BUNGOMA COUNTY HIV & AIDS STRATEGIC PLAN

2014/2015 – 2018/2019

My County, My Responsibility

BUNGOMA COUNTY
HIV & AIDS STRATEGIC PLAN

2014/2015 – 2018/2019

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Acronyms and abbreviations

ART	Anti Retro Viral Therapy
BCC	Behaviour Change Communication
BCHASP	Bungoma County HIV and AIDS Strategic Plan
SW	Sex Workers
CACC	Constituency AIDS Control Committee
CSO	Civil Society Organizations
CEC	County Executive Committee Member
CREADIS	Community Research in Environment and Development Initiatives
eMTCT	Elimination of Mother to Child Transmission
ETR	End Term Review
ERC	Ethics Review Committee
FBOs	Faith Based Organizations
HRBA	Human Rights Based Approach
HTC	HIV Testing and Counselling
ICC	Inter Agency Coordinating Committee
IDUs	Intravenous Drug Users
KNASP	Kenya National AIDS Strategic Plan
KARPR	Kenya AIDS Response Progress Report
KASF	Kenya AIDS Strategic Framework 2014/15-2018/19
KAIS	Kenya AIDS Indicator Survey
KEPH	Kenya Essential Package for Health
MCH	Maternal Child Health Care Services
MSM	Men Having Sex with Men
MOT	Modes of Transmission
NACC	National AIDS Control Council
NCDs	Non Communicable Diseases
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PreEp	Pre Exposure Prophylaxis
PEP	Post Exposure Prophylaxis
PITC	Provider Initiated Testing and Counselling
PWID	People Who Inject Drugs
SARAM	Service Availability and Readiness Assessment Mapping
SCACs	Sub County AIDS Committees
SCACCs	Sub County AIDS Control Coordinators.
SCASCO	Sub County AIDS and STI Coordinator
SD	Strategic Direction
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TBD	To Be Determined

Foreword

HIV and AIDS remains among the greatest public health concerns not only in Bungoma County but also in the whole country. The epidemic has continued to cause deaths and suffering among the residents, and its effects are felt in the entire spectrum of our county.

Following the national government's declaration of HIV and AIDS as a national disaster in 1999, and with the establishment of the National AIDS Control Council (NACC) in 2000, the response to this epidemic has been guided by the National AIDS Strategic Plans I,II and III. There have been significant achievements towards stemming new infections and forestalling AIDS related deaths. The country enacted a new constitution in 2010 which brought in a devolved system of governance, and more importantly, empowered the county governments to manage the public health sector.

We have, therefore, prepared this Bungoma County AIDS Strategic Plan to meet the unique needs of our county.

The Bungoma AIDS Strategic Plan is aligned to the Kenya AIDS strategic framework, the County Integrated and Development Plan (CIDP), Health Strategic and Investment Plan, the Constitution of Kenya 2010 and the Kenya Vision 2030.

We hope this plan will galvanize an expanded, multi-sectoral county response to the HIV epidemic.

It is important that our efforts be well coordinated coupled with enhanced accountability to reduce our HIV incidence. The Kenya AIDS Response Progress Report 2016 showed Bungoma County to be among the 3 leading counties in new HIV infections moving from 83 new infections in 2013 to 1145 new infections (+1280%) in 2015 (KARPR 2016).

My Government is fully committed to the implementation of this plan through provision of leadership and oversight towards achievement of the results, reduction of new HIV infections, provision of treatment to all those eligible and protection of People Living with HIV (PLHIV), orphans and vulnerable children (OVC) and communities affected by the epidemic.

I, therefore, wish to take this opportunity to call upon all stakeholders in Bungoma County to use this BCHASP in planning and implementing HIV and AIDS interventions so that we significantly reduce this epidemic.

H.E. Keneth Lusaka
The Governor, Bungoma County

Preface

The County Government of Bungoma has demonstrated its resolve towards the HIV response by developing the Bungoma County HIV and AIDS Strategic Plan (BCHASP) 2014/15-2018/19. In the wake of the new constitutional dispensation seeking local solutions to local issues, the BCHASP epitomizes devolution by providing a Bungoma County-specific HIV and AIDS response. BCHASP seeks a prudent utilization of resources and collaborative platforms to increase synergy and efficiency in HIV programming.

In developing the BCHASP, the County Health Department and other implementing partners have taken into account the social, political, cultural and development dynamics of the county thus creating an opportunity for a multi-sectoral response since HIV is not just a health issue but cuts across other social economic dynamics.

In Bungoma County, the adult HIV prevalence is 2.8%, with a total of 30,091 people living with HIV. It is estimated that 27,780 adults live with HIV and 2,311 children (0-14 year olds) live with HIV (KARPR 2016). The same report indicated that Bungoma had 542 HIV related deaths in 2015 while 25,136 adults are in need of treatment.

In addition, Bungoma County has 2,883 adolescents (10-19 year olds) living with HIV and an annual new HIV infections of 120 people among the same cohort (KARPR 2016).

Among young adults aged 15-24 years, Bungoma has 4,143 of youth living with HIV and 388 new HIV infections annually among members of the same group (KARPR 2016).

Recent HIV incidence studies indicate that Kenya achieved reduction of new HIV infections by 20 percent among adults and 49% among children with impressive gains made in counties between 2013 and 2015 against 2019 set targets.

Sixteen counties reduced their number of new HIV infections by more than 50%(KARPR 2016). However, the same report indicated that Bungoma County is among the top four counties that had an increase in their new HIV infections and contributed to 1.6% of new infections in Kenya between 2013 and 2015. To address these new HIV developments in the County, BCHASP commits to the provision of a comprehensive HIV prevention, treatment, care services and mitigation of negative social and economic impacts of the HIV epidemic through a human rights-based approach.

BCHASP further binