MACHAKOS COUNTY

HIV & AIDS STRATEGIC PLAN (MCHSP)

2015/2016 – 2018/2019

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Acronyms and Abbreviations

ACT	Acceleration of Care and Treatment
ACUs	AIDS Control Units
AIDS	Acquired Immune Deficiency Syndrome
ALHIV	Adults Living With HIV
APOC	Adolescent Package of Care
ART	Anti-Retroviral Therapy
ARVs	Anti-Retroviral medicines
BCC	Behavior Change Communication
CASCO	County AIDS and STI Coordinator
CEC	County Executive Committee
CHC	County HIV Committee
CHEWs	Community Health Extension Workers
CHMT	County Health Management Team
CHVs	Community Health Volunteers
CHWs	Community Health Workers
CLHIV	Children Living With HIV
COBPAR	Community Based Programme Activity Reporting
CSOs	Civil Society Organization
CSR	Corporate Social Responsibility
DHIS	District Health Information System
EBIs	Evidence Based Interventions
EID	Early Infant Diagnosis
EIT	Early Infant Treatment
eMTCT	Elimination of Mother-to-Child transmission
FBO	Faith Based Organization
FSWs	Female Sex Workers
GBV	Gender Based Violence
HAART	Highly Active Anti-retroviral Therapy
HCWs	Health Care Workers
HEIs	HIV Exposed Infants
HIPROS	HIV Partner Reporting Online System
HPV	Human Papilloma virus
HTS	HIV Testing Services
IEC	Information, Education and Communication
IGA	Income Generating Activities
IPV	Intimate Partner Violence
KAIS	Kenya AIDS Indicator Survey
KASF	Kenya AIDS Strategic Framework
KDHS	Kenya Demographic Health Survey
KEMSA	Kenya Medical supply Authority
KEMRI	Kenya Medical Research Institute
KEPH	Kenya Essential Package for Health
KP	Key Population
KVPs	Key and Vulnerable Populations
LMIS	Logistic Management Information System
MCH	Maternal Child Health
MCHSP	Machakos County HIV & AIDS Strategic Plan
MDAs	Ministries, Departments and Agencies

M&E	Monitoring and Evaluation
MIPA	Meaningful Involvement of PLHIV
MoEST	Ministry of Educations, Science & Technology
MoH	Ministry of Health
MoT	Modes of Transmission
MSM	Men who have Sex with Men
MTEF	Medium Term Expenditure Framework
NACC	National AIDS Control Council
NGO	Non Governmental Organization
NASCOP	National AIDS and STI Control Programme
NSP	Needle and Syringe Program
OI	Opportunistic Infection
OPD	Out Patient Department
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PHDP	Positive Health Dignity & Prevention
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PLWD	People Living with Disability
PMTCT	Prevention of Mother-To-Child Transmission
PrEP	Pre Exposure Prophylaxis
PWID	People Who Inject Drugs
RTKs	Rapid Test Kits
SCACCs	Sub-County AIDS Coordinating Committees
SD	Strategic Direction
SGBV	Sexual and Gender Based Violence
SGR	Standard Gauge Railway
SP	Strategic Plan
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SWs	Sex Workers
TAT	Turn Around Time
TB	Tuberculosis
TBA	Traditional Birth Attendants
TWG	Technical Working Group
TSC	Teachers Service Commission
VL	Viral Load

Foreword

The publication of this first County HIV & AIDS Strategic Plan (2015/16-2018/19) marks a milestone in our county's response to the HIV epidemic. The four-year strategy gives a clearer understanding of the key drivers of the epidemic and the increasing unity of purpose among all the stakeholders who are driven by a shared vision to attain zero new HIV infections.

Working together over the past few years, we have been able to register some marked progress in a number of critical areas in our response, such as a significant reduction in the vertical transmission of HIV and expanding access to a comprehensive package of HIV services. For its part, the County Government has expanded its menu of options across the continuum of services from prevention, treatment, care, support and addressing the social drivers of ill health, as well as locating the strategy into the broader development agenda of government.

Our Anti-Retroviral Treatment (ART) expansion programme has resulted in an increase in ART facilities county-wide to about 53 currently, and more people accessing treatment. The County will continuously strengthen our prevention strategies especially on vertical HIV transmission and ensure no child will be born with HIV.

With the MCHSP (2015/16-2018/19), I am confident that we are ready to build on the above achievements. Once again, our strength lies in our unity. In the next four years our key strategic objectives will include:

1. Reducing new HIV infections by 75% from1543 to 386 by 2019
2. Reducing AIDS related mortality by 25% from 1098 to 274 by 2019
3. Reducing HIV related stigma and discrimination by 50%
4. Increasing domestic financing of the HIV response to 50%.

Let us once again join hands as we deepen and strengthen our response and seek innovative ways to sustain our interventions. Let us also bear in mind that all our efforts contribute to the global vision of an AIDS-free world. This vision is attainable; let us continue to strive towards it.

Dr. Alfred Mutua

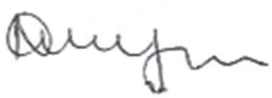
H.E. the Governor

Acknowledgements

The implementation of the County HIV & AIDS Strategic Plan (2015/16-2018/19) will be as strong and successful as the partnership that is built around it. Every sector, every organisation and every individual has a role to play in its implementation. In this regard, the process of writing this plan bodes well for the future and we would like to acknowledge and thank all of those involved in the consultation, research, writing and production of this visionary and life-saving policy.

Sincere gratitude goes to the Office of the Governor for the immense support offered during the development of this plan, the office of the Chief Officer and CHMT for their tireless support, ICAP for both technical and financial support, UoN MARPs Project, NEPHAK and Measure Evaluation among others for their technical support; and the NACC for walking us through this process both technically and financially.

Finally, I wish to thank and appreciate the drafting team who contributed their time and ideas in the development of this plan.



Mrs Naomi Mutie

CEC Health

Executive Summary

The Machakos County HIV & AIDS Strategic Plan (MCHSP) was developed to guide the multi-sectoral HIV response in the County and is aligned to the Kenya AIDS Strategic Framework (KASF) 2014/15-2018/19, Machakos County Health Investment Plan 2013-2017, Machakos County Integrated Development Plan, 2015 among other national guidelines and policies. This Plan will also serve as an investment and resource mobilisation framework in the County HIV response.

This Strategic Plan takes cognizance of the social, economic, cultural and political context of the County. The plan considers various dynamics affecting the County HIV response such as the major transport corridors, Vision 2030 flagship projects, and the County's proximity to Nairobi.

The Strategic Plan is premised on the various best practices and challenges in the HIV response experienced in the past. The county has in place HIV programmes with documented progress towards the achievement of several key indicators. This has been attributed to the enabling HIV response environment, utilization of national policies and guidelines, and more recently the Machakos County Government HIV and AIDS Act of 2015 which provides legal guidance on the implementation of the response.

With an estimated HIV prevalence of 5%, the county is clustered as a medium incidence, medium burden county in the country. The Strategic Plan seeks to achieve a 'County free of HIV infection, stigma and AIDS related deaths'. This vision will be achieved by providing high quality, non-discriminatory, accessible, affordable and comprehensive HIV services in the County. The County objectives are:

1. Reduce new HIV infections by 75%
2. Reduce AIDS related mortality by 25%
3. Reduce HIV related stigma and discrimination by 50%
4. Increase domestic financing of the HIV response to 50%.

The Strategic Plan identifies the following eight Strategic Directions (SDs), to guide the implementation of the HIV response:

- **SD 1:** Reduce new HIV infections
- **SD 2:** Improve health outcomes of all PLHIV
- **SD 3:** Promote and protect human rights to facilitate access to services
- **SD 4:** Strengthen integration of health services and community systems
- **SD 5:** Strengthen research and innovation to inform County objectives
- **SD 6:** Enhance information, data demand and use
- **SD 7:** Increase domestic financing for a sustainable HIV response
- **SD 8:** Promote accountable leadership for the delivery of the MCHSP results by all sectors and actors

The Strategic Plan will be guided by a clear implementation and M & E plan which is divided into health facility based and non-facility based. Further, the Strategic Plan will utilize various components to ensure a functional County M&E system.

Chapter 1

Background

1.1 Machakos County in Context

Machakos County comprises 8 sub-counties, namely; Athi River, Kangundo, Kathiani, Machakos, Masinga, Matungulu, Mwala and Yatta. The County covers 6,208 square kms and has a population of 1,098,584; Male – 49%, Female – 51% (KNBS 2009). The population annual growth rate is 1.7% with a current estimate of 264,500 households of which only 17% have access to electricity. Only a third of the Machakos County population is using water from improved source and sanitation facilities (MICS, 2008).

Figure 1.1: Machakos Sub-Counties

Source: KNBS

1.1.1. Population by Age and Gender

The county has a predominantly young population with about 59.2% of the population aged 24 years and younger. A further 25.8% of the population is aged between 25 and 59 years of age.

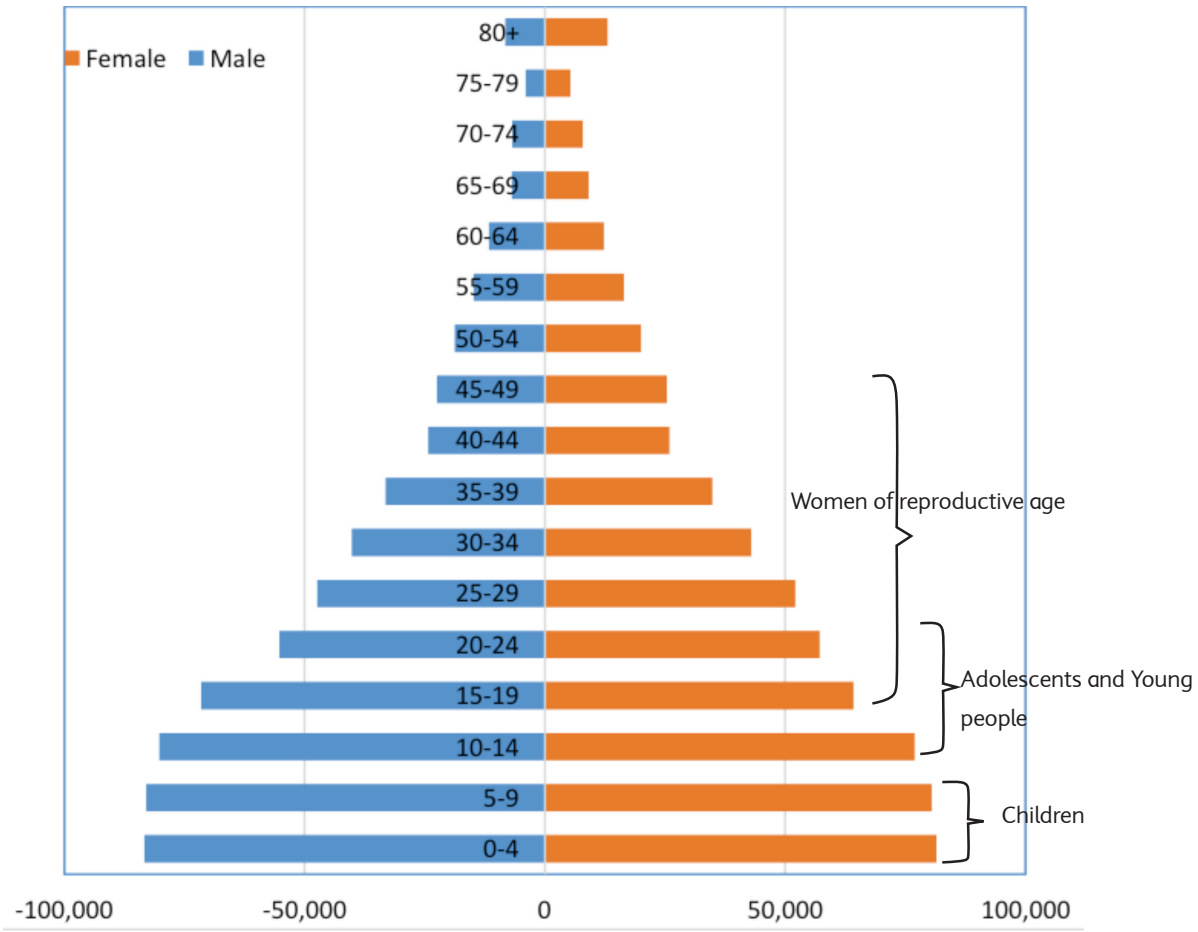


Figure 1.2: Population distribution by gender and age projections, 2015

1.1.2 Poverty Index

The County has a Poverty Index of 59.6% against a national average of 47.2% (KIHBS 2009). This positions the County at 33 out of the 47 counties. 52% of the population lives in the urban centres, which is way above the national average of 29.9%.

1.1.3 Geographic, Social-Cultural and Economic Features

The Akamba people are the dominant habitants of Machakos County. The local climate is semi arid with a hilly terrain covering most parts of the County. The beautiful hilly scenery is perfect for tourist related activities such as camping, hiking safaris, eco-tourism and cultural tourism, dance and music festivals among many more. A number of establishments ensure the region has a well rounded hospitality industry. Subsistence agriculture is practiced with maize and drought-resistant crops such as sorghum and millet being grown. However, the County also plays host to the open air market concept with major market days where large amounts of produce are traded (fruits,

vegetables and other foodstuffs). The County hosts national and international sport competitions. Sand and stone mining, and the traversing transport corridors attract migrant workers into the County. The County is also home to the upcoming Konza Technology City due to its proximity to Nairobi, good infrastructure and availability of large expansive land. The County is home to important industrial and residential centres such as Athi River and Mlolongo. It is also experiencing exponential growth in Mavoko and Machakos Town due to cement, steel industries and flower farms. The proliferation of bars, hotels and other entertainment areas has led to an increase in drug and alcohol abuse, and unsafe sexual practices along the transport corridor and urban settings.

1.1.4 HIV & AIDS Planning and Implementation

Prior to devolution, HIV & AIDS Strategic Planning has been done nationally through the Kenya National Strategic Plans (KNASPs) I to III. Implementation of the HIV strategic plans in the county has thus been guided by the KNASP. Implementation has been through several structures that include facility based structures (dispensaries, health centres and hospitals) including those run by private and faith-based organizations; community based interventions through the CSOs and community units and workplace interventions through the AIDS Control Units (ACUS). The National AIDS Control Council established multi-sectoral District Technical Committees (DTCs) and Constituency AIDS Control Committees as coordinating structures. However the DTCs were disbanded and eight CACCS (referred to as Sub-County AIDS Coordinating Committees (SCACCs) were established and are functional. In facility based HIV response, the County has the County AIDS and STI Coordinator (CASCO) and eight Sub-County AIDS and STI Coordinators (SCASCOs).

1.1.5 HIV & AIDS Financing

Nationally HIV funding is from three sources, namely: Partners (68%), Public Sector (17%) and the Private Sector (15%). This scenario is reflected at the county level with Partners contributing a higher proportion. HIV commodities such as the HIV test kits, ARVs, laboratory reagents and condoms are procured nationally and distributed to the counties. Machakos County has a health budget with no specific budget line for HIV. Currently most of the ongoing HIV programs in the County are financed by International Centre for HIV and AIDS Programme (ICAP) and the University of Nairobi (UoN) MARPS Project. Other partners include BIDII, ABC, Hope World Wide through the Global Fund project, KANCO and North Star Alliance.

1.1.6 HIV & AIDS Policy Environment

The constitution and legal framework form the base around which all actions are defined. Though health is a devolved function, the national government formulates policies, guidelines and legislative frameworks through which all health programmes are to be implemented in the country. HIV response in the county is guided by these national policies, guidelines and legislations. In addition to the national policies, guidelines and legislations, the county is guided by the Machakos County Government HIV and AIDS Management Act (2015) which stipulates that the county: establishes the county committee whose functions include organization of public consultative forums and facilitate public education, establishes a committee in every sub-county to assist in the implementation of the Act and establishes a fund whose monies shall be used for among other functions the transmission, management and control of HIV and AIDS[1].

1 Machakos County Government HIV and AIDS Management Act (2015)

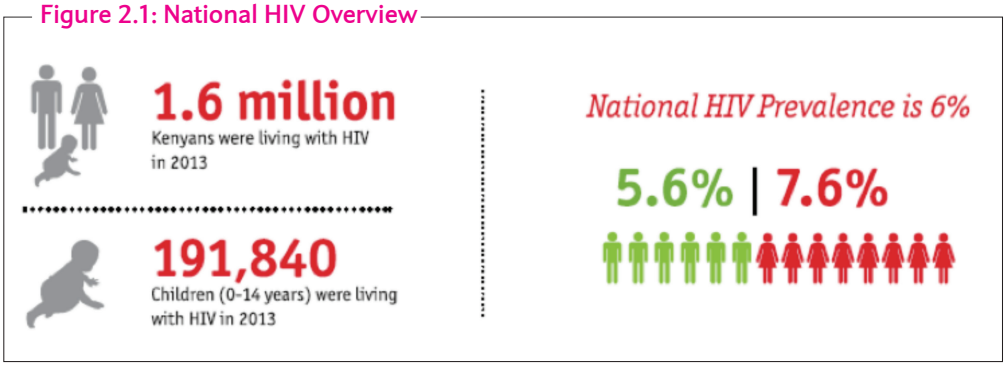
Chapter 2

Situational Analysis

2.1 National Overview

Kenya is one of the six HIV 'high burden countries in Africa – about 1.6 million people were living with HIV infection at the end of 2013. Women in Kenya are more vulnerable to HIV infection compared to men, with the national HIV prevalence at 7.6 percent for women and 5.6 percent for men (Kenya HIV Estimates, 2014).

Figure 2.1: National HIV Overview



The epidemic is geographically diverse, ranging from a high prevalence of 25.7% in Homa Bay County in Nyanza region to a low of approximately 0.2% in Wajir County in North Eastern region. The high burden of HIV and AIDS in Kenya accounts for an estimated 29 percent of annual adult deaths, 29% of maternal mortality, and 15% of deaths of children under the age of five (NACC, 2013).

2.2 County HIV Profile

Machakos is clustered as a medium incidence, medium burden county with an HIV adult prevalence of 5.0%. HIV prevalence in 2014 remained higher among women (6.8 percent) than in men (2.9%) (Kenya HIV County Profile, 2014).

Table 2.1: County HIV Profile

Indicators	Number/percentage
Total Population (2013)	1,115, 957
HIV adult prevalence (overall)	5%
HIV prevalence among women	6.8%
HIV prevalence among men	2.9%
Number of adults living with HIV	27,100
Number of children living with HIV	4,135
Total number of people living with HIV	31,235
% of people never tested for HIV by 2009	73%
% of HIV Positive pregnant women who do not deliver in a health facility	64%

Source: Kenya HIV County profile, 2014

2.3 County Morbidity & Mortality

Table 2.2: Morbidity and mortality in the county

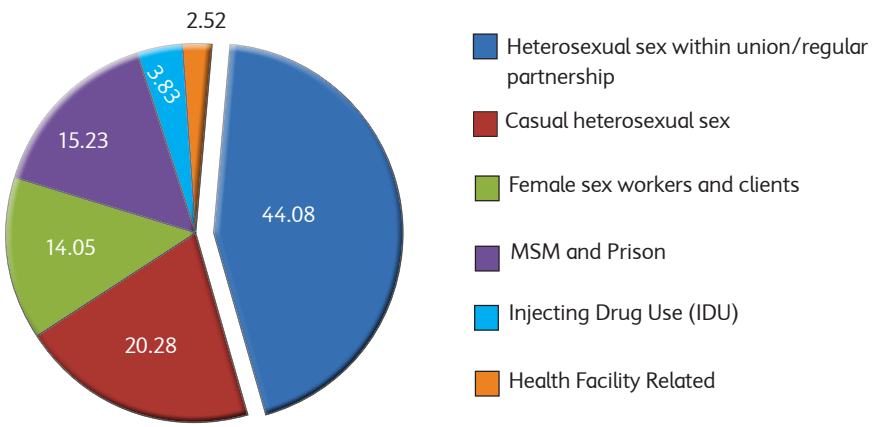
Mortality	Rates
Annual Death Rate/Crude Death Rates	106/1000
Child Mortality	14/1000
Neo- natal	31/1000
Post Neo-natal	8/1000
Perinatal	49/1000
Adult Mortality	30/1000
Maternal Mortality	358/100,000
Under 5	52/1000
Infant Mortality	39/1000

Source- Machakos County Health Strategic & Investment Plan-2013/14-2017/18)

2.4 Sources of New Infections

There is no county specific data indicating the sources of new HIV infections. However, the Modes of Transmission Survey of 2008 provides an indication of the sources of new HIV infections in the county.

Figure 2.2: New HIV infections by population segment and source



Source: Mode of Transmission Survey 2008

Key drivers of the epidemic in the county:

- Vertical transmission (Mother-to-Child HIV transmission)
- Alcohol & substance abuse
- Culture, gender roles & norms
- Poverty & unemployment
- Stigma & discrimination
- Migrant population along transport corridor and infrastructure (Standard Railway Gauge (SRG) , Mombasa - Nairobi; Thika - Garissa highway) and proposed Konza techno city workers
- Economic activities (sand harvesting, stone mining, conferencing, sporting events and fishing along the seven forks)
- Media and technology- Young people accessing pornography and online dating on internet
- Urbanization
- Early sexual debut

2.5 County HIV programmes

The county has extensive HIV prevention, treatment, care and support programmes. Over the years, the county has had stand-alone HIV services in VCTs and CCCs. This has in a way fueled stigma and discrimination associated with HIV positive clients.

Table 2.3: HIV prevention, care and support site in the county

Health Facilities	Number
Total number of health facilities	350
HTS sites	235
PMTCT sites	200
ART, TB and STI sites	58
Psychosocial support groups	67
Community Units	71
Number of CBOs intervening in HIV activities	240

Cash transfer beneficiary households

5001 out of 16,356 with an orphan benefitted from cash transfer program.

Only 31% of poor households with an orphan are beneficiaries of cash transfer programmes.

There is evidence that cash transfer reduces risks of HIV by delaying sexual debut. (Kenya County HIV Profile 2014)

2.6 Key programmatic achievements and challenges

Table 2.4 : Interventions, achievements and challenges

Intervention area	Achievements
Condom	2013/14 - 29,378 clients received condoms
	2014/15- 19,479 clients received condoms
Key Populations	One functional wellness centre
	UoN MARPS project
PMTCT	96.5% HTS at first ANC visit
	53% coverage of 4th ANC attendance
	90% HIV positive pregnant mother initiated on HAART in 2013/14
	98% of HIV exposed infants tested with DNA- PCR at 6 weeks
Blood and blood products	County receives safe blood from NBTS
HTS	51% uptake of HTS in the general population
BCC	The county benefits national mass media campaigns on reduction of stigma and discrimination, abstinence, condom use and safe sex.

County HIV partners

- ICAP
- KANCO
- IOM – GK prison project
- Red Cross - GF
- UoN MARPS Project
- NEPHAK
- North Star Alliance
- OVC project by World Vision and Child Fund
- Build Africa
- Plan International
- Aphia Plus Kamili
- EGPAF (Data review)
- BIDII
- Deaf Empowerment Kenya
- LVCT Health
- Free Pentecostal HIV/AIDS Youth Project

Challenges in HIV Prevention

- New HIV infections despite availability of prevention interventions
- Undefined condom distribution structures at the community level
- Repeat testers in HTS settings
- Lack of follow up on people in HIV testing and treatment cascade
- Late consultation of pregnant women
- High prevalence of pregnancies in known HIV positive women
- High HIV prevalence in Female Sex Workers (FSWs)
- Low coverage of adolescents and youth-friendly prevention services
- Inadequate monitoring and evaluation of HIV prevention activities done at the community
- Delayed access to DNA/PCR testing for infant in PMTCT
- Erratic supply of condoms and Random Test Kits (RTKs)
- Stigma and discrimination

Table 2.5: Treatment, care and support for those living with HIV

Population	Estimated No. of PLHIV	On Care	On ART
Adults	28,100	18 ,293	17, 173
Children	3,717	2,054	1991

Source : DHIS 2015

Challenges in Treatment, Care and Support

- Inadequate skills among healthcare providers
- Ignorance among care givers
- Low coverage of ART in children –only 67% who are eligible are on care
- Data quality issues
- Non disclosure and stigma among adolescents and adults
- Weak psychosocial support
- Insufficient linkage between HIV testing and HIV care and treatment services
- Insufficient adherence to ART for specific groups like children, adolescents and pregnant mothers

2.7 SWOT Analysis

Table 2.6: Summary of the SWOT analysis for Machakos County

STRENGTHS	WEAKNESS
• County Health Strategic Plan and an M&E framework • Partner support (ICAP, APHIA Plus, UoN MARPS Project, Kenya Red Cross, World Vision, KANCO, NEPHAK, Child Fund, UNICEF, IOM, Plan International, Build Africa, Global Fund, Bidii • Skilled manpower • Existing database and HIV county statistics • Existing policies, standard operating procedures, guidelines, curriculum for training • Existing HIV delivery service structures, all levels and some sectors	• Donor dependency in HIV program • Inadequate HIV services coordination • Inability to authoritatively state the resource requirements in HIV programming • Lack of prioritization of HIV services in the county budget making process • Uncoordinated reporting structures for HIV services • Lack of established legal structures in the county to address HIV issues, e.g. HIV tribunal • Erratic supply of HIV commodities attributable to unreliable supply chain • Inadequate supply of data tools, data quality issues, low demand and use of data • Weak workplace HIV interventions • Low HTS coverage (51%) • Inadequate capacity in HIV management among healthcare workers
OPPORTUNITIES	**THREATS**
• Integration of HIV services at all health facilities • Facilities at lower KEPH levels offering HTS • Existing political structures • Involvement of county leaders to fight stigma • School health programs • Establishment of a county HIV fund in line with the Machakos County Government HIV & AIDS Managment Act of 2015 • Youth friendly services at Machakos Level 5 Hospital • Partners support	• Low HIV status awareness among individuals • Poor health seeking behaviour among pregnant and breastfeeding mothers • Existing Traditional Birth Attendants (TBA) • Institutionalized stigma in healthcare settings limiting access to services by KPs and PLHIV • Under reporting of GBV and unawareness of channels of redress • Lack of awareness on PEP availability • Increasing number of Key and vulnerable populations (KPs and vulnerable groups) such as sand and stone miners, migrant persons due to proximity to Nairobi

Chapter 3

Rationale, Strategic Plan Development Process and Core Values

3.1 Rationale

The Kenya Constitution 2010 introduced the devolved system of governance. This resulted in two levels of governments, the county governments (47) and one national government. Each of these levels of governments have their functions, some distinct, others concurrent and the rest overlapping. The health sector functions were devolved with the county governments being allocated the service delivery functions while the national government formulates policy, guidelines and training functions. Machakos County is one of the 47 Counties mandated to provide healthcare services to its residents. The HIV and AIDS response is a health sector function that was devolved. The National Government through the Ministry of Health provides policy and legislative frameworks through which all health sector programmes are to be implemented. The National AIDS Control Council (NACC), a national HIV coordinating government agency, developed the Kenya AIDS Strategic Framework (KASF) 2014/15-2018/19. This framework guides the counties in the development of county specific HIV and AIDS plans for the period of 2014/15 to 2018/19. The MCHSP is therefore aligned to the following documents:

- Kenya AIDS Strategic Framework (KASF) 2014/15-2018/19
- Kenya Vision 2030
- UNAIDS 90-90-90 Strategy
- Constitution of Kenya 2010
- Kenya's Fast Track Plan to end HIV and AIDS among Adolescents and Young people 2015
- Kenya Health Sector Strategic and Investment Plan 2014-2018
- Machakos County Integrated Development Plan 2013-2017
- Machakos County Health Sector Strategic Plan 2013-2017
- Kenya HIV Prevention Revolution Roadmap
- Machakos County Government HIV and AIDS Act (2015)

3.1.1 Purpose of the MCHSP

The purpose of the 2015-2019 MCHSP is to:

a) Guide the implementation of a multi-sectoral, and comprehensive HIV and AIDS response.

b) Provide direction for the planning, co-ordination, implementation and M & E of an evidence-based multi-sectoral county response.

c) Formulate county targets and monitor results for all sectors.

d) Serve as an investment and resource mobilisation framework on which government and development partners will provide both technical and financial support at the county, sub- county, facility, and community levels.

3.2 Process of Developing the HIV Plan

The development of the MCHSP started after the launch and county dissemination of the KASF 2014/15-2018/19. The county KASF dissemination exercise was held on 24th and 25th June 2015 at Godka Hotel, Chuka town, Meru. The dissemination meeting was multi-sectoral and drew participants and actors from different sectors. The dissemination workshop had representation of 40 key stakeholders from the County Government (Ministry of Gender and Social Services Development, County Public Health Officer, County Deputy Director Preventive and Promotive Health, CACCs, Sub-CASCOs, the Chair Health Committee member, partners - ICAP and PSK, youth representative, CSOs, Private Sector, Faith Sector representative (Redeemed Gospel Church Machakos),Maendeleo ya Wanawake, Key Populations - UoN MARPS project, and Networks of People Living with HIV (NEPHAK and KENEPOTE) .

During the meeting participants reviewed and approved the Terms of Reference for the Technical Working Group (TWG) that was to oversee the development of the county HIV strategic plan.

During the two-day workshop, participants were taken through the County HIV situation analysis and deliberated on the strategic directions for the County HIV strategic plan. The team agreed on County HIV Committee TOR and membership as indicated below:

i. County Executive Committee - Health
ii. County Director Health
iii. CASCO
iv. Youth representation
v. NACC County HIV Coordinator
vi. Epidemiologist
vii. County M & E Officer/ County Health Records Officer
viii. County Nutritionist
ix. County Pharmacist
x. County Director Education
xi. County Social Services Representative
xii. Implementing partner (eg Bidii (NGO), ICAP
xiii. Organization working with Key Population (e.g. University of Nairobi/ North Star Alliance)
xiv. NEPHAK
xv. Attorney General Representative.
xvi. County Public service board
xvii. Private sector
xviii. Faith sector

Among the representatives above, a drafting team of seven people was selected. This comprised the County Deputy Director, NACC representative, CASCO, CACC, Person Living with HIV, Partners representative and the Deputy Public Health Officer.

The team met for one week in November 2015 and came up with a zero draft. The draft was then circulated to all stakeholders via email and subjected to the national review team for inputs. The TWG met in March 2016 to incorporate all the inputs from stakeholders and the national review team and came up with the final draft. The final draft was subjected to technical review in March 2016, and was validated by county stakeholders and agreed upon in April, 2016.

The validation processes resulted in a communiqué of the issues arising from the final draft which was signed by the County Director Preventive and Promotive Health services and the TWG secretary. The Technical Review Team incorporated the comments and inputs from the communiqué and came up with the MCHSP 2015/16-2018/19.

3.3 Core Values

The MCHSP is guided by the following core values:

- **Non-discrimination** - The County seeks to offer non-discriminatory HIV services.
- **Professionalism** – Observing professional standards of practice & ethics.
- **Results-oriented and Evidence-based:** The management and coordination of the response will be evidence based and focused on measurable outcomes.
- **Multi-sectoral approach:** The SP will guide an approach to interventions enabling all communities and sectors to work towards the same objectives, while retaining their autonomy.
- **Meaningful involvement of PLHIV :** In an effort to dispel the myths and misunderstandings that drives stigma and discrimination, the county seeks to mobilise the role and involvement of PLHIV.
- **Accountability:** The SP will strengthen and consolidate transparency and accountability in respect of HIV treatment and care at all levels and in all sectors.

Chapter 4

Vision, Mission and Strategic Directions

4.1 Vision

A County free of new HIV infections, stigma and AIDS related deaths.

4.2 Mission

To provide high quality, non-discriminatory, accessible, affordable, comprehensive HIV services in the county.

4.3 Strategic objectives

4.3.1 Reduce new HIV infections by 75% from1543 to 386 by 2019

- Reduce new HIV Infections in adults from 1 463 to 366 by 2019
- Reduce new HIV infections in children from 80 to 20 by 2019
- Increase eMTCT program effectiveness from 81.4% to 95 % by 2019

4.3.2 Reduce AIDS related mortality by 25% from 1098 to 824 by 2019

- Diagnose and link 90% of all PLHIV (90% of the estimated 28 100 Adults Living with HIV and 3717 Children Living with HIV
- Start and retain 90% (22,761) of those diagnosed HIV positive on ART
- Achieve 90% (20,485) viral suppression of all persons on ART

4.3.3. Reduce HIV related stigma and discrimination by 50%

4.3.4. Increase domestic financing of the HIV response to 50%.

4.4 County Strategic Directions

SD1: Reduce new HIV infections	**SD2:** Improve health outcomes of all PLHIV	**SD3:** Promote and protect human rights to facilitate access to services	**SD4:** Strengthen integration of health services and community systems
SD5: Strengthen research and innovation to inform county priorities	**SD6:** Enhance information, data demand and use	**SD7:** Increase domestic financing for a sustainable HIV response	**SD8:** Promote accountable leadership for the delivery of the MCHSP results by all sectors and actors

4.4.1 Strategic Direction 1: Reduce New HIV Infections

The County has a number of programs aimed at reducing new HIV infections that include health education and promotions, condom distribution, Prevention of Mother-to-Child Transmission (PMTCT), Post Exposure Prophylaxis (PEP), Blood safety measures, and targeted Behaviour Change Communication (BCC) messaging. The county is traditionally a male circumcising thus Voluntary Male Medical circumcision not emphasized in this plan. Despite the HIV prevention programmes in place, the County had 1543 new HIV infections (1463 adults and 80 children) in 2014[2]. Over the course of this SP, the county has set a target to reduce new infections by three-quarters, thus reaching 386 by June 2019. To achieve this target the county will:

- Increase coverage of combination prevention approach
- Intensify targeted HIV prevention to priority populations
- Maximize efficiency in service delivery through integration
- Leverage opportunities through creation of synergies with other sectors

4.4.1.1 Increase coverage of combination prevention approach

"Combination prevention" approach best addresses documented weaknesses in HIV prevention programming and offers the best chances to generate significant, sustained reductions in HIV incidence. Combination prevention programmes are rights-based, evidence-informed, and community-owned programmes. They use a mix of biomedical, behavioural, and structural interventions. Scalway argues forcefully for increased resources into communication, based on evidence that these campaigns have significantly affected knowledge as well as behaviours[3]. The campaigns intend to focus resources on the mix of programmatic and policy actions required to address both immediate risks and underlying vulnerability. They aim to operate synergistically and consistently on multiple levels (e.g. individual, relationship, community, society) and over an adequate period of time. They mobilise community, private sector, government and global resources in this collective undertaking.

2 NACC, NASCOP; 2014, Kenya HIV county profiles.

3 Scalway, T. (2010). Presenting the evidence for social and behavioural communication. JHHESA. South Africa

Table 4.3: Interventions to increase coverage of combination prevention

MCHSP Results	Key Activity/ Intervention Area	Sub-Activities/Interventions			Target Population	Geographical Areas by County/Sub-County	Responsibility
		Biomedical	**Behavioural**	**Structural**			
- New HIV infections among adults reduced by 75% from 1463 to 366 - New HIV infections among children reduced by 75% from 80 to 20	eMTCT	Implement all 4 prongs of eMTCT. Prevention of HIV among women of child bearing age. Prevent unintended pregnancies among women living with HIV Prevent transmission from a woman living with HIV to her infant. Provision of care and treatment to women living with HIV and their children. All HEIs started on prophylaxis Optimum follow up of HEIs upto 2 years	Promote use of mentor mothers. Scale up male engagement in PMTCT. Psychosocial support groups for pregnant women.	Challenge and actively work to change gender norms that negatively affect the health of women, children and men. Implement innovative strategies that will encourage men to accompany their partners to ANC and for reproductive health services. Implement PMTCT in all health facilities offering ANC.	Women in the reproductive age bracket (15-49), men	All sub-counties	All health facilities Community gatekeepers, CSOs Faith sector, Partners

Interventions to increase coverage of combination prevention

MCHSP Results	Key Activity/ Intervention Area	Sub-Activities/Interventions			Target Population	Geographical Areas by County/Sub-County	Responsibility
		Biomedical	**Behavioural**	**Structural**			
- New HIV infections among adults reduced by 75% from 1463 to 366 - New HIV infections among children reduced by 75% from 80 to 20	HTS	Offer targeted HTS Provision of adequate RTKs Adequate staffing	Engage media and religious leaders to demystify HIV in the county Enhance community dialogue in HIV and stigma. Scale up male and female condom demonstration & distribution. Scale up targeted messaging and condom distribution channels.	Increase the capacity of communities to grow their own food, and in turn improve food security. -Challenge social and cultural norms and values that encourage multiple concurrent sexual partnerships Synchronized reporting in DHIS	General population Employees	All facilities Workplaces Community	All county facilities Partners CSOs
	Treatment as prevention	Initiate HIV positive persons on ART as per the national guidelines. Pre-exposure Prophylaxis (PreP) as per the national guidelines. Post exposure Prophylaxis (PEP) to rape and GBV survivors and other priority populations.	Reinforce adherence to ART to reduce viral load. Promote proper consistent condom use. Offer adherence counseling.	Empowering communities to guard against human rights violation (including those of minorities) Strengthen linkage to care and treatment. Prompt structures for viral load testing and accessing results.	PLHIV General population	All facilities	All county facilities Partners CSOs Networks of PLHIV

4.4.1.2 Intensify targeted HIV prevention to priority populations

There is overwhelming evidence that a significant reduction in prevalence or incidence can be achieved through a strategy that targets specific populations. For example, Thailand is often cited to have significantly reduced its prevalence through targeting sex workers. The county will prioritise the following populations:

a) Key Populations

Men who have Sex with Men (MSM) and People Who Inject Drugs (PWID) are criminalized in Kenya. Female Sex Workers (FSWs) remains marginalized and subject to significant legal penalties under existing regulations. Stigmatizing attitudes and discriminatory behaviours serve as a significant disincentive to access necessary services for the prevention, care and treatment of HIV. The UoN MARPS has been implementing KP interventions in all the sub-counties except Kangundo and Masinga and estimates that the county has 3000 FSWs, 150 MSM and 50 PWID. Nationally, HIV prevalence among MSM is almost three times more than the prevalence in the general population. About 18.2% of MSM and 29.3% FSWs are living with HIV[4].

b) Adolescents and Young people

Adolescents and youth form 16% of all PLHIV and contribute 29% of all new HIV infections in Kenya[5]. The County has a predominantly young population with about 59.2% aged 24 years and below. One in every 11 children under 18 years (9%) in the county is an orphan, and 1 in 18 is vulnerable[6]. The county HIV prevalence among the 15-24 years is estimated to be 3.2%[7] against a County Prevalence of 5%. Although sensitization activities will target the general youth population, most HIV prevention interventions will target the most vulnerable youths, including in and out-of-school youth.

c) Children and pregnant mothers

The county has an estimated 80 infants infected with HIV annually due to mother-to-child transmission. There were about 1757 HIV positive pregnant women in Machakos County in 2011[8]. Of the estimated 32,000 annual deliveries in the county, approximately 29,000 have attended at least one ANC visit. The global strategy for eMTCT recommends implementation of a four-pronged strategy. Moving towards the eMTCT national target of 95%, the proportion of mothers delivering outside health facilities who may not be aware of their status, under utilization of PMTCT services by pregnant mothers, and defaulters could explain the county PMTCT effectiveness of 81.4% in 2015 (DHIS 2015).

Table 4.2: PMTCT summary (ANC and Maternity)

Indicator	NASCOP County Profile Report for Kenya, 2013	DHIS 2015
Proportion of mothers attending 4 ANC visits	48.8 %	52.9%
Overall PMTCT test acceptance rate	96.5%	96.5%
HIV positive women delivering in hospital	31.9%	_
Overall Prophylaxis for HIV exposed infants	100%	95%
MTCT rates at 1st test	10.2%	_

4 Integrated Bio-behavioural Survey conducted in Nairobi in 2010 and Polling booth survey conducted in Nairobi and Mombasa sites in 2013
5 NASCOP: Adolescent, Youth and HIV in Kenya. 2014 Fact sheet
6 Multi-cluster Indicator Survey 2008
7 NASCOP County Profile Report for Kenya, 2013
8 Kenya HIV County Profile, 2014

d) PLHIV and discordant couples

According to the Kenya HIV County Profile 2014, the Machakos County has 31,235 people living with HIV. Among couples who are married or living together, 6% are discordant with one partner infected and the other uninfected (KDHS, 2008-09). Machakos County couple discordance rate is 9.7%[9] . The focus in this group will be to reduce HIV transmission within PLHIV and to the general population and to ensure that the HIV negative partner in discordant couples remains negative.

e) Male engagement as part of the county HIV response

Sexual Reproductive Health (SRH) programmes and services have been focused primarily on women, with men often lacking information to make informed decisions about healthy behaviour and the roles they might play in promoting overall family health, including accessing HIV prevention, care and treatment services. Studies demonstrate that when given the opportunity to participate in SRH programmes, such as family planning and the PMTCT programmes, men wish to be positively involved in promoting the health of their families and communities (Peacock et al. 2009). The reality is that women's decision-making about their pregnancies and health are deeply influenced by their partners, communities and social norms and beliefs regarding HIV and AIDS (UNAIDS 2011).

Barriers to men's participation in PMTCT services can be organized into the following categories: factors related to HIV knowledge, stigma and discrimination; health facility factors; logistical or access challenges; and barriers related to gender norms. It is clear that much remains to be done to increase knowledge among men about HIV testing and counselling. Some studies showed that men were well aware of media efforts to promote their involvement in testing, but they said that these media campaigns did a less effective job of explaining why men should be tested and what benefits they would derive from testing (e.g. Larsson et al. 2010). Health-facility factors serve as a strong deterrent to utilization of services in one study, Men mentioned the negative attitudes of staff members (Theuring et al. 2009; Reece et al. 2010). Reproductive health seeking was seen by men as "women's work". Men saw the antenatal clinic as women's space, and the definition and organization of the programme as fundamentally female oriented (Reece et al. 2010). Consequently, men perceived that attending the antenatal clinic would be "unmanly" (Montgomery et al. 2006; Chinkonde et al. 2009). They felt uncomfortable at being the only man present in the clinic (Falnes et al. 2011) and feared stigmatization by other men.

f) People Living with disabilities

There is no data showing that HIV prevalence in people with disabilities is higher than in the general population in Kenya. 5.02% of Machakos County population are disabled (KNBS, 2009). The focus in this group is to address vulnerability to HIV and access to services.

g) Gender Based Violence (GBV) survivors

GBV is identified as a significant driver of HIV and AIDS. The county Intimate Partner Violence (IPV) prevalence is at 41.3% among women seeking HTS services, physical violence at 31%, psychological violence at 35% and sexual violence at 22%. GBV is primarily directed against women and girls and increases their risk of infection by a factor of 3[10]. 46% of women in Machakos believe that the husband is justified in beating them if they go out without telling them, neglect children, refuses to have sex with him, argue with him or burn food (MICS, 2008).

9 NASCOP County profile report for Kenya, 2013

10 Machakos County GBV and HIV report (LVCT, 2013)

Table 4.4 Interventions to intensify targeted HIV prevention to priority populations

MCHSP Results	Key Activity/ Intervention Area	Sub-Activities/Interventions			Target Population	Geographical Areas by County/Sub-County	Responsibility
		Biomedical	Behavioural	Structural			
- New HIV infections among adults reduced by 75% from 1463 to 366 - New HIV infections among children reduced by 75% from 80 to 20	Key Populations	Provision of facility-based services package including systematic initiation of treatment as prevention, regular screening and testing for STIs and HIV, condom provision of family planning services. Provision of community-based services such as HTS, STI screening, condom distribution through outreach strategies. Provision of key commodities including lubricants and condoms. Alcohol screening and addiction support. Provide Pre-exposure prophylaxis services as per the national ART guidelines. Screen and manage HPV among FSWs, MSM and Hepatitis B and C for PWID and other high risk populations.	Establishment of support groups for different categories of KPs through peer education approach Organize mass campaigns targeting KPs to increasing their awareness and service utilization. Scale up targeted messaging and distribution channels for KPs. Sensitize HCWs in KP programming. Develop targeted intervention towards harm reduction. Develop innovate and sustainable models to improve health seeking behaviours. Empower KPs to negotiate for safe sex (safer sex negotiation skills).	Lobby for 100% condom county legislation. Advocacy with law enforcement and local authorities to improve protection of FSW and MSM through a human rights approach Strengthen KPs participation in policy development and program implementation Linkage of KPs to health facility level interventions to ensure continuum of care. Address violence against KPs through a human rights approach. Strengthen health facilities in KP programming.	MSM PWID FSW and their clients	All health facilities Drop in centres	All health facilities Partners Law enforcers Chair Health Committee CSOs

Interventions to intensify targeted HIV prevention to priority populations

MCHSP Results	Key Activity/ Intervention Area	Sub-Activities/Interventions			Target Population	Geographical Areas by County/Sub-County	Responsibility
		Biomedical	**Behavioural**	**Structural**			
- New HIV infections among adults reduced by 75% from 1463 to 366 - New HIV infections among children reduced by 75% from 80 to 20	Adolescents and young people	Offer age appropriate contraceptives, condoms and microbicides. Increase access to sexual and RH services. Home-based HTS during school holidays Parent follow up as index clients for children testing. Special/dedicated clinic days Prevention With Positives (PWP) interventions for young people Establish youth friendly HIV services points. Initiate and promote disclosure process for adolescents and young persons born with HIV.	Scale up evidence-based interventions (EBI) like Sister to Sister, healthy choices etc. Strengthen health service providers to support care givers to initiate disclosure of HIV status. Interventions aimed at sustaining abstinence in adolescents and youth and safer sex messaging including information on sexual and reproductive health (SRH), HIV and STIs, GBV, life skills, and referral for HIV testing and STIs treatment. Offer peer to peer education in and out of school.	Lobby for social and media protection legislation Scale up services for GBV survivors and PMTCT for women aged 15–24 years. Scale up targeted cash transfer to keep boys and girls in schools and delay sexual debut. Strengthen school health programs. Engage Ministry of Education, Science and Technology (MoEST), universities and colleges to address stigma and discrimination in school settings.	Adolescents and young people Guardians HCWs	All sub-counties Secondary schools Universities and tertiary institutions	County Government MoH MoEST Partners CSOs
	Children and pregnant mothers	Implement all the 4 prongs of eMTCT at 100% health facilities in the county. Initiate all HIV pregnant and lactating mothers and Children Living with HIV on ART. Early Infant Male Circumcision (EIMC) as per national guideline	Advocate for pregnant mothers to attend ANC clinics and deliver in health facilities. Use of mentor mothers. Male engagement in PMTCT. Psychosocial support groups for pregnant women.	Integrate EID of HIV with immunization. Integrate PMTCT services at MCH.	Children and pregnant mothers	All sub-counties	All county facilities Partners CSOs Networks of PLHIV

Interventions to Intensify targeted HIV prevention to priority populations

MCHSP Results	Key Activity/ Intervention Area	Sub-Activities/Interventions			Target Population	Geographical Areas by County/Sub-County	Responsibility
		Biomedical	**Behavioural**	**Structural**			
- New HIV infections among adults reduced by 75% from 1463 to 366 - New HIV infections among children reduced by 75% from 80 to 20	Male engagement	Capacity building of healthcare staff on HIV counseling and testing for couples. Scale up couple counseling. Extended working hours to include evening and weekends.	Challenge and actively work to change gender norms that negatively affect the health of women and children. Implement innovative strategies that will encourage men to accompany their partners for RH services.	Challenge social and cultural norms and values that encourage multiple concurrent sexual partnerships. Renaming of Maternal Child Health Clinic (MCHC) to Family Health Clinic	HCWs Men	All sub-counties	All health facilities Partners CSOs Community gatekeepers Faith sector Media
	PLHIV and discordant couples	Scale up Positive Health Dignity and Prevention (PHDP) initiatives.	Strengthen psychosocial support groups for children living with HIV. HIV positive pregnant women, discordant couples and PLHIV.	Implement stigma reduction campaigns.	PLHIV Discordant couples Adolescents and young persons living with HIV	All sub-counties	All Health facilities Partners CSOs Faith sector
	People Living with Disability (PLWD)	Scale up HTS among PLWD by disability category. Increase access to ART and other HIV services. Train HCWs on sign language to enhance service provision. Integrate HIV sensitization during medical assessments	Develop appropriate IEC materials customized to each specific category. Sensitization campaigns intended to reduce stigma and discrimination in the community	Raise awareness of people with disabilities to enable them to claim for their rights. Implement disability conducive infrastructures in health facilities Advocate for condom packaging and ART labels with Braille.	HCWs PLWD	All sub-counties	All Health facilities Partners, CSOs, Community gatekeepers, Faith sector media, County Social services

Interventions to Intensify targeted HIV prevention to priority populations

MCHSP Results	Key Activity/ Intervention Area	Sub-Activities/Interventions			Target Population	Geographical Areas by County/Sub-County	Responsibility
		Biomedical	**Behavioural**	**Structural**			
- New HIV infections among adults reduced by 75% from 1463 to 366 - New HIV infections among children reduced by 75% from 80 to 20	GBV survivors	Offer PEP as per national guidelines	Offer psychosocial support. Carry out community mobilisation for uptake of PEP services. Build capacity of CSOs and community units to monitor and prevent GBV.	Address gender norms which predispose women, adolescents and young people to violence. Establish a gender desk in police stations/posts. Sensitise law enforcers on HIV prevention for GBV survivors. Lobby county legislation on GBV	General population KPs Adolescents and young people	All sub-counties	HCWs CSOs Partners Chair Health committee

4.4.1.3 Leverage opportunities through creation of synergies with other sectors

a) Education sector

There are 943 and 376 primary and secondary schools respectively in the County[11]. Primary school enrollment is at 85%, secondary school enrollment is at 76% and the dropout rate is at 4.7%[12]. Child labour is at 14.2% in the former Eastern Province (Multiple Indicator Cluster Survey, 2008). There is evidence that education plays an important role in offering protection against HIV. School going children and young people are less likely to become infected compared to those who do not attend school, even if HIV and AIDS are not included in the curriculum. According to UNAIDS, education reduces the vulnerability of girls to HIV, and each year of schooling offers greater protective benefit[13].

b) Transport sector

The county is transversed by major transport corridors (Nairobi-Mombasa, Thika-Garissa highways) and Standard Gauge Railway, attracting migrant populations. People working in the transport sector are especially vulnerable to HIV and AIDS due to the nature and environment of their workplace and economic activities. Transport workers and staff work long hours and away from home and family. They are therefore at risk of engaging in risky sexual behaviour that can lead to HIV infection. The Boda boda riders, truckers and turn boys also need to be targeted in the county HIV prevention program.

c) Media

There has been a tremendous increase in media stations, including local newspapers, FM stations, and vernacular television stations in the County. The media can be a strong ally if utilized positively to disseminate the right messages in the HIV response. However some unregulated information being disseminated in media houses affects HIV programming. For instance indecent exposure misleading advertisements, talk shows and other programs. However, Media networks will play a big role in information dissemination and community education through implementation of integrated BCC broadcast programs on HIV and AIDS.

d) Workplace HIV interventions

Workplace HIV interventions are critical in HIV response. The ILO[14] provisions on workplace policy include the following:

- Protection of the rights of those affected by HIV and AIDS
- Prevention through information, education and training
- Care and support for workers and their families

The workplace programs are implemented by the private and public sectors. All the ten county sectors will develop and implement a HIV workplace policy as per the national guidelines and performance contracting requirements.

e) Faith sector

The faith sector complements health service delivery in the County. For example, the Catholic Church has 20 mission health facilities across the County. The influence that religious and Faith-Based Organizations command among the general populace cannot be underrated. Churches and religious organizations are key stakeholders in the HIV response.

f) Prisons

There are two GK prisons in the County - Machakos and Yatta. Risk factors in the prisons include rape, injecting drug use and men who have sex with men. This places the inmates at a high risk of HIV infection. The focus with this group is to reduce HIV vulnerability and transmission.

11 www.elimuonline.com
12 Machakos County Integrated Development plan 2015
13 UNAIDS. A strategic approach: HIV, STIs and TB and education. Geneva: UNAIDS, May 2009
14 ILO workplace policy on HIV/AIDS (2004)

Table 4.5: Interventions to leverage opportunities through creation of synergies with other sectors

MCHSP Results	Sector	Sub-Activities/Interventions	Target Population	Geographic areas by County/sub-county	Responsibility
- New HIV infections among adults reduced by 75% from 1463 to 366 - New HIV infections among children reduced by 75% from 80 to 20	Education sector	- Increase knowledge on HIV and HIV status, STIs and HPV among teachers and students - Targeted HTC outreaches in schools and universities - Implement school based treatment literacy programmes - Build and Strengthen HIV prevention in Boy and Girl Movements(scouts and girl guides) - Sensitise the beneficiaries of Cash transfer on toll free numbers and readdress channels. - Create and strengthen Children Living with HIV support groups - Sensitise teachers and support staff of ART adherence - Implement education policy, guidelines and teacher training that includes age appropriate HIV, sexual and reproductive health and rights - Ensure girl and boys stay in schools through social security programmes, conditional cash transfers and sanitary towels for girls - Address stigma in schools - Strengthen school health programs - Strengthen Beneficiary Welfare Committees to monitor use of cash transfer funds to OVCs.	Students, teachers, school support staff	Schools Academic Institutions	-County Department of Health -County Director of Education Partners County Department of Social Development CSOs
	Transport sector and construction workers	- Offer comprehensive prevention care and treatment services in the roadside wellness centres and appropriate referrals and linkages. - Implement HIV prevention care and treatment services targeting construction workers. - Use public transport systems for prevention messages, condom distribution targeting the transport workers and communities along the transport corridor. - Sensitise boda boda riders and SGR construction workers on HIV prevention care and support - Establish peer educators and support networkers for HIV prevention care and support in the boda boda settings - Develop capacity through cross-county collaboration and coordination of HIV/AIDS activities, along the transport corridor	Long distance truckers, boda boda riders, SGR construction workers	Major Transport corridors traversing the county. SGR Camps	County Department of Health, County Department of transport, CSOs, Partners

Interventions to leverage opportunities through creation of synergies with other sectors.

MCHSP Results	Sector	Sub-Activities/Interventions	Target Population	Geographical Areas by County/Sub-County	Responsibility
- New HIV infections among adults reduced by 75% from 1463 to 366 - New HIV infections among children reduced by 75% from 80 to 20	Media	- Develop and initiate consistent broadcast programs on HIV and AIDS through the local FM/TV stations. - Develop age appropriate messages as pamphlets in newspapers - Create new and strengthen existing coalitions of media organizations on specific themes of HIV prevention; - Promote health service utilization including comprehensive HIV services; - Documentaries on Success stories, best practices and prevention messaging - Strengthening and provision of specific support to media associations of PLHIV , adolescents and young people for Meaningful involvement of People living with HIV and AIDS (MIPA)	General Population, KP, men, pregnant mothers, adolescents and young people	All sub counties	County Ministry of Public service, labor and ICT, All Media houses
	Machakos and Yatta GK Prisons	- Offer frequent and regular HTS and TB screening - Establish prison dispensaries - Train Prison warders on ART/TB management - Facilitate use of HIV protection interventions - Implement EBIs - Promote behavior formation among inmates - Advocate for policies that promote access to HIV prevention commodities - Risk reduction counseling for HIV negative testers - Establish psychosocial support mechanisms - ART adherence session in Prisons and Remand - Review of prison policy on HIV prevention to include condom use, PrEP, safe injecting needles and conjugal visits	Inmates Prison staff	GK Prison Machakos and Yatta	County department of Health, GK prison adminstration

Interventions to leverage opportunities through creation of synergies with other sectors

MCHSP Results	Sector	Sub-Activities/Interventions	Target Population	Geographical Areas by County/Sub-County	Responsibility
- New HIV infections among adults reduced by 75% from 1463 to 366 - New HIV infections among children reduced by 75% from 80 to 20	Work place	- Promotion and social marketing of condoms in hotspots (hotels, lodges and bars) - Implementation of a minimum package of HIV services in the workplace (sensitization, BCC, HTS, referral to clinical services, reduction of stigma and discrimination). - Use of stigma reduction champions in Workplaces - Mainstreaming HIV prevention activities in workplaces in all the sectors. - Support HIV prevention as a Corporate Social Responsibility (CSR)	County Ministries Department and Agencies (MDAs)	Sub county/ county offices	County public service boards
	Faith Sector	- Offer HIV prevention services in faith based facilities. - Offer HIV sensitization and life skills in faith Based schools and learning institutions - Address notion of HIV healing through faith as a barrier to HIV treatment and adherence - Initiate behavior formation among adolescents and young people - Strengthen pre-marriage counseling to include HIV prevention - Offer Psychosocial support to PLHIV - Conduct and adapt stigma-free HIV prevention campaigns - Empowerment of religious leaders to address HIV prevention, care and treatment.	General population	- All churches, - All Mosques	Machakos County religious leaders HIV stigma reduction spearheading forum

Table 4.6: Interventions to maximize efficiency in service delivery through integration

MCHSP Results	Key Activity/ Intervention Area	Sub-Activities/Interventions			Target Population	Geographical Areas by County/Sub-County	Responsibility
		Biomedical	**Behavioural**	**Structural**			
- New HIV infections among adults reduced by 75% from 1463 to 366 - New HIV infections among children reduced by 75% from 80 to 20	HTS	Integrate HTS with other health services. Scale HTS models to include PICT, Index client testing, door to door testing, moonlight HTS and targeted community outreaches. Offer targeted HTS in all health facilities entry points such as outpatient departments and clinics.	Advocate for increased uptake of HTS. Regular outreaches and contact with KPs. Peer to peer outreaches in schools and out of schools with adolescents. Implement PHDP	Address access barriers to HTS services through community outreaches and other strategies. Address norms that limit health seeking behaviours amongst men.	General population KPs	All sub-counties	All Health facilities CASCO Faith sector Partners CSOs
	STI management	Scale up STI management in all health facilities.	Behaviour change interventions. Promote condom use and safe sex practices.	Use community strategy to improve linkages between communities and facilities Establish drop in centres	General population KPs	All sub-counties	All county facilities Partners CSOs

4.4.2 Strategic Direction 2:

Improve Health Outcomes and Wellness of all PLHIV

Patients may be lost at various stages in the care continum. To reduce morbidity and mortality, early identification of HIV positive people and enrollment in care would support the 90-90-90 UNAIDS goal and maximize the effectiveness of existing program strategies to virtually eliminate progression to AIDS, premature death and HIV transmission.

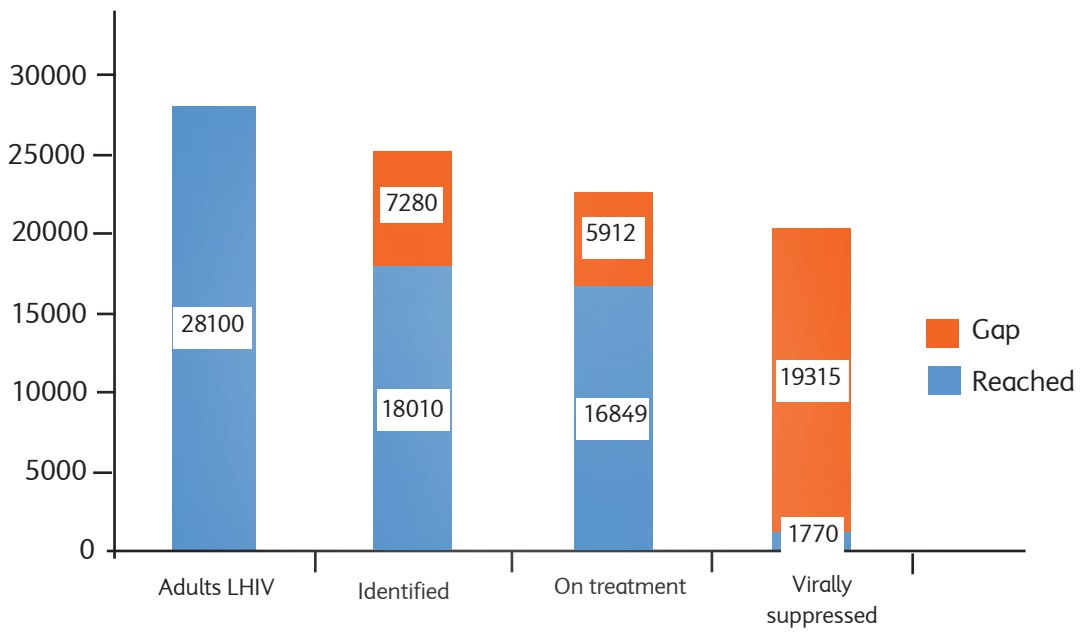
The interventions underpinning this SD relate to:

- Diagnose and link 90% of all PLHIV
- Start and retain 90% of those diagnosed on ART
- Achieve viral suppression for 90% of patients on ART

4.4.2.1 Diagnose and link 90% of all PLHIV

HIV testing is the gateway to accessing HIV treatment and care and a successful public health response to HIV requires robust HIV Testing services (HTS). By July 2015, of the estimated 28 100 PLHIV in the County, 18 010 were aware of their HIV status, with a gap of 7,280 PLHIV not aware of their status. The county will re-focus its HTS program to meet the goal of having 90% of PLHIV know their status by 2019.

Figure 4.1: Machakos County adult gap analysis



Source NASCOP ACT Dashboard, 2015

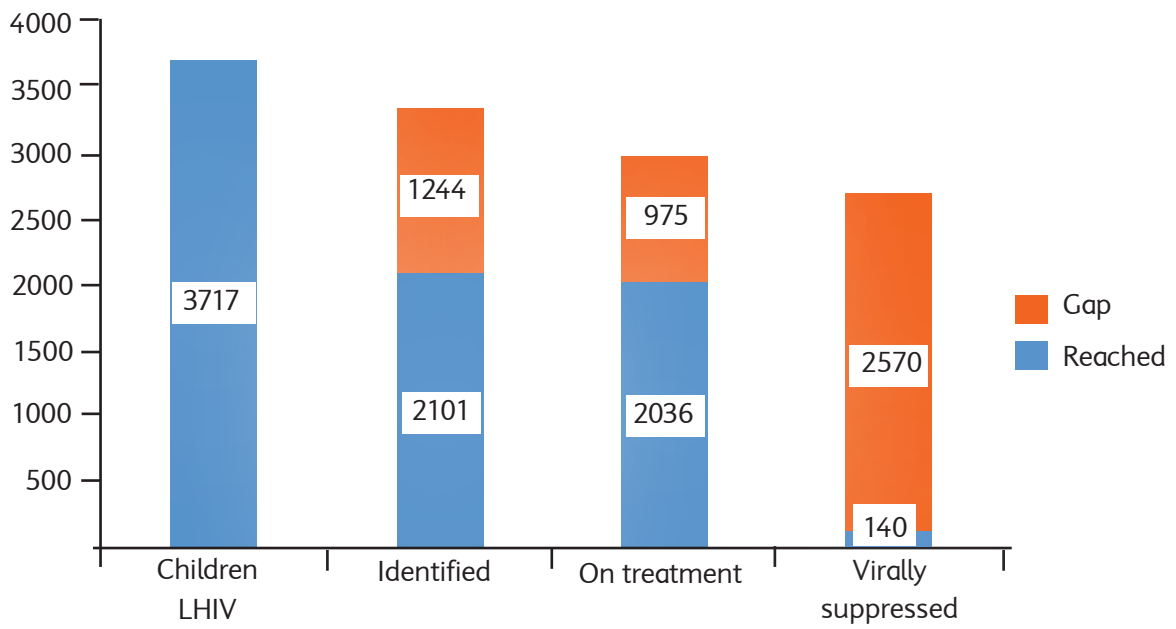
4.4.2.2 Paediatric ART

Disease progression in HIV-positive infants is particularly rapid in the first few months of life, and early ART initiation has been shown to significantly reduce the risk of mortality[15]. ART coverage among HIV infected infants remains low. HIV in infants is primarily due to transmission from women who did not receive ART in pregnancy, and who are not in the health system for ready facilitation of infant follow-up. Additional challenges to the scale up of paediatric ART, particularly in infants, include

15 Violari et al. for the CHER Study Team. N Engl J Med 2008;

collection of blood samples for DNA-PCR from infants requires special skills and supervision, and that the DNA-PCR testing is performed in central laboratories, requiring well coordinated logistics for sample transportation and communication of results. These challenges will be addressed by strengthening Early Infant Diagnosis (EID) and Early Infant Treatment (EIT) through a well established exposed infant follow up program ensuring infants are tested at 6 weeks (DNA-PCR), 12 and 24 months (rapid test), including improving access to HTS by appointing HTS dedicated cadres as well as improving sample transportation and transmission of results.

Figure 4.2: County paediatric gap analysis



Source NASCOP ACT Dashboard, 2015

Table 4.7: Interventions to diagnose and link 90% of all PLHIV

MCHSP Results	Key Activity/ Intervention Area	Sub-Activities/Interventions			Target Population	Geographic areas by County/sub-county	Responsibility
		Biomedical	Behavioural	Structural			
90% of all PLHIV diagnosed and linked to care	HTS adolescents and young people	Home based HTS during school holidays. Parent follow up as index clients for adolescents and young people testing. Establish youth friendly clinical services.	Integrate HIV care in youth friendly sexual and reproductive health services. Behavior formation interventions.	Education subsidy programmes to keep children in school. Adolescences and youth friendly centres	Guardians Adolescents and young people	All sub-counties	Health facilities, CHMT CASCO CSOs Partners KEMSA
	HTS - KPs	Targeted HTS. Scale up STI screening and management.	Implement snow balling to reach KPs Train peer educators in conducting accompanied referrals to healthcare facilities.	Stigma reduction campaigns.	KPs General population	All sub-counties	Health facilities, CHMT CASCO CSOs Partners
	HTS - Men, children and pregnant women	Implement the full package of eMTCT within ANC. Targeted testing in all entry points (ANC, Maternity and Postnatal clinics) Increase access to DNA/PCR testing for infants in PMTCT.	Involve CHVs and mentor mothers in referring and follow up on ANC and postnatal mothers. Sensitise communities on the updated HTS services.	Implement male friendly services. Challenge cultural practices that keep men from taking up SRH services.	Pregnant women Children Men	All sub-counties	Health facilities, CHMT CASCO Partners CSOs Community gate-keepers Faith sector

Interventions to diagnose and link 90% of all PLHIV

MCHSP Results	Key Activity/ Intervention Area	Sub-Activities/Interventions			Target Population	Geographic areas by County/sub-county	Responsibility
		Biomedical	Behavioural	Structural			
90% of all PLHIV diagnosed and linked to care	HTS - Men, children and pregnant women	PITC for children at points of care, i.e. OPD, paediatric wards, MCH, and other clinics. Follow up parents as index clients for children testing.			Pregnant women Children Men	All sub-counties	Health facilities, CHMT CASCO Partners CSOs Community gate-keepers Faith sector
	HTS - General population	Provide for HTS counsellor supervision and mentorship. Targeted HTS.	Sensitise communities on uptake of HTS services. Targeted HTS campaigns. -Public education	Stigma reduction campaigns.	General population	All sub-counties	Health facilities CHMT CASCO Partners CSOs

4.4.2.3 Start and retain 90% of those diagnosed on ART

Early ART has by far the most substantial effect on HIV incidence among all scientifically tested interventions[16].

16 UNAIDS. Ambitious treatment targets: writing the final chapter of the AIDS epidemic. In: UNAIDS, ed. Geneva: UNAIDS, 2014.

4.4.2.4 Achieve viral suppression for 90% of patients on ART

This strategy aims to have at least 90% of those infected attain undetectable level of virus in their bodies. Suppressed viral load is critical for controlling the harmful effects of HIV infection on people's health and also reduces the risk of infecting others and opportunistic infections (OIs). In the county, only 5.7% PLHIV had their viral load tests in July 2015. The main challenge in achieving this 90 mark is access to viral load tests. Though the County has a viral load machine, it is yet to be operationalised. The County still relies on KEMRI and national laboratories for Viral Load tests.

Table 4.8: Interventions to start and retain 90% of all PLHIV on ART

MCHSP Results	Key Activity/ Intervention Area	Sub-Activities/Interventions			Target Population	Geographic areas by County/ sub-county	Responsibility
		Biomedical	**Behavioural**	**Structural**			
90% of those diagnosed HIV positive started and retained on ART	ART – Adolescents and young people	Integrate HIV care and treatment into youth friendly services. Reduce pill burden through Fixed Dose Combination (FDCs). Increase ART central sites. Special dedicated clinic days.	School based follow up by CHVs and CHEWS. Provide care givers with HIV education, literacy and empowerment. Adolescent support groups linked up with health facilities. School based treatment literacy programs.	Review Teacher training curriculum to include updated HIV information.	Care givers Teachers School support staff Youth out of school Youth in school	All sub-counties	Health facilities CASCO MoEST TSC Partners CSOs Faith sector County Director of Education
	ART – Adolescents and young people	Utilise technology including social media for education, recruitment and retention in care. Introduce electronic appointment cards.	Utilize teacher/ school support staff to provide support for adherence to ART in schools. Supportive disclosure.	Address socio cultural barriers to drug adherences. Empower families to initiate and sustain livelihoods.	Care givers Teachers School support staff Students who are out of school Adolescents and young people	All sub-counties	Health facilities CASCO MoEST (TSC), Partners CSOs Faith sector County Director of Education
	ART – KPs	Integrate ART services in drop in centres Sensitise HCWs on KPs programming.	Reduce self stigma to increase access to care and treatment. Address stigma and discrimination by healthcare providers. Establish and strengthen psychosocial support groups to promote adherence.		MSM PWID FSW and their clients	All sub-counties	Health facilities, CHMT CASCO Partners CSOs
	ART- Men, children and pregnant women	Initiate ART as per national guidelines.	Family psychosocial support. Supportive disclosure. ART adherence counselling. Nutritional support.		Men Children Pregnant women	All sub-counties	Health facilities, CHMT CASCO Partners CSOs

Table 4.9 Interventions to achieve 90% viral suppression of PLHIV

MCHSP Results	Key Activity/ Intervention Area	Sub-Activities/Interventions			Target Population	Geographic areas by County/sub-county	Responsibility
		Biomedical	**Behavioural**	**Structural**			
90% of patients on ART achieving viral suppression	Conduct viral load tests	Put strategies to identify those who are due for viral load by flagging all those due. Improve TAT from collection points to KEMRI. Improve TAT from KEMRI to the facilities. Operationalise the viral load testing and Versertrek for sputum culture in Machakos Level 5 Hospital (Integrate VL machine with molecular biology equipments. Utilize National Public Health Laboratories for referrals Build capacity for HCWs to interpret viral load results. Revive and strengthen multi-disciplinary teams to discuss clients, i.e. those with high viral load. Strengthen ACT quarterly reviews.	Mobilise commodities for uptake of viral Load testing. ART adherence campaigns. Treatment literacy. Nutritional support.	Consistent and sustainable supply of Dried Blood Spot (DBS) filter papers commodities.	ALHIV CLHIV Adolescents and young people living with HIV	All sub-counties	Health facilities, CASCO Partners CSOs Networks of PLHIV, KEMSA KEMRI

4.4.3 Strategic Direction 3:

Promote and Protect Human Rights To Facilitate Access To Services

The Constitution of Kenya (2010) provides an overarching conducive legal framework for more comprehensive and people driven health services, and ensuring a rights – based approach to health is adopted, and applied in the country[17]. Strategies to address the HIV epidemic are hampered by an environment where human rights are not respected. For example, stigmatization and discrimination against marginalized groups such as sex workers, and MSM drive these populations underground. This impedes efforts to reach them with prevention initiatives, thereby increasing their vulnerability to HIV. Similarly, failure to provide access to appropriate information about HIV, or treatment, and care and support services further fuels the AIDS epidemic[18].

According to UNAIDS, HIV continues to be driven by gender inequalities and harmful norms that promote unsafe sex and reduce access to HIV as well as SRH services for men, women and transgender persons. The pervasive social, legal and economic disadvantages faced by girls and women reduce their ability to protect themselves from HIV infection.

This SD is anchored on Article 27 of the Kenya Constitution which outlaws discrimination on the basis of one's health status, provides for equality between men and women and allows the use of affirmative action to redress past discrimination. The strategies are aimed at removing barriers to access HIV services by PLHIV, KPs and other priority groups, improving policies and legal frameworks, reducing HIV related stigma and discrimination, reducing gender based violence and improving access to legal and social justice.

This plan is cognizant of the diversity of the county, in particular, groups such as women, pregnant women, men, adolescents, children, sex workers, PWID, MSM and persons with disabilities. In this regard, the strategies, where appropriate, addresses the specific access needs of particular groups. Ensuring access to healthcare services requires that interventions be planned and implemented in a manner that is group specific and group sensitive. There is a need to commit to intensifying county efforts to create enabling legal, social and policy frameworks in the Machakos context, in order to:

- Eliminate stigma, discrimination and violence related to HIV and sexual orientation to promote access to HIV prevention, treatment, care and support.
- Promote non-discriminatory access to HIV services.
- Provide legal protection for people infected/affected by HIV, including inheritance rights and respect for privacy and confidentiality..
- Promote and protect all human rights and fundamental freedoms with particular focus to KVPs, PLHIV and those affected by HIV.

Strengthen mechanisms for monitoring abuses to include stigma and discrimination, social exclusion, child labour and gender-based violence.

17 United Nations, 1948. Universal Declaration of Human rights, Article 25

18 OHCHR, (2014). HIV/AIDS and Human Rights

Table 4.10: Interventions to promote and protect human rights to facilitate access to services

MCHSP Results	Key Activity/ Intervention Area	Sub-Activities/Interventions			Target Population	Geographical areas by County/sub-county	Responsibility
		Biomedical	Behavioural	Structural			
Stigma and discrimination reduced by 50%	Address HIV related stigma and discrimination	Sensitize healthcare workers to reduce stigmatizing attitudes in healthcare settings.	Develop community groups / forums and utilize PLHIV to campaign against HIV-related stigma and discrimination. Engage media to facilitate campaigns to reduce stigma and discrimination, GBV and promote uptake of HIV services and prevention interventions. Mobilise and engage religious leaders to address HIV stigma and discrimination in their settings	Educating the community and HCW on legal issues, rights and gender issues in relation to HIV and AIDS. Sensitise county assembly on the need to enact laws and policies that prohibit discrimination and support access to HIV prevention, treatment, care and support. Build capacity within CSOs to increase access to justice. Decentralize HIV Tribunal services to the county.	HCWs Community	All sub-counties	Networks of PLHIV CHMT Media Faith sector CSOs County Social Development Chidren's Department, HIV Tribunal Partners
	Promote non discriminatory access to education, health care, employment and social services	Offer non discriminatory HIV services	Sensitization forums involving the law enforcement officers, KPs and human rights advocates.	Engage Social Services to implement child labour protection policies including cash transfers program for OVC. Engage MoEST to address stigma and discrimination in the schools, universities and colleges.. Invest in community programmes to change harmful gender norms, negative stereotypes.	HCWs Law enforcers OVCs	All sub-counties	Health facilities, CHMT, Social Services; MoEST Children's Department Faith sector Media Community gatekeepers Partners

Interventions to promote and protect human rights to facilitate access to services

MCHSP Results	Key Activity/ Intervention Area	Sub-Activities/Interventions			Target Population	Geographical areas by County/sub-county	Responsibility
		Biomedical	Behavioural	Structural			
Improved protection of human rights	Strengthen mechanisms for monitoring abuses	Monitor human rights abuses cases in health settings.	Capacity building for KPs to recognise and report abuses of their rights. Build capacity within civil society to monitor human rights abuses and increase access to justice.	Strengthen the county capacity to document, monitor and address human rights abuses. Empowering communities to guard against human rights violations, including those of minorities.	KPs CSOs	All sub-counties	Community leaders Law enforcers County Health Management Team Health workers Faith sector CSOs Partners
	Address SGBV	Waive charges for filling of P3 forms for sexual violence survivors in hospitals. Continuous training of community health workers on GBV to identify and refer cases.	Develop a GBV/ HIV action plan. Begin a 'zero tolerance' to GBV campaigns that involves men as protectors.	Prioritize GBV county legislation in the County Assembly. Establish a rehabilitation, psychosocial and shelter services for survivors of GBV. Utilize FIDA lawyers for pro-bono legal services.	GBV survivors	All sub-counties	Community leaders Law enforcers CHMT HCWs Faith sector CSOs Partners Chair Health Committee County Social Services County Gender Committee FIDA County Focal person CHC

4.4.4 Strategic Direction 4:

Strengthen Integration of Health and Community Systems

Successful implementation of the County HIV response relies upon strong and functional health systems to achieve more equitable and sustained improvements across health services and health outcomes[19]. In the case of Community Systems Strengthening, the process will be modeled around strengthening community service delivery for the provision of HIV prevention, treatment, care and support services. The expected results are:

- A competent, motivated and adequately staffed workforce to deliver HIV services
- Improved access to HIV commodities
- Strengthened community service delivery of HIV prevention, treatment, care and support
- Enhanced linkages between the community and health systems

Table 4.11: Interventions to strengthen integration of health and community systems

MCHSP Result	Key Activity/ Intervention Area	Sub-Activities/Interventions	Responsibility
Adequately staffed health facilities	Recruit and retain Competent , motivated and adequately staffed health workforce	Recruitment of staff to improve staff: population ratio in line with the recommended Kenya staffing norms. Redeployment of staff to ensure availability of appropriate competent and skilled HCWs. Develop and implement a staff retention policy. Ensure health workers have access to prevention and other HIV and TB related services, immunization against vaccine-preventable diseases, especially Hepatitis B. Consider task shifting as a way of increasing the pool of knowledgeable HIV and TB-related service providers and more-to less specialized health workers. Ensure package of HIV and TB prevention, treatment and care services to health workers and their families on a priority basis and should be tailored specifically to their needs.	County Public Service Board CEC Health Partners CHMT

19 WHO. Everybody's Business: Strengthening Health Systems to improve Health Outcomes; WHO's Framework for Action: Geneva: WHO 2007

Interventions to strengthen intergration of health and community systems

MCHSP Result	Key Activity/ Intervention Area	Sub-Activities/Interventions	Responsibility
Adequately staffed health facilities	Recruit and retain Competent, motivated and adequately staffed health workforce	Address stress and burnout, prohibiting HIV, TB-related and other forms of discrimination On job training of all HIV service providers Implement Continuous Medical education (CME) on HIV Create incentives in terms of remuneration, promotions, Provision of study leaves and sponsorships to HCWs Implement staff recognition such as end of year awards for best performing HCWs.	County Public Service Board CEC Health Partners CHMT
Improved access to HIV commodities and services	Procurement and supply of HIV commodities	Strengthen HIV commodity management and supply chain. Provide functional HIV diagnostic equipment (VL, RTKs, CD4 machines). Strengthen capacity of the county, sub county and facilities to appropriately plan for, procure, store. Distribute and manage inventories of commodities Strengthen and link DHIS and LMIS systems for better management of supplies Timely distribution of HIV and TB commodities from county to sub county level Timely distribution of HIV and TB commodities (OIs drugs, Condoms, test kits, TB Drugs) from KEMSA to facilities Establish commodity security committees at the county and sub county levels	CHMT County HIV Committee(CHC) Partners KEMSA

Strengthen intergration of health and community systems

MCHSP Result	Key Activity/ Intervention Area	Sub-Activities/Interventions	Responsibility
Strengthened community service delivery of HIV prevention, treatment, care and support	Create and strengthen existing community health units, CSOs and networks	Refresher course and periodic updates for CHEWs, and CHVs. Integrate HIV services into the community health units. Strengthen capacity, governance and leadership of CSOs and workplace HIV response. Empower communities to take charge of their health. Establish standards for guiding community and workplace HIV interventions and practice. PHDP strengthening. Psychosocial support group strengthening. Encourage adoption of treatment buddy system to reduce defaulter rates. Community sensitization on county budgeting process to advocate for HIV budget allocation. Establish new community health units as per national guidelines. Strengthen SCACCs to coordinate the HIV response in their local context. Strengthen CSOs reporting through COBPAR.	CHMT (Community Strategy focal person) County Health Department CHEWs CHVs Partners CHC SCACCs
Enhanced linkages between the community and health systems	Enhance referral and linkage services between community and facility	Quarterly community dialogue and health action days. Provision of HIV commodities and reporting tools to the CHEWs. Motivation and support for CHVs. Strengthen referral system from Level 1 to other levels of care. Implement the national guideline on referrals. Increase the number of health facilities offering KEPH. Upscale service delivery at the dispensary level to include HIV services.	CHMT (Community Strategy focal person) County Health Department CHEWs CHVs Partners CHC SCACCs CSOs

4.4.5 Strategic Direction 5:

Strengthen Research, Innovation and Information Management to Meet MCHSP Objectives

Recognizing the importance of research, innovations and information management in healthcare systems is key to accelerating healthcare transformation. One major problem that often plagues progress in health research is the slow translation of research into practice. It is therefore necessary to combine practical experience with scientific understanding in order to ensure improved performance while implementing HIV interventions.

Table 4.12: County research priorities

SD	KEY RESEARCH TOPICS
SD1 **Reduce new HIV infections**	• Determine optimal effective models for increasing HTS to linkage, care and adherence (implementation research). • Granulate County HIV epidemic by sub-county, age and population including size estimates for adolescents, youth and KPs. • Determine optimal models for integration at service delivery that provide best HIV outcomes (implementation research).
SD 2 **Improve health outcomes and wellness of all PLHIV**	• Identify and test interventions that address determinants and barriers to linkages into care for PLHIV disaggregated by age, gender and sub populations. • Determine HIV transmission rates among HIV positive adolescents and individuals unaware of status. • Determine optimal interventions for addressing gender and social cultural factors affecting the effectiveness of PMTCT (implementation research). • Determine outcomes and causes of LTFU among PLHIV on care and treatment (behavioural research).
SD3 **Strengthen integration of health and community systems**	• Determine human rights related barriers to access HIV, TB and SRH services by sub population, geography and facility type, that is public/private (behavioural research). • Determine the impact of stigma and discrimination on key outcomes including HTS uptake, enrollment and retention in care and adherence. • Evaluate effective and optimal intervention to reduce stigma, discrimination and social exclusion in the county (implementation research).
SD4 **Promote and protect human rights to facilitate access to services**	• Determine the optimal distribution and retention of skilled workforce on HIV at the county. • Determine effective mechanisms of task shifting and its impact on quality of HIV service and quality of care • Evaluate cost effective technology applications in service delivery, commodities and supply management
SD7&8 **Increase domestic financing and promoting accountable leadership**	• Document effective models for engagement of county leadership for sustainability and ownership of the HIV response (implementation research). • Evaluate effectiveness of existing HIV coordinating mechanisms at the county.

Table 4.13: Interventions to strengthen research and innovation to inform County objectives

MCHSP Result	Key Activity/ Intervention Area	Sub Activities/Interventions	Responsibility
Increased capacity to conduct HIV research	Build capacity for research	Train HCWs on HIV related research. Undertake meta-analysis of all researches done at the county to establish base for further research. Enhance collaboration with local training institutions with a view of enhancing interests in HIV research and dissemination of the same. Establish an Ethical Review Committee for coordinating HIV research activities. Establish institutional framework for coordination of research activities. Establish a multi-sectoral county Research unit	CHMT CHC CEC Health Learning institutions Partners
	Funding for research	Partner with universities and colleges to prioritise HIV research. Lobby for HIV research budget line in the HIV budget.	County research unit CEC Health Academic institutions National research agencies Partners
Increased evidence based planning and programming	Application of research findings in decision making	Establish platforms for sharing research findings. Establish a resource centre for HIV related information. Utilize research findings to direct improvements in HIV services. Document and share local innovations. Promote utilization of strategic information for research and monitoring and evaluation.	County research unit HCWs CHMT Partners CSOs

4.4.6 Strategic Direction 6:

Enhance Information, Data Demand and Use

The County generates a lot of data on HIV response activities on a daily basis. However, the quality of the generated data has been compromised by the missing figures and poor record keeping attributed to lack of effective demand for data in planning and decision making. In the absence of data,planning is done by proxy leading to setting unrealistic and unattainable targets. Currently the exercise of HIV data collection, demand and use is characterized by the following challenges:

- Inadequate supply of tools for data collection. Most of the data collection centres experiences shortage of registers and data capturing forms during some months of the year.
- Inadequate staff/manpower for data collection.
- There is no data analysis at the point of collection (service centres.)
- Low dissemination rate of data and information to potential users at the county level.
- There is no feedback mechanism after the data has been forwarded to higher levels.
- Poor quality data.
- Parallel reporting to various stakeholders at source.

Table 4.14: Interventions to enhance information, data demand and use

MCHSP Result	Key Activity/ Intervention Area	Sub-Activities/Interventions	Responsibility
Increased data and information demand and use	Increase access to strategic information	Strengthen routine and non routine HIV information systems. Conduct M&E supervision. Conduct periodic data quality audits and verification. Quarterly and annual HIV bulleting, reports and other information products. Establish and strengthen a functional multi-sectoral HIV M&E Committee. Honor county and national reporting obligations. Harmonise and create linkages between data collection tools and databases. Promote data demand and use of HIV strategic information to inform planning and programming. Strengthen and enforce partner reporting through DHIS and HIPORS. Operationalise and sustain the HIV Situation Room. Harmonization of data collection tools to capture all the required variables and data elements especially on adolescents and young people priority groups. Strengthen County M&E system. Joint multi-sectoral data review and dissemination forums. Establish a HIV page on the County website.	CHRIO Program Officers CHMT CASCO Partners SCACCs NASCOP NACC

4.4.7 Strategic Direction 7:
Increase Domestic Financing for a Sustainable HIV Response

Nationally HIV funding is from three sources, namely Partners (68%), Public sector (17%) and the Private sector (15%). This scenario is reflected at the county level with Partners contributing the highest proportion. Currently most of the ongoing HIV programs in the County are donor supported, for example, programs financed by International Centre for HIV and AIDS Programme (ICAP) and University of Nairobi (UoN) who operate within institutional framework managed by the County Government. In FY 2015/2016 the two Partners factored a total of Ksh 76.2 million in their budget to finance HIV response in the County.

The county will work with other partners to supplement the HIV response budget, e.g. the Global Fund.

Given the increasing demand for HIV related response and donor fatigue in releasing more funds, the County Government has recognized the need to enhance domestic mobilization of financial resources to ensure sustainable HIV response. During the 2015/16 financial year the County Budget was KShs. 10.94 Billion with Ksh 2.37 Billion generated from the local revenue and Ksh 8.57

Billion from the Central Government (Machakos County Budget 2015/16).

Meanwhile, the County Government has enacted a law where funds will be factored in the Annual Budget to finance HIV activities to supplement Partners' efforts. The funds will be sourced from: money appropriated by the County Assembly, grants or donations from other agencies and all monies lawfully accruing to the funds. It is proposed in the Kenya AIDS Strategic Framework (KASF) that the County Budget allocation to HIV response be increased from 1% to 2% of the revenue collected.

Table 4.15: Interventions to increase domestic financing for a sustainable HIV response

MCHSP Result	Key Activity/Intervention Area	Sub-Activities/Interventions	Responsibility
Increased domestic financing for sustainable HIV response to 50%	Government and non-Government funding	Establish a HIV budget line in the County Health Budget. Conduct partner mapping and re-distribution. Lobby for a legislation for partners to disclose their resource envelopes. Lobby for an increase in budget allocation to HIV response from 1% to 2% of the locally generated revenue. Prepare and present a session paper on increasing domestic funding of HIV activities to the CEC - Health. Hold an annual gala dinner, charity walks for raising funds for HIV activities. Entering into PPPs with both local and private investors. Partnering with local and foreign organizations. External funding.	CEC Health Chair Health Committee CEC Finance CHC Private sector Partners CSOs Networks of PLHIV
	Promote innovative and sustainable domestic HIV financing options	Lobby for establishment of county HIV response fund/ kit Lobby for clients to take up NHIF insurance Initiate Community Based Health care Financing (CBHF) Establish a HIV budget line in the Health allocation Initiate Public Private Partnerships(PPP) for HIV response Appeal to philanthropists Undertake charitable events e.g. marathons, charity walk	CEC Health, Chair County Assembly Health Committee CEC Finance CSOs Partners

4.4.8 Strategic Direction 8:

Promote Accountable Leadership for Delivery of the MCHSP Results by all Sectors and Actors

HIV and AIDS affect all sectors of the economy; however the response should be spearheaded by the Ministry of Health as a devolved function. County planning, prioritization, implementation, monitoring, resource allocation and budgeting of programmes and interventions in counties are functions under the devolved government. Over the years, previous HIV programmes have experienced weakness in leadership in terms of service delivery, accountability, county ownership, community participation, stakeholder engagement and coordinated development partner support. The successful implementation of this strategic plan will highly depend on addressing these weaknesses.

As per the County Government Act, 2012, the County Executive Committee is required to design a performance management plan to evaluate implementation of county policies by the County Public Service Board. It further requires that the County Governor submits the county plans and policies to the county assembly for approval together with an annual report on the implementation status. In line with this requirement, this plan identifies the following intervention areas;

- Good governance and political commitment for a multi-sectoral HIV and AIDS response at all levels.
- Effective and well-functioning County HIV & AIDS coordinating framework.
- An enabling policy, legal and regulatory framework aligned to the Constitution of Kenya 2010.

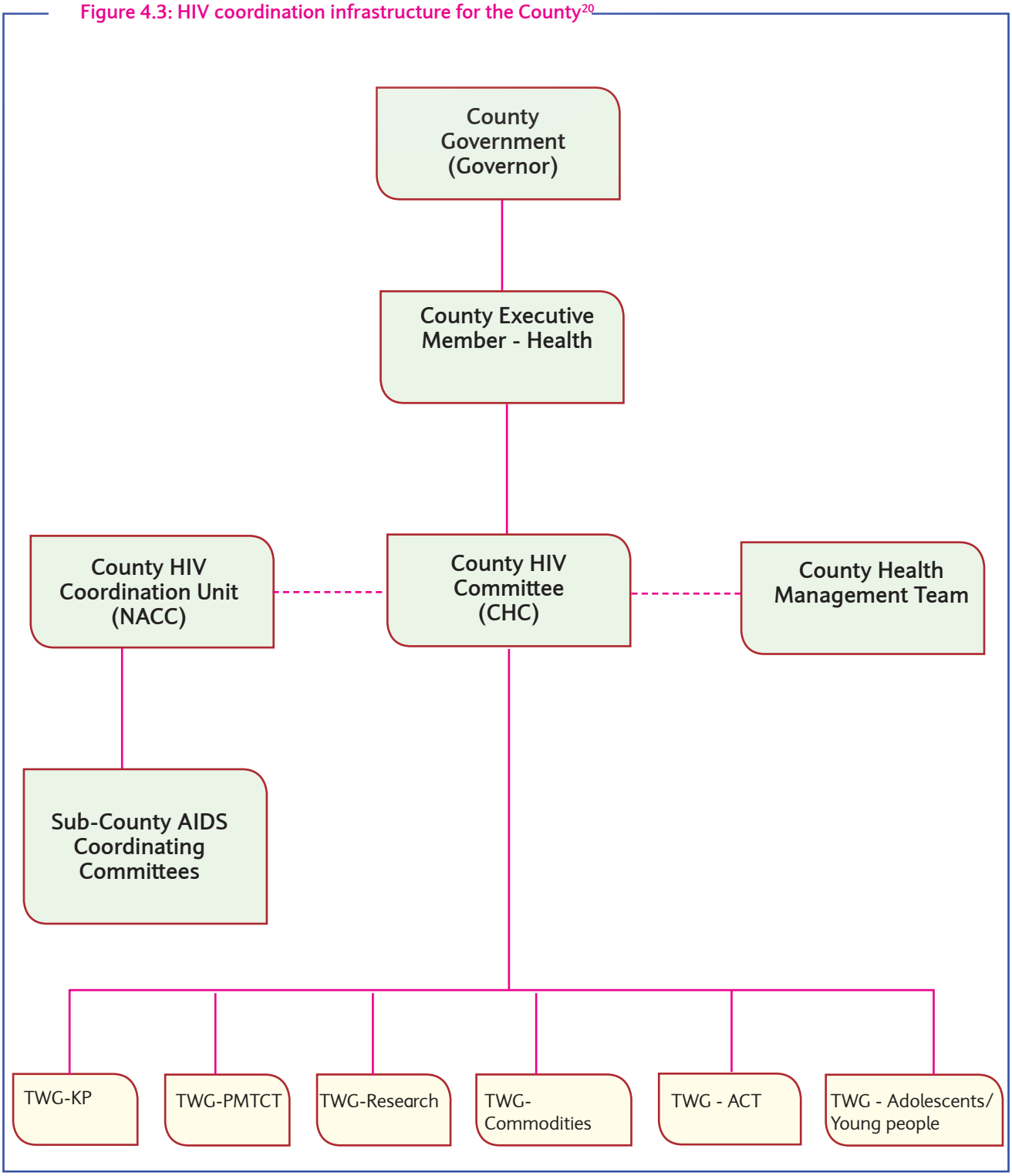
Table 4.16: Interventions to promote accountable leadership for delivery of MCHASP results

MCHSP Result	Key activity	Sub-activities/Interventions	Responsibility
Accountable leadership and governance	Build and sustain high level political and technical commitment for strengthened county ownership of the HIV response	Lobby for Prioritization of HIV response in County fiscal budget. Coordinate stakeholders in implementing MCHSP Mobilize local communities to participate in HIV response Lobby for enabling county level policies, legislation or guidelines for HIV response Mobilise and allocate adequate resources for HIV Include PLHIV representatives in the county decision making hierarchy	Governor's Office CEC Health Chair County Assembly Health Committee CSOs CEC Finance

Interventions to promote accountable leadership for delivery of MCHSP results

MCHSP Result	Key activity	Sub-activities/Interventions	Responsibility
Accountable leadership and governance	Establish and strengthen functional and competent HIV co-ordination mechanism	Form and strengthen a county HIV coordinating committee CHC and TWGs. Operationalization of a well, effective and efficient stakeholders' coordination and accountability framework Establish and support Sub-county HIV co-ordination committees (SCACCs)	CEC Health CHMT Partners
	Lobby for County HIV policy, legal and regulatory framework	Establish an enabling policy, legal and regulatory framework for HIV and AIDS response in the county. Lobby for Legal framework for a multi-sectoral HIV and AIDS response through a county legislation.	CEC Health CHMT Chair Health Committee Partners CSOs

Figure 4.3: HIV coordination infrastructure for the County[20]



20 Adopted from KASF 2014/15-2018/19

Chapter 5

Coordination and Implementation Arrangements

One of the guiding principles towards achieving the County HIV objectives is multi-sectoral accountability. The success of the HIV plan relies on identification and involvement of all the stakeholders at the community, MDAs, work place, schools and health facility levels. Different actors will be responsible for delivery in the HIV response.

The MCHSP will be implemented through the cooperative efforts of national agencies, county actors, implementing partners and CSOs. The county will establish a County HIV Committee(CHC) chaired by the CEC Health and Technical Working Groups (TWGs) in various program areas.

Role and responsibilities of key stakeholders

Committees	Roles and Responsibilities
County HIV Committee (CHC)	- Provide leadership and oversight - Mobilize resources - Set the county HIV agenda, - Approve County HIV targets, - Approve County HIV Plans/Strategy, - Present County HIV budgets to Health sector working Group and County Assembly, - Receive and approve reports on MCHSP performance
Technical Working Groups (TWGs)	Provide oversight to program areas
National agencies	**Roles and Responsibilities**
National AIDS Control Council	- Coordinate the multi-sectoral HIV response in the country - Provide policy and guidelines for HIV response - Offer technical support to the county - Monitoring and evaluation of the country HIV response - Secretariat functions to the County HIV Committee (CHC)
NBTS	Supply safe blood products

National agencies	Roles and Responsibilities
NASCOP	- Support utilization of the DHIS systems - Review, print and distribute data collection registers to capture emerging issues e.g. adolescent disaggregated data. - Provide Support and technical assistance in implementing facility based EMR system - Review and disseminate HIV related guidelines - Ensure commodity availability
KEMSA	- Timely distribution of HIV commodities to the county as per county needs. - Strengthen and improve LMIS
KEMRI and National Laboratories	- Support the County in VL testing and Drug Resistant Testing (DRT), DBS-PCR and sputum for culture - Expeditious relay of results
Prisons	- Enhance HIV transmission and management programs - Uphold human rights of detainees
County Department/ sectors	**Roles and Responsibilities**
County Department of Health	- Champion county HIV legislations - Scale up HIV interventions targeting priority populations - Offer non discriminatory HIV services in health facilities - Use strategic information to inform programming - Resource mobilization for scale up of interventions - Procure HIV commodities and infrastructures - Ensure that HIV line budget is not diverted to other activities
County Department Finance	- Allocate appropriate resources per the work plans of line ministries and departments for HIV interventions - Allocate a budget line for HIV in the County Health budget - Establish a HIV fund - Streamline audit mechanisms to ensure efficiency and effectiveness of allocated funds
County Department of Agriculture	- To provide leadership in integration of HIV in livelihood programmes
County department of Education	- Ensure that the rights of infected and affected children are protected - Strengthen school health programs to include life skills, drug adherence and abstinence - Put in place policies to keep boys and girls in school - Address stigma and discrimination in school/ college settings - Implement infection control in school/college settings - Initiate and sustain school feeding programmes - Implement the HIV curriculum in schools
County legislative arm	- Legislate appropriate policies and laws - Mobilize communities to participate in HIV response
County Department of Youth and Sports	- Integrate HIV prevention care and treatment into sporting activities and other youth forums - Establish youth resource centers - Initiate sustainable IGAs for youths out of school

County departments	Roles and Responsibilities
County Department of Labour and Social Services	- Implement OVC social protection programs - Incorporate HIV into existing social protection schemes, including nutritional support platforms - Implement structural interventions that empower vulnerable populations especially OVCs, PLWD, youth and women e.g. IGAs
County Department of Tourism	- Encourage free condom outlets in hotels, bars and lodgings - Incorporate HIV in internal and external training programme including tourists training institution - Promote HIV prevention in bars, hotel and lodges - Enforce laws that protect the minors in lodges and bars
County department of transport	Use public transport systems for HIV prevention and health promotion messaging
County Public Service Board	Ensure that all County Departments have HIV related work-plan programmes

Key partnerships	Roles and responsibilities
CSOs	- Actively engage in demand creation for HIV services - Support adherence and defaulter tracing - Work as "watch dog" of the county government to ensure accountability of results - Participate in the county budgeting process (MTEF) and resource mobilization - Educate communities on legal issues, rights and gender
Implementing Partners	- Promote locally owned programs in a coherent manner - Promote and rely on the county M& E system - Advocate for and support the county initiatives for resource mobilization to sustain programs beyond external funding - Strengthen county capacity and provide technical assistance for coordinated harmonized and evidence informed HIV response
Media	- Scale up anti stigma and discrimination campaigns - Encourage journalists to identify and report issues in HIV - Prioritise HIV in CSR interventions - Media monitoring of content (quality and upto date HIV information) - Provide secondary data to complement sector data
Academic institutions	- Undertake research in HIV to inform county planning and decision making - Mainstream HIV in curriculum development - Support HIV trainings - Address Stigma and discrimination in their settings - Offer psychosocial support to students and staff living with HIV
Private sector	- Prioritize HIV response as CSR agenda - Carry out HIV prevention, care and support in their settings - Invest in HIV response programmes
Faith Sector	- Offer psychosocial support to PLHIV and support to OVCs - Mobilize communities to access HTS, care and treatment services
Community opinion leaders	- Spearhead revoking practices that drive or spread the epidemic; and - Reintroduce traditional practices that prevent HIV and AIDS, STIs.

Table 5.1: Implementation Plan

			2015/2016				2016/2017				2017/2018				2018/2019				
SD	**MCHSP Result**	Key Activity	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Responsibility**
1	New HIV infections among adults reduced by 75% from 1463 to 366 New HIV infections among children reduced by 75% from 80 to 20	Increase coverage of combination prevention approach	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	All health facilities, Community gate keepers ,CSOs, Faith sector, Partners, County Social services
		Targeted HIV prevention to priority populations	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	All health facilities, Community gate keepers, CSOs, Faith sector, Education sector Partners, Law enforcers
		Leverage opportunities through creation of synergies with other sector	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	County MOH, County MOE, Partners, County Social Development Office, CSOs, County transport department, local media
2	90% of all PLHIV diagnosed and linked to care	HTS adolescents and young people	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	All Health Facilities, CHMT, CASCO,/ SCASCO, CSOs, Partners, KEMSA.
		HTS - KP	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Al health Facilities, CHMT, CASCO,/ SCASCO, CSOs, Partners
		HTS - Men, Children and pregnant women	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Health Facilities, CHMT, CASCO,/ SCASCO Partners, CSOs, Community gate keepers, Faith sector
		HTS General population	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Health Facilities, CHMT, CASCO,/ SCASCO Partners, CSOs
		HTS and Linkages	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Health Facilities, CHMT, CASCO,/ SCASCO Partners, CSOs
	90% of all PLHIV diagnosed and linked to care	ART –Adolescent and young people	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	MOEsT, TSC, County MoH, Partners, CSOs, Faith Sector, County director of education
		ART – KP	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Health Facilities, CHMT, CASCO,/ SCASCO Partners, CSOs
		ART General Population	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Health Facilities, CHMT, CASCO,/ SCASCO Partners, CSOs
		ART- men, Children and pregnant women	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Health Facilities, CHMT, CASCO,/ SCASCO Partners, CSOs
	90% of all patients on ART Achieving viral suppression	Conduct viral load tests	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	All health Facility, CASCO,/SCASCO partners, CSOs, Networks of PLHIV, KEMSA,KEMRI

Implementation Plan

			2015/2016				2016/2017				2017/2018				2018/2019				
SD	**MCHSP Result**	Key Activity	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Responsibility**
3	50 % Reduction in stigma and discrimination	Strengthen Mechanisms for Monitoring Abuses	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Community leaders, law enforcers, County Health Management Team/ Health Workers, Faith sector, CSOs, partners
		Address HIV related stigma and discrimination	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Networks of PLHIV, County Health Management Team, Media,, Faith sector, CSOs , County Social development, Children department, HIV tribunal, partners
		Promote non discriminatory access to education, health care, employment and social services	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	CHMT, Social Services; MoEST, Children department, faith Sector, Media, Community gate keepers, Partners
4	Competent, motivated and adequately staffed workforce to deliver HIV services	Staffing	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	County Public service board ,CEC health, Partners, CHMT
	Improved access to HIV commodities and services	Procurement and supply of HIV commodities	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	CEC health HMT, County HIV Committee (CHC), Partners
	Strengthened community service delivery of HIV prevention, treatment, care and support	Create and Strengthen existing the community Health units and networks	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	CHMT (Community Strategy focal person), Sub County MoH,- CHEWS,CHVs Partners, CHC, SCACCS
	Enhanced linkages between the community and health systems	Enhance referral and linkage services between community and facility.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	CHMT (Community Strategy focal person), Sub County MoH,- CHEWS,CHVs, Partners, CHC, SCACCS, CSOs

Implementation Plan

			2015/2016				2016/2017				2017/2018				2018/2019				
SD	**MCHSP Result**	Key Activity	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Responsibility**
5	Increased capacity to conduct HIV research	Build Capacity for Research	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	CHMT, County Research unit, CHC, CEC Health, learning institutions, Partners
		Funding for Research				x				x				x				x	County research unit, CEC Health, Learning Institutions, national Research agencies
	Increased evidence based planning and programming	Application of research finding in decision making	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	HCWs, CHMT, Partners, CSOs
6	Increased availability of strategic information to inform HIV response	Increase access to Strategic information	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	CHRIO/PROGRAM OFFICERS/CHMT, CASCO Partners, SCACCS, NASCOP, NACC, NEPHAK
		MCHSP Mid term Review								x	x								CEC Health, CHMT, CHC, Partners
7	50% increase in domestic financing for sustainable HIV response	Establish a HIV budget line in the Health Budget				x				x				x				x	CEC Health, Chair County Assembly Health Committee, CEC Finance, CHC, CSOs and Networkers of PLHIV
		-Conduct Partner mapping and re distribution					x	x											CEC Heath, CHMT
		Lobby for a legislation for partners to disclose their resource envelopes					x	x	x	x	x	x							CEC Health, Chair County Assembly Health, communities
		Lobby for increase in budget allocation to HIV response from 1% to 2% of locally generated revenue				x				x				x				x	CEC Health, Chair County Assembly Health Committee, CEC Finance, CHC , CSOs and Networkers of PLHIV
		Prepare and present a session paper on increasing domestic funding of HIV activities to the County Executive Committee					x	x											CHMT
		Hold an annual dinner gala, charity walks for raising funds for HIV activities			x				x				x				x		CEC Health, , CEC Finance, CHC, Private sector, Partners
		Promote public private partnership	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	CEC Health, , CEC Finance, CHC, Private sector, Partners
		Establish HIV investment Fund				x	x	x	x	x	x	x	x	x	x	x	x	x	CEC Health, Chair County Assembly Health Committee, CEC Finance, CSOs

Implementation Plan

			2015/2016				2016/2017				2017/2018				2018/2019				
SD	**MCHSP Result**	Key Activity	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Responsibility**
8	Governance and political commitment	Prioritization of HIV response in County fiscal budget				x				x				x				x	Governor's Office ,CEC Health, Chair County Assembly Health Committee, Communities, CEC Finance
		Resource mobilization	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
		Enhance good governance to strengthen multi partner and multi sectorial accountability for strategic plan implementation	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
	Coordination framework	Formation of a coordinating committees in line with KASF implementation framework (ICC, County HIV committee, M&E committee				x	x												CEC Heath, MOH, CHMT, Partners
		Operationalization of a well, effective and efficient stakeholders coordination and accountability framework				x	x												
	County HIV policy, legal and regulatory framework	Establishment of an enabling policy, legal and regulatory framework for HIV & AIDS in the county	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	CEC Health, CHMT, Chair County Assembly Health Committee, Partners, Communities
		Lobby for Legal framework for multi-sectorial HIV/AIDS response through a county legislation				x	x	x	x	x	x	x							

Critical assumptions

In the implementation of the MCHSP 2015/16-2018/19, the following key assumptions are made;

- Adequate funds will be made available in time.
- Political stability and security will prevail.
- All stakeholders including partners and non-state actors will be supportive.
- Political will and support will be sustained.
- National agencies, County departments, private sector, CSOs, Faith sector and partners will respond positively and cooperate.

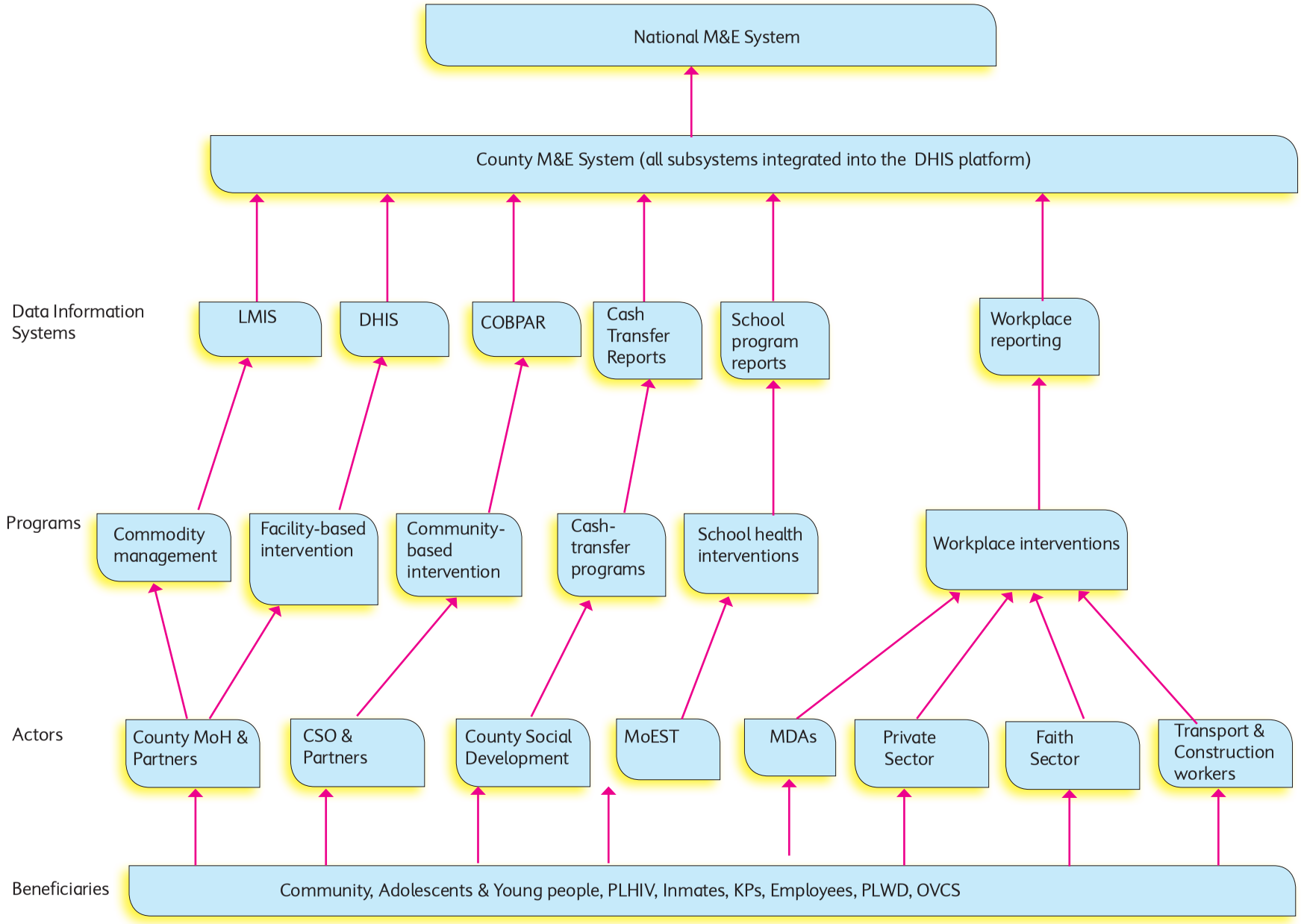
Chapter 6

Monitoring and Evaluation Plan

The HIV Monitoring and Evaluation (M&E) system is primarily divided into two: health facility-based and non- facility based or community-based, components of monitoring and evaluating the County HIV response. The County will utilize the following essential components to ensure a functional M&E system:

- Establish a MCHSP Monitoring Committee with clear Terms of Reference.
- Invest in human capacity and M&E – recruit and build the capacity of the existing M&E staff for facility and community based systems.
- Establish and strengthen Technical Working Groups (TWGs) – i.e. KPs, PMTCT, adolescents and young people, HIV commodities, acceleration of care and treatment (ACT) and research.
- Develop Annual Costed County HIV M&E workplan.
- Routine HIV program monitoring – strengthen Standard Operating Procedures (SOPs) guiding data collection and management.
- Strengthen routine reporting of facility and community based activities – strengthen DHIS, COBPAR and HIRPOS.
- Survey and surveillance – the County will benefit from national surveys and surveillance (KDHS, KAIS, MoT, KNASA) in tracking some indicators.
- County HIV Database – the Situation Room will be used to generate data consolidated from different subsystems to include DHIS, LMIS, COBPAR, HIPROS.
- Support supervision and data auditing – quarterly support supervision and data audits in facility and community based M&E systems.
- HIV research – the Research TWG will develop coordination mechanism for HIV research in the county to be adopted by partners and universities in conducting HIV research.
- Data dissemination and use – the M&E Committee will develop data dissemination mechanisms to ensure all stakeholders have access to the most up-to-date information available that can inform program decisions. The information products will include quarterly HIV reports, dash boards and MCHSP indicators snapshots.
- Midterm and End term reviews – there will be a midterm and end term review of the MCHSP.
- Data from various reporting systems will be consolidated at the County M&E system (Figure 6.1 below).

