HIV PREVENTION AND CARE INTERVENTIONS FOR THE ADOLESCENT GIRLS AND YOUNG WOMEN AGED 10 – 24 YEARS IN TURKANA, MACHAKOS, KILIFI, KISII AND SIAYA COUNTIES OF KENYA.

GLOBAL FUND CONCEPT NOTE

JANUARY 2, 2019

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Executive Summary

The Kenya Red Cross Society (KRCS) is the non-state Principal Recipient (PR) for the Global Fund HIV Grant, running from January 2018 to June 2021. The grant is focussing on creating demand for health services from the community through increasing access to community HIV testing and counselling; expanding services for HIV prevention; providing community HIV care and support and strengthening community health systems. The KRCS is committed to ensuring that the vulnerable communities in the country have access to much needed services in the most efficient, effective, reliable and trusted manner at any time and whenever required.

KRCS is committed to scaling-up programs to support adolescent girls and young women (AGYW) in 5 counties namely Turkana, Kisii, Kilifi, Machakos and Siaya Counties. The program aims to facilitate the provision of comprehensive HIV prevention package of biomedical, behavioural and structural interventions to reduce the adolescent girls and young women's vulnerability to HIV. It targets adolescent girls and young women (AGYW) aged 10-24 years in and out of school due to their vulnerability to HIV infections; the youth 15-24 years account for 46% of new HIV infections. The HIV infection among these groups is driven by early sex debut especially among girls; low knowledge of HIV and high pregnancy rate. For instance, unmet FP need among married women aged 15-19 and 20-24 years. Other factors contributing to new infection in these groups are intergeneration sex; harmful cultural practices such as early marriages as well as gender based violence. Healthcare services are not friendly to the AYP.

Youth led and youth serving organizations are the implementing partners or Sub Recipients who will directly implement the program, with the support from the county stakeholders and the local administrators in the five counties. These organizations will contribute expertise in working with young people. There will be investments in youth led and young serving organizations to strengthen their capacity to design, plan, implement and monitor activities as part of the essential intervention to ensure AYP effectively take up their role in the HIV response.

The overall objective of this program is to develop and implement an HIV prevention interventions to reduce HIV risk and scale up access to HIV prevention and treatment. The program is expected to achieve results and outcomes, which include increased awareness on HIV prevention and behaviour change among AGYW, increased access to HIV prevention services among AGYW; increased awareness and improved response to SGBV cases at community level and improved livelihood for girls and young women as a measure for HIV prevention. The program will also contribute to behaviour change and uptake of HIV prevention services among young women.

To this end, the program will support the delivery of evidence-informed package of interventions for HIV prevention, treatment and care and support among AGYW outlined in the Global Fund technical brief for adolescents girls and young women in high-HIV burden settings. Quality control and accountability are critical during the life cycle of the program and critical measures are in place. Additionally, a robust monitoring and evaluation framework highlighting program indicators and means of continuous measuring the immediate results and outcomes from the program. An evaluation will also be carried out both during and after implementation process and will including formative, process and outcome evaluations.

ADDRESSING HIV RISK IN ADOLESCENT GIRLS AND YOUNG WOMEN AGED 10 – 24 YEARS.

INTRODUCTION AND BACKGORUND

The incidence of HIV is declining or stabilizing in many settings, yet levels of new infections remain unacceptably high among adolescent girls and young women (AGYW). In almost all countries with generalized epidemics, young women aged 15–24 years are three to five times more likely than their male counterparts to be living with HIV; and in sub-Saharan Africa, 71% of new infections in adolescents are among girls[1]. In a pattern that is consistent across most high prevalence countries, HIV incidence rates rise dramatically between the ages of 15 and 24, and more steeply among females than males[2].

As the world's population of adolescents grows, particularly in east and southern Africa, high incidence among young people will equate to rises in the absolute numbers of new infections. The role of adolescent HIV prevention in broader epidemic control is recognized with the growing commitment at global and national levels to prioritise young people in efforts to end the AIDS epidemic. With the 'All In to End Adolescent AIDS' campaign, for example, UNICEF and global partners seek to reduce new HIV infections among adolescents (10–19 years) by 75% between 2015 and 2020, and 'end' the AIDS epidemic among adolescents by 2030 (to fewer than 200 infections [3]per year). The complexity of this goal is not underestimated, and the multidimensional nature of AGYW vulnerability has to date proven resistant to change by single interventions, sectors or disciplines. The need for combination approaches, and 'packages' of interventions, is increasingly recognised. For example, a recent issue of *Disease Control Priorities* recommends an essential and cost-efficient 'package' to be delivered in adolescence – through a mixed approach involving the community, media and health systems. Similarly, a 'call for action' on HIV prevention, 'HIV Prevention 2020', specifies a combination of primary prevention interventions, to be designed comprehensively and delivered effectively and at scale among populations at greatest risk

Adolescents and the youth 15-24 years account for 46% of new HIV infections. HIV infection among this groups is driven by early sex debut especially among girls; low knowledge of HIV (women-11% and men 43%) and high pregnancy rate (70%). For instance, unmet FP need among married women 15-19 is 29.7% and 30.1% among those aged 20-24 years; 44% of adolescents aged 15-19 have never heard of FP methods4. Other factors contributing to new infection in this groups are intergeneration sex; harmful cultural practices such as early marriages as well as gender based violence[5]. Healthcare services are not friendly to the adolescents and young people. Those LHIV especially learners in school suffer from stigma which affects adherence to treatment.

