These TWGs are chaired by the Ministry of Health and meet quarterly to discuss program progress, evidence and other advocacy issues related to KP groups.

Step 2 | Consult the community to understand their needs and priorities: **The national KP program**, in partnership with **transgender community members**, **transgender-led organizations**, **implementing partners**, and **donors**, conducted several consultations to understand and define the needs and priorities of transgender people. Importantly, the consultations also served as advocacy spaces with donors where they were encouraged to allocate resources for transgender population-focused interventions. The consultations also confirmed that the transgender community did consider HIV prevention and treatment as one of their health priorities.

Step 3 | Advocate for the recognition of transgender people as a key population in the National Strategic Plan for HIV and AIDS. The national KP program along with trans-led organizations **advocated for the transgender population to be considered as a key population group in the national strategic plan (NSP)**. Evidence-based advocacy ensured that the transgender population were successfully included as key populations (along with FSW, MSM and PWID) in the Kenya AIDS Strategic Framework II 2020-2024 (NACC, KASF II). Not only does this commit the country in recognizing and prioritizing transgender people in the HIV response; it also determines lines of accountability for the implementation of tailored HIV prevention programs for transgender people in Kenya.

Step 4 | Tailor HIV prevention interventions to meet the needs of transgender people: NASCOP along with transgender-led organizations, implementing partners, donors and development partners led **the development of National Guidelines for STI and HIV Programming with Transgender People in Kenya**. This guideline outlines the implementation approach and services required by transgender people in the HIV response. The guideline describes the essential and the desirable HIV prevention and treatment package for the transgender population. The guidelines borrow from global guidance and emphasize the importance of a combination prevention approach. These guidelines will ensure that HIV prevention programs with transgender people in Kenya are scaled up using consistent standards and approaches.

Step 5 | Mobilize resources for scale-up of HIV programming for transgender people. **NASCOP conducted advocacy meetings with donors such as PEPFAR, for resource allocation**. This resulted in PEPFAR including targets related to coverage of transgender populations in COP 2020. Resources from Key Populations Intervention Fund (KPIF) under PEPFAR was also allocated to build the capacity of trans-led organizations in Kenya. The country also developed its Global Fund application for 2021-23 and has prioritized 100% coverage of estimated transgender people by year 3.

Step 6 | Invest in continued capacity building initiatives for implementers of the national transgender guidelines. NASCOP has initiated the process of **developing a team of trainers from the transgender-led organizations to train implementers on HIV programming with the transgender population** as per the national guidelines. As programs scale up, the need for capacity building will increase and hence this team of transgender trainers would be a critical resource.

Step 7 | Implement transgender-focused interventions in selected sites: **HIV prevention interventions focusing exclusively on transgender populations have been initiated in Nairobi, Kisumu and Mombasa**. These interventions are implemented by civil society organizations already working with FSW and MSM. It has provided opportunities to develop diverse models of service delivery (standalone, integrated, mobile, referral) to address the needs of the community. The learnings from these interventions would be documented and shared for scale-up in other counties with Global Fund resources. The vision is to strengthen trans-led organizations to implement HIV programs with transgender populations.

Step 8 | Inclusion of transgender people as a subpopulation in the KP monitoring and evaluation framework: NASCOP included transgender people as a KP subpopulation in the KP monitoring tool **so that coverage and service provision of transgender people in the programs are reported separately**. Before, transgender people were reported under MSM or as an FSW subpopulation. This has helped the country generate program data specifically for the transgender subpopulation, and monitor progress. There are plans to include the transgender population as a subpopulation in the next round of KP outcome surveys.

PROGRAM ACHIEVEMENTS

1. **Population size estimates for transgender people in Kenya are available**. This has helped to set coverage targets and guide service provision and budgeting for HIV programs for the transgender population.
2. Transgender people are identified as **a key population group in the Kenya AIDS Strategic Framework** II 2020-2024.
3. The **national guidelines for STI and HIV programming** with the transgender population in Kenya has been finalized and validated.
4. Transgender population-specific **programming has been initiated in Kisumu, Mombasa and Nairobi** counties in Kenya.
5. A strong **transgender-led advocacy agenda** and voice has emerged in Kenya.

KEY CHALLENGES

1. The trans-led groups had *internal* consultation for several years and once they accepted the need to leverage the HIV platform, they approached NASCOP and other stakeholders for consultation and discussion to develop more concrete plans.

2. **Lack of documentation around the HIV risk** and vulnerability of transgender people in Kenya posed challenges for developing a strong evidence base and advocacy agenda. In addition, the **lack of information on the population size estimation** further compounded the challenge. Therefore, the program had to **first invest time and money to generate and review emerging evidence** to make a strong case.

3. The needs and priorities of transgender people were unique and unfamiliar to many stakeholders, hence **sensitization sessions had to be conducted** with policymakers, donors and implementers **to ensure that programs designed for transgender people address these unique needs**. The national KP Program had to also create several opportunities and forums where the teams could **co-create the transgender program with the transgender community** themselves.

COST CONSIDERATIONS

Transgender people in Kenya live in several counties and are not necessarily found in hotspots. **This distribution does not enable economies of scale**, like the FSW programs for example. Further impacting on the unit cost of reaching the transgender population is the fact that **new programs have additional costs to take into account, such as start-up costs; costs related to differentiated service delivery models; costs of targeted interventions such as mental health, gender-affirming surgeries and hormone replacement therapy etc**. Lastly, the ratio of peer educators to peers is maintained at 1:30 which is much lower than for other key population programs.

A high-level cost estimation calculates **the cost of reaching a transgender person as 6 times greater than reaching an FSW.**

KEY LESSONS

1. Transgender people must be included in all deliberations as **equal partners**.

2. The **role of a national KP Program led by NASCOP** was very critical to driving the agenda of inclusion of transgender people in the national HIV response.

3. Programs and policies for transgender people need to **respond to their specific and unique needs and priorities**.

4. Interventions need to be designed in such a way that they **prioritize structural barriers related to gender identity, stigma, violence and the law** as these structural barriers limit the populations access to other HIV prevention and treatment services.

5. **Evidence and data are essential** ingredients for successful advocacy and detailed program design. It is necessary to continually invest in evidence generation through routine monitoring of programs, community-based monitoring, research or outcome and impact-related surveys.

6. Transgender people are spread out across the country and hence in many counties, programming with transgender people would have to be integrated with other KP programs. In counties where there is an optimal population to initiate a transgender people-focused stand-alone intervention, **the resource allocation has to be higher due to lower estimates of transgender people – the programs may not have economies of scale** which programs with FSW or MSM may have. Hence budget allocation has to be higher for transgender people specific interventions.

“The bi-directional capacity building and skill development approach with NASCOP and Trans networks in Kenya is a historic shift towards building sustainable and resilient health systems infrastructure for Trans Kenyans.”

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“The best time for initiating a programme is when the community is ready and are willing to participate in design and implementation of the intervention. Transgender community voices matter and they are a critical part of our key population programme”

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