Figure 6.1: Data Flow



Chapter 7

Risk Mitigation Strategy

The risk management plan is a tool to assist in identifying risks that have the potential to impact on the successful outcomes of the strategic plan as a whole. By identifying these risks and especially by presenting possible strategy to prevent or mitigate them, the matrix becomes a reference document for both the funding mechanisms and monitoring and evaluating the plan.

Table 7.1: Risk and Mitigation Plan

Risk Category	Risk Name	Status	Probability (1-5)	Impact (1-5)	Risk Average Score	Response	Responsibility	When
Technolo-gical	Loss of data	Low	2/5	4/5	3/5	- Install data back-up - Give user rights	CEC Health	Year 1
Political	Displacement of populations	Low	1/5	4/5	3/5	Set up a disaster management kit	CEC Health CEC Finance	Year 1 - Year 5
Operational	Partner dependency	High	4/5	5/5	4.5/5	Establish HIV budget line in the County Budget	CEC Health CEC Finance, Chair of Health committee	Year1 - Year 5
	Herbalist and Faith healing	Medium	3/5	4/5	3.5/5	- County legislation on herbal medicine to include vetting and licensing - Community empowerment in health decisions	CEC Health Chair Health Committee	Year 1
	Existence of briefcase CBOs/NGOs	Low	1/5	1/5	1/5	- Vetting of CBOs/NGOs - County legislation on CBO and NGOs	County Social Service Chair Health Committee	Year 1 to Year 5
	Uncertainty of program support	High	3/5	4/5	3.5/5	Establish a County HIV funds kitty	CHC	Year 1

Risk and Mitigation Plan

Risk Category	Risk Name	Status	Probability (1-5)	Impact (1-5)	Risk Average Score	Response	Responsibility	When
Legislation	Lack/weak legislation Weak enforcement	Medium	2/5	3/5	2.5/5	- Review of existing legislation - Enactment of a County HIV/AIDS Act - Enhance enforcement of legislation	CEC Health, Chair Health Committee CHC	Year 1 & Year 2

Chapter 8

Costing and Resource Mobilization Strategies

The County Resource Needs for this strategic plan period was calculated using Stover County HIV Resource Model. The template utilises EPI and program data to form the baselines and projects the resource needs over a period of time. The model assumes that the medical services are included in the health budget rather than the HIV budget. The baseline information utilised in this model is as follows:

EPI and Program Data	As at Dec 2015	Default value
HIV prevalence among 15-49 year old adults	5.0%	5.0%
Adults receiving ART	17,173	11,542
Children receiving ART	1,991	1,609
Number receiving PMTCT	1,085	1,085
Number receiving HTS	270,697	148,343

Interventions		Unit costs of services		
	Coverage as at Dec 2015	Revised value	Default value	Units
ART	75.0%	KSh51,612	KSh51,612	per patient
PMTCT	53.0%	KSh1,748	KSh1,748	per mother/baby
HTS	51.0%	KSh513	KSh513	per person tested
Adolescent friendly services		KSh6	KSh6	per service
Key Populations	55.0%	KSh6,440	KSh6,440	per person reached
Behaviour change		KSh138	KSh138	per person reached
OVC support	30.0%			
Program support		15.5%	15.5%	% of other services

Where the default values are national level costs and program costs are calculated as a percentage of other costs.

NB: The model does not cater for estimated costs of training and capacity building, research, M&E, which will be determined by activity budgets.

MCHSP Resource Needs

Resource Needs (Millions of Ksh.)					
	2015	2016	2017	2018	2019
ART	994	948	902	857	811
PMTCT	2	2	2	2	3
HTS	69	77	85	93	101
Condoms	41	41	46	52	58
Key Populations	6	9	12	14	18
Behaviour change	140	173	206	243	283
OVC	120	136	136	138	140
Program support	211	219	219	220	222
Total	1,544	1,606	1,609	1,620	1,635

Annexes

Annex 1: Results Framework

Strategic Direction 1: Reduce New HIV Infections						
MCHSP Results	**Service Delivery Area**	**Indicators**	**Baseline**	**Data Source**	**Mid Term Target**	**End Term Target**
New HIV infections among adults reduced by 75% from 1463 to 366 New HIV infections among children reduced by 75% from 80 to 20	New HIV infections	Number of new HIV infections in adults (15+)	1453	County Estimate 2013	726	366
		Number of new HIV infection in children (0-14)	80	County Estimate 2013	40	20
		Number of new infections among infants (0-12 months	44	DHIS2015	22	11
		Annual number of HIV related deaths	1098	County Estimate 2013	900	824
		Number of infants born to HIV-infected mothers that are HIV positive at 8 weeks	17	DHIS2015	9	4
	Adolescents programme	Percentage of young women and men aged 15-25 who have had sexual intercourse before age 15	12.%*	KAIS 2012	8.0%	5%
	HTS	Percentage of the population counseled and tested	51%	DHIS - 2015	60%	75%
	PEP	Number of health facilities providing PEP services	200/250	DHIS	240	250
	General population	Percentage of people aged 15 - 49 who had sexual intercourse with more than one partner in the last 12 months	8.4%*	KAIS 2012	6%	4%
		Percentage of people aged 15 - 49 who had sexual intercourse with more than one partner in the last 12 months and reported condom use during the last sexual intercourse	37.7%*	KAIS 2012	50%	75%
	PMTCT	Number of pregnant women attending ANC whose male partner was tested for HIV	679/28049 (2.4%)	DHIS 2015	25%	30%
		Number and percentage of infants born to HIV infected women starting on cotrimoxazole prophylaxis within 2 months of birth	703/ 1024 (68.6)	DHIS	75%	90%
		Number and percentage of infants born to HIV infected women who receive DNA - PCR test for HIV within 2 months of birth	596/1024 (58.2%)	DHIS	65%	75%
		Number and percentage of pregnant women who know their HIV status (1ST ANC visit)	28049 (87%)	DHIS	30400 (95%)	32000 (100%)

MCHSP Results	Service Delivery Area	Indicators	Baseline	Data Source	Mid Term Target	End Term Target
New HIV infections among adults reduced by 75% from 1463 to 366	PMTCT	Percentage of HIV positive women who receive anti- retroviral medicine to reduce risk of mother-to-child transmission (ANC - PMTCT)	836/1024 (81.6%)	DHIS 2015	92%	95%
		Percentage of new ANC clients seen at health facilities (1st ANC visit)	87%	DHIS 2015	95%	100%
		Percentage and number of clients whose male partners were tested in MCH	679/32000 =2.1%	DHIS 2015	10%	30%
		Percentage of clients who finished four ANC visits	53%	DHIS 2015	75%	80%
New HIV infections among children reduced by 75% from 80 to 20	Key Populations	Number of targeted tests for high risk populations	2811/5120 =55%	UoN MARPS Project	60%	75%
		Number and percentage of KP reached with HIV prevention programmes	2811/5120 =55%	UoN Marps	60%	75%
		Number of syringe distributed to PWID by Needle and Syringe Program (NSP)	No data			
	Leverage opportunity for HIV prevention	Percentage of County Government Ministries, Departments and Agencies (MDAs) with result based HIV plans aligned to MCHSP	0	Public sector reporting tool (2014)	100%	100%

Strategic Direction 2: Improve Health Outcomes and Wellness of all PLHIV						
MCHSP Results	**Service Delivery Area**	**Indicators**	**Baseline**	**Data source**	**Mid Term Target**	**End Term Target**
90% of all PLHIV diagnosed and linked to care	ART Program	Percentage of people diagnosed HIV positive linked with care within 3 months	72%	DHIS 2015	80%	90%
		Percentage of PLHIV receiving HIV care services	63%	DHIS 2015	75%	90%
90% of those diagnosed started and retained on ART	ART Program	Number and percentage of adults and children enrolled in HIV care and eligible for cotrimoxazole prophylaxis currently receiving cotrimoxazole prophylaxis	99.8% (20305)	DHIS 2015	100%	100%
		Number and percentage of eligible clients newly initiated on highly active ART in the last 12 months	464/1006 = 46%	DHIS 2015	24%	12%
		Percentage of adults and children currently receiving ART among all eligible people living with HIV (using national criteria)	75%	DHIS 2015	85%	90%
		Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (24 months, 36 months, 60 months)	12 Months 78%	DHIS 2015	81.8%	90%
			24 Months	DHIS 2015	76.5%	90%
			36 Months	DHIS 2015	73%	90%
			60 Months	DHIS 2015	70%	90%
	HIV/TB co-morbidity	Percentage of TB/HIV co-infected clients who are receiving ARTs	98%	DHIS 2015	100%	100%
		Percentage of HIV patients screened for TB	100%	DHIS	100%	100%
90% of patients on ART achieving viral suppression	Viral Load	Percentage of ART patients with an undetectable viral load at 12 months after initiation of ART	TBD	DHIS	80%	90%
		Percentage of people on ART tested for viral load who have a suppressed viral load in the reporting period	41%	NASCOP Report Dec 2015	80%	90%
Structural interventions						
Improved quality of care treatment	Capacity building	Percentage of health facilities providing HIV care and treatment services	53/245=21%	RHIS	50%	75%
		Percentage of health facilities implementing continuous quality improvement activities according to MoH standardized protocols	80%	RHIS	100%	100%
	Access to ART services	Number of health facilities providing care and treatment according to MoH standardized protocols				
			53/245	RHIS	75/245	100/245

Strategic Direction 3: Strengthen integration of health and community systems						
MCHSP Results	**Service Delivery Area**	**Indicators**	**Baseline**	**Data Source**	**Mid Term Target**	**End Term Target**
Stigma and discrimination reduced by 50%	Stigma and discrimination	Percentage of PLHIV who self-reported that they experienced discrimination and/or stigma due to their HIV status	49.2%	Stigma index survey	30%	25%
		Percentage of women and men ages 15 – 49 expressing accepting attitudes towards people living with HIV	Men: 32.6%* Women: 46.9%*	KDHS 2009	75%	80%
	GBV	Percentage of ever married or partnered women and men ages 15 – 49 who experienced sexual and/or gender based violence	6.6%*	KDHS 2009	3%	0%
	PLHIV	Percentage of PLHIV who experienced sexual and/or gender-based violence	TBD	KDHS/KAIS		
	KP	Percentage of MSM who experienced sexual and/or gender-based violence	24%*	IBBS	15%	10%
		Percentage of sex workers who experienced sexual and/or gender-based violence	44%*	IBBS	25%	10%
	CT-OVCs	Percentage of OVCS reached with social protection programs	31%	County estimates 2014	50%	75%
Structural Interventions						
Improved protection of human rights	Human rights and improved access to justice	Number of cases filed by PLHIV at the HIV Tribunal	0	HIV Tribunal	10	20
		Number of PLHIV and KPs accessing legal services at the HIV Tribunal	0	HIV tribunal	10	20

* National data

Strategic Direction 4: Strengthen integration of health and community systems						
MCHSP Results	**Service Delivery Area**	**Indicators**	**Baseline**	**Data Source**	**Mid Term Target**	**End Term Target**
Adequately staffed workforce	Healthcare Workforce	Ratio of cadres of healthcare staff to population in line with staffing norms	1.69/1000*		2.0/1000	2.4/1000
Improved access to HIV commodities and services	Health Facilities Commodity management	Percentage of health facilities providing KEPH defined HIV&AIDS services	53/245 (21%)	RHIS	60%	80%
		Percentage of health facilities dispensing ART that experienced a stock-out of ARVs at least once in the last 12 months	0	RHIS	0	0
Strengthened community service delivery of HIV prevention, treatment, care and support	Community Units and Community Based Organisations	Number of CUs implementing AIDS competency guidelines	10/71	County Focal office	40/71	71/71
		Number of Community Health Units given training on HIV module	10/71	County Focal office	40/71	71/71
		Number of Community Health Workers reporting on HIV programmes	10/71	County Focal office	40/71	71/71
		Number and percentage of community-based organizations that submit timely, complete, and accurate reports according to guidelines	47%*	COBPAR	75%	80%
	Health systems strengthening	Number of health facilities providing integrated HIV services	53/245	RHIS	75/245	100/245
		Number of health facilities implementing universal precautions to prevent HIV infection	196	RHIS	245	245

SD 5: Strengthen research and innovation to inform County priorities						
MCSP Results	**Service Delivery Area**	**Indicators**	**Baseline**	**Data Source**	**Mid Term Target**	**End Term Target**
Increased capacity to conduct HIV research at county level	Build capacity for research	Number of prioritized biomedical and behavioural research conducted	TBD	RHIS	3	6
		Number of people trained in HIV related research	0	RHIS	10	20
		Number of HIV related studies undertaken at postgraduate levels in tertiary institutions	0	RHIS	3	8
	Funding for research	Proportion of HIV funds utilized on research	0*	KNASA	5%	7%
Increased evidence based planning and programming	Application of research finding in decision making	Number of research products disseminated to inform policy, planning, and programming	TBD	RHIS	100%	100%

* National data

SD 6: Enhance information, data use and demand						
MCHSP Results	**Service Delivery Area**	**Indicators**	**Baseline Data**	**Data Source**	**Mid Term Target**	**End Term Target**
Increase availability of strategic information to inform HIV response	Increase access and strengthen to strategic information	Number of planned M&E reports generated	2	RHIS	8	16
		Number of planned M&E reports disseminated	2	RHIS	8	16
		Established and functional MCHSP/KASF monitoring committee	0		1	1

SD 7: Increase domestic financing for sustainable HIV response						
MCHSP Results	**Service Delivery Area**	**Indicators**	**Baseline Data**	**Data Source**	**Mid Term Target**	**End Term Target**
Increase domestic financing to 50%	Government funding	Establish HIV specific budget line	0	County Budget	1	1

SD 8: Promote accountable leadership for delivery of the MCHSP results by all sectors						
MCHSP Results	**Service Delivery Area**	**Indicators**	**Baseline Data**	**Data Source**	**Mid Term Target**	**End Term Target**
Functional coordination framework	Establishment of a coordination framework	County HIV coordinating committees in place	SCACCs-8	RHIS	SCACCs-8	SCACCs-8
			County HIV Committee -0		County HIV Committee -1	County HIV Committee -1

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Location of Machakos County