Ministry of Health

NATIONAL GUIDELINES

for HIV and STI Programming among Transgender People

NASCOP

National Guidelines for HIV and STI Programming among Transgender People
National AIDS & STI Control Programme
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National Guidelines for HIV and STI Programming among Transgender People

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FOREWORD

The HIV epidemic in Kenya is characterised as mixed. The epidemic is generalised among the general population—with an HIV prevalence of 4.9% among people between the ages of 15 and 64 years—but it is concentrated among key populations, who disproportionately bear the burden of infection. Because of behavioural, biological, and structural factors that heighten their risk of and vulnerability to infection, HIV prevalence is 29.3% among female sex workers (FSWs), 18.2% among men who have sex with men (MSM), and 18.7% among people who inject drugs (PWID). NASCOP'S Key Populations Programme therefore targets these populations with a combination of behavioural, biomedical, and structural interventions that are tailored to reduce their HIV risk and vulnerability.

High HIV burden in transgender populations has been documented worldwide, yet some countries do not prioritize transgender people for HIV prevention programming. A recent study in Kenya found that HIV incidence among transgender women was 20.6 per 100 person-years, compared to 5.1 per 100 person-years among men who have sex with men exclusively.[1] This shows that transgender people urgently need to be given priority in HIV prevention programming.

In 2018 Kenya conducted a key population size estimation study that also mapped transgender people. The study found an estimated 4,305 transgender people in FSW and MSM hotspots. Though Kenya has been reaching some transgender people through the existing FSW and MSM programmes, it is essential to tailor HIV prevention interventions to specifically address the needs of transgender people.

To address this gap, NASCOP'S Key Populations Programme, in partnership with transgender community members, implementing partners, and donors, has developed these guidelines to standardize programming and the provision of services for the transgender community in the country.

It is our hope that these guidelines will enable Kenya to reduce the number of new HIV infections by improving programme coverage, quality, and effectiveness among the transgender community.

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[1] Kimani M, van der Elst EM, Chiro O, Odour C, Wahome E, Kazungu W, Shally M, de Wit TFR, Graham SM, Operario D, and Sanders EJ. 2019. PrEP interest and HIV-1 incidence among MSM and transgender women in coastal Kenya. *J Int AIDS Soc.* 22(6):e25323. doi: 10.1002/jia2.25323.

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CASCO	County AIDS and STI Coordinator
CIN	Cervical Intraepithelial Neoplasia
COE	Committee of Experts
DIC	Drop-In Centre
EATHAN	East African Trans Health and Advocacy Network
EC	Emergency Contraception
EpiC	Meeting Targets and Maintaining Epidemic Control
FSW	Female Sex Worker
GBMSM	Gay Bisexual Men Who Have Sex with Men
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HOYMAS	Health Options for Young Men on HIV/AIDS/STI
HRT	Hormone Replacement Therapy
HTS	HIV Testing Services
IEC	Information, Education and Communication
ITGNC	Intersex, Transgender & Gender Nonconforming
KASF	Kenya AIDS Strategic Framework
KHIS	Kenya Health Information System
KP	Key Population
M&E	Monitoring and Evaluation
MAAYGO	Men Against AIDS Youth Group
MOH	Ministry of Health
MPEG	Mamboleo Peer Empowerment Group
MSM	Men Who Have Sex with Men
MSW	Male Sex Worker
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
NTDS	National Transgender Discrimination Survey
NYARWEK	Nyanza Rift Valley and Western Kenya Network
PEP	Post-Exposure Prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
TEA	Transgender Education and Advocacy
TSU	Technical Support Unit
TWG	Technical Working Group
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
VOWWEK	Voices of Women in Western Kenya
WHO	World Health Organization

GLOSSARY

Cisgender
A person who identifies with his or her assigned-at-birth gender.

Cishet
A person who is both cisgender and heterosexual. A person is cishet if he or she is cisgender, meaning identifying with his or her assigned-at-birth gender, as well as heterosexual, or attracted exclusively to people of the opposite sex.

Gender
Gender refers to the roles, behaviours, activities, attributes and opportunities that any society considers appropriate for boys and girls, and men and women. Gender also refers to the relationships between people and can reflect the distribution of power within those relationships.[2]

Gender-affirming surgery
Surgical procedures that change a person's sexual characteristics to better reflect their gender identity. These surgeries include chest contouring, breast augmentation, orchiectomy, vaginoplasty, hysterectomy, clitoral release, metoidioplasty, and phalloplasty. Surgeries for transgender people can give relief from gender dysphoria, increase safety and comfort, and lessen or eliminate the need to take hormone therapies. "Sex change surgery" is considered a derogatory term by many.

Gender dysphoria
A conflict between a person's physical or assigned gender and the gender with which he/she/they identify. Emotional and mental dysphoria is significant distress and/or difficulty functioning, associated with the conflict between the way they feel and think about themselves. Physical dysphoria is discomfort with the gender they were assigned, and is sometimes described as being uncomfortable with their body.

Gender expression
How a person represents or expresses their gender identity to others, often through behaviour, clothing, hairstyle, voice, or body characteristics.

Gender identity
An individual's internal personal sense and experience of gender.

Gender nonconforming
Gender expression that does not match masculine or feminine gender norms. People who exhibit gender variance may be called gender variant, gender nonconforming, gender diverse, gender atypical or non-binary, and may be transgender or otherwise variant in their gender identity. In the case of transgender people, they may be perceived, or perceive themselves as, gender nonconforming before transitioning, but might not be perceived as such after transitioning. Some intersex people may also exhibit gender variance.

Hormonal therapy
Transgender hormone therapy is a form of hormone replacement therapy (HRT) in which hormonal medications are administered to transgender or gender variant individuals for the purpose of more closely aligning their secondary sexual characteristics with their gender identity.

Intersex
An umbrella term used to describe a wide range of innate bodily variations of sex characteristics. Intersex people are born with physical sex characteristics (such as sexual anatomy, reproductive organs, hormonal patterns and/or chromosomal patterns) that do not fit typical definitions for male or female bodies. Intersex conditions are also known as differences in sex development (DSD).

[2] Manandhar M, Hawkes S, Buse K, Nosrati E, Magar V. 2018. Gender, health and the 2030 agenda for sustainable development. *Bulletin of the World Health Organization*. 96:644-653. doi: http://dx.doi.org/10.2471/BLT.18.211607.

Key population
UNAIDS considers gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and prisoners and other incarcerated people as the five main key population groups that are particularly vulnerable to HIV and frequently lack adequate access to services.

Sex
Refers to the biological characteristics that define humans as female, male, or intersex. It refers to biological diversity. While male sex and female sex have few variations, intersex sex has 46 variations.

Sexuality
Encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors.

Sexual orientation
A term used to describe sexuality, using sex of the persons of attraction to classify sexuality of the subject. We have heterosexual sexuality (attracted to opposite sex), homosexual sexuality (lesbian and gay), bisexuality (attracted to both sexes), and asexuality.

Transgender
An umbrella term for people whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth; it includes people who are transsexual, transgender or otherwise gender nonconforming.[3] "Trans" is shorthand for "transgender." (Note: Transgender is correctly used as an adjective, not a noun, thus "transgender people" is appropriate but "transgenders" and "tranny" are often viewed as disrespectful.)

Transgender man
A term for a transgender individual who identifies as a man and does not conform to the gender (woman) assigned to their assigned sex at birth. This can sometimes be shortened to "transman."

Transgender woman
A term for a transgender individual who identifies as a woman and does not conform to the gender (man) assigned to their assigned sex at birth. This can be shortened to "transwoman."

Transition(ing)
A process wherein one begins to live and socialize as the gender with which they identify, rather than the gender they were assigned at birth. Transitioning may include medical and legal aspects, such as taking hormones, having surgery, or changing identity documents (e.g., driver's license, passport, and other identity documents) to reflect one's gender identity. Medical and legal steps are often difficult for people to afford.

Transphobia
Irrational fear of, aversion to, or persistent discrimination against transgender people. Transphobia can take many forms, including negative attitudes and beliefs, aversion to and prejudice against transgender people, irrational fear and misunderstanding, mis-gendering, derogatory language, bullying, abuse, and even violence. The stress of transphobia on transgender people can be very harmful and can cause depression, fear, isolation, hopelessness, and suicide.

Transgender population
Transgender people have a gender identity or gender expression that differs from their sex assigned at birth. Transgender, often shortened as trans*, is also an umbrella term. In addition to including people whose gender identity is the opposite of their assigned sex (transgender men and transgender women), it may include people who are not exclusively masculine or feminine (people who are non-binary or genderqueer, including bigender, pangender, genderfluid, or agender).

Transsexual
Is a term that explicitly references medical transitioning (e.g., transsexual FtM denotes female to male while transsexual MtF denotes male to female. Medical transitioning can be surgical or through hormone replacement therapy.

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[3] World Health Organization (WHO). 2016. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. Geneva: World Health Organization. https://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/.

INTRODUCTION

The HIV epidemic in Kenya is characterized as mixed. The epidemic is generalised among the general population—with an HIV prevalence of 4.9% among people between the ages of 15 and 64 years—but it is concentrated among key populations, who disproportionately bear the burden of infection. Because of behavioural, biological, and structural factors that heighten their risk of and vulnerability to infection, HIV prevalence is

29.3%
among female sex workers (FSWs)

18.2%
among men who have sex with men (MSM)

18.7%
among people who inject drugs (PWID)

NASCOP'S Key Populations Programme therefore targets these populations with a combination of behavioural, biomedical, and structural interventions that are tailored to reduce their HIV risk and vulnerability.

There is growing concern to improve HIV-prevention efforts among transgender people, because research findings show a high HIV burden among them, especially among transgender women.[4] In a meta-analysis assessing the burden of HIV infection among transgender women worldwide, the pooled HIV prevalence was 19.1%.[5]

A recent study in Kenya found that HIV incidence among transgender women was 20.6 per 100 person-years, compared to 5.1 per 100 person-years among men who have sex with men exclusively.[6] This shows that transgender people urgently need to be given priority in HIV prevention programming in Kenya.

In 2018 Kenya conducted a key population size estimation study that also mapped transgender people. The study found an estimated 4,305 transgender people in FSW and MSM hotspots. Though Kenya has been reaching some transgender people through the existing FSW and MSM programmes, it is essential to tailor HIV prevention interventions to specifically address the needs of transgender people.

This information and evidence was used to advocate for inclusion of transgender people as a key population subpopulation in the Kenya AIDS Strategic Framework II (2020-2024).

Historically, HIV studies and programmes have conflated men who have sex with men with transgender people, especially transgender women.[7] Leaders in the transgender community, globally, have called for an end to this conflation and for the recognition of the transgender population as a unique population, different from MSM. The World Health Organization's 2016 consolidated guidelines for key populations state, "the high vulnerability and specific health needs of transgender people necessitate a distinct and independent status in the global HIV response."[8]

In regards to HIV and AIDS, in 2014 UNAIDS launched the ambitious 90-90-90 targets for HIV treatment:

BY 2020

90%	90%	90%
of all people living with HIV	of all people with diagnosed HIV infection	of all people receiving antiretroviral therapy
will know their HIV status	will receive sustained antiretroviral therapy	will have viral suppression [9]

[4] United Nations Development Programme (UNDP) et al. 2016. Implementing comprehensive HIV and STI programmes with transgender people: Practical guidance for collaborative interventions. New York (NY): United Nations Development Programme. https://www.unfpa.org/sites/default/files/pub-pdf/TRANSIT_report_UNFPA.pdf.

[5] Baral SD, Poteat T, Strömdahl S, Wirtz AL, Guadamuz TE, Beyrer C. 2013. Worldwide burden of HIV in transgender women: A systematic review and meta-analysis. *Lancet Infect Dis.* 13(3):214-22. doi: 10.1016/S1473-3099(12)70315-8.

[6] Kimani M, van der Elst EM, Chiro O, Odour C, Wahome E, Kazungu W, Shally M, de Wit TFR, Graham SM, Operario D, and Sanders EJ. 2019. PrEP interest and HIV-1 incidence among MSM and transgender women in coastal Kenya. *J Int AIDS Soc.* 22(6):e25323. doi: 10.1002/jia2.25323.

[7] Poteat T, German D, Flynn C. 2016. The conflation of gender and sex: Gaps and opportunities in HIV data among transgender women and MSM. *Glob Public Health.* 11(7-8): 835–848. doi:10.1080/17441692.2015.1134615.

[8] World Health Organization (WHO). 2016. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. Geneva: World Health Organization. https://www.who.int/hiv/pub/guidelines/keypopulations/en/.

[9] Joint United Nations Programme on HIV/AIDS (UNAIDS). 2014. 90-90-90: An Ambitious Treatment Target To Help End the AIDS Epidemic. Geneva: Joint United Nations Programme on HIV/AIDS. https://www.unaids.org/sites/default/files/media_asset/90-90-90_en.pdf.

UNAIDS' ambitious but achievable targets fell right into place with the Sustainable Development Goals (SDGs) launched in 2015. SDG 3, "Good health and well-being," set 13 targets. The targets relevant to HIV and AIDS programming include the following:

- By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.
- Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.
- By 2030, ensure universal access to sexual and reproductive health care services, including family planning, information and education and the integration of reproductive health in national strategies and programmes.

Kenya has adopted Universal Health Coverage (UHC), which is one pillar of the President's Big Four Agenda, with an aspiration that by 2022 everyone in Kenya will be able to use the essential health services through a single unified benefit package without the risk of financial catastrophe. Of course, UHC is not just a financial aspiration. UHC means that all people and communities can use promotive, preventive, curative, rehabilitative, and palliative health services, and the services should be of sufficient quality to be effective.

UHC is one of the pillars of health care, along with people-centred health, inclusive leadership, and health in all policies. Article 43 of the Constitution of Kenya (2010) guarantees that "every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care," enshrined in the Bill of Rights.[10]

UHC is also in line with the WHO's Constitution, which declares that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, and that governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures.[11]

Several factors influence transgender people's HIV risk and vulnerability. The transgender community's—and especially transgender women's—experience of transphobia, discrimination, violence, and criminalisation can have severe and damaging effects on their physical and mental health, and can limit their access to and use of vital services.[12] They also suffer power imbalances in relationships and alienation from family and friends. Policies and laws do not recognize the existence of transgender people, so many of them are not given information, commodities, and treatment that they need to protect themselves from HIV infection. Such exclusion increases transgender people's vulnerability to HIV infection.

Achieving access to health care for transgender people requires acceptance of diverse expressions of identity and gender. Programming with transgender people needs a multisectoral approach to include departments for social protection, the registration of persons department, and the national health investment fund, among other departments relevant to the transgender community. The East African Transgender Health and Advocacy Network (EATHAN) recommends that government bodies and non-governmental organisations collaborate to gather data and information that will help in shaping intervention activities.[13] Additionally, the 2019 National Transgender Discrimination Survey (NTDS) recommended increasing transgender people's access to transgender sensitive health care.[14] It is against this backdrop that NASCOP has developed national guidelines for HIV and STI programming among transgender people.

GUIDING PRINCIPLES

The purpose of these guidelines is to ensure effective STI and HIV programming among transgender people through the delivery of quality combination prevention interventions. In engaging the transgender community, the following principles will be adhered to:

1. **Meaningful involvement of the transgender community**
   Meaningful involvement, participation, and leadership of the transgender community in the design, implementation,

[10] Kenya National Commission on Human Rights. 2017. The Right to Health: A Case Study of Kisumu County. Nairobi: Kenya National Commission on Human Rights. http://www.knchr.org/Portals/0/OccasionalReports/The%20Right%20to%20Health%20in%20Kisumu%20County.pdf?ver=2018-01-18-142546-863

[11] World Health Organization. 2006. Constitution of the World Health Organization. *Basic Documents*, Forty-fifth edition, Supplement, October 2006. https://www.who.int/governance/eb/who_constitution_en.pdf

[12] United Nations Development Programme (UNDP) et al. 2016. Implementing comprehensive HIV and STI programmes with transgender people: Practical guidance for collaborative interventions. New York (NY): United Nations Development Programme. https://www.unfpa.org/sites/default/files/pub-pdf/TRANSIT_report_UNFPA.pdf

[13] Imathiu K, Muruga BW, Leone D, Tirop-Salat J. 2018. Nilinde Nisife: How Safety & Security Affects Access to Health & HIV Services among ITGNC Persons in East Africa. Nairobi: EATHAN (East Africa Trans Health & Advocacy Network).https://www.kelinkenya.org/wp-content/uploads/2018/06/Nilinde-Nisife-EATHAN-Report-June2018.pdf.

[14] Trans* Alliance, Nduta S, Smith L, and Okeyo N. 2020. Transform: A Report of the National Transgender Discrimination Survey in Kenya (NTDS) - A Baseline Study of Transgender Persons in Kenya: Life Experiences and Access to Health Services. Nairobi: Epilson Publishers.

monitoring, and evaluation of programmes are essential for building transgender people's trust, making programmes more comprehensive and more responsive to their needs, and creating more enabling environments for HIV prevention.

2. **Integration of services**
   Transgender people commonly have multiple co-morbidities and poor social situations. Their needs vary, from health to social inclusion and gender identity. Integration of services for transgender people with existing structures and services provides the opportunity for client-centred prevention, diagnosis, treatment, and care.

3. **Multisectoral approach to implementation**
   The needs of transgender people are diverse, so programming should take a multisectoral approach. The entry point for the community is through the HIV programme, but working with other sectors, such as departments of social protection and law enforcement, is key to ensure that other challenges faced by transgender people are addressed to reduce barriers to health services.

Other guiding principles include the following:

- Non-maleficence (do no harm) and beneficence (do what's good for the person).
- Meaningful engagement—Recognize that the beneficiaries (transgender people) are part of the solution through their lived experiences and their participation.
- Human-centred approach, with respect for transgender people.
- Rights-based approach—Uphold the human rights and dignity of transgender people (e.g., service use should be voluntary, not mandatory).
- Flexibility, innovation, and iterative learning—Create an environment that encourages flexibility, innovation, and learning.
- Evidence-based approach to programming.

CHAPTER 1

Epidemiology of HIV among Transgender People in Kenya

01

1.1 INTRODUCTION

HIV prevalence is especially high among transgender people because of a myriad of factors that increase their risk of and vulnerability to infection. High-risk sexual behaviour and unsafe injecting practices increase their HIV risk. Structural factors, such as poverty, stigma, discrimination, and violence, increase their vulnerability to infection.

A baseline study conducted in Kenya by Trans* Alliance found that many transgender people face significant barriers to HIV care and other medical and social support services because providers often discriminate against transgender clients and are uninformed on gender-affirming care. Trans* Alliance reported that only 16% of transgender people who reported to be HIV positive were in care and treatment. A 2019 study in Nairobi found that transgender people compared to cisgender GBMSM were more likely never to have tested for HIV (15.0% v 6.8%).

To reduce HIV vulnerability and risk among transgender people, the Ministry of Health, through NASCOP and many partners, implements behavioural, biomedical, and structural interventions—described in Chapter 2—through Kenya's Key Populations Programme.

1.1.1 Prioritisation of tailored programming for transgender people

The Government of Kenya initiated HIV prevention programming for populations at elevated risk for HIV within the second Kenya National AIDS Strategic Plan period (2005-2010). The Key Populations Programme was launched on 7 July, Saba Saba Day, 2009. The decision to target key populations was premised on increased global recognition that HIV-related morbidity and mortality were significantly higher among sex workers, clients of sex workers, men who have sex with men, transgender people (including transgender sex workers), people who inject drugs, and members of the adult population whose livelihoods were inextricably linked with the sex trade, such as the fishing community. It was also recognized that clients of sex workers and men who have sex with men can function as epidemiological bridges by which HIV spreads from key populations to the general population.

In the initial years, Kenya's Key Populations Programme focussed on three subpopulations: female sex workers, men who have sex with men, and people who inject drugs. Although some transgender people received services through MSM and FSW programmes, these services were not tailored to their specific needs and did not address their distinct risks and vulnerabilities. Moreover, programming among transgender people was difficult because they were not optimally organised and did not prioritise HIV prevention as a critical need. However, between 2013 and 2018 transgender people formed community organisations and began advocacy. These organisations include Transgender Education and Advocacy (TEA), Trans Alliance, East African Transgender Health and Advocacy Network (EATHAN), and Jinsiangu, as well as regional organisations, such as NYARWEK and Pwani Trans, and others specific to certain groups within the transgender population, such as Trans Sisters and Voices of Women.

With increased availability of evidence and advocacy, in 2020 Kenya officially recognized transgender people as a key population in the Kenya AIDS Strategic Framework II.

1.1.2 Goal of the guidelines

These guidelines were formulated to inform and standardise the design and implementation of STI and HIV programmes and services for transgender people to reduce HIV transmission.

1.1.3 Rationale for programming guidelines for transgender people

NASCOP has developed guidelines on programming for sex workers, men who have sex with men, and people who inject drugs. However, those guidelines do not adequately address issues faced by transgender people or provide thorough operational direction for programme implementation with transgender people. Hence there was a need for a document that provides

[15] Trans* Alliance, Nduta S, Smith L, and Okeyo N. 2020. Transform: A Report of the National Transgender Discrimination Survey in Kenya (NTDS) - A Baseline Study of Transgender Persons in Kenya: Life Experiences and Access to Health Services. Nairobi: Epilson Publishers.

[16] Smith AD, Kabuti R, Irungu E, Nyamweya C, Fearon E, Weatherburn P, Bourne A, Kimani J. 2019. The Burden of HIV and Other STIs among Transgender Persons in Nairobi, Kenya. CROI (Conference on Retroviruses and Opportunistic Infections) Conference, in CROI 2019, p. 332. https://www.croiconference.org/abstract/burden-hiv-and-other-stis-among-transgender-persons-nairobi-kenya/.

[17] National AIDS and STI Control Programme (NASCOP), Ministry of Health. 2016. Reaching the Unreached: The Evolution of Kenya's HIV/AIDS Prevention Programme for Key Populations. Nairobi: National AIDS and STI Control Programme, Ministry of Health.

[18] Ministry of Health. 2020. Kenya AIDS Strategic Framework II (2020–2024). Nairobi: Ministry of Health.

guidelines for transgender people programmes and explains their implementation, especially at a time when Kenya is initiating exclusive programmes for transgender people.

1.2 HIV IN KENYA

Kenya has the fifth-largest number of persons living with HIV in the world, with about 1.3 million adults living with HIV and about 36,000 adults getting infected annually.[19] The first case of HIV in Kenya was detected in 1984. By the mid-1990s, HIV was a major cause of illness in the country, putting huge demands on the health care system and the economy. In 1996, 10.5% of Kenyans were living with HIV.

Prevalence has more than halved since then, with 4.9% of adults aged 15–64 years and 0.7% of children aged 0-14 years living with HIV by 2018. This progress is due mainly to the rapid scaling up of HIV treatment and care, with 96% of adults and 93% of children living with HIV in Kenya accessing ART in 2018.[20]

Kenya's HIV epidemic is driven by sexual transmission and is mixed, meaning it is generalised in the general population but concentrated among people from key populations, which include female sex workers, men who have sex with men, transgender people, and injecting drug users. In 2009, it was estimated that 30% of new annual HIV infections in Kenya were among these groups, though they represented less than 2% of the population.[21]

Geographic location is also a factor in the epidemic's distribution, with the top five high-prevalence counties all being in the western part of the country. The counties include Homa Bay: 19.6%, Kisumu: 17.5%, Siaya: 15.3%, Migori: 13.0%, and Busia: 9.9%. As a result, HIV prevalence ranges from <0.1% in Garissa to 19.6% in Homa Bay County.[22]

1.3 HIV AMONG TRANSGENDER PEOPLE

» Global and Kenyan perspectives

From the few HIV related studies on transgender people and the World Health Organization's *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*, the following is evident:

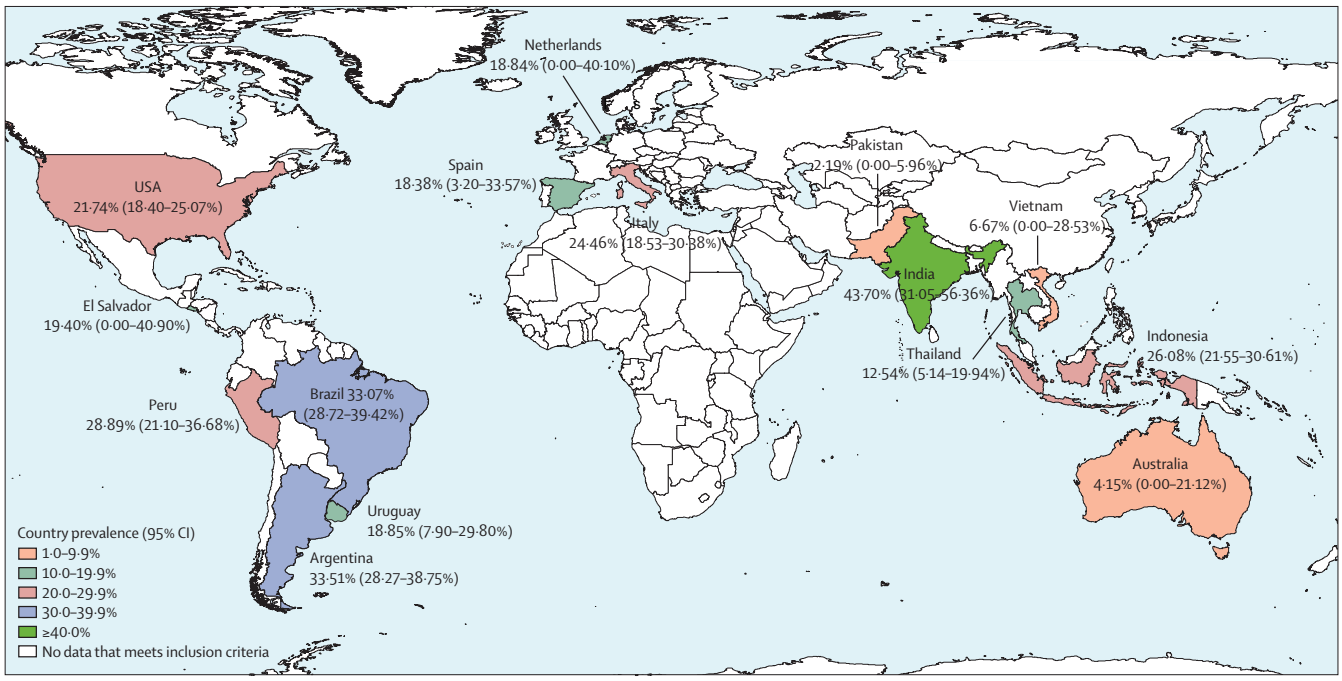
- Transgender women had odds of HIV infection 49 times greater than all adults of reproductive age.[23] A separate meta-analysis of HIV among transgender women sex workers found that these women had a pooled HIV prevalence of 27.3%, compared with 14.7% among transgender women who did not engage in sex work.[24]
- The high vulnerability and specific health needs of transgender and/or gender-nonconforming people necessitates a distinct and independent status in the global HIV response.[25]
- Transgender-specific HIV data are limited and focus primarily on transgender women, who show a heavy burden of HIV disease (Figure 1). Limited information about transgender men exists.

[23] Baral, S. D., Poteat, T., Strömdahl, S., Wirtz, A. L., Guadamuz, T. E., & Beyrer, C. 2013. Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. *Lancet Infectious Diseases*, 13(3), 214–222. doi:10.1016/s1473-3099(12)70315-8.

[24] Operario D, Soma T, and Underhill K. 2008. Sex work and HIV status among transgender women: Systematic review and meta-analysis. J Acquir Immune Defic Syndr. 48(1): 97–103. doi: 10.1097/QAI.0b013e31816e3971.

[25] World Health Organization (WHO). 2016. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. Geneva: World Health Organization. https://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/.

Figure 1. Worldwide burden of HIV in transgender women [26]



A global meta-analysis of HIV prevalence among transgender women documented 19.1% HIV prevalence among 11,066 transgender women across 15 countries.[27] A recent study in Kenya showed risk of HIV acquisition among transgender women to be 20.6%, compared to 4.5% among men who have sex with men exclusively.[28] A 2017 study in Nairobi found that transgender people compared to cisgender GBMSM were more likely to be HIV positive (39.9% v 24.6%), and to have a confirmed STI.[29]

1.4 HIV RISK, VULNERABILITY, AND THE NEEDS OF TRANSGENDER PEOPLE

HIV prevalence among transgender people is high because of behaviours that increase their risk of infection and circumstances that make them vulnerable.

Risk

UNAIDS defines HIV risk as, "the risk of exposure to HIV or the likelihood that a person may acquire HIV," usually as a result of specific behaviours that enable HIV transmission to occur.[30] Unprotected sex; sex with multiple, concurrent partners; and sharing injecting equipment are behaviours that carry high risk of HIV transmission among transgender people.

Vulnerability

An individual is vulnerable to HIV when his or her or their ability to avoid infection is diminished by inadequate personal knowledge or skills; by cultural norms that validate risky behaviours; by barriers to health care; or by circumstances that make risk reduction difficult or impossible. Many of the factors that cause vulnerability are structural, or beyond the control of individuals.

By influencing access to income, information, prevention services and commodities, and care and treatment, structural factors affect how well individuals or populations can protect themselves from and cope with HIV infection. Structural factors include violence, punitive legislation and policing practices, harmful social and cultural norms (including practices, beliefs and laws that stigmatize and disempower certain populations), education, poverty, and health care quality and accessibility.

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[26] Baral, S. D., Poteat, T., Strömdahl, S., Wirtz, A. L., Guadamuz, T. E., & Beyrer, C. 2013. Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. *Lancet Infectious Diseases,* 13(3), 214–222. doi:10.1016/s1473-3099(12)70315-8.

[27] Baral, S. D., Poteat, T., Strömdahl, S., Wirtz, A. L., Guadamuz, T. E., & Beyrer, C. 2013. Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. *The Lancet Infectious Diseases.* 13(3), 214–222. doi:10.1016/s1473-3099(12)70315-8.

[28] Kimani et al. 2019. PrEP interest and HIV-1 incidence among MSM and transgender women in coastal Kenya. *J. Int. AIDS Soc.* 22(6):e25323. doi: 10.1002/jia2.25323.

[29] Smith AD, Kabuti R, Irungu E, Nyamweya C, Fearon E, Weatherburn P, Bourne A, Kimani J. 2019 The Burden of HIV and Other STIs among Transgender Persons in Nairobi, Kenya. CROI (Conference on Retroviruses and Opportunistic Infections) Conference, in CROI 2019, p. 332. https://www.croiconference.org/abstract/burden-hiv-and-other-stis-among-transgender-persons-nairobi-kenya/.

[30] Joint United Nations Programme on HIV/AIDS (UNAIDS). 2015. UNAIDS Terminology Guidelines 2015. Geneva: UNAIDS. https://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf.

» Needs

When planning HIV prevention programming for transgender people, it is important to recognize and respond to needs that affect their HIV risk and vulnerability. Transgender people's needs can be grouped into eight main categories:

- Gender identity related documentation
- Reform of laws that are unjustly used against transgender people
- Stigma and discrimination
- Health care
- Livelihood
- Social support
- Mental well-being
- Violence prevention and response

1.4.1
Gender identity related documentation

Transgender people need their gender identity to be legally recognised and correctly documented, because possessing accurate and consistent identification documents is essential to basic social and economic functioning in Kenya. But the documents of many transgender Kenyans do not match their gender identity, because obtaining documents that match their gender identity is a burdensome process.

Transgender people without valid documentation may face arbitrary arrest and detention by law enforcement, and are likely to have difficulty accessing services such as healthcare, banking, education, employment, and travel. The barriers and legal jeopardy created by incorrect documentation contribute to their HIV vulnerability.

Although the Audrey Mbugua Case set a major precedent in allowing for the alteration of gender markers in government issued documents, the legal grounding was limited to instances where the law did not explicitly provide for the requirement that a gender marker be included in the document (in this case, Ms Audrey Mbugua's academic certificate). In cases where the law requires a gender marker in a document (such as a birth certificate, passport, or national identity card), changing that gender marker is not a simple process.

1.4.2
Reform of laws that are unjustly used against transgender people

The police repeatedly and systematically arrest, fine, harass, and detain transgender people. Transgender people need protection from criminal laws and punitive provisions that are unjustly used against them.

Transgender people are often accused of violating Kenya's personation laws contained within the Penal Code, and the Sexual Offences Act of Kenya. Such violations include:

» Cross-dressing or impersonation

Unjust use of criminal laws includes when transgender people's gender expression is criminalised through "cross-dressing" or "impersonation" provisions that prohibit "posing as a woman," "cross-dressing," or "cross-dressing for immoral purposes." Such laws negate the existence of transgender people by supporting fixed, binary concepts of gender, based on moral or religious beliefs about strict gender roles for women and men that are determined by a person's sex assigned at birth.

» Immorality, public indecency, public nuisance, vagrancy, and loitering laws

Laws or regulations on "immoral" or "indecent" behaviour are applied in ways that penalise transgender people's gender expression. Public indecency or vagrancy laws are also often used to target transgender people in public places, even though such laws do not directly criminalise gender identity or expression.

» Laws related to homosexuality and sex work

Laws related to homosexuality and sex work are often used by law enforcement officials as a form of harassment and abuse. This unjust application of the law often falls disproportionately on transgender women, who are often considered by law enforcement officials to be men who have sex with men, whose behaviour is deemed to be criminal according to current laws.

» Falsification of documents

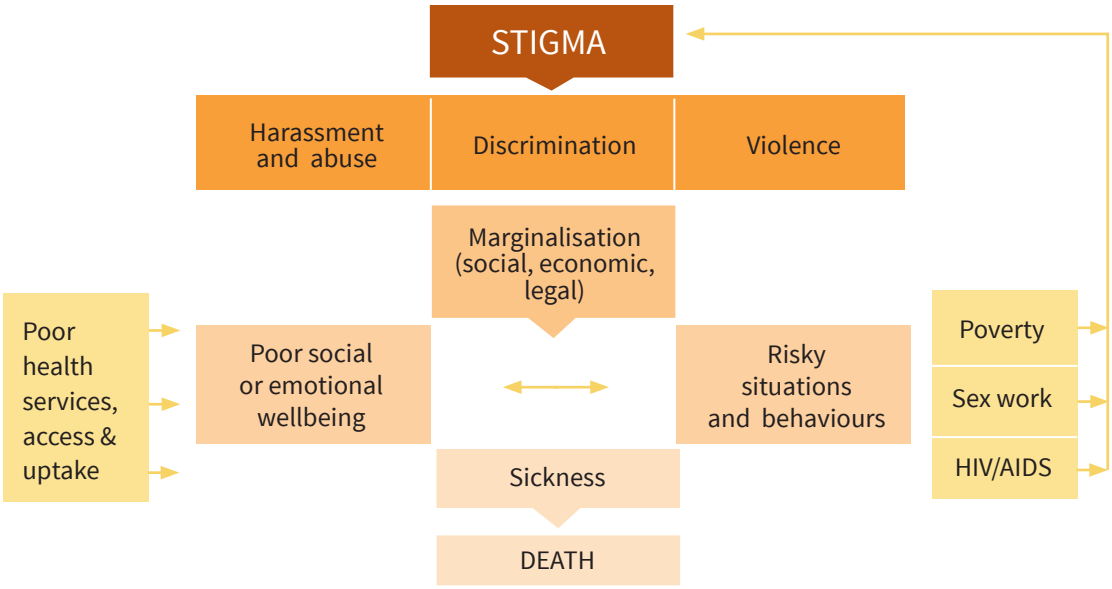
Due to the difficulty of legally amending gender markers in this region, transgender people may try to get fraudulent identity documents so they can navigate their daily lives based on their self-defined gender identity or expression.

1.4.3
Stigma and discrimination

A major barrier for transgender people is transphobia, which is prejudice against people whose gender identity[31] or gender expression[32] does not conform to social norms and expectations. It is a reaction to the real or perceived difference between the biological sex attributed to a person at birth and their gender identity or expression.

Beliefs, misconceptions, and biases against transgender people are at the root of isolation, rejection, stigma, and discrimination that make it difficult for transgender people to access vital services, and thereby contribute to their HIV vulnerability. Research identifies a slope from stigma to sickness (Figure 2), whereby the daily experience of social stigma and prejudice, as well as associated discriminatory, harassing, and abusive practices, is so consistent and marked as to nudge many transgender people towards the social, economic and legal margins of society, and damage their psychological health and well-being.[33]

Figure 2. Sigma-sickness slope[34]



1.4.4
Health care

Transgender people need access to health care services that acknowledge their gender identity and that treat them with dignity and respect. Barriers to health care contribute to transgender people's vulnerability to HIV infection.

In health care settings, transphobia often takes the form of derogatory labelling, demeaning interactions, and breaches of confidentiality. Lack of awareness, capacity, and preparedness to address transgender people's specific issues may prevent health care professionals from offering transgender friendly services. Stigma and discrimination against transgender people result in low HIV testing rates, limited engagement in HIV care, and reluctance to seek drug treatment and other coping services.

A transgender person trying to access treatment for an STI will struggle with identification forms and with the examination related to the treatment. Such health care services or prerequisites to treatment are referred to as transgender exclusionary, because they discourage transgender people from seeking medical services and from disclosing their sexual behaviour and health problems to health workers.

A recent study by Müller and others documented difficulties encountered when members of the LGBTI community in Kenya sought health care.[35] They found that 59% of participants had told a health care provider about their sexual orientation and/

[31] Gender identity is a person's internal, deeply felt sense of being male, female or some alternative gender or combination of genders. A person's gender identity may or may not correspond with her or his sex assigned at birth.

[32] Gender expression is a person's ways of communicating masculinity, femininity or some combination externally through their physical appearance (including clothing, hair styles and the use of cosmetics), mannerisms, ways of speaking and behavioural patterns.

[33] Winter S. 2012. Lost in transition: Transgender people, rights and HIV vulnerability in the Asia-Pacific region. Bangkok: United Nations Development Programme.

[34] Winter S, Diamond M, Green J, Karasic D, Reed T, Whittle S, Wylie K. 2016. Transgender people: Health at the margins of society. *The Lancet* 388(10042):P390-400. https://doi.org/10.1016/S0140-6736(16)00683-8.

[35] Müller A, Daskilewicz K, and the Southern and East African Research Collective on Health. 2019. Are we doing alright? Realities of violence, mental health, and access to healthcare related to sexual orientation and gender identity and expression in Kenya: Research report based on a community-led study in nine African countries. Amsterdam: COC Netherlands. http://www.ghjru.uct.ac.za/sites/default/files/image_tool/images/242/PDFs/Dynamic_feature/SOGIE%20and%20wellbeing_04_Kenya.pdf.

or gender identity. Almost a third of participants had been denied health care, and 35% reported being called names or being insulted by health care staff at some point. Participants' sexual orientation and gender identity also directly influenced health care, as 43% of participants reported trying to hide a health concern related to their sexual orientation or gender identity from a health care provider.

One of the most important services sought by transgender people—gender-affirming surgical and medical procedures—is often inaccessible to them. While hormones or surgery may be offered for cancer treatment, contraception, or reproductive health, transgender people find it challenging to access such treatments, as it is believed that in their case such treatments are cosmetic and medically unnecessary.

Transgender people need hormone replacement therapy (HRT), but many cannot access HRT practitioners. Currently there are no surgeons doing vaginoplasty or phalloplasty in Kenya. Medical professionals often refuse to do orchiectomy or top surgery, citing the "no harm" principle, cultural or religious objections, or an unwillingness to "interfere with God's creation." Consequently, many transgender people jeopardise their health by using unsafe equipment to inject themselves with hormones purchased without a prescription.

The routine health programme data and national surveys do not collect information about transgender people, but such information is essential for building a foundation of knowledge regarding the health and needs of transgender people.

1.4.5 Livelihood

Transgender people need equal inclusion and participation in the workforce. Transgender people have limited livelihood options due to transphobic violence, stigma, and discrimination in society and workplaces. Lack of national identification documents that match their gender identity and discriminatory employment practices are barriers to economic opportunities. Even when they get economic opportunities, stigma and harassment at their workplaces often cause them to leave work. Many transgender people are forced out of school because of transphobic bullying and violence. Hence, they do not complete education, and they become ineligible to apply for employment. These render them vulnerable to poverty and predispose them to risky occupations. For instance, lack of livelihood options is a key reason why a significant proportion of transgender people do sex work.

The National Transgender Discrimination Survey found that 49% of respondents were denied a job because of their gender identity status, 37% were denied promotion at work, and 42% lost their job for being transgender in the workplace.[36]

1.4.6 Social support

Families of many transgender people do not know how to deal with a transgender family member, because there is no societal point of reference on how to support them. Many transgender people will not fit in church settings due to transphobia and homophobia.

Mistreatment by relatives can lead transgender people to be homeless, to drop out from school, or to engage in sex work, all of which increase their HIV vulnerability. Family support can protect transgender people against health risks and can improve their self-esteem.[37]

1.4.7 Mental well-being

Transgender people's mental well-being needs include counselling to help them cope with gender dysphoria, and to reduce self-harm and destructive coping mechanisms such as drug abuse. But psychosocial services for transgender people are underdeveloped or nonexistent in most settings in Kenya.

Unaddressed mental health well-being issues, such as depression or anxiety, coupled with either emotional, physical, or social dysphoria, make transgender people vulnerable to HIV infection if such conditions lead to destructive coping mechanisms, such as drug abuse and self-harm behaviour, which elevate their risk of HIV infection. Low self-esteem may keep transgender

[36] Trans* Alliance, Nduta S, Smith L, and Okeyo N. 2020. Transform: A Report of the National Transgender Discrimination Survey in Kenya (NTDS) - A Baseline Study of Transgender Persons in Kenya: Life Experiences and Access to Health Services. Nairobi: Epilson Publishers.

[37] United Nations Development Programme et al. 2016. Implementing comprehensive HIV and STI programmes with transgender people: Practical guidance for collaborative interventions. New York (NY): United Nations Development Programme. https://www.unfpa.org/sites/default/files/pub-pdf/TRANSIT_report_UNFPA.pdf.

people in unhealthy relationships, which predispose them to intimate partner violence or weaken their bargaining power for safe and enjoyable sex.

Loneliness and feelings of being social pariahs can contribute to depression, self-harm, and despair, especially when transgender people are separated from family due to their identity. A recent study in Kenya found that about 28% of transgender respondents had attempted suicide due to rejection, discrimination, inability to meet daily needs, intimate partner violence, or other reasons.[38]

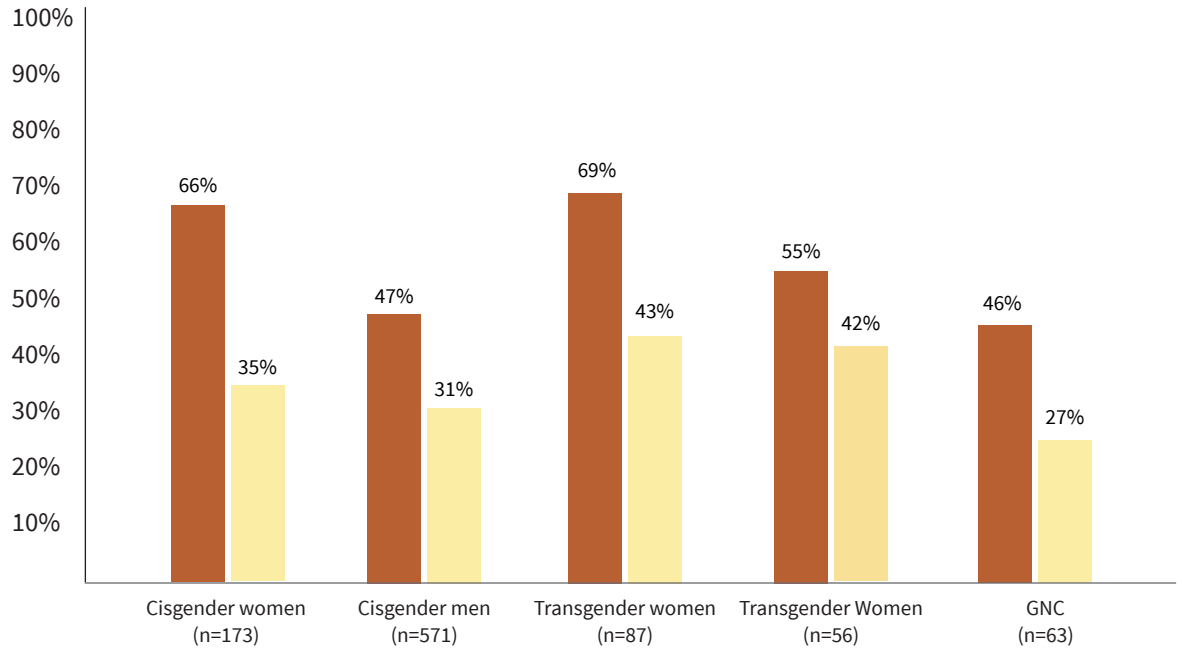
1.4.8
Violence prevention and response

Violence prevention and response among transgender people is a key programming priority. Global evidence demonstrates that HIV and violence are linked in multiple ways, whereby violence increases the risk of HIV, and living with HIV increases the risk of violence.[39] Experiences of violence limit HIV testing and decrease disclosure and adherence.[40]

In Kenya, it is commonly believed that violence toward transgender people is deserved and that transgender people bring this violence onto themselves. The public assigns responsibility for violence to the victims. These beliefs are used to justify physical and sexual violence, stigma, discrimination, and emotional abuse against transgender people.[41]

A recent study in Kenya found that vulnerability indicators for groups included in key population programming are greatly improved. However, transgender and gender nonconforming persons scored highest on negative indicators, such as being exposed to physical and sexual violence.[42] The study found that the proportion of lesbian or bisexual cisgender women who had experienced sexual violence by an intimate partner was double that found in the general population, and the proportion of transgender women (regardless of their sexual orientation) who had experienced sexual violence by an intimate partner was triple that found in the general population. Similar differences were also seen in physical violence, as shown in Figure 3.

Figure 3. Physical violence, by gender identity



[38] Trans*Alliance, Nduta, S., Smith, L.G., & Okeyo, N. 2020. Transform: A Report of the National Transgender Discrimination Survey in Kenya (NTDS) - A Baseline Study of Transgender Persons in Kenya: Life Experiences and Access to Health Services. Nairobi: Epilson Publishers.

[39] Decker MR et al. 2013. Estimating the impact of reducing violence against female sex workers on HIV epidemics in Kenya and Ukraine: a policy modeling exercise. Am J Reprod Immunol. 69(s1):122-32. doi: 10.1111/aji.12063.

[40] Joint United Nations Programme on HIV/AIDS (UNAIDS). 2010. Global Report: UNAIDS Report on the Global AIDS Epidemic 2010. Geneva: UNAIDS. http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/20101123_globalreport_en%5B1%5D.pdf.

[41] Linkages. 2016. The Nexus of Gender and HIV among Transgender People in Kenya. https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-kenya-tg-gender-analysis-2016.pdf.

[42] Müller A, Daskilewicz K, and the Southern and East African Research Collective on Health. 2019. Are we doing alright? Realities of violence, mental health, and access to healthcare related to sexual orientation and gender identity and expression in Kenya: Research report based on a community-led study in nine countries. Amsterdam: COC Netherlands. http://www.ghjru.uct.ac.za/sites/default/files/image_tool/images/242/PDFs/Dynamic_feature/SOGIE%20and%20wellbeing_04_Kenya.pdf.

Violence is sometimes particularly intense against those who are marginalised in other ways, such as transgender sex workers, young transgender people, transgender people living with HIV, transgender people who are currently transitioning and are therefore more likely to be identified as transgender, and transgender people who are drug users. They face cases of arbitrary detention, violence, and inhumane treatment by family members, intimate partners, and law enforcement agents.

While in custody, transgender women engaged in sex work are often mistreated. There have been numerous cases of police officers beating transgender Kenyans, both on the streets and within police stations, most often profiled as sex workers. The NTDS found that 43% of those interacting with police reported police officers treated them with disrespect, and over a third (38%) reported having been harassed by police officers.[43]

Some 28% of the sample reported that they were very uncomfortable seeking help from police, 27% of the respondents were somewhat uncomfortable, 18% were comfortable, and 12% indicated that they were somewhat comfortable.

Fears of being further subjected to stigma and discrimination and of being arrested for impersonation prevent transgender people from reporting violence, particularly to the authorities. Hence, in addition to the need for violence prevention, there is also a need to address barriers to justice for the transgender community.

The relationship between needs, vulnerability, risk, and outcomes is illustrated in Figure 4.

Figure 4. Summative logical model on needs, vulnerability, risk, and outcomes

NEEDS	VULNERABILITY	RISK	OUTCOMES
• Supportive policy environment/laws • Recognition of gender identity • Violence prevention and response • Transgender sensitive health care	• Stigma and poor mental health • Low educational achievement • Incarceration • Unemployment • Poverty/homelessness • Low service uptake	• High-risk sexual behaviour • Self-treatment • Substance use • Engagement in transactional sex and sex work	• High rates of HIV infection and low retention in care

[43] Trans* Alliance, Nduta S, Smith L, and Okeyo N. 2020. Transform: A Report of the National Transgender Discrimination Survey in Kenya (NTDS) - A Baseline Study of Transgender Persons in Kenya: Life Experiences and Access to Health Services. Nairobi: Epilson Publishers.

1.5 TRANSGENDER TYPOLOGIES – HIV PROGRAMMING BEYOND THE BINARY

» Who are transgender people?

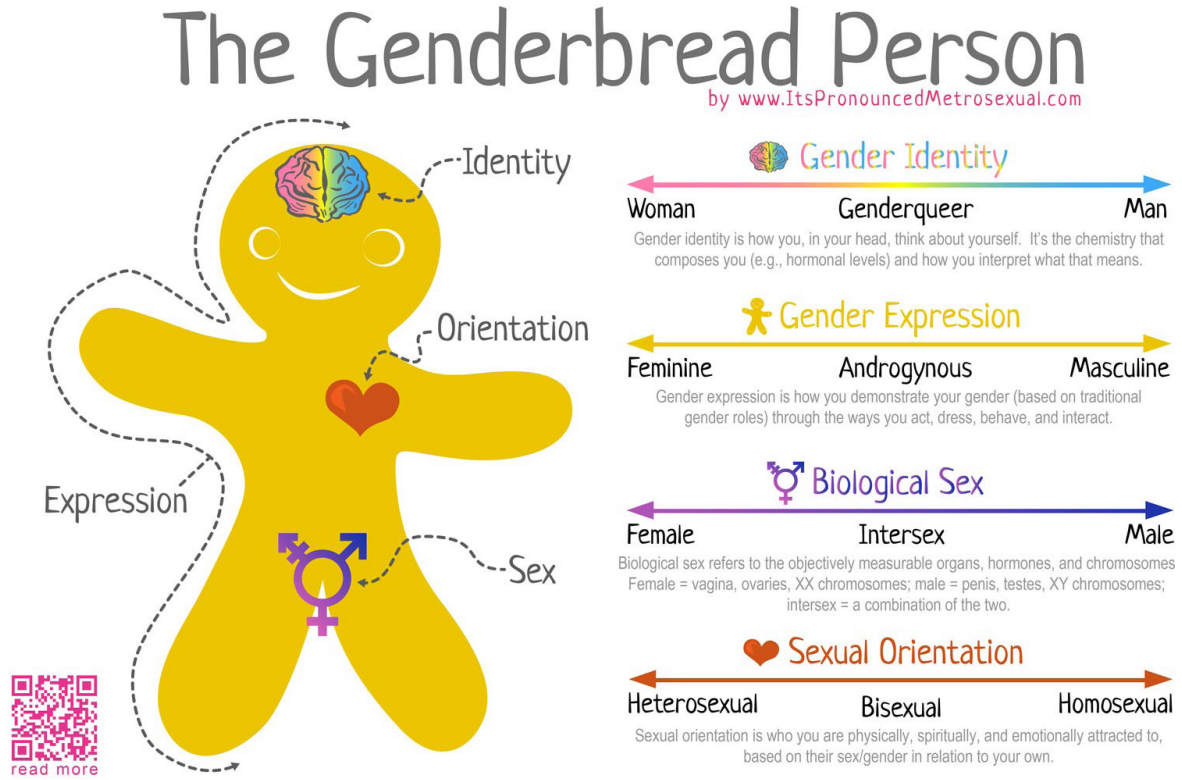
The three main typologies of transgender people are transgender women, transgender men, and gender nonconforming persons.

Transgender men identify as men and do not conform to the sex (female) and gender (woman) they are assigned at birth. Transgender women identify as women and do not conform to the sex (male) and gender (man) assigned at birth. Gender nonconforming people have gender expression that does not match masculine or feminine gender norms.

Being transgender is independent of sexual orientation. Transgender people may identify as heterosexual, homosexual, bisexual, asexual, or may decline to label their sexual orientation.

It is easier to understand who transgender people are by looking at gender as a continuum rather than two sides. So, for example, for gender identity, on the slide rule of woman-ness or man-ness we will find gender nonconforming persons right at the centre, and anyone else on either side of the gender nonconforming persons on the continuum is what we refer to as transgender people. These people may have gender expression that is feminine or masculine or anything in between, as shown in Figure 5.

Figure 5. Gingerbread person



CHAPTER 2

Combination Prevention Interventions

02

2.1 INTRODUCTION

HIV-prevention programming begins with mapping and estimation. Mapping is done to learn where and on what scale to intervene, and to estimate the resources that intervention will require. Using data from mapping and estimation, implementing organisations can plan how best to reach and serve the key population. Macro-planning locates service providers and establishes service outlets in areas that have large concentrations of transgender people. Implementing organisations then launch combination prevention interventions that reduce people's HIV risk and vulnerability.

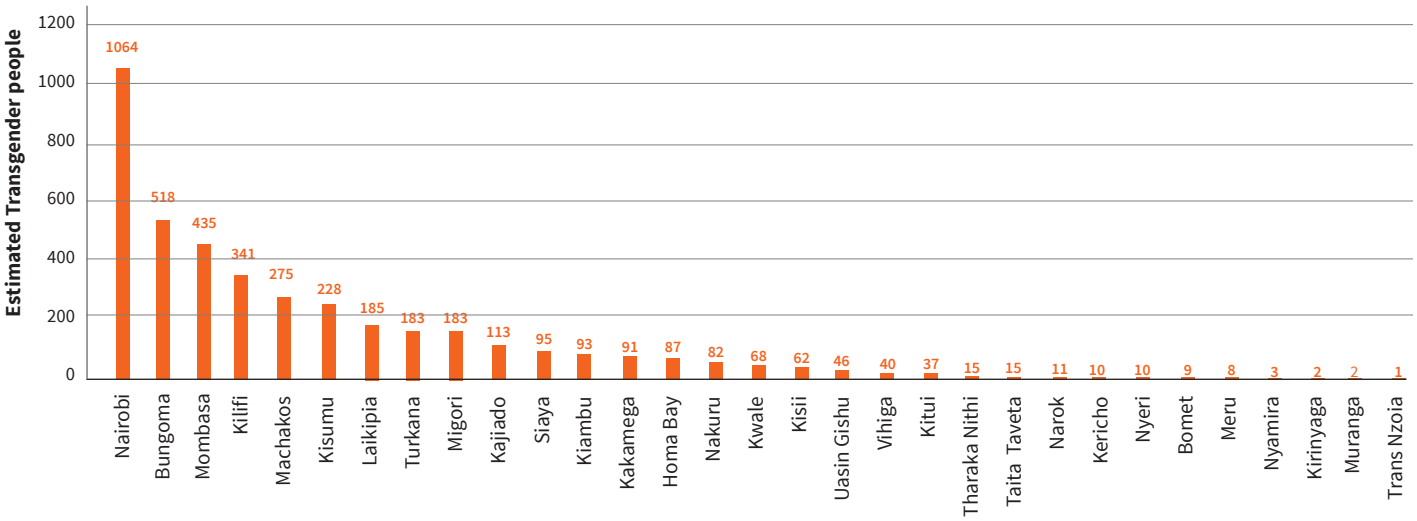
2.2 UNDERTAKING MAPPING AND SIZE ESTIMATES

Mapping of key populations and population size estimates are necessary to start a programme, for budget and programme planning, and for deciding how many services to place, and where. Size estimates are also essential for estimating levels of coverage, using data on key populations' contact with fixed-site or outreach services. Site-based size estimates, rather than country- or county-based estimates, are crucial to developing a programme, as they help implementing organisations develop site-based intervention plans.

The mapping and size estimates conducted by Kenya in 2018 estimated the transgender population for the first time. A total of 1,218 FSW and MSM hotspots that the transgender population use were identified in 34 counties in Kenya. In those hotspots 2,826 to 5,783 transgender people were estimated, with an average of 4,305. The exercise did not map any separate, exclusive hotspot for the transgender population. Two-thirds of the transgender population were reported to use bars with lodging (1,455/4,305, 34%) or bars without lodging/ Changaa den /Mangweni (1,409/4,305, 33%). Little variation existed in the average number of transgender individuals per hotspot.

Nairobi County had the greatest share (1064/4305, 25%) of the transgender population, followed by Bungoma (518/4,305, 12%), Mombasa (435/4,305, 10%) and Kilifi (341/4,305, 8%) counties (Figure 6). County estimates of the transgender population ranged from 1,064 in Nairobi to none in Busia, Embu, and Makueni counties. In the 34 mapped counties, 10 counties collectively accounted for about 82% (3,525/4,305) of the total estimated transgender population.[44]

Figure 6. Estimated transgender population by county



[44] National AIDS & STI Control Programme (NASCOP), Ministry of Health. 2019. Key Population Mapping and Size Estimation in Selected Counties in Kenya: Phase 1 Key Findings. Nairobi: NASCOP.

In a key populations programme, size estimates are updated periodically using programme data, and remapping may be done if social, political, or economic forces lead to significant changes in the transgender population.

Note: Maps and other data containing information about key populations (e.g., location, type of sex work practised) should be considered confidential and stored securely at a central location, such as a safe space (drop-in centre). Programme planners and implementing organisations should guard against the possibility of maps being obtained by law enforcement authorities or other groups who might use them to locate and close sites or otherwise cause harm to key populations.

Mapping and size estimation is a multi-stage process, focusing increasingly on local levels to refine the information and make it more accurate. Mapping should always be done discreetly, so as not to draw undue attention to the activity. For more details on mapping and size estimation, refer to Section 2.2 of the *National Guidelines for HIV/ STI Programming with Key Populations.*[45]

2.3 MACRO-PLANNING AND MICRO-PLANNING FOR PROGRAMME COVERAGE

Designing appropriate, large-scale HIV-prevention programmes targeting transgender populations requires
a. documenting the size and distribution of the population,
b. identifying and characterising transgender population locations, and
c. planning appropriate service provision.

For the purposes of this guideline, the term "scaling-up" refers to increasing the coverage of essential services in an HIV prevention programme for transgender populations.

"Coverage" is defined as the proportion of the transgender population that receives a defined set of services that address their risks and vulnerabilities. Achieving high coverage depends on two levels of planning: macro- and micro-planning.

Macro-planning is the use of national or subnational epidemiological and mapping data to map the distribution of an epidemic or disease and to plan for population-level impact through interventions. The goal of macro-planning is to achieve and maintain intervention coverage of at least 90% of the transgender population at the national or regional level by rapidly establishing appropriate community- and facility-level services in locations that contain a high concentration of transgender people.

Micro-planning is individual-level outreach and service delivery planning that is informed by information that programme staff collect about the risk behaviour and vulnerability of each individual in the sites and networks where transgender people gather. The goal of micro-planning is to achieve and maintain intervention coverage of 100% of the transgender population within every targeted site and network.

2.3.1 Macro-planning

Macro-planning involves the evidence-based selection of geographic regions requiring services, and then mapping those regions to identify the area or areas with the highest densities of transgender populations. Next, the size and characteristics of the transgender population should be identified and the local context described, which includes listing the existing relevant service providers. This also includes understanding the needs and concerns of the population. The needs, service gaps, and best configuration of services should be determined in consultation and partnership with the transgender community, and partnerships formed with existing or new service providers to deliver these services. In these partnerships, transgender population led organisations should be preferred.

Advocacy with and involvement of transgender people, stakeholders, and power structures are crucial. As the goal of macro-planning is to establish appropriate services in optimal locations, high-level programme monitoring can identify the "opportunity gaps," defined as the number of people who need but have not received outreach or services.

[45] National AIDS & STI Control Programme (NASOP), Ministry of Health. 2014. National Guidelines for HIV/STI Programming with Key Populations. Nairobi: NASCOP.

The techniques used for macro-planning are scalable and can be applied at multiple administrative levels to make coherent allocation decisions between different regions. The particular geographic divisions within which macro-planning can occur depend on the objectives and the geographic boundaries within which the relevant administrative and resource allocation decisions are made. In general, when developing a new programme or scaling up an existing programme, regions should be selected based on feasibility of programme implementation. In Kenya, it is appropriate to work at the national and county levels because these are generally where planning occurs. It is important not to lose the larger picture and interconnectedness of specific sites by focusing only at a very local level.

In addition to identifying transgender population locations and quantifying the populations, mapping results can be used to identify the presence of existing programmes and services. As the basic concept of scaling up involves increasing the proportion of the target population receiving a defined set of programmes and services, mapping is key to determine the target population size and locations. Denominators, which specify the size of the target population, are essential for setting goals and assessing programme coverage.

Macro- and micro-planning and implementation can occur in tandem. While programmes are being established at the macro-level, ensuring that all major sites are covered and service providers have been identified and secured, at the micro-level the community is involved in validating sites that were identified during mapping, identifying peer educators, and exploring networks.

2.3.2 Micro-planning

Micro-planning, has been developed on the premise that each site (i.e., area that contains a high proportion of the target population) and each transgender person in every site and network spot has different risks and needs. The programme team should be able to recognise this differential need and design a programme prioritising the needs, risks, and vulnerability. Hence micro-planning involves identifying and/or validating specific sites and networks, and collecting details about individuals' risk practices in those locations.

Micro-planning also includes detailed service implementation planning, direct service provision, and routine monitoring. At the micro level, achieving 100% coverage within specific sites and networks is the goal.

Achieving this high coverage depends on placing programmes and services in sites. Hot spots /sites have (or have the potential for) higher levels of HIV transmission compared to other areas because of the characteristics of the sexual structure and transmission dynamics of HIV. Appropriate and effective planning and implementation of outreach and service delivery to reach a high proportion of the transgender populations within hot spots /sites are essential.

Implementation of the micro-plan should be informed by

- **the geographic distribution of transgender populations** (counties where they are located),
- **the estimates of the people** (based on mapping and estimation, programmes need to prioritise the areas which have larger transgender populations),
- **the number of sexual partners** (people who have more sexual partners or engage in sex work are at higher risk) and **other risk practices** (like condomless sex),
- **the age of the transgender population** (younger – below 24 years people are more at risk),
- **the number undergoing transition** (those who are undergoing transition can experience psychological stress and anxiety and physical risk), and
- **other vulnerabilities that they experience, including stigma and violence**.

For more details on macro- and micro-planning, refer to Section 2.5 of the *National Guidelines for HIV/ STI Programming with Key Populations.*[46]

[46] National AIDS & STI Control Programme (NASOP), Ministry of Health. 2014. National Guidelines for HIV/STI Programming with Key Populations. Nairobi: NASCOP.

2.4 COMBINATION PREVENTION PACKAGE FOR TRANSGENDER POPULATIONS

Effective prevention strategies use a combination of behavioural, biomedical, and structural interventions in coordination to simultaneously address HIV risk and vulnerability. Combination prevention programmes operate on individual, family, community, and societal levels to address the specific needs of the populations at risk of HIV infection. Combination prevention takes a bottom-up approach that encourages ownership of the response by local communities.

The HIV-prevention programme for the transgender population is based on a combination prevention approach. To ensure that transgender populations across the country receive the essential services to minimise risk and vulnerability to HIV and STI infections, an essential service package has been developed for programmes in Kenya. The essential package contains the vital services, activities, facilities, and information that all HIV programmes with transgender populations should provide. The efficacy of the components of the essential package is strongly supported by evidence. However, new research and new international guidelines show that there are other interventions that are showing promising results for key populations. These interventions are recommended as desirable elements, though they are not considered necessary for preventing the spread of HIV. If organisations have resources and expertise, they can add desirable interventions in their programme.

2.4.1
Essential combination prevention package and desirable elements

The package has been designed keeping in mind the goal of HIV prevention among transgender people. This package is in line with global guidance for HIV prevention among transgender people.

» Essential package

- Peer-to-peer outreach
- Behaviour change interventions
- Risk assessment, risk-reduction counselling, and skills-building
- Pre-exposure prophylaxis (PrEP)
- Post-exposure prophylaxis (PEP)
- Sexual and reproductive health services
- Harm reduction interventions
- Differentiated HIV testing services
- Differentiated HIV care and treatment
- Prevention and management of co-infections and co-morbidities
- Condom and lubricant programming
- Violence prevention and response
- Addressing stigma and discrimination
- Community empowerment

» Desirable Elements

- Hormone replacement therapy
- Gender-affirming surgeries
- Review of laws and policies

The delivery of biomedical interventions, such as STI management; HIV testing and counselling; and HIV treatment, care, and support, can often be provided through referrals and linkages with local public- and private-sector providers, with the national guidelines setting the benchmarks. Given the varied geographic and cultural settings in which transgender populations live and work, implementers need to work closely with these populations to define the mode of delivery of behavioural and structural interventions.

2.5 BEHAVIOURAL INTERVENTIONS

2.5.1
Introduction

Behavioural interventions are a range of communication programmes at the societal, community, organisational, or individual level that aim to change sexual behaviour by disseminating messages that encourage people to reduce behaviours that increase

risk of HIV and to increase behaviours that are protective. Behavioural interventions also aim to increase people's acceptance of and demand for biomedical interventions. They are delivered as part of the comprehensive package. Behavioural intervention may take place through face-to-face contact, through broadcast mass media, and through digital media, such as the Internet. Behavioural interventions may address individuals or groups. One-on-one counselling may focus on awareness of personal risk and risk reduction strategies. For example, counsellors or community workers may discuss risk behaviours, relate a participant's activities directly to HIV risk, and suggest strategies to reduce this risk. In contrast, peer-to-peer interventions and group sessions may focus more on awareness of risk.

2.5.2
Objectives of behavioural interventions

1. To improve knowledge and skills related to HIV and STI prevention among the transgender population
2. To increase access to prevention commodities among the population
3. To improve peer-to-peer contact, solidarity, and social support among transgender people
4. To enhance referral and linkage to services

Behavioural interventions should contribute to an increased number of protected sexual acts, encourage adherence to biomedical components that prevent HIV transmission, and enhance individual- and group-level ownership and sustainability of programmes.

2.5.3
Package of essential behavioural interventions

The package of essential behavioural interventions includes

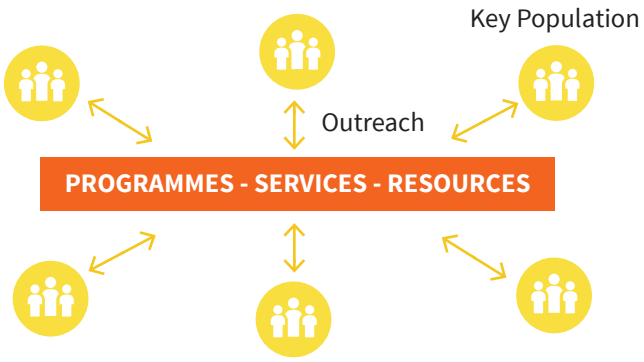
- peer-to-peer outreach;
- behaviour change interventions; and
- risk assessment, risk-reduction counselling, and skills-building.

Peer-to-peer outreach

Outreach entails actively delivering information, products, and services to existing or potential service users in locations where they typically spend time, rather than relying on them to come to programme sites. Outreach is documented as it occurs, and these records are analysed to plan outreach and to monitor and assess programme implementation, coverage, and performance.

As illustrated in Figure 7, outreach thus serves as a two-way channel that delivers HIV-prevention essentials to transgender communities while simultaneously providing implementers and public health authorities with information that is used at multiple levels for programme management.

Figure 7. Outreach model



≫ Guiding principles of outreach

- Respect for the community, whereby transgender people are valued as individuals who have rights to confidentiality, dignity, and a safe and secure life and work environment.
- Teamwork that bridges gaps between project staff, service providers, and community by building relationships of mutual respect, trust, acceptance, and learning, and by delivering quality outreach services.
- Self-representation/empowerment that builds capacities of community members as leaders, participants, and owners of HIV-prevention programmes.

» Planning outreach

Outreach planning is undertaken at all levels of programming. The outreach planning tools listed in Table 1 facilitate a peer educator's individual-level planning and follow-up. Outreach is planned according to the individual risk and vulnerability profiles of key population members and their sexual partners. By giving a visual picture of the site that a peer educator is managing, these tools help the peer educator understand the extent to which programme services have reached key populations, and identify and monitor problem areas.

Outreach planning has the following benefits:

- Individual tracking.
- Repeat visits for monthly screening.
- Ability to collect, analyse, and act upon data.
- Peer educator's site management creates and strengthens community ownership.
- Shift from push to pull in services.
- Defined area of operation.

Table 1. Outreach planning tools

Tool	Objective	Purpose
Spot Analysis	Prioritise spots for outreach.	Improve outreach quality.
Contact Listing	Develop a unique list of key populations in the spots.	
Site Load Mapping	Prioritise outreach to the spots.	
Peer Plan	Reach all key populations in the peer list on a regular basis.	Build peer educator capacity to monitor his/her own performance.
Opportunity Gap Analysis	Understand gaps in reach and service uptake among the key populations.	Improve service levels and continuously improve programming.

Micro-planning for outreach includes five main activities

1. **Site load mapping:** Transgender community-led mapping is used to systematically validate and define hot spots and their logical geographical boundaries.
2. **Site analysis:** Spot profiling is performed to inform the delivery and components of HIV prevention programmes, per transgender community member and per location. A simple tool collates relevant information on a particular location where transgender people are known to congregate.
3. **Contact listing / Peer educator social network analysis:** For each location, the peer educators make a list of all the transgender people that they know personally, and then they compare lists. Decisions are made about which peer educator will take responsibility for outreach, education, and monitoring for each individual transgender person.
4. **Peer educator planning:** A hot spot-based peer educator plan is the core micro-planning tool that is developed by a peer educator for the hot spot and the transgender community they work with. This tool helps the peer educator plan outreach at the appropriate time, day, and place.
5. **Opportunity gap analysis:** With the opportunity gap analysis tool, peer educators compare the transgender community's actual service use against expected use to identify barriers that obstruct transgender community members' use of programme services. This exercise reveals issues that the programme must address to increase service delivery.

» Implementing outreach

The first step in outreach is recruitment of peer educators. Peer educators are members of a transgender community who are trained to conduct programme outreach to their peers.

Peer educators are best qualified and situated to establish regular contact with transgender community members. However, regardless of the peer educator's level of social agency, it is important to respect privacy when carrying out outreach, so recipients feel that they can safely confide in the peer educator.

Projects also need to learn how to relate to the people/gatekeepers around transgender communities.

The frequency and schedule of outreach will be guided by factors such as the size of the area and the number and typology of transgender community individuals within that area. Also, local conditions can change. For example, new peers may move into the area and operate at different hours or in as-yet unmapped areas. It is a good practice to review the outreach service to see whether it is happening at the right times and is reaching the right transgender communities. Programme reviews should include consultation with service users.

The mapping exercise will have determined the presence of other local projects running outreach services. Implementing partners within the same geographic location should consult with each other and discuss local needs, coordinate outreach times, and avoid replication/duplication. Coordination, communication, and joint work mean less fragmentation and confusion for service users and more reliable programme data collection and reporting. Implementing partners should also gather feedback about street dynamics, such as problematic areas, people, cultures, and population. This will optimize programming.

» Peer education

Peer education is an arrangement by which individuals teach their peers. A systematic review and meta-analysis of HIV-prevention interventions found peer education to be significantly associated with increased levels of knowledge about HIV, reduced STI prevalence, and increased condom use with casual and regular sex partners.[47]

» Peer educators

Peer educators are people from the transgender community who work with their colleagues to influence attitude and behaviour change. They share many of the same characteristics and life experiences of their transgender population and should be selected to represent the transgender population contexts present within the programme catchment area. That is, they live the life of the transgender community being served. It is important to note that MSM/MSWs cannot be peer educators for transgender people / transgender sex workers and vice versa.

» Role of the peer educator

Peer educators are expected to perform the majority of the outreach, with outreach workers providing managerial/technical support where needed. A strong supportive structure of full-time outreach staff is required to sustain continuity and provide on-going support to peer educators. The ideal peer educator is able to reach contacts at least once in 15 days.

Peer educators' roles and responsibilities

1. Contact new transgender community members and transgender community members already enrolled.
2. Conduct individual risk assessment, risk reduction, skills building for risk reduction.
3. Generate demand for services—encourage and motivate peers to know their HIV status.
4. Distribute and demonstrate use of condoms, condom-compatible lube, needles, syringes, and related equipment.
5. Provide correct HIV/STI and reproductive health information.
6. Provide dialogue-based interpersonal communication (IPC) materials on HIV risk:
   a. condom and lubricant demonstration and distribution
   b. negotiating with clients and partners

[47] Medley A, Kennedy C, O'Reilly K, Sweat M. 2009. Effectiveness of peer education interventions for HIV prevention in developing countries: a systematic review and meta-analysis. *AIDS Educ Prev.* 21(3):181-206. doi:10.1521/aeap.2009.21.3.181

c. health care services

7. Assess the needs of peers and, if necessary, refer for HIV/STI/TB/PEP/PrEP/viral hepatitis/HIV self-testing, violence prevention and redress to transgender competent facility.
8. Advocate for rights and safety with power structures, such as police, venue owners/managers, etc.
9. Monitor service provision by attending review meetings and by preparing and presenting daily reports to outreach workers.
10. Provide information regarding transitioning and hormone therapy.
11. Assess violence and provide support.