Drivers of the epidemic among adolescents and the youth 15-24 years

The main driver of the generalized epidemic is heterosexual transmission through multiple sexual concurrences amidst low condom use (40% women and 42.8% men)[6]. In 2015, the Kenya HIV estimates showed that new infections among young adults 15-24 years contributed to half of all the new HIV infections among adults. A number of factors are attributed to these infections:

- Multiple sexual partnerships and low condom use: among young females (15-24 years) with multiple sexual partners, 62.5% did not use a condom during the last sexual intercourse. Similarly, 31.1% of young men of the same age group who had multiple sexual partners did not use a condom. Among the general population 15-49, condom at last sex with a non-regular partner for men is 72% and women is 55.5%7. This points to a remaining gap against the recommended 90% condom use sat high risk sex.

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[1] Faculty of Epidemiology and Population Health, London School of Hygiene & Tropical Medicine, Keppel Street, London, WC1E 7HT, UK
2 Evaluating the impact of the DREAMS partnership to reduce HIV incidence among adolescent girls and young women in four settings
3 United Nations, 2012. World Population Monitoring: Adolescents and Youth. United Nations Department of Economic and Social Affairs, Population Division.Google Scholar
4 Kenya Demographic and Health Survey, 2014
5 Kenya AIDS Strategic Framework 2014-2019
6 Kenya Demographic health survey page 228-232

- Transactional sex: Transactional sexual relationships are non-marital, non-commercial sexual relationships based on an assumption that sex will be exchanged for material support or other benefits. Adolescent girls and young women engage in these relationships for three main groups of reasons: accessing basic needs, increasing their social status and receiving material expressions of love from male partners.
- Age-disparate sex: The age of sexual partners is a key factor that contributes to HIV incidence being substantially higher among adolescent girls and young women than among males of the same age. The majority of women are in age-disparate relations with men who are between one and 10 years older[8]. In such relationships, not only is there a higher likelihood of older men being already infected, but also of unequal power dynamics within the relationship that may prevent safer sex.
- Gaps in knowledge and limited personalized risk perception: Although knowledge of basic prevention methods is relatively high in priority countries, there are still considerable gaps in comprehensive basic knowledge among adolescent girls and young women. Knowledge of specific risk factors (such as transmission in sexual networks or the risk of age-disparate sex and anal sex), of newer biomedical prevention methods (such as PrEP), or of links between HIV and gender-based violence, is likely to be lower. Although they may understand that the population-level risk of HIV is high, there still are gaps in personalized risk perception.
- Human rights and gender barriers such as punitive laws, criminalization of certain sexual behaviors as well as services meant for harm reduction, stigma which influences health seeking behavior among key groups and hinders quality services in the health system; and service delivery that is not friendly and accommodating to the needs of key populations and vulnerable groups such as adolescents and men who have sex with men[9]. Gender based violence is another area of concern; 38% of women aged between 15-49 years have experienced physical violence, while 14% reported sexual violence[10].
- Sexual violence and early marriage. Levels of violence prior to age 18 as reported by 18 to 24 year olds (lifetime experiences) indicate that during childhood, 32% of females and 18% of males experience sexual violence and early marriages. Eleven percent (11%) of women aged 15-19 are currently married, as compared with just 1% of men the same age.
- High school dropout rates increasing vulnerability to HIV infection: There is also low transition from primary to secondary school (dropout rates of 22.7 % among boys and 23.5 among girls).[11]
- HIV stigma: HIV related stigma is high in the country estimated at 45% composite index[12] with geographical variations in counties. Stigma affects to uptake of HIV testing which is key to entry into treatment.
- Barriers to accessing sexual and reproductive health and HIV services: Age of consent laws, stigma, service provider bias and discrimination limit the ability of young women to access health services, counselling and prevention tools (such as condoms, contraception, HIV testing and other services)

Why focus on adolescent girls and young women (AGYW)?

AGYW present a myriad of challenges including high rates of teen pregnancies, drugs and substance abuse, sexual and gender based violence, high rates of unemployment among others. Underneath these challenges are harmful cultural and religious practices that impede efforts to address them. The program intend to contribute to the prevention of new HIV infections and reduction of AIDS related mortality among adolescent girls and young women. New HIV infections among adolescent girls and young women are substantially higher than among males of the same age because HIV is more commonly acquired from male

8 Maughan-Brown B, Kenyon C, Lurie MN. Partner age differences and concurrency in South Africa: implications for HIV-infection risk among young women. AIDS and Behaviour. 2014; 18(12):2469–76. doi: 10.1007/s10461-014-0828-6.
9 Kenya AIDS Strategic Framework, page 30-33
10 Kenya Demographic Health Survey, 2014 (KDHS)
11 Basic Education Statistical Booklet 2014 Page 19
12 National HIV and AIDS Stigma and Discrimination Index Summary Report 2014.

sexual partners who are a few or several years older. Gender inequality also disproportionately affects girls and women, but addressing it requires working with both women and men to consider not only unequal power dynamics, but also risk practices and underlying social and gender norms.

The United Nations (UN) Political Declaration on Ending AIDS adopted in June 2016 calls for reducing new HIV infections to fewer than 500 000 per year by 2020, and it sets a specific target to reduce new HIV infections among adolescent girls and young women aged 15 to 24 years to fewer than 100 000 (75% reduction) by 2020. Achieving this target demands dramatic acceleration of action and expanding of programmes for adolescent girls and young women. In line with the global target, this program will focus on age appropriate adolescent interventions in cohorts of girls aged 10 to 14 years; 15 to 19 years and young adult women aged 20 to 24 years.

Kenya Country Context: HIV Prevention among AGYW in Kenya

In September 2015, Kenya adopted its fast track plan to end HIV and AIDS among Adolescents and Young People (AYP) with the aim of reducing new HIV infections among AYP by 40%, reducing AIDS related deaths among AYP by 15% and reducing stigma and discrimination by 25% between 2014 and 2017. Although HIV prevalence has dropped in Kenya, young people, and particularly young women, are still disproportionally affected. The national HIV prevalence for youth shows that prevalence peaked at 9-10% and 3-4% in the mid-1990s, for female and male respectively. The prevalence declined to about 3.5% and 1.4% for female and male respectively by 2006 and has stabilized since then among men with a modest decline among female.[13]

Adolescents and the youth 15-24 years account for 46% of new HIV infections in Kenya. HIV infection among this groups is driven by early sex debut especially among girls; low knowledge of HIV (women-11% and men 43%) and high pregnancy rate (70%). For instance, unmet FP need among married women 15-19 is 29.7% and 30.1% among those aged 20-24 years; 44% of adolescents aged 15-19 have never heard of FP methods[14]. Other factors contributing to new infection in this groups are intergeneration sex; harmful cultural practices such as early marriages as well as gender based violence1516. Healthcare services are not friendly to the adolescents and young people. Those LHIV especially learners in school suffer from stigma which affects adherence to treatment.

HIV prevention in Kenya is premised on the application of evidence based interventions to achieve set targets and goals as outlined in the national strategic plans. Over the years the country has invested in interventions to reduce sexual transmission of HIV among key groups – young people, sex workers, men who have sex with men. Other vibrant prevention programmes target prevention of new HIV infections among children, STI prevention among people living with HIV and voluntary medical male circumcision to reduce risk of HIV infection among men. Reproductive health is an essential priority in the Kenya Essential Package for Health (KEPH) system. This strategy captures the spirit of the Constitution of Kenya, National Adolescent sexual reproductive health policy, Kenya SRH policy, KASF (2014 – 2019) and County Integrated Development Plan (2018 – 2022).

This AGYW interventions will addresses AGYW HIV response that is focused on evidence based behavioural interventions; addressing gender based violence through a community response; capacity building of peer led organizations; provision of HTS, care and treatment and viral suppression; linkage to services for sexual reproductive health needs including STIs, GBV and Contraceptives; address stigma and discrimination; set up of wellness centres; and improve coordination of multi-sectoral interventions for adolescents and young women. The program intend to form a strong basis for future scale up of the adolescent and young women HIV program in Kenya.

[13] HIV Estimates Report 2018

[14] Kenya Demographic and Health Survey, 2014

[15] Kenya AIDS Strategic Framework 2014-2019

[16] Addendum to the Kenya AIDS Strategic Framework (2020-2021

AGYW INTERVENTIONS DESCRIPTION

The AGYW interventions are part of the national response and the grant is there to fill some of the gaps of this response in selected five counties namely Turkana, Machakos, Kilifi, Kisii and Siaya counties. The program is targeting adolescent girls and young women (AGYW) aged 10 – 24 years in and out of school. The AGYW are most vulnerable to HIV infections. AGWY aged 15 – 24 years account for almost 1 in 3 infection in this region and they acquire HIV 5 – 7 years earlier than their male peers. In Kenya, adolescents and the youth 15-24 years account for 46% of new HIV infections. HIV infection among this groups is driven by early sex debut especially among girls; low knowledge of HIV (women-11% and men 43%) and high pregnancy rate (70%). For instance, unmet FP need among married women 15-19 is 29.7% and 30.1% among those aged 20-24 years; 44% of adolescents aged 15-19 have never heard of FP methods[17]. Other factors contributing to new infection in this groups are intergeneration sex; harmful cultural practices such as early marriages as well as gender based violence[18]. Healthcare services are not friendly to the adolescents and young people.

AGYW Beneficiary Profiles

The target number of beneficiaries is from Population Program by Age Cohorts programing for 2017 at the base data on 2009 population census data. For each County, the total female population in the county is used and a proportion of the population in the targeted age cohort is calculated. Where this existed, it is used. The reference documents are the county Integrated Development Plans 2013- 2017.[19] The programs are applied to the proportions by age group to the sub county population in the proposed sub counties for implementation. The proposed targeted AGYW beneficiaries are:

Name of County	10 - 14 years	15 - 19 years	20 - 24 years	Sum for the whole target AGYW age cohort	Number of AGYW to be reached with defined package of services	Proportion of AGYW to be Reached	Number of AGYW to be reached with Dignity Kits
Turkana County	110,841	87,309	62,008	260,158	78,654	30%	9,000
Machakos County	80,086	66,875	59,501	206,462	40,303	20%	4,030
Kilifi County	99,251	79,139	73,382	251,772	61,960	25%	6,196
Kisii County	90,070	80,024	75,905	245,999	50,814	21%	5,081
Siaya County	64,448	54,797	47,485	166,730	47,677	29%	4,768
TOTAL	**444,696**	**368,144**	**318,281**	**1,131,121**	**279,408**	**25%**	**29,075**

SOURCE: Population Programions by Age Cohorts in County Integrated Development Plan, 2013 – 2017 (for each county)

The interventions will target specific 3-4 sub counties in each county and will reach any girls in the targeted age group. The sub counties will be selected based on the following criteria;

1. HIV Prevalence per sub county
2. Teenage pregnancy rate
3. Number of ALHIV per sub county
4. Female School Dropout rate

[17] Kenya Demographic and Health Survey, 2014

[18] Kenya AIDS Strategic Framework 2014-2019

[19] County Statistics Office, Turkana, Machakos, Kilifi, Siaya and Kisii 2014

Recommended Combinations of Packages for AGYW clustered by age

The service package for the AYP in this intervention will include **comprehensive health education, ASRH information, risk assessment and counselling on safe behaviour** as a minimum package of services to promote the adoption of HIV prevention behaviour and service uptake. Additional services to the beneficiaries will include Family Planning information and commodities, HTS, STI screening and treatment, TB screening and treatment, ART services, PAC, PrEP, PRC and Cervical cancer screening and treatment. The program will utilize an integrated model to ensure maximum realization of results.

Age Group		Biomedical Interventions	Behavioural Interventions	Structural Interventions
10 – 14 years	Essential package	HIV and sexual and Reproductive health education through clubs	CSE and Life skills training Communicating with parents using Families Matter!	• GBV screening and response • Community mobilisation for legal action against sexual offenders
	Desirable Elements	HTS,VMMC, PrEP, PEP, Post rape care, HPV vaccines		• Initiatives to keep girls in school • Conditional Cash transfer and dignity kits
15 – 19 years	Essential package	• HIV testing services • Sexual and Reproductive health and HIV education • Promotion of condom use • Cervical cancer screening and treatment • STI screening and treatment • TB screening and treatment • ART services	• Life skills training using Healthy Choices • Positive Health, Dignity and Prevention for AYPLHIV	• Promote Post HIV test clubs • Programmes to prevent Gender-Based Violence • Protection from cultural issues directly linked to HIV risk such as wife inheritance • Addressing intergenerational sex through targeted messages • Provision of dignity kit to most vulnerable AGYW • Economic empowerment through vocational skills
	Desirable Elements	VMMC, PrEP, PEP, PRC, EC, HPV vaccines		• Conditional Cash transfer • Programmes to keep girls in school • Economic empowerment through micro-finance
20 – 24 years	Essential package	• HIV testing services • Promotion of condom use • Family Planning, • Cervical cancer screening and treatment • STI screening and treatment • TB screening and treatment ART services,	• Life skills training using SHUGA series • Positive Health, Dignity and Prevention for AYPLHIV	• Promote Post HIV test clubs • Programmes to prevent Gender-Based Violence • Protection from cultural issues directly linked to HIV risk such as wife inheritance • Addressing intergenerational sex

	Desirable Elements	VMMC, PrEP, PEP, PRC, EC, HPV vaccines		• Conditional Cash transfer and dignity kits • Economic empowerment

Broad Objective

The interventions a aim to ensure that AGYW in selected sub counties in Turkana, Machakos, Kilifi, Kisii and Siaya counties have access to the essential package of biomedical, behavioral and structural interventions above to reduce their vulnerability to HIV infection.

Specific Objectives

1. To reach 279,407 AGYW with defined package of services to support HIV prevention and risk reduction.
2. To increase linkage of APY living with HIV to treatment, care and support services through structure peer support approaches to improve the county achievement of the 90-90-90 targets.
3. To increase the involvement of young people and youth focused organizations in driving demand for increased uptake and adherence among AGYW
4. To contribute to the reduction in STI's and HIV infections among AGYW
5. To contribute to reduction of HIV risk amongst AGYW within the selected sub-counties in Turkana County through conditional cash transfers and other tailored HIV interventions.

Key Strategies and Interventions

Approaches to maximize synergies and integration within the health system will be leveraged in the entire program delivery. They include strategies to increase and sustain knowledge of HIV status, address leaks in the retention cascade, strengthen linkages to reproductive health services, and improve capacity and linkages between community and facility level interventions. The interventions emphasizes a strong community participation in the design and implementation of program, including in the selection of beneficiaries, the targeting and monitoring of program implementation. The key interventions will include;

1. Behavioral change as part of programs for adolescent and youth;
2. HIV prevention, treatment, care and support programs for AGYW
3. Gender-based violence prevention and treatment interventions for AGYW
4. Community mobilization and norms change while addressing stigma, discrimination
5. Continuation of Cash transfer for 9,000 adolescent girls and young women in Turkana County.

Program Activities

Intervention 1: Behavioral change as part of programs for adolescent and youth;

Activity 1: Provide evidence-based behavioural interventions to AGYW on HIV/STI risk reduction.

The evidence based interventions (EBIs) are aimed at increasing HIV knowledge awareness and risk perception tailored to the way that AGYW receive information. The program will roll out EBIs namely My Health My Choice (MYHC), Healthy Choices for a Better Future (HCBF) and Shuga series for young people in community settings and family matters targeting parents. The program will implement the following EBIs to reach all AGYW with structured prevention interventions.

Families Matter! Program (FMP) to parents and caregivers of adolescents aged 10 -12 years. FMP! Seeks to improve positive parenting and effective communication between parents/primary caregivers and their 10-12 year-old children on sexuality and sexual risk reduction, including accurate information about HIV that can translate to delayed sexual debut. The intervention is delivered to caregivers of adolescents aged

10-12 years through a series of 6 consecutive weekly sessions covering 2 modules in each session lasting 1-2 hours weekly.

Healthy Choices! Is a group intervention targeting children aged 10-13 years old for HC I and 14-17 year old for HC II. The interventions entails 8 sessions focusing on decision making, sex communication, negotiation and refusal skills with the aim of delaying sexual debut, promoting safer sex practice, HIV and STI risk reduction and condom use

Sister to Sister (S2S): Alongside HTS, we plan to deliver S2S interventions to AGYW aged 18-24 years, to promote consistent condom use, discuss the dangers of unprotected inter-generational sex and promote and provide/refer for FP services. S2S address barriers to condom use and emphasises correct knowledge, skills and empowerment to use condoms correctly and consistently. Sister-to-Sister, delivered by female health care workers and peer educators, is for women ages 18-45 years in groups of 3 to 5. The intervention aims to eliminate or reduce risk behaviours and prevent HIV and STI infections through increasing self-efficacy and condom use negotiation

SHUGA Series! A multi-media behaviour change communication intervention, SHUGA targets youth between 15-24 years with the following key themes. 1) Sexual concurrency, correct and consistent condom use, sexual agency, personal risk perception, reduction of stigma and discrimination towards PLHIV, transactional sex, GBV and parent/child communication 2) SHUGA is a 10-session intervention (150 minutes per session) in groups of a maximum of 20 participants delivered by facilitators, preferably a male and female within the age group of 18-29 years 3) SHUGA utilises a combination of brainstorming, guest speakers, small group discussions and homework assignments.

Positive Health, Dignity and Prevention (PHDP)! A rights-based approach that ensures all newly diagnosed AGYW are linked and access treatment and care services. The approach places the person living with HIV at the centre of managing his or her own health and wellbeing. It is a model which links HIV treatment, prevention, and support and care issues within a human rights framework. PHDP approach emphasises the importance of addressing prevention and treatment simultaneously and holistically.

Numbers to be reached with the various EBIs

EBI	10 – 14 years	15 – 17 years	18 – 24 years	Total
Families Matter	79,446	-	-	**79,446**
Healthy Choices	79,446	34,985	-	**114,431**
Sister to Sister	-	-	41,929	**41,929**
SHUGA Series	-	-	122,548	**122,548**
PHDP	33,172	27,285	23,362	**83,820**
Total	**192,065**	**62,270**	**187,839**	

The assumption on target setting is that a third of all AGYW reached with defined package of information, will also be reached with age appropriate EBIS in the two and half years of the program life**.**

Activity 2: Comprehensive Sexuality Education and HIV prevention education

School-based comprehensive sexuality education (CSE) can prevent HIV infections particularly delivered together with a comprehensive package of health services to adolescents, including access to condoms, as that curriculum-based programs alone might not have an effect on the number of young people infected with HIV, STIs or the number of pregnancies. The program will work with the approved CSE curriculum to provide CSE in schools within the targeted sub counties with the aim to improving self-esteem, self-efficacy and changing attitudes and gender and social norms. In settings where girls are not in formal education, the program will use community based forums to deliver CSE and HIV prevention education.

Activity 3: Conduct quarterly community-based outreach to AGYW for HIV-Prevention and risk reduction in the administrative wards.

The program will deliver a comprehensive community-based comprehensive outreach conducted by a multidisciplinary team (an HIV/TB clinician, nurse, RH personnel, HTS counsellors, a social worker) and peer educators as mobilisers. The services to be provided during the outreach will include health education; HIV/TB services, ASRH information; risk assessment and counselling on safe behaviour; promotion, demonstration & distribution of male condoms; HTS, cervical cancer and STI screening and referral; TB screening and referral; ASRH services including family planning; and GBV information, screening and referral linkage. This will provide a platform in which the program will provide integrated health services by supporting the health providers to deliver comprehensive, consistent and multidisplinary care and support services to AGYW in one place, at one time. The aim is to provide a package of comprehensive services along the continuum of prevention and care that work in time and place for AGYW, with effective referral system. The quarterly comprehensive outreaches will be conducted per ward targeting all the targeted sub county of implementation in the 5 counties. In addition, the program will build capacity and facilitate youth led organizations, peer educators and CATS to conduct outreaches to reach AYP with prevention messages in and out of school (HTS, PrEP, Condom distribution, SGBV, PEP)

Intervention 2: HIV prevention, treatment, care and support programs for AGYW

Activity 1: Expanding HIV Testing Services (HTS) to reach 90% of AGYW in the targeted counties.

The program use the existing mix of clinical and community platforms to increase HTS and referrals of AGYW and their partners for testing. Support will be provided for peer led messaging and mobilization of adolescents and young women for HTS. To scale up HIV testing services to reach 90% of the targeted AGYW to increase the numbers who know their correct HIV status using community HTS strategies such as door-to-door testing, self-testing, outreach-based testing and conditional peer club testing

In addition, peer led HIV testing and messaging for young people during the community-based outreaches. The program intends

1. To train and support peers as lay providers of HTS to increase uptake of HIV testing among AGYW through AYP friendly testing services.
2. The trained Peers to work with trained HTS Counsellors from linked health facilities to test AGYW enrolled in the program by providing HTS in the YFS Centres, Safe Spaces, and through index-family HTS.
3. Promote HIV self-testing (HIVST) and voluntary assisted partner notification services to increase uptake of HIV testing among adolescent and young people.
4. Provide linkage to counselling and treatment services through preferred health facilities and follow up on effectiveness of referrals.
5. Support linkage to prevention services for AGYW who test negative including linking boys to VMMC services.
6. Promoting Pre-exposure Prophylaxis (PrEP) by sharing information on the use of ARVs by HIV-negative individuals to avoid HIV infections, as an additional prevention choice for AGYW at substantial risk of HIV.
7. Support PrEP uptake and adherence among AGYW by tailoring adherence support to AGYW needs in ways that reach them by offering provider counselling, adherence clubs, community-, peer- or school-based support, or SMS reminders.
8. Support referral linkage to post-exposure prophylaxis (PEP) services for all AGYW with an exposure that has the potential for HIV transmission, initiated as soon as possible and ideally within 72 hours

Activity 2: Link all HIV positive AGYW to TB, HIV care and treatment and STI services.
To ensure that all known positive and newly diagnosed AGYW are effectively linked to HIV care and treatment services at a facility of choice. The HIV positive AGYW will be screened for GBV, cervical cancer, STIs and TB and those who require further diagnosis referred to health facilities. The program will support the establishment of linkages and referral pathways to ensure a smooth transition from paediatric to adult HIV services and continuum of care. The program will

1. Support monthly AYLHIV support groups per health facility CCC run by trained facilitators and a network of community adolescent treatment supporters [CATS]); to provide AYPLHIV structured treatment literacy and adherence counselling support.
2. Train peers on peer education and counselling skills to support AYPLHIV ages 17–24 years in youth centres and through home visits; to counsel AYPLHIV about the potential benefits and risks of disclosure of their HIV status to others and empower and support as necessary.
3. Strengthen one existing adolescent/youth wellness centre run by CATS. These will help with ART initiation for AGYW living with HIV and strengthen adherence support.
4. Support to caregivers on parent-child communication for better treatment outcomes (provide caregivers with resources for teaching young people including YPLHIV about SRHR)
5. Capacity building on HIV prevention messages for peer educators and a network of community adolescent treatment supporters [CATS] to deliver HIV prevention messages and services to AGYW within the community
6. Support peer based adherence support to enable learning from others facing the same challenges to facilitate their treatment adherence and engagement in care.
7. Equipping peer educators, and community adolescent treatment supporters [CATS] with the minimum package of commodities to effectively deliver services
8. Develop and implement a referral directory for health facilities and services for effective referral and linkage.
9. Train HCWs in the linked health facilities on delivering "AYP responsive" health services and community based approaches that can contribute to treatment adherence among AYPLHIV.

Intervention 3: Gender-based violence (GBV) Prevention and Management for AGYW

Activity 1: Increased awareness and improved response to GBV cases at community level

The program will leverage the power of the existing HIV movement such as networks of People Living with HIV, youth led organization and youth focused organizations to champion for sexual and reproductive health service and rights-based approach in the County and promote rights based services to AGYW. The program will identify and deploy HIV prevention champions especially the county first lady and county women representative to promote the mitigation of GBV

1. Engaging AGYW and AYPLHIV to organise themselves within the community and champion against breaches of their human rights
2. SGBV awareness forums to sensitize AYWs on facts and linkage to a well-functioning referral system, including post rape care and post exposure prophylaxis (PEP).
3. Differentiated gender based responses will also be targeted at young women and girls at the community level
4. Awareness-raising campaigns that provide information about rights and laws related to HIV and SGBV through community mobilization and education; and peer outreach on different legal or human rights fora in which one can advocate or seek redress
5. Age-appropriate sexuality and life-skills education programmes that also seek to reduce gender inequality and gender-based violence;

Activity 2: Provide training and sensitization to improve GBV reporting and post-violence care.

The program will train the SR program staff, MoH staff from health facilities within the implementing sub counties, peer educators and a network of community adolescent treatment supporters [CATS]) on adolescent-friendly post-violence screening and care.

The trained personnel will hold discussion forums with AGYW, families, teachers, local leaders, police, social welfare officers, legal officers, and other key community members on SGBV reporting and existing response services. In addition, our field staff will partner with relevant Civil Society Organizations to rally community support to end GBV

Activity 3: Support HIV and GBV -related legal services

HIV and GBV-related legal services can facilitate access to justice and redress in cases of HIV-related discrimination or other legal matters. Specifically, these services may include:

1. Legal information and referrals;
2. Legal advice and representation through pro-bono lawyers.
3. Alternative/community forms of dispute resolution;
4. Engaging religious or traditional leaders and traditional legal systems (e.g. village courts) with a view to resolving disputes and changing harmful traditional norms; and
5. Strategic litigation through pro-bono lawyers.

Activity 4: Sensitization of law-makers and law enforcement agents

There is need to inform and sensitize those who make the laws (MCAs) and those who enforce them (Ministers of Interior and Justice, police, prosecutors, judges, lawyers, traditional and religious leaders) about the important role of the law in the response to HIV and GBV. The interventions will include:

1. Sensitization of police regarding HIV and GBV; and the importance of appropriately addressing domestic and sexual violence cases in the context of HIV
2. Facilitated discussions and negotiations among HIV service providers, those who access services and police to address law enforcement practices that impede HIV prevention, treatment, care and support
3. Information and sensitization of MCAs, personnel of Ministries of Justice and Interior, judges, prosecutors, lawyers, and traditional and religious leaders on the legal, health and human rights aspects of HIV

Intervention 4: Community mobilization and norms change while addressing violence and harmful sociocultural practices including gender norms

Activity 1: Conduct community mobilization and awareness on harmful cultural and social norms and promote norms change.

Community mobilization is the process that helps the communities identify, respond to, and address their needs. The program will engage the communities in dialogues around power and harmful gender norms related to HIV and violence against women.

i) Identify and recruit community activists and champions at community level to work with girls, boys, women and men
ii) Train community activists and champions on social mobilization and awareness creation on norm change. Part of the training will be to collect baseline data to assess knowledge and attitudes on SGBV within the community.
iii) The program will also work with community adolescent treatment supporters [CATS]) specific to HIV prevention among AGYW in each of the Wards, comprising of teachers, administrators, parents and other key stakeholders. The groups will meet quarterly to receive progress reports and give direction where needed.
iv) Conduct quarterly community dialogue meetings to understand and have a clearer perspective on HIV/AIDS awareness to curb stigma and influence action and challenge the social norms.