For transgender people, the ideal peer educator to key population member ratio, as derived from programme experience and community consultations, is **1:30**.

» Peer education implementation

The coverage and effectiveness of service delivery depend on the quality of the peer education and outreach programmes. To ensure that quality is maintained, NASCOP with partners developed a set of 12 standards for peer education to ensure that coverage and service delivery quality across programmes are maintained.[48]

Peer education standards

- Standard 1: Management
- Standard 2: Selection process
- Standard 3: Training
- Standard 4: Retention
- Standard 5: Access to health services
- Standard 6: Peer education and outreach services
- Standard 7: Supplies, materials, and tools
- Standard 8: Enabling environment
- Standard 9: Referral system
- Standard 10: Supportive supervision
- Standard 11: Ongoing support
- Standard 12: Monitoring and evaluation

Since outreach is the basis of service provision and since peers are the cornerstone of outreach, identifying the *right* peer educators is critical.

The right peer educator is representative of their community in terms of

			
Age (18-25, 26-35, 36-49, 50 and above)	**Transgender person**	**Site** (location of work)	**Personal social network** (wide social network of peer group members)

[48] National AIDS & STI Control Programme (NASCOP). Ministry of Health. 2010. Standards for peer education and outreach programs for sex workers. Nairobi: NASCOP.

» Selection criteria for a peer educator

To qualify as a peer educator, a transgender community member should have the following:

SOCIAL AGENCY

1. Be a recognized member and/or leader in the community
2. Be accepted by their community
3. Have regular contact with the group of peers as per the suggested peer ratio
4. Be knowledgeable about the local context and setting and current issues

PERSONAL QUALITIES

1. Be a role model
2. Be prepared to commit a certain amount of time to peer education activities
3. Be committed to the goals and objectives of the programme
4. Be a good mobiliser
5. Have good listening, communication, and interpersonal skills
6. Be concerned about the well-being of the peers
7. Be honest, trustworthy, and maintain confidentiality
8. Be tolerant, nonjudgmental, and respectful of others' ideas and behaviours

ORGANISATIONAL APTITUDE

1. Be fluent in the appropriate language
2. Be able to organise and conduct educational sessions
3. Be willing to learn in the field

ADDITIONAL SELECTION CRITERIA

1. Representative of the social networks or site they are responsible for
2. Representative in terms of age of their social network
3. Sensitive to the values of the community
4. Values accountability to their transgender community and not just to the programme
5. Demonstrates self-confidence and shows potential for leadership
6. Committed to being accessible to their peers in times of crisis

» Criteria for selection of an outreach worker

1. Active in the community, with time to do outreach
2. Committed to the goals and objectives of the programme
3. Knowledgeable about the local context and setting
4. Accepted by the community
5. Accountable to the community as well as to the programme
6. Respectful of all communities of transgender people
7. Able to maintain confidentiality
8. Good listening, communication, and interpersonal skills
9. Self-confident and with potential for leadership
10. Potential to be a strong role model for the behaviour promoted by the programme
11. Willing to learn in the field
12. Committed to being available to other transgender people if they experience violence or an emergency

Behaviour change interventions

Communicating with key populations to promote health-seeking behaviour, safer sex, uptake of counselling and testing for HIV, and other aspects related to the prevention, care, and treatment of HIV is a constant challenge. Provision of information on topics such as hormonal therapy or gender enhancement procedures can be used to start conversations during outreach.

For the transgender community, communication and targeted information should focus around the following key areas:

STI and HIV risk and vulnerability	General health	Diversity within the transgender community	Hormone therapy	Screening and first-line support for mental health and violence	Mental well-being

» Use of social media

Online social media can be used to pass behaviour change communication to the transgender community. Transgender community members who are involved in programme mapping, design, implementation, and monitoring can determine the platform that will best reach their own community and generate the most positive responses. Social media can expand programmatic reach to individuals who may not otherwise access transgender specific health information, but it should not replace all face-to-face interactions.

Good-practice standards for online programmes and outreach efforts using smartphone applications ensure the safety and privacy of members and participants. Consistent monitoring by community outreach workers trained in HIV prevention and sexual-health promotion is critical to ensure the accuracy and integrity of any information presented. This is particularly important where social media pages are used, as they may be easily subject to unwanted advertising and unsolicited posts from outside the intended audiences. Since it is not possible to verify the identity of online community members with total accuracy, it is especially important to take safety measures when designing and implementing any form of ICT (information and communications technology) programme.

» Steps to ensuring online safety

- When using social media platforms to connect with other individuals for dating or other personal reasons, exercise great caution when sharing any personal information. When meeting in person with someone through an online connection, always meet in a public place and inform a trusted friend about the time and location of the meeting.
- Precautions must be taken to restrict announcements about safe space (drop-in centre) gatherings or other social events that are for transgender community members only to social media pages that have restricted access to members only.

» Promotion and distribution of condoms, lubricants, and other protective commodities

Although condoms, water-based lubricants, and clean needles and syringes are highly effective at preventing the spread of HIV and STIs, the use of such products depends upon behaviour change interventions that distribute such commodities, increase demand for them, build people's skills for their correct use and disposal, and normalise their use. For the transgender community, access to commodities such as dental dams and finger condoms is also key.

Behavioural interventions to promote protective products should occur at three levels:

I. **Individual-level** intervention through which peer educators explain the importance of correct and consistent use of such products, demonstrate their use, and train key populations to persuade their partners to use such products.

II. **Community-level** intervention through which peer educators and outreach workers promote behavioural and attitudinal norms about safe sex and safe injecting practices, medical treatment of gender dysphoria, options for peer-peer support, and access to mental health interventions.

III. **Facility-level** intervention through which service providers reinforce behaviour-change messages about the importance of using condoms, lubricant, and clean injecting equipment, and about transgender people's gender-affirming healthcare needs.

Risk assessment, risk reduction counselling, and skills-building

Counselling and skills-building provide key populations with information and skills for HIV risk reduction. When conducting risk assessment, questions should focus on frequency of oral, anal, and vaginal sex; number of clients and regular partners; condom use with clients and regular sex partners; lubricant use; douching; dry sex; mental health; hormonal therapy (self or prescribed); PrEP use; frequency of HIV testing; and substance use.

The counsellor should be able to counsel in a non-judgmental way and avoid stigmatization and embarrassment. Counselling can be provided in the clinics and drop-in centres. Counselling should be done in a safe and private space, and confidentiality must be maintained. Counsellors should provide options to transgender people and encourage them to solve their problems.

Risk-reduction plans should have behavioural goals and should follow the following steps:

- Conduct initial and on-going individual HIV/STI risk assessment.
- Develop a personalized risk-reduction plan in collaboration with the transgender person.
- Routinely monitor progress of risk reduction and modify/adjust the plan as necessary.
- Provide risk-reduction supplies (i.e., condoms and water-based lubricant).
- Build the transgender person's skills to reduce their risks.
- Routinely reinforce their risk-reduction skills.
- Assess other needs of the transgender person and link them to other programmes that address those needs.

2.5.4 Implementation considerations

1. The following strategies are recommended to increase safer sexual behaviours and increase uptake of HIV testing and counselling among transgender people:
   - targeted Internet-based outreach
   - venue/hotspot-based outreach

   Implementing should be at individual-level behavioural interventions, facility-level behavioural interventions, and community-level behavioural interventions.
2. Health literacy: People from key populations, including the transgender community, often lack sufficient health and treatment literacy. This may hinder their decision making on HIV risk behaviours and their health-seeking behaviour. Services provided at outreach and facilities should regularly and routinely provide accurate health and treatment information to members of the transgender community.
3. Community-based entry points are often different for transgender women, transgender men, and gender nonconforming people. Determining where those spaces are and how best to use them as sites for sexual-health education, peer counselling, condom and lubricant promotion, and other HIV programming can therefore be done only with the meaningful participation of community members. Recruiting and retaining transgender people as community outreach workers ensures not only that programmes are established in the right locations, but also that they are responsive to the changing preferences and priorities of their beneficiaries.
4. Behavioural interventions should design health messages and outreach that target transgender people through family members /caretakers, as these are key for ensuring that transgender people access information and services.

2.6 BIOMEDICAL INTERVENTIONS

2.6.1 Introduction

Biomedical interventions are those that directly influence the biological systems through which the virus infects a new host, so as to block virus transmission (e.g., condoms, PrEP, PEP), decrease infectiousness (e.g., antiretroviral therapy [ART] in prevention), or reduce risk of acquiring infection (e.g., voluntary medical male circumcision, STI management).[49]

Specifically, these interventions involve clinical testing, diagnosis of infections and their treatment, and other clinical services that improve the health of transgender people. Biomedical interventions should be provided through community outreach, community-friendly clinic programmes, and referral clinics, with the involvement of peer educators, project outreach staff, counsellors, doctors, and community self-help groups.

2.6.2 Objectives of biomedical interventions

1. To reduce HIV and STI risk
2. To enhance the provision of HIV/STI-related services and other essential health interventions by transgender-competent health care providers
3. To improve access to quality transgender-specific clinical care and psychosocial support services
4. To improve the well-being of transgender people

ESSENTIAL BIOMEDICAL INTERVENTIONS

- Pre-exposure prophylaxis (PrEP)
- Post-exposure prophylaxis (PEP)
- Sexual and reproductive health services
- Harm reduction interventions
- Differentiated HIV testing services
- Differentiated HIV care and treatment
- Prevention and management of co-infections and co-morbidities
- Condom and lubricant programming

DESIRABLE BIOMEDICAL INTERVENTIONS

- Hormone replacement therapy
- Gender-affirming surgeries

2.6.3 Package of essential biomedical interventions

Pre-exposure prophylaxis (PrEP)

Oral pre-exposure prophylaxis is the use of antiretroviral drugs by people who do not have HIV in order to protect themselves from acquiring HIV. PrEP has been documented to be an effective intervention among all populations at high risk for HIV. Kenyan guidelines recommend that PrEP should be offered as a choice to people who are at substantial risk of HIV infection, as part of a combination HIV prevention programme. Transgender people who have sexual partners with undiagnosed or untreated HIV infection may be at substantial risk of acquiring HIV, depending on their sexual behaviours. PrEP is thus considered an additional intervention in the HIV prevention package for transgender women, and particularly for transgender people who have sex with male partners and those who are in serodiscordant relationships.

Transgender-led organisations can play a significant role in informing people at higher risk about PrEP availability as well as about when PrEP should be used, providing links to health care services for those who are interested, and promoting adherence. Understanding the rates at which transgender people are able to adhere to PrEP and addressing the barriers preventing adherence is crucial to the long-term success of the intervention.

[49] PEPFAR (The U.S. President's Emergency Plan for AIDS Relief). 2011. Guidance for the Prevention of Sexually Transmitted HIV Infections. http://www.pepfar.gov/ documents/ organization/171303.pdf.

Provision of PrEP to the transgender population should be as per the *Framework for the Implementation of Pre-Exposure Prophylaxis of HIV in Kenya*.[50]

Post-exposure prophylaxis (PEP)

Post-exposure prophylaxis is the administration of antiretroviral medications to an individual as soon as possible after they have been exposed, or potentially exposed, to HIV in order to reduce the chance of becoming HIV positive. It is the only known way to reduce the risk of infection after exposure to HIV. PEP for HIV is a 28-day course of a combination of antiretroviral drugs (ARVs) that must begin within 72 hours after occupational or accidental HIV exposure, such as injury from an infected needle; vaginal, oral, or anal rape; or condom burst.

Due to the prevalence of sexual violence perpetrated against transgender women, health care workers should ask any transgender woman who seeks trauma-related care about her risk of HIV exposure. Transgender people and community outreach workers should receive education on PEP so that they know where it can be accessed in a timely and transgender-competent manner. The services should be provided as per the *Guidelines on Use of Antiretroviral Drugs for Treating and Preventing HIV Infection in Kenya*.[51]

Sexual and reproductive health services

Sexual and reproductive health (SRH) services include family planning, post-abortion care, emergency contraception, prevention of mother-to-child transmission (PMTCT), and STI diagnosis and treatment. When providing SRH services for transgender women, it is important to help them access appropriate gender-affirming treatment and to warn of the higher risk of thrombosis from oestrogens in oral contraceptives (ethinyl estradiol) compared to feminising hormone therapy. Although oestrogens may significantly reduce fertility, they may not prevent pregnancy. Fertility and contraception should therefore be discussed with transgender women who retain their penis and testes and have unprotected sex with fertile non-transgender women. Transgender women who desire biological offspring should discuss their reproductive options, such as freezing and storing sperm, before starting feminizing hormone therapy, since it is unknown whether viable sperm will be produced after oestrogen is taken.

Transgender men who have a uterus and ovaries can become pregnant when having vaginal intercourse, even when taking androgens. Transgender men who desire pregnancy should be informed that testosterone reduces fertility, and it is unclear if full fertility returns when androgens are stopped. Before starting masculinizing hormone therapy, reproductive options, including egg retrieval and storage, should be discussed with transgender men who desire biological offspring. Even though testosterone reduces fertility, it is not a contraceptive, and transgender men having unprotected sex with fertile non-transgender men are at risk for pregnancy and STIs, and should be screened and given information about their contraceptive options. Contraception needs for transgender men who have sex with cis men should be considered. Consideration should be given to offering transgender men who have sex with men appropriate contraceptive options that do not lead to unwanted systemic feminization.

» Elements of post-abortion care

Post-abortion care is the care given to women who have had an unsafe abortion. It consists of the emergency treatment of complications from an unsafe abortion, family planning counselling/services, and provision of provider-initiated testing and counselling. Post-abortion care should be provided when needed, with compassion and in line with national guidelines.

» Emergency contraception (EC)

Emergency contraception—also referred to as the "morning-after pill"—is provided to women who are not currently using a contraceptive method and not already pregnant, to prevent pregnancy after unprotected vaginal sex. Transgender people should have access to EC due to their increased likelihood of engaging in unprotected sex.

Currently no guidance exists on how frequently EC can be used. Therefore, service providers should use caution and monitor how many times EC is used. The use of long-term family planning methods (e.g., contraceptive pills, IUD, etc.) is recommended.

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[50] National AIDS & STI Control Programme (NASCOP). Ministry of Health. 2017. Framework for the Implementation of Pre-Exposure Prophylaxis of HIV in Kenya. Nairobi: NASCOP. https://www.prepwatch.org/wp-content/uploads/2017/05/Kenya_PrEP_Implementation_Framework-1.pdf.

[51] National AIDS & STI Control Programme (NASCOP). Ministry of Health. 2018. Guidelines on Use of Antiretroviral Drugs for Treating and Preventing HIV Infection in Kenya. Nairobi: NASCOP. http://cquin.icap.columbia.edu/wp-content/uploads/2017/04/ICAP_CQUIN_Kenya-ARV-Guidelines-2018-Final_20thAug2018.pdf.

» Prevention of mother-to-child transmission (PMTCT)

HIV can be transmitted from an HIV-positive woman to her child during pregnancy, childbirth, and breastfeeding. Mother-to-child transmission, which is also known as vertical transmission, accounts for the vast majority of infections in children (0-14 years). The global community has committed itself to accelerate progress on the prevention of mother-to-child HIV transmission through an initiative with the goal to eliminate new paediatric HIV infections. *Start Free Stay Free AIDS Free* embraces the goals adopted by UN member states in the 2016 Political Declaration on Ending AIDS. It commits to the dual elimination of mother-to-child transmission of both HIV and congenital syphilis (syphilis can result in miscarriage, stillbirth, neonatal infections, and death). As PMTCT is not 100% effective, elimination of HIV is defined as reducing the final HIV transmission rate to 5% or less among breastfeeding women, and to 2% or less among non-breastfeeding women by 2020. PMTCT has enabled millions of children to be born HIV-negative through effective testing and treatment for them and their mothers.

The WHO thus recommends a four-pronged approach to a comprehensive PMTCT strategy, which includes primary prevention of HIV infection among women of childbearing age; preventing unintended pregnancies among women living with HIV; preventing HIV transmission from women living with HIV to their infants; and providing appropriate treatment, care, and support to mothers living with HIV, their children, and families.

Transgender men who wish to get pregnant and have babies should have access to the same services for prevention of mother-to-child transmission, and should follow the same recommendations as women in other populations.

» STI prevention, screening, diagnosis, and treatment

STIs are caused by more than 30 bacteria, viruses, and parasites, and are spread predominantly by sexual contact, including vaginal, anal, and oral sex. STIs include gonorrhea, chlamydial infection, syphilis, trichomoniasis, chancroid, genital herpes, genital warts, HIV infection, and hepatitis B infection. Key populations are at higher risk for STIs due to unprotected sex, sex with multiple partners, and increased frequency of partner change. Several STIs may facilitate the sexual transmission of HIV infection.

Screening, diagnosis, care, support, and treatment of STIs are crucial parts of a comprehensive response to HIV. Effective prevention and treatment of STIs among key populations requires attention to both symptomatic and asymptomatic infections. STI screening consists of either etiological testing (lab tests) to identify the specific STI and/or syndromic diagnosis (diagnosis on the basis of STI symptoms). STI management should be in accordance with the *Kenya National Guidelines for Prevention, Management and Control of Sexually Transmitted Infections*.[52] It should also be confidential and free from coercion, and patients must give informed consent for treatment including partner notification services.

Health-care providers should be sensitive to and knowledgeable about the specific health needs of transgender people. In particular, genital examination and specimen collection can be uncomfortable or upsetting whether or not the person has undergone genital reconstructive surgery.

» Prevention of STIs

STI control is based on five major strategies:

- Education and counselling of persons at risk on ways to avoid STIs through changes in sexual behaviours and use of recommended prevention services
- Identification of asymptomatically infected persons and of symptomatic persons unlikely to seek diagnostic and treatment services
- Effective diagnosis, treatment, and counselling of infected persons
- Evaluation, treatment, and counselling of sexual partners of persons who are infected with an STI
- Pre-exposure vaccination of persons at risk for vaccine-preventable STIs

» Screening

Periodic screening of transgender people for asymptomatic STIs is recommended. In the absence of laboratory tests, symptomatic people from the transgender community should be managed syndromically in line with the national STI management guidelines. A regular STI check-up is an opportunity to reinforce prevention and address other health needs. The check-up may consist of probing for symptoms of STIs and checking for signs of ano-genital infections, including anal, vaginal, and proctoscopic examinations.

[52] National AIDS & STI Control Programme (NASCOP), Ministry of Health. 2018. Kenya National Guidelines for Prevention, Management and Control of Sexually Transmitted Infections. Nairobi: NASCOP.

Treatment occurs with the initial assessment, following a flowchart designed to guide the health care worker in making diagnostic and treatment decisions. Implementing partner clinics should have the following two components: management of symptomatic infections using national syndromic management flowcharts and laboratory diagnoses where available.

Active referral networks should be established, and screening and testing programmes should be integrated with other services used by the transgender community. STI diagnosis and treatment services should be co-located with HIV services used by the transgender community. Special attention should be paid to ensuring community-friendly STI service delivery.

The following packages of STI/HIV services are to be provided:

- Health promotion and STI prevention activities, such as promoting correct and consistent use of condoms and water-based lubricants and other safe sexual practices
- Provision of free condoms and lubricants
- Screening, diagnosis, and treatment of genital, oral, and anal STIs as per national guidelines
- Health education and counselling for treatment compliance
- Counselling for use of prevention methods (condoms, PrEP, and PEP)
- Quarterly check-ups for STIs
- Follow-up services
- Referral links to other relevant services

Harm reduction interventions

Harm reduction is a range of public health policies and practices that aim to mitigate the consequences associated with certain behaviours. Harm reduction programmes for transgender women who inject soft-tissue fillers, Botox, or hormones can reduce adverse side effects and lower the risk of infection. Similarly, harm reduction programmes for transgender people who use and inject drugs can prevent overdose, reduce the spread of infections like HIV and viral hepatitis, and reduce drug- and alcohol-related fatalities.

» Opioids

For people dependent on opioids, opioid substitution therapy (OST)—sometimes referred to as medically assisted therapy (MAT)—is highly effective in reducing injecting behaviours that put opioid dependent people at risk for HIV.[53] MAT can reduce opioid use and improve retention in HIV treatment.[54] Access and adherence to MAT can improve health outcomes, reduce overdose, reduce criminal activity, result in better psychosocial outcomes, and decrease risk to pregnant women dependent upon drugs and to their infants. Methadone and buprenorphine, are the most commonly used drugs used to manage heroin and other opioid dependence.

Needle and syringe programmes and opioid substitution therapy are part of the comprehensive harm reduction package recommended in Kenya's *National Guidelines for HIV/STI Programming with Key Populations.*[55]

Transgender women face multiple barriers to accessing appropriate gender transition services, and these barriers make them more likely to self-medicate and self-inject without appropriate supervision, training, equipment, or drugs and medications. Harm reduction programmes should caution transgender women about the following substances and risky practices.

» Soft-tissue fillers/silicones

Transgender women who wish to feminize their bodies often seek hormonal treatments (oestrogens and androgen blockers). The timeline for seeing effects from hormone therapy varies, but many of the changes, such as breast growth, can take an average of two years. For transgender women who want to have more rapid changes, or for those who are unable to access transition care, the non-medical use of soft tissue fillers may be the only available option.

Injectable fillers provide rapid and welcome physical changes, and many transgender women are willing to risk potential complications. These fillers are sometimes obtained from unlicensed or non-medical practitioners. Soft-tissue fillers, or silicones (dimethyl polysiloxane), are usually injected into the hips, buttocks, thighs, breasts, lips, and face.

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[53] Institute of Medicine of the National Academies. 2007. Preventing HIV Infection among Injecting Drug Users in High Risk Countries: an Assessment of the Evidence. Washington, DC: National Academy of Sciences. https://www.nap.edu/catalog/11731/preventing-hiv-infection-among-injecting-drug-users-in-high-risk-countries.

[54] Ward J, Mattick RP, and Hall W, eds. 1998. Methadone Maintenance Treatment and Other Opioid Replacement Therapies. Sydney: Harwood Academic Publishers. http://www.drugsandalcohol.ie/3767.

[55] National AIDS & STI Control Programme (NASOP), Ministry of Health. 2014. National Guidelines for HIV/STI Programming with Key Populations. Nairobi: NASCOP.

The silicone is usually not medical grade and may be contaminated or mixed with sealants, baby or cooking oils, or even cement. The use of soft-tissue filler injections may be associated with several adverse outcomes, including blood-borne and tissue infections, granuloma formation, metabolic abnormalities, silicone migration, cosmetic defects, nodules, and ulceration.

Services for transgender people should use a harm reduction approach, whereby health care workers provide clean needles, gloves, advice about aseptic techniques to reduce injection site infections, and referrals to medical support where available. Clients should be advised against sharing needles or participating in pumping parties, where the risk of blood-borne contamination is greatest.

» Botox

Another common augmentation is injecting Botox to remove fine lines and wrinkles. Though it is advisable to administer Botox via an experienced healthcare provider, due to the expense, many transgender women opt to have Botox injected informally, such as at a "Botox party," where people inject one another with Botox without a licensed health care worker or the medical equipment necessary to respond to complications or side effects.

If the injections are not placed correctly, eyelid droop, cockeyed eyebrows, crooked smile, and dry or excessive tearing may result. Botulism-like signs and symptoms (muscle weakness all over the body, vision problems, trouble speaking or swallowing, trouble breathing, and loss of bladder control) are possible if the botulin toxin spreads to other parts of the body, but this is rare. If needles for the injection are shared between people, the risk of blood-borne infection significantly increases. Health care workers should explain the risks of injecting Botox without appropriate medical supervision or equipment, and should offer safer alternatives, like medical supervision or clean needles, to reduce side effects and possible blood-borne infection.

» Hormones

An additional source of injection risk for transgender people is hormone injection. Transgender people who cannot obtain hormones from a legitimate source may inject hormones from an alternate unsafe source. Healthcare providers providing services to transgender people should refer those interested to access hormones and other gender-affirming health services from a competent health professionals.

Differentiated HIV testing services

HIV testing services (HTS) refers to the full range of services that should be provided together with HIV testing. These include counselling (pre-test information and post-test counselling); linking to appropriate HIV prevention, treatment, and care services and other clinical and support services; coordinating with laboratory services to support quality assurance; and delivering correct results. HTS is an important opportunity to put those at risk of HIV in contact with primary prevention programmes and encourage later retesting. The transgender population, being a subset of key populations, should be offered quarterly testing, as per the national key population guidelines.

Increasing rates of HIV testing among transgender people is a major challenge. Expanding culturally appropriate, focused HIV testing is key to improving access to services and reducing HIV's impact on transgender communities. Tailoring HIV testing activities to eliminate the barriers faced by transgender people might increase their rates of testing. Promoting partner testing may also increase rates of HIV testing and linkage to care.

There is a need for non-discriminatory, confidential, high-quality, voluntary, and safely accessible HIV testing, prevention, and education services for the transgender population.

Programmes should consider offering HIV prevention and testing services in a range of outreach settings to increase the availability and use of these services by transgender people. Given the reluctance among transgender people to access facility-based HTS, it is very important that community-based options be available, and these should be offered by a range of providers and models. Community-based HIV testing and HIV self-testing should be linked to prevention, care, and treatment services. Health service providers should be trained in transgender competent care to provide stigma-free services.

Differentiated HIV care and treatment (ART)

The goal of HIV care and treatment is to restore the immune system, reduce HIV and AIDS related morbidity and mortality, improve quality of life, decrease viral load, and reduce HIV transmission to partners of transgender people who are living with

HIV. The UNAIDS 90-90-90 targets emphasize the importance of "reach–test–treat–retain," which entails 90% of all people living with HIV knowing their HIV status, 90% of all people with diagnosed HIV infection receiving sustained antiretroviral therapy, and 90% of all people receiving antiretroviral therapy having viral suppression.

Transgender people should have the same access to HIV care and treatment as other populations. HIV care and treatment services are widely available in public, faith-based, and private facilities in Kenya for those with confirmed HIV positive status. It is important that transgender people diagnosed with HIV be referred promptly to care and support programmes and begin antiretroviral therapy as soon as possible. There should be ongoing support, follow-up, and engagement for long-term adherence to ART, which ultimately leads to a suppressed viral load.

These services should be welcoming and competent in the care of transgender people. Barriers to engagement and retention in HIV care include stigma, past negative experiences, prioritisation of hormone therapy, and concerns about interactions between ART and hormone therapy. Health care providers in the ART centres can be trained in transgender medical issues especially integration of HIV care into hormone therapy so that patient centred HIV care can be provided.

Strategies such as differentiated service delivery, including ART delivery at the community level, and psychosocial support could help positive transgender persons to initiate and be retained on ART, leading to viral suppression.

Prevention and management of co-infections and co-morbidities

This includes screening and treatment for tuberculosis, cancers, hepatitis, diabetes, alcohol use, and mental health issues.

» Tuberculosis (TB) screening and treatment

People from the transgender community should have the same access to TB prevention, screening, and treatment services as other populations. All transgender people should be regularly screened for TB using a clinical algorithm. All TB clients should receive the recommended treatment regimen for TB in addition to prevention, diagnosis, care and support as per the national guidelines.

» Screening and treatment for cervical, anal, and other cancers

Cervical cancer screening is the process of identifying precursor/precancerous lesions (CIN) or cancerous cells in the cervix. Human papillomavirus (HPV) is an STI and etiological agent of cervical cancer cases.

Cervical cancer screening leads to early detection and treatment of CIN, decreasing the incidence of cervical cancer.

» Specific considerations are needed for transgender men

- Transgender men who retain their female genitalia often miss out on cervical screening and other sexual health services, as they may not seek out or may be excluded from those services. As a result, they face increased risk of ovarian, uterine, and cervical disease.
- Following total hysterectomy, if there is a history of high-grade cervical dysplasia and/or cervical cancer, the person can be referred for a Papanicolaou test of the vaginal cuff on an annual basis.
- Following removal of ovaries, but where the uterus and cervix remain intact, WHO cervical screening guidelines for natal females can be followed after detailed history taking. It is important to inform the service provider of current or prior testosterone use, as cervical atrophy can mimic dysplasia.

» Elements of cervical cancer screening

Cervical cancer screening should be conducted in line with national guidelines. The type of screening technique will be determined by service providers and will comply with national standards.

» Screening for anal and other cancers

Screening for breast cancer, ano-rectal, and prostate cancer should be part of routine care, and links to treatment services should be provided. People infected with HIV are at least 20 times more likely to be diagnosed with anal cancer than uninfected people. Like cancer of the cervix, anal cancer is associated with human papillomavirus. Screening can be performed for anal cancer and its precursors, known as anal high-grade squamous intraepithelial lesions (HSIL), particularly for transgender people who engage in anal sex.

» Viral hepatitis screening, vaccination, treatment, and care

Hepatitis B virus (HBV) has had a significant impact on key populations, including transgender people, especially transgender women. The major modes of HBV transmission include sexual intercourse, unsterile medical injections, blood transfusions, and injecting drug use / hormone use. Although hepatitis C virus (HCV) is rarely transmitted sexually, it is of significant concern to people who inject drugs. Both HBV and HCV can cause acute inflammatory hepatitis, which can result in fulminant liver failure. Chronic infection can result in liver fibrosis and ultimately cirrhosis and hepatocellular carcinoma; conditions resulting in increased mortality. Additionally, HBV and HCV can complicate HIV treatment, and HCV can accelerate the progression of HIV disease.

For people who inject drugs, sharing contaminated needles and syringes is the most common mode of HCV transmission, although sharing other equipment, such as spoons and filters, has also been associated with HCV transmission. HCV is substantially more infectious than HIV, and many people who inject drugs are repeatedly exposed to HCV. This results not only in higher incidence rates but also in reinfection after clearance of HCV. HCV is more difficult to transmit through unprotected sexual intercourse than HIV. There is evidence that, among people who are co-infected with HIV and HCV, traumatic sexual practices or ulcerative STIs are conducive to sexual transmission of HCV.

HBV vaccination is inexpensive, safe, and effective. It produces an immune response adequate to protect against infection in close to 100% of children and about 95% of adults, lasting at least 10 years. The risk of acute infection is very low in fully vaccinated individuals.

Service providers for transgender people should inform the clients about the risk of viral hepatitis, vaccination for HBV, and treatment for HCV. Where feasible, vaccination for HBV should be provided to transgender people either directly or through referral. Transgender people should be also encouraged to take tests for diagnosis of HCV and complete treatment if positive, either through direct administration or referral. When treating viral hepatitis among transgender people taking hormones for gender affirmation, it is important to screen for interactions between hormone therapy and hepatitis medications. Due to the more rapid progression of hepatitis-related liver diseases in people infected with HIV, treatment for hepatitis and HIV should be prioritized in people who are co-infected.

» Diabetes screening and management

Gender-affirming hormone therapy may sometimes contribute to weight gain and other risk factors for diabetes. For example, oral oestrogens may increase triglycerides and insulin resistance, and testosterone may increase hemoglobin/haematocrit, although these effects appear to be modest. Research suggests that transgender people may also have a high prevalence of tobacco use and hazardous drinking, which can increase the risk of diabetes.

When screening transgender patients, it is important to know that gender-affirming hormone treatment may increase blood pressure, blood glucose, and weight. It is recommended that transgender patients taking masculinizing or feminizing hormone therapy are counselled about the need for regular screening for diabetes and high blood pressure.

» Alcohol Use

All transgender people should be screened for alcohol use. Alcohol and substance use/dependence increase HIV-risk by diminishing inhibitions. Those with harmful alcohol or other substance use should be provided access to evidence-based interventions, including brief psychosocial interventions involving assessment, specific feedback and advice either directly through the programmes or through referral.

» Mental health issues

In addition to being disproportionately burdened by STI and HIV, transgender people experience high rates of depression, anxiety, smoking, alcohol and substance abuse, and suicide as a result of chronic stress, social isolation, and disconnection from a range of health and support services.

Transgender people living with HIV experience double jeopardy because of their gender identity and expression as well as their HIV status. It is therefore important that they are able to access comprehensive, transgender-competent psychosocial support from qualified transgender-competent psychologists either directly or through referral.

Every clinical visit should include a mental health history and an assessment for active mental health concerns. Screening also requires provision of appropriate referrals to transgender-affirming mental health services when needs are identified.

Transgender and gender nonconforming people, in general, have three types of needs that affect their mental health:

Exploration of gender identity

This includes determining exactly what one's gender identity is, coming to terms with this gender identity, self-acceptance, and exploring individual–level ways to actualise this identity in the world. This may also include preparation and assessment for various gender affirming treatments and procedures.

Coming out and social transition

This includes coming out to family, friends, and co-workers, dating and relationships, and developing tools to cope with being transgender.

General mental health issues, possibly unrelated to gender identity

The variety of mental health concerns experienced by transgender people includes mood disorders, generalised anxiety, substance abuse, and post-traumatic stress disorder (PTSD).

Condom and lubricant programming

The goal of condom and lubricant programming is to increase the availability, accessibility, affordability, and use of condoms and condom-compatible lubricants among transgender people. Male condoms, when used correctly and consistently, reduce sexual transmission of HIV and other STIs in both vaginal and anal sex by up to 94%. Using lubricants can reduce tearing of the anal or vaginal lining. Small tears increase one's risk of contracting or spreading HIV and other STIs. Condoms and condom-compatible lubricants are recommended. Adequate provision of lubricants for transgender people who have sex with men needs emphasis.

A dental dam is a stretchy, flat latex barrier that can be placed over the vagina or anus to prevent transmission of infection during oral sex. For protection of oneself and sex partners against HIV and other STIs, both need to use condoms, dental dams, and lubricants where appropriate.

2.6.4
Desirable biomedical interventions

Hormone replacement therapy

Transgender people need to take hormones to align their physical appearance with their gender identity. This also has positive implications and is mentally therapeutic. Hormone therapy makes transgender people feel more at ease with themselves, both physically and psychologically. Feminising medications include oestrogen-based formulation and sometimes medication to reduce effects of testosterone. Masculinising medications include testosterone-based formulation and medication to lower oestrogen levels.

Hormones should be prescribed by a trained health care worker using acceptable guidelines. As part of the broader gender affirming health services, it is important that this brings on board coordination of an endocrinologist, a clinical psychiatrist/psychologist, a urologist, a gynaecologist, and a medical lab scientist, as well as accompanying physician specialists in orthopaedic medicine, cardiology, liver, and renal health.

In a transgender people programme, the community drop-in centres should map, strengthen linkages and integration with specific transgender-competent public health facilities that community members can access on referral in its catchment area. It is important that these public health centres receive regular capacity building in transgender-competent health care.

Clients should be informed about the risk of hormone use and about the reversible and irreversible changes that will occur, so that they are able to plan ahead.

» HIV and hormonal therapy

Qualitative data suggest that hormone therapy is a greater priority to transgender people than HIV treatment and care. HIV infection and ART are not contraindications for the use of hormone therapy. Offering hormone therapy directly or through referral can facilitate and motivate transgender people to access clinical services for HIV and STIs.

Gender-affirming surgeries

Transgender people may have surgery to more closely align their appearance with their gender identity. There is no single model of sex-change surgery, but rather a variety of surgeries that people may choose. Even in high-income countries, gender-affirming surgical procedures are not widely available because there are few surgeons specifically trained. The drop-in centre for transgender people should map the potential service delivery points that offer these specialised services and refer those who are interested.

2.6.5 Service delivery models

A variety of service delivery models can be used to provide a comprehensive continuum of HIV prevention, diagnosis, treatment, and care to transgender people, depending on the context of the county, including the estimated number of transgender people and available resources.

The transgender community is currently part of the key populations in Kenya, and thus the services could be provided through transgender-led DICs, within the existing key population friendly DICs and integrated sites within government facilities. The services could be provided in the static or outreach clinics preferred by the community as well as through referral. These services should be acceptable, accessible, and available to transgender people.

There is limited data on clinic-based interventions designed for the transgender community, however some approaches to reach the transgender population may be adapted from the existing key population models.

» Stand-alone key population clinics / drop-in centres

In Kenya, there are key population friendly clinics, which are stand-alone and housed within the drop-in centres for key populations.[56] These facilities offer a minimum package of services to the key populations, and the service providers are sensitised to provide key population friendly services. The transgender community, being part of the key populations, can easily access services from these facilities. However, there is need for additional services and specialists within these spaces to provide services tailored to transgender-specific needs.

» Integrated key population clinics

Some key population clinics are integrated within government health facilities that provide space. The key population programme either hires additional service providers or uses existing trained service providers from the health facility to provide services. The transgender community, being part of the key populations, can easily access services from these facilities.

However, there is need for additional training and linkage with specialised services within these clinics to provide services tailored to transgender-specific needs.

» Government health clinics

The HIV programme with transgender people can map the government facilities near the intervention sites and identify a few of these facilities as referral sites, based on the preference of the community. Service providers in these referral sites should be trained to provide gender-affirming services that are confidential and nondiscriminatory.