Activity 2: Increase awareness on Human Rights and Gender-related to HIV among the AGYW

Programs to prevent HIV in AGYW must incorporate efforts to address human rights and gender barriers, weak structures to protect rights; weak response system across the continuum from community level to health system to the justice sector; and lack of legal aid to support persons affected that may be limiting access to treatment care and support services. This program will attempt to address human rights and gender-related barriers to increase access to justice and to promote and protect SRH rights of AGYW by ensuring they have access to AGYW friendly services. The program will

1. Address stigma and discrimination reduction through sensitization of AYPLHIV and community leaders; integrating HIV/TB, human rights and gender related issues in prevention.
2. Sensitise law makers and law enforcement agents at county and community level.
3. Promote legal literacy ("know your rights" campaigns) by conducting standardised and coordinated know your rights campaigns on HIV, human rights and the law.
4. Build the capacities of one youth led organizations in each sub county to screen for violations and report human rights violations; and actively participate in the response
5. Facilitate the development of implementation plan with the youth led organizations in each sub county to support conduct know your rights campaigns to AGYW especially AYPLHIV.
6. Create awareness on the HIV tribunal role will be raised to improve access to its services.
7. Training of health care providers and other leaders on human rights to establish an enabling environment and promote "friendly" services that meet the needs of AGYW and other vulnerable groups.
8. Legal literacy programmes to teach AYP living with or affected by HIV about human rights and the national and local laws relevant to HIV

Intervention 5: Continuation of Cash transfer for adolescent girls and young women in Turkana County.

Activity 1: Provide Cash transfers for socioeconomic support to AGYW

The program support the continuation of the current cash transfers and provision of dignity kits to 9,000 young women in Turkana County. Continued support is critical to enable this CT to be implemented over a sufficient period to learn lessons and further programming. The cash transfer conditioning is based on HTS and STI screening and treatment as part of the health service provision at enrolment and every subsequent year. The cash transfer intervention, is re-designed to last two years, started in December 2018 and end in November 2020.

Activity 2: Provide Dignity Kits for structural intervention among most vulnerable AGYW

In addition to the 9,000 CT girls who will receive dignity kits, 10% of the AGYW beneficiaries from the other four counties will also receive the dignity kits. The 10% beneficiaries will represent the most vulnerable of the AGYW in each county. The county stakeholders will generate the vulnerability criteria to be used to identify the most vulnerable AGYW to receive the dignity kits. The criteria will be agreed on in the county AYP TWG meetings and implemented per county.

Activity 3: Provide socioeconomic support and vocational training to AGYW

The program will support out-of-school AGYW to register with the Ministry of Gender and Social Services and enrol them in vocational training and give them a start-up kit on a cost sharing basis; train them on entrepreneurship skills, income generating activities, financial education, and group savings and loans; and link them to relevant institutions such as Uwezo Fund and Youth Fund to access small business loans. This interventions will be considered for AGYW that are not in school including female heads of households.

Summary of interventions for adolescent girls and young women

Strategic Priority		**HIV: adolescent girls and young women**	
Module	**Interventions**	**Brief description of activities to be undertaken**	**Outcomes expected** (e.g. expected increase in targets and/or program quality)
Module 5: Prevention programs for adolescents and youth, in and out of school	Behavioral change as part of programs for adolescent and youth	Roll out of evidence based behavioural interventions[20]; capacity building for peer led organizations to conduct outreaches in and out of schools; and building capacity of school staff (matron and counsellors)	Increased awareness on HIV prevention and behaviour change among adolescents and young people
	Gender-based violence prevention and treatment programs for adolescents and youth	An SGBV information package for adolescents and young people will be developed and disseminated to boys and girls in clubs to raise awareness. Differentiated gender based responses will also be targeted at young women and girls at the community level.	Increased awareness and improved response to SGBV cases at community level
	HIV testing services	Support will be provided for peer led messaging and mobilization of adolescents and young women for HTS.	Improved livelihood for girls and young women as a measure for HIV prevention
	Community mobilization and norms change	Care givers will be sensitized on parent-child communication for better treatment outcomes for YPLHIV.	Contribute to behaviour change and uptake of HIV prevention services among young women
	Addressing stigma, discrimination	Matching fund will support establishment of 3 adolescents' wellness centres integrating HIV prevention services.	Increased access to HIV prevention services among adolescents and young women

Expected Results/Outcomes of the Program

The AGYW interventions are geared towards transforming adolescent girls and young women in different ways

1. Increased awareness on HIV prevention and behaviour change among AGYW
2. Increased access to HIV prevention services among AGYW
3. Increased awareness and improved response to SGBV cases at community level
4. Improved livelihood for girls and young women as a measure for HIV prevention
5. Contribute to behaviour change and uptake of HIV prevention services among young women

IMPLEMENTATION ARRANGEMENTS

The program implementation arrangements will provide for the required capacity for efficient and effective program delivery as well as ensure accountability of the program implementation. The program will bring together a number of stakeholders for program delivery both at national and county level. It is therefore necessary to establish clarity in regard to their roles, responsibilities and accountabilities; and

[20] "Health Choices" and ""Shuga" are evidence based intervention that have several modules delivered through video and facilitator assisted discussion to a group of young people over a period of about 3 months. The group goes through a serious of sessions focusing on different topics and are allowed time to practice what they learn before proceeding to the next module in order to reinforce behaviour change.

establish systems and mechanisms for evolving consensus and ensuring coordination for achieving the objectives. The key structures involved are as follows:

1) **HIV ICC** is responsible for supervision of all activities (capacity assessments, technical guidance, Financial Management, procurement, safeguards, QA/QC, Monitoring and Evaluation etc.) carried out by the PR. They will also review the quarterly progress reports on the program implementation and deliverables.
2) **HIV Prevention Technical Working Group** is responsible for the overall technical and quality review of the AGYW interventions carried out for technical soundness and coordination with other AGYW programs in the country.
3) **County AYP Technical Working Group** is responsible for the management and supervision of the program activities carried out under the program at county level. The team will also be responsible for proper coordination with other AGYW programs in the county, accountability during program implementation and sustainability of the interventions and its benefits beyond the life of the program in the county.
4) **The principle Recipient** is responsible for program implementation and budget execution. The PR's overall role is to monitor, coordinate, and manage the program; with appropriate quality assurance measures to ensure compliance with the agreed deliverables.
5) **The 10 Sub Recipients** are responsible for program coordination and implementation, monitoring and evaluation at the program implementation area as well as coordination with key stakeholders at community, sub county and county levels.

The involvement with relevant ministries at national and county level notably the ministry of health, Ministry of education, ministry of gender and youth affairs, ministry of interior among others is critical for multi-sectoral coordination of the AGYW interventions. In addition, relevant civil society organizations and institutes working with AYP in each of the county may be needed given the nature of the activities, which may cut across sectors.

PROGRAM IMPLEMENTATION DESIGN

Phase I: October to December 2018

1. Entry meeting with key sectors in each of the 4 county government.
2. Orientation of the implementing partners on the interventions and implementation arrangement
3. Meeting with key stakeholders at County, Sub County and Community levels.
4. Household & beneficiary re-verification– use of qualitative methods e.g. community mapping, wealth ranking, focus groups, interviews.
5. Implementation of two intervention – direct cash transfers and dignity kit distribution.
6. Carry out a Post Distribution Monitoring (PDM) to re-inforce accountability, improve programming, cash payments methodologies and identify and prevent protection risks.
7. Training and implementation of the IFRC reporting system.
8. Develop an M&E frameworks with clear indicators for AYP interventions.

Note that all the activities under the phase above have been implemented. The remainder have been moved to phase II

Phase II: January to June 2019

1. Prepare baseline information collection tools.
2. Baseline data collection for the program to generate baseline data as base indicators against which the outcome of the interventions will be assessed.
3. Capacity building of the implementing partners to prepare them for the implementation phase
4. Agreement with key service providers on service access to AGYW per county
5. Strengthening of the Adolescent TWGs and Gender Committees in each of the 5 counties to bring on board other developmental partners and coordinate the response.
6. Training of Master trainers and TOTs for each EBI planned
7. Mapping the community structures for activity implementation

8. Structure and implement the EBIs and structured outreaches to reach AGYW in community settings
9. Implementation of a 360 degrees system that will track EBIs, commodity distribution as well reporting.
10. Assessment of the immediate social outcomes of the 2 intervention. Conduct a study on immediate social effect of distributing cash and dignity kits amongst the beneficiaries.
11. Based on the findings from the study and assessment at the end of phase II, a review will be done to identify challenges and implement recommendation to further improve the program.

Phase III: July 2019 to June 2021

1. Implementation of all the additional interventions as agreed with the relevant stakeholders in a systematic and continuous basis.
2. Technical support, coaching and supervision of the activities being implemented by the Implementing partners
3. Conduct Routine spot check and RDQA for the commodities and key activities.
4. Conduct end line evaluation to measure impact of the program

BENEFICIARY MANAGEMENT

Through International federation of Red Cross and Red Crescent movement, the program will utilize the robust technology that has been in use worldwide for the other emergencies cash transfer programs. The system has the capacity for the following;

- Operate both closed and open loop cash transfers. It can facilitate Cash disbursement either directly or through mobile transfers
- Tracking commodities and services received by each beneficiaries.
- Generate Financial and programmatic reports

KRCS will maintain the database. All beneficiaries will use there biometrics and/or iris identification to receive cash, commodities and other key services.

QUALITY ASSUARANCE

Control and accountability are critical during the life cycle of a program. In phase 2 of the program quality assurance will be regularized and develop risk mitigation measures. Some of the controls to be implemented are as follows

1. Promote community accountability and feedback mechanism for KRCS and monitor CT feedback
2. Verifying competency of the trained EBI TOT whether they have the necessary facilitation skills required for learning to be enhanced.
3. Check adherence on the conditionality if the CT by the beneficiaries
4. Follow up on HTS proficiency testing and qualification of the HTS providers
5. Confirm girls received the essential package of services and report
6. Test suitability of the service providers is they are youth friendly and non-discriminative
7. Evaluate comprehensiveness of the services rendered
8. Assess the use of cash by the girls through post distribution monitoring
9. Audit the CT software regularly
10. Ascertain eligibility of the beneficiaries
11. Assess agents capacity and efficiency in disbursing cash

MONITORING AND REPORTING

All the above activities will be monitored to assess if the program is achieving its expected impact on the society through the M&E framework. A thorough monitoring and evaluation including community

monitoring of the interventions will ensure learning and continued improvements in the response. An evaluation will be carried out both during and after implementation process and will include;

1. Formative evaluation
2. Process evaluation
3. Outcome evaluation