» Outreach/mobile clinics

Outreach/mobile clinics are conducted at the hotspots targeting the hard-to-reach key populations. Outreach clinics normally

[56] "Stand-alone" clinics are clinics that serve only members of a key population (e.g., transgender people) and are managed by them.

are conducted in a hired place in the hotspot or near the hotspot which is safe and accessible for the key populations. Mobile clinics are normally conducted using a fully equipped mobile van at the hotspots. Peer educators mobilise peers at physical or virtual sites to receive services at outreach/mobile clinics, which run during times and at locations preferred by the community. Outreach clinics should be held wherever dense clusters of key populations exist in hotspots that are distant from key population friendly clinics. In case provision of a comprehensive package of services for transgender persons is not possible through outreach clinics, appropriate referral should be made for follow-up.

» Referral networks

Some facilities may not provide the entire comprehensive package of services for transgender people, so there is a need for a referral system that refers transgender people to service providers in other facilities. A referral network includes making and tracking referrals, establishing a referral directory, and monitoring the referral process.

2.6.6 Implementation considerations

1. **Right capacity** - Capacity of providers to provide gender affirming services is strengthened. Capacity of transgender community should be built to provide some of these services.
2. **Optimal staffing** - The clinics should have optimal of service providers that directly or through referral
3. **Accessible services** - Programmes should use mapping data to know where to place the services to reach high number of estimated population.
4. **Acceptable services** - The location of the services including the referrals services and selection of the service providers need to be done in consultation with the transgender community.
5. **Adequate commodities** - Essential commodities required by transgender people, including condoms, lubricants, PrEP, PEP, ART, viral hepatitis vaccines and treatment, STI drugs, needles, and syringes, should be available at all times directly or through referral.
6. **Flexible timing** - Clinic timings need to be flexible to accommodate transgender people's varied schedules.
7. **Right tools** - Service delivery points need to have appropriate national tools for data collection, national guidelines for service provision, IPC materials for education, and appropriate referral tools.
8. **Right infrastructure** - Service delivery points need to be secure and large enough for services to be provided in privacy. It is ideal if the service delivery point also has space for a drop-in centre where community members can access information, psychosocial support, and other services.
9. **Comprehensive and integrated services** - Service delivery points should attempt to provide comprehensive services either directly or through referral to cater for the diverse needs of transgender people. Integration of gender-affirming services within primary health care facilities catering to the needs of transgender can be strengthened for sustainability.

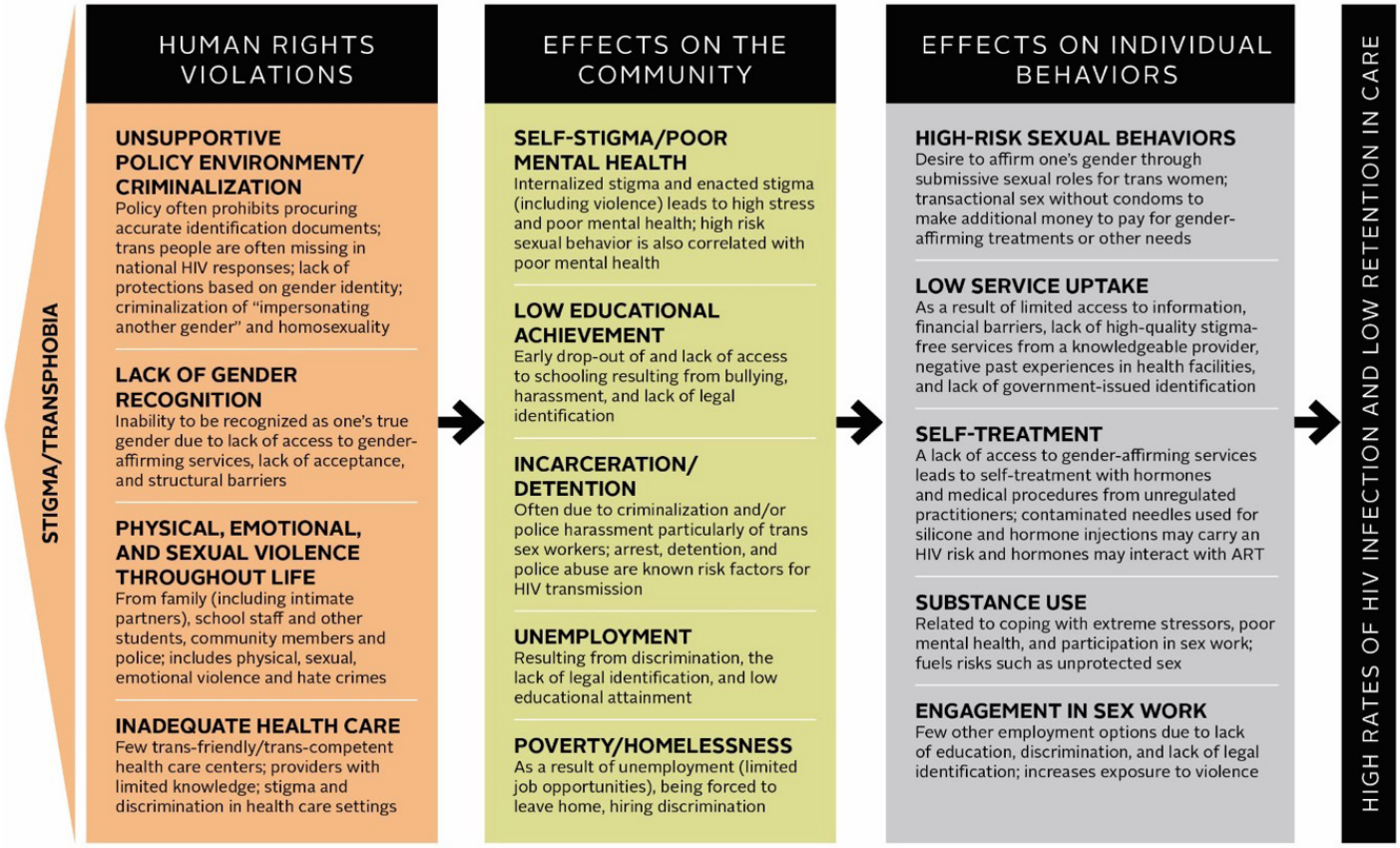
2.7 STRUCTURAL INTERVENTIONS

2.7.1 Introduction

HIV-prevention efforts with transgender people cannot fully succeed without addressing structural issues that make people vulnerable to HIV infection. In addition to behavioural and biomedical interventions, which target high-risk individuals and groups, HIV prevention programmes must simultaneously address structural factors. For key populations, many factors that influence a person's risk are largely outside that person's control. Particularly for transgender people, social, legal, economic, and other contextual factors both increase vulnerability to HIV and obstruct access to HIV services. Such factors include punitive legislation and policing practices, stigma and discrimination, poverty, and violence. By limiting access to information, prevention services and commodities, and care and treatment, these factors affect how well individuals or populations can protect themselves from, and cope with, HIV infection.[57]

Figure 8 describes how structural factors that violate human rights affect transgender people collectively and as individuals.

Figure 8. The effects of human rights violations on the transgender community and individuals [58]



Structural interventions address social, economic, political, and environmental factors that affect individual or group HIV risk and vulnerability, and typically involve at least one of the following: effecting policy or legal changes, challenging harmful social norms, catalysing social and political change, and empowering communities and groups. These approaches must be implemented in combination with behavioural and biomedical approaches and should be based on scientifically derived evidence and on the wisdom and ownership of communities.

Structural approaches to HIV prevention should be implemented in a contextually sensitive way. Most structural interventions need collaborative effort and networking skills, and may be beyond the scope of an individual implementing partner /CBO.

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[57] WHO. 2014. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. Geneva: WHO. http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1Con.

[58] Source: FHI 360/LINKAGES.

[59] Gupta GR et al. 2008. Structural approaches to HIV prevention. Lancet. 372(9640):764-75. doi: 10.1016/S0140-6736(08)60887-9.

[60] Auerbach J. 2009. Transforming social structures and environments to help in HIV prevention. Health Aff . Millwood. 28:1655. doi: 10.1377/hlthaff.28.6.1655.

[61] Merson MH et al. 2008. The history and challenge of HIV prevention. Lancet. 372(9637):475–488. doi:10.1016/S0140-6736(08)60884-3.

Implementers should, therefore, network and collaborate with organisations that can address these issues and develop a comprehensive structural intervention strategy for the specific key population in the local area.

2.7.2
Objectives of structural interventions

- To reduce HIV and STI vulnerability
- To create an enabling environment for service delivery to transgender people
- To reduce violence, stigma, and discrimination against transgender people
- To increase recognition and respect for transgender people through laws and policies
- To protect, fulfil, and respect the rights of transgender people
- To create awareness on transgender people's needs and issues among the general public and other minorities
- To create dialogue platforms on transgender issues
- To meaningfully involve transgender people in HIV programming
- To empower, strengthen, and build capacity of the transgender community

2.7.3
Structural interventions package

The structural interventions package is designed to reduce transgender people's HIV vulnerability by empowering them to access services and advocate for their rights, by reducing stigma and discrimination, by preventing violence, and by reviewing discriminatory laws and policies (Figure 9).

Structural interventions package

1. **Violence prevention and response:** Implement strategies to ensure that violence against the transgender community is addressed and reduced.
2. **Addressing stigma and discrimination:** Address all aspects of stigma and discrimination by educating and training various stakeholders about the transgender community.
3. **Community empowerment:** Build the capacity of the transgender community to mobilise and empower them to address service barriers.
4. **Law and policy review:** Undertake a law and policy review to understand the legal environment and thereafter engage various stakeholders to ensure support to the transgender community for service delivery and access.

Figure 9. Structural interventions package

Violence prevention and response

In programming for violence screening and support for transgender people, programmes should be guided by the following principles:[62]

- Do no harm.
- Promote the full protection of human rights of transgender people.
- Respect the right of transgender people to make informed choices (self-determination) and to access the full range of services recommended for victims/survivors of violence (provided to them free of stigma and discrimination).
- Promote gender equality and challenge harmful gender norms that contribute to violence.
- Be responsive to local patterns of violence and barriers to accessing services.
- Use participatory methods to ensure that transgender people are involved in design, implementation, and evaluation activities for violence screening and support.
- Build capacity of programme staff and transgender communities to understand and address the violence and the link to HIV.
- Integrate violence screening and support into HIV prevention, care/treatment programming, and research.
- Ensure privacy, confidentiality, and informed consent during all interaction with victims/survivors of violence.
- Monitor and evaluate programmes to identify any unintended harmful impacts and develop strategies to improve violence screening and support programming.

To activate and implement violence screening, support, and linkages, the programme will undertake the following actions:

- Engage, train, and sensitise key stakeholders.
- Hold community dialogues to challenge oppressive cultural and social norms.
- Empower transgender-led programmes and organisations to implement violence and response interventions.
- Undertake campaigns to highlight violence against transgender people (e.g., through social media, road shows).
- Develop and distribute IEC materials.
- Provide legal aid to transgender survivors of violence through lawyers, paralegals, and trained community members.
- Arrange legal clinics to empower transgender people on legal mechanisms and protections.

Addressing stigma and discrimination

WHO recommends that health services should be made available, accessible, and acceptable to key populations based on the principles of avoidance of stigma, nondiscrimination, and the right to health. Health care services are perceived as one of the highest perpetrators of stigma and violence.[63]

Complementary actions should be undertaken to reduce stigma related to HIV and transgender people in health care settings and communities. Programmes should be put in place to sensitise and educate health care providers on nondiscrimination and transgender people's rights to high-quality, gender-affirming, and noncoercive care; confidentiality; and informed consent. Transgender groups and organisations should be made essential partners and leaders in designing, planning, implementing, and evaluating HIV testing, care, and treatment services.

To address stigma and discrimination, the programme will

- provide gender-affirming HIV testing, prevention, and treatment services under one roof, so that transgender people do not have to go to different places for different services;
- integrate transgender-specific care within mainstream health facilities;
- involve transgender people in delivery, promotion, and monitoring of services;
- train health care workers on sensitivity and gender-affirming care (e.g., through exchange programmes); and
- develop proper data collection and management tools (i.e., tools that correctly capture transgender identities).

[62] National AIDS Control Council (NACC). Ministry of Health. 2017. National Violence Prevention and Response Protocol: A Means to Enhancing HIV Prevention. Nairobi: NACC. https://www.iavi.org/phocadownload/National%20Violence%20Prevention%20and%20Response%20Protocol%20NACC%202017.pdf.

[63] National AIDS and STI Control Programme (NASOP). Ministry of Health. 2014. National Guidelines for HIV/STI Programming with Key Populations. Nairobi: NASCOP.

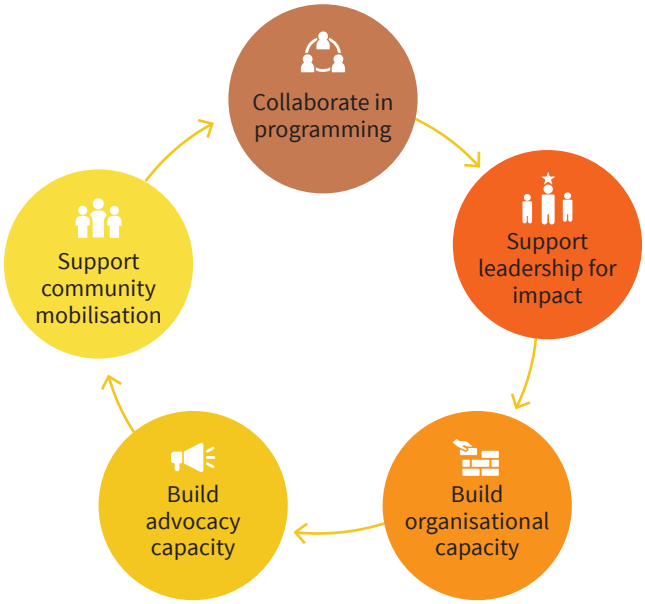
Community empowerment

Community empowerment is the process whereby transgender people take individual and collective ownership of programmes in order to achieve the most effective HIV responses. Community empowerment addresses the social, cultural, political, and economic determinants that underpin HIV vulnerability, and seeks to build partnerships across sectors to address them. Programmes should implement a package of capacity building interventions to enhance community empowerment among key populations.

Key elements of community empowerment among transgender people, shown in Figure 10, include:

- Collaborate with transgender communities in programming: meaningful involvement, inclusion, and leadership of transgender people is essential to establishing partnerships that have integrity and are sustainable in service delivery.
- Support transgender-led organisations to foster and support community leadership to achieve high impact.
- Build organisational capacity of transgender organisations to conduct robust and comprehensive programmes, strengthening resource mobilisation, governance, project management, and community systems.
- Build capacity of transgender organisations to influence policy through public advocacy promoting human rights.
- Support community mobilisation and sustain social movements, foster networking, and build organisational relationships to engage with state and non-state actors to advocate for access to health and social services.

Figure 10. Key elements of community empowerment for transgender people



Advocacy for transgender people in the context of HIV service delivery aims to
- facilitate universal access to health services,
- support the creation of an enabling environment for transgender programming and realisation of their rights, and
- promote stakeholders' recognition and understanding of the transgender community.

When planning advocacy, it is essential to involve and engage the key stakeholders, including transgender people. For guidance on building key populations' advocacy capacity, see the training manual, *Strength in Strategy and Numbers: A Training Manual on Building the Advocacy Capacities of Key Populations in Kenya*.[64]

Another critical aspect of community empowerment is strengthening livelihood support and addressing barriers to livelihoods for transgender people.

To address livelihood barriers, the programme should engage stakeholders to
- advocate for the design and development of workplace policies that would address and prevent violence, stigma, and

[64] National AIDS Control Council (NACC). 2014. Strength in Strategy and Numbers: A Training Manual on Building the Advocacy Capacities of Key Populations in Kenya. Nairobi: National AIDS Control Council. https://hivpreventioncoalition.unaids.org/wp-content/uploads/2020/02/Strength-in-Strateg-and-Numbers-A-training-Manual-on-Building-the-Advocacy-Capacities-of-Key-Populations-in-Kenya.pdf.

discrimination, and accommodate transgender people;
- build the capacity of the transgender community on livelihood support skills, so that they can undertake income generating activities; and
- undertake advocacy to the general population through campaigns and sensitisation for them to employ transgender people.

Law and policy review

Law and policy review is a desirable structural intervention to identify and review laws, policies, and practices that act as a barrier to health services. Laws and policies should be reviewed and revised by policymakers and government leaders, with meaningful engagement of transgender people and other stakeholders.

To achieve legal review, transgender programmes will need to
- undertake a needs assessment of the existing laws and policies;
- engage the policymakers and implementers through sensitisations, trainings, and exchange programmes for them to understand and be aware of the transgender community and their needs;
- meaningfully engage and participate in policy-making processes to ensure that their needs have been considered; and
- empower transgender-led programmes and organisations to advocate for policy change.

CHAPTER 3

Programme Management

03

3.1 INTRODUCTION

Programme management is key for ensuring effective implementation and monitoring of transgender programme activities. This chapter lists the programme's stakeholders, describes their roles, and makes recommendations for capacity building.

3.2 MANAGEMENT OF TRANSGENDER PROGRAMMES

Key stakeholders

In designing and implementing the transgender programme, the first thing should be identification of key stakeholders and their roles in the implementation process. This guideline therefore lists stakeholders who are key in setting up and ensuring effective implementation of programmes.

NASCOP

Anchored within the National Health Sector Strategic Plan, the National AIDS and STI Control Programme bears overall responsibility for implementing/managing key population HIV programmes in the country. Within the transgender programme, NASCOP will play a key role in developing standards in design, planning, implementation, quality assurance monitoring and evaluation in service delivery. The roles of NASCOP will include

- coordinating stakeholders to ensure optimal programme coverage;
- providing technical support to transgender programme implementing partners;
- monitoring service and data quality;
- coordinating development and review of transgender community affirming guidelines, including the M&E tools, training curriculums, and implementation guides;
- ensuring establishment of national and county Technical Working Groups (TWGs) / Committee of Experts (COE) and chairing the same;
- coordinating capacity building of stakeholders, including implementing groups, transgender people, clinical service providers, peer educators, and paralegals, through development of training guidelines and mentorship guides;
- providing TOT trainings and certification of training modules as defined by the transgender programme guide; and
- leading in the development of the implementation science agenda, conducting transgender-specific research, and dissemination of results.

NACC

The overriding mandate of National AIDS Control Council is to coordinate stakeholders in the multisectoral response to HIV and AIDS in Kenya. Within the architecture of transgender programme activities, NACC together with NASCOP will lead in multisectoral coordination and inclusion of transgender people in the national strategic framework. The NACC's key roles shall include

- including transgender programming in the UHC agenda,
- providing an enabling policy environment for transgender people,
- being part of the TWGs/COE at the national and county levels, and
- mobilising resources for programming with transgender people.

Donor organisations

Donor organisations are the key stakeholders who provide the resources to facilitate implementation of transgender programmes. These include PEPFAR, Global Fund, DFID, individual anonymous donors, etc. The roles of this category of stakeholders will include

- being part of the TWG/COE;
- coordinating with the national programme to understand national programme priorities;
- allocating funds for programme implementation in line with national programme priorities;
- prioritising funding for transgender community programming where there is need, in coordination with national and county government;
- supporting innovations and research;
- enhancing capacity of transgender community implementing partners;
- ensuring a robust and seamless system of leadership, governance, and management within transgender implementing organisations, with the support of NASCOP; and
- enhancing skills of transgender communities on resource mobilisation and sustainability.

» Transgender people led organisations / Organisations implementing interventions for transgender people

In their respective programme locations, the implementing organisations develop a programme proposal and workplan that guides the implementation of the intervention. The role of the organisations is to ensure the following:

- Transgender people in their intervention sites receive services that are in line with /address the national guidelines, as agreed in the contract/proposal.
- The transgender organisations are responsible for providing the essential combination prevention package discussed in the guidelines.
- The transgender organisations will report on indicators set by NASCOP on a monthly basis within five days of the month's end.
- The transgender organisations are responsible for
  - local problem solving, for which they may seek advice from the technical support unit in collaboration with the County AIDS and STI Coordinator (CASCO) and NASCOP;
  - recruiting the implementation team with required skills to provide quality services for the transgender community;
  - setting up and implementing monitoring and evaluation systems as guided by NASCOP;
  - reporting to NASCOP, using the standardised key population programme M&E system and structures;
  - being part of the TWGs/COE;
  - ensuring provision of transgender community friendly services in community facilities;
  - ensuring confidentiality and protection of transgender community personal data;
  - sensitising the service providers on the transgender population;
  - creating demand for services among the transgender community; and
  - strengthening transgender networks and collaborations through cross learning and exchange skills transfer.

» County Health Management Team (CHMT)

At county level, overall responsibility for the implementation of transgender population programming will belong to the County Health Management Team under the leadership of the Health Services Department County Health Executive and comprised of the following offices:

- County Health Executive
- Chief Health Executive
- County Director of Health
- County AIDS and STI Control Programme Coordinator

The responsibilities of CHMT are to

- facilitate an enabling environment for implementation and delivery of services,
- supervise service delivery and recommendation for accreditation and assignment of Master Facility List (MFL) code,
- conduct county-level key population Technical Working Group / Committee of Experts and other subcommittee meetings,
- facilitate integration of gender-affirming services with county public health facilities, and
- coordinate the implementation of HIV programmes for transgender people at the county level.

» Committee of Experts (COE)

The COE has membership of various stakeholders, including the communities, government agencies, donor organisations, implementing partners, and other development partners. Key mandate of the COE is to provide technical guidance for programme implementation, such as

- policy, strategy, and guidelines development and approval;
- training and capacity building;
- regular review of progress of the programme, especially to identify gaps and recommend solutions to address the same;
- sharing of learnings and results on implementation and research;
- feedback and guidance on commodity and supplies;
- service delivery;
- partnerships, networking, and resource mobilisation;
- conflict resolution; and
- oversight and technical support where needed.

COE is a space for coordination and engagement with stakeholders from varied sectors. In Kenya, there is already a COE for key populations. When needed, the COE can create subcommittees for specific subpopulations to discuss issues related to each specific population.

» Community Advisory Board (CAB)

CABs are formed at the implementation level. CABs consist of transgender community representatives, implementing agencies, law enforcers, religious leaders, peers, and health facility administrators who build and foster partnerships between the implementing partners and the transgender population. CAB members are the link between the community and the intervention, and are responsible for bringing feedback from the community to the board and sharing decisions or information discussed at CAB meetings to their respective transgender organisations/communities to ensure that programme needs are met.

» KP community led networks

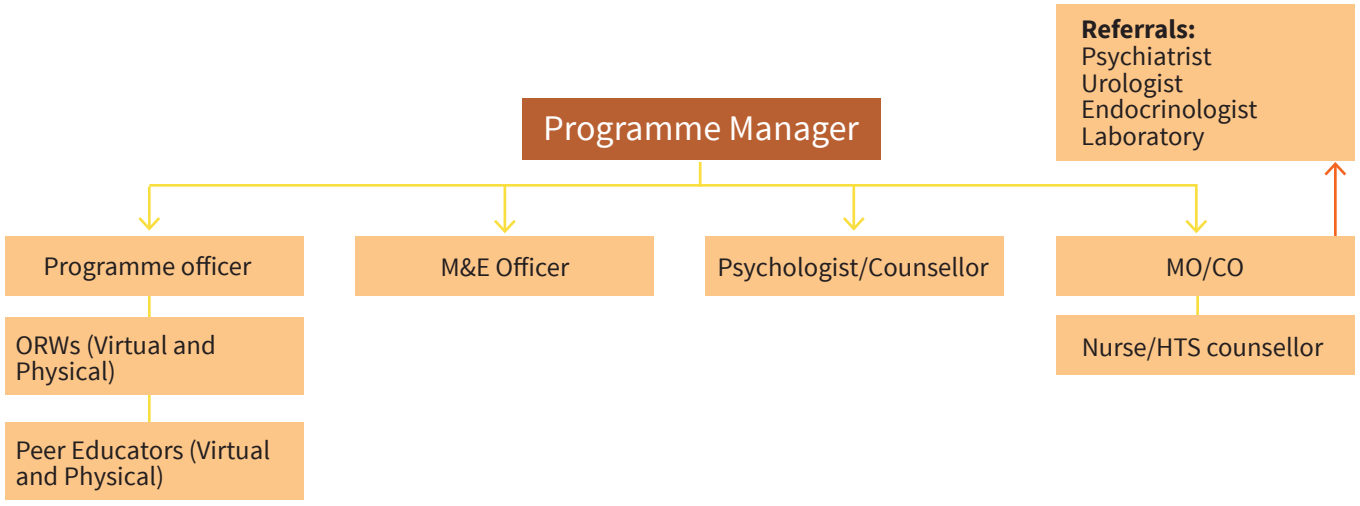
Transgender-led organisations are members of key population community led networks. These networks are key stakeholders in HIV programming. The roles of the networks are to

- facilitate safe space for the transgender community to co-exist within the networks, and
- create a stronger voice for the key population community to advocate for their needs.

» Programme Management Team

Figure 11 is the organogram of the team implementing the HIV prevention programme with transgender people.

Figure 11. Organogram for the HIV programme with transgender people



» The roles of the team managing HIV prevention programming with transgender people

- Programme manager will oversee the overall implementation of the programme. This position should have a combination of skills for key population programme implementation, including the behavioural, structural, and biomedical aspects, and capacity for monitoring and evaluation.
- Programme officer will oversee outreach and behaviour change communication interventions. Programme officers should have experience working with key populations and skills in communication and outreach. This position will manage the work of outreach workers and peer educators.
- Outreach workers and peer educators will be responsible for outreach to the transgender population, provision of commodities, referrals, follow-up, and structural intervention. They will also be responsible for supporting transgender people in responding to stigma and discrimination. PEs and ORWs can be further split into virtual and physical PEs and ORWs. The roles are described in detail earlier under behavioural interventions.
- Monitoring and evaluation officers will generate reports and monitor the quality of reporting.
- Psychologist/counsellor will provide mental health interventions for the clients.
- Clinical officers and nurses / HTS counsellor will provide biomedical components of the programme. Counsellors will also support behaviour change of transgender people accessing the services during the process, and this will include HIV testing services and referrals.

» Referral networks

- Psychiatrists will be on referral basis where resources do not allow direct recruitment. Psychiatrists will provide mental health services, including treatment to individuals who need more specialised psychiatric services.
- Endocrinologists and urologists will provide services on referral basis.

» Employment considerations

The DICs may include non-transgender and transgender people on staff. Transgender people can occupy all positions for

which they are qualified within the implementation team, including leadership positions. Community outreach through peer educators and outreach workers should be done by transgender people only. Recruitment and stipends/ honorariums / other forms of remuneration for programme staff and peer educators should follow national guidelines and any other Ministry of Health guidance on remuneration and recruitment of health workers and community health workers.

Staff members will be hired with specific roles and job descriptions, but they will need to be flexible in delivering services, adapting to new situations, and incorporating new approaches. Since a crucial goal of effective HIV and STI programmes is to empower transgender communities, non-transgender staff will learn from transgender people, while also serving as mentors. Capacity strengthening of transgender staff is important and will be conducted routinely, with the intent of progressively increasing their engagement and leadership.

» Capacity building

It is important to continually build the capacity of both the transgender and non-transgender staff for progressive and continuous programme implementation. The staff shall be capacitated through various ways (e.g., online and venue-based trainings, field exposure, supervision and mentoring, and interactive problem-solving sessions). Materials will be tailored to meet individual capacity-building needs, with pre- and post-assessments to monitor quality of trainings.

Capacity building for programme staff may include

- orienting staff to the issues experienced by transgender people, ensuring correct use of names and terms;
- acquainting staff with specifics of the project (e.g., intervention elements, reporting procedures); and
- building technical skills in new areas (e.g., clinical skills, including hormone replacement therapy; anal, vaginal, penile and oral examinations for STIs; counselling on transgender issues; specificities of working with young/adolescent transgender people).

CHAPTER 4

Monitoring and Evaluation

04

4.1 INTRODUCTION

Monitoring and evaluation (M&E) is a key component of transgender programme design and implementation. In this section, the guidelines provide guidance on the minimum requirements for setting up a strategic information system that will facilitate effective monitoring, evaluation, learning, and research. Monitoring and evaluation of the programme will be guided by routine data collected during implementation, research data collected for specific learning, and the ability to triangulate the two data forms to guide and inform innovation and targeted implementation. This section will therefore be guided by three subsections:

- Data collection system based on the programme's needs. This will include the tools for data collection, reporting, and systems for data use and decision making.
- Logical framework describing the relationship between activities and expected measurable outputs and outcomes.
- Reporting structure.

4.2 DATA COLLECTION SYSTEM

HIV interventions with transgender people will generate and use programme data for programme improvement. NASCOP's Key Populations Programme has a system of data collection that collects data at all service delivery points. Data collection tools for transgender interventions will need to record service and commodity data collected at the community level by peer educators and outreach workers, and at the clinic level by health care workers.

The 2018 revised version of the key populations data collection tools accommodate the transgender typology, and therefore the transgender programme will fit in the national key populations data collection system with additional tools developed to collect data on transgender-specific needs, if needed.

The key populations data collection toolkit consists of standardized data collection tools developed by NASCOP's Key Populations TWG with an accompanying reference manual which guides users on how to fill, when to fill, and who should fill. The tools are disaggregated by KP typology as FSW, MSM, MSW, PWID, PWUD, Transgender. The data collected is aggregated in longitudinal registers for services and commodities.

The following are the pack of tools:

1. Community outreach tool

- Contact Form
- Peer Educator Outreach Calendar (Key Populations)
- Outreach Worker's Summary Sheet (Key Populations) (MOH 728)
- Hotspot Listing Tool (Key Populations)
- Peer Educator Follow Up Tracking Form
- Peer Tracking Register (Key Populations)
- Peer Educator /ORW Overdose Encounter Reporting Tool
- Referral Register for Social-Protection Services

2. Clinical tools

- Clinic Enrolment Form
- Clinic Visit Form
- STI Treatment Data Collection Form
- Alcohol Abuse Screening Tool
- Patient Health Questionnaire-9 (PHQ-9) for Depression Screening
- Health Care Worker Overdose Encounter Reporting Tool

3. Programme level tools

- Violence Reporting Form
- Training Summary Tool
- KP Cohort Register

4. Commodity Tools

- Stock Control Card
- Counter Requisition & Issue Voucher (Form S11)

- Facility Daily Activity Register (F-DAR) for Commodities (STI, Overdose Management, and Hep B&C)
- Facility Issuing Register for Condoms, Lubricants, Needles and Syringes and HIV Self-Test Kits
- Outlet Register for Condoms and HIV Self-Test Kit

» Monthly and quarterly reports

The transgender interventions will be required to report service data and commodity data every month through the Kenya Health Information System (KHIS) using the approved reporting tools: the Key Populations Reporting Form MOH 731 Plus for key populations and the Facility Consumption Data Report and Request (F-CDRR) for key populations. These reports should be submitted before the 5th day of every month to the sub-county health records and information officers (MOH 731 plus) and sub-county pharmacist (F-CDRR-MOH 739) at the respective counties of implementation for entry into the KHIS.

Additionally, the programmes are expected to submit a quarterly report to NASCOP before the 15th of the month following the quarter.

In summary, the following three reports will be expected:
- Key Populations Reporting Form (MOH 731 Plus) – reportable monthly
- Facility Consumption Data Report and Request (F-CDRR) for Condoms, Lubricants, Needles and Syringes, Overdose, STI, Hepatitis B&C, and HIV ST (MOH 739) – reportable monthly
- NASCOP KP Quarterly Reporting Tool – reportable quarterly

The programme monitoring system is in the process of developing electronic medical records (EMR) for individualised tracking and will include reports for transgender clients.

4.3 LOGICAL FRAMEWORK

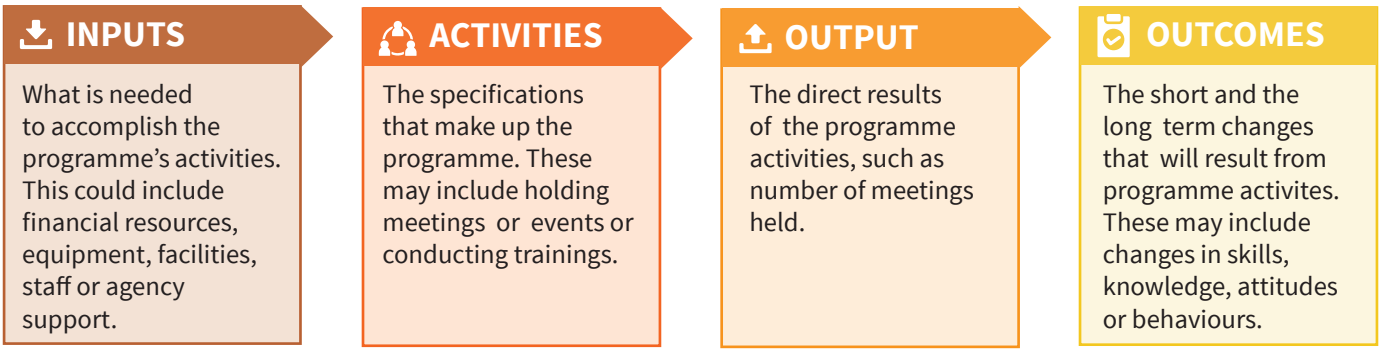
4.3.1
Indicators to measure programmes with transgender people

Typically, the types of data needed to measure programme progress and achievements are:
a. inputs required for implementing the programme's activities,
b. immediate outputs related to the inputs,
c. outcomes derived from the outputs, and
d. impact (Figure 12).

Evaluation logic dictates that it is essential to show that outputs have been achieved before starting to look for outcomes, and that adequate outcomes have been achieved before looking for impact.

All programmes are expected to conduct routine monitoring of inputs and outputs. Most programmes should also conduct some basic process evaluations informed by data from input and output monitoring. In Kenya, NASCOP conducts outcome monitoring and outcome evaluations. Impact monitoring is also the responsibility of the national level.

Figure 12. Intervention logic



Key indicators to measure an HIV prevention programme for transgender population include:

≫ Impact level

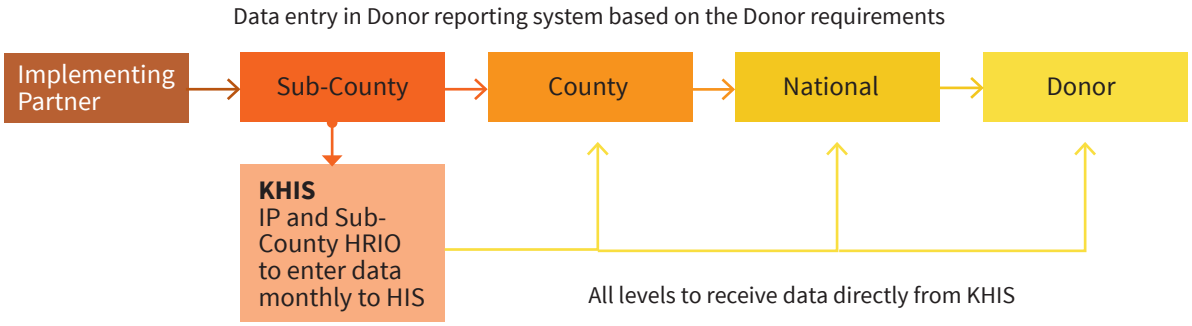
- Percentage of transgender people who are living with HIV (by age)

≫ Outcome level

- Percentage of transgender people reporting using a condom in their last anal sex with a non-regular male partner
- Percentage of transgender sex workers reporting the use of a condom with their most recent client
- Percentage of transgender people who inject drugs reporting the use of sterile injecting equipment the last time they injected
- Percentage of transgender people living with HIV who know their HIV status at the end of the reporting period
- Percentage of transgender people living with HIV and on ART who are virologically suppressed
- Percentage of transgender people who avoid health care because of stigma and discrimination
- Percentage of transgender sex workers who avoid health care because of stigma and discrimination
- Percentage of transgender people who inject drugs who avoid health care because of stigma and discrimination
- Percentage of transgender people living with HIV reporting their rights were violated who sought legal redress
- Percentage of transgender people living with HIV not on ART at the end of the reporting period
- Percentage of transgender people reached with HIV prevention programmes - defined package of services
- Percentage of transgender sex workers reached with HIV prevention programmes - defined package of services
- Percentage of transgender people who inject drugs reached with HIV prevention programmes - defined package of services
- Percentage of eligible transgender people who initiated oral antiretroviral PrEP during the reporting period
- Percentage of transgender people that have received an HIV test during the reporting period and know their results
- Percentage of transgender sex workers that have received an HIV test during the reporting period and know their results
- Percentage of transgender people who inject drugs that have received an HIV test during the reporting period and know their results
- Percentage of transgender people newly diagnosed with HIV initiated on ART
- Percentage of transgender people on ART among all people living with HIV at the end of the reporting period

4.4 REPORTING STRUCTURE

Figure 13. Reporting structure



- All implementing partners will be responsible for primary data collection at the community and/or facility level and will subsequently report the same through the national reporting system, KHIS at the facility and sub-county levels (Figure 13).
- County, national, and donors will access individual programme reports through the national reporting system monthly.

ANNEXE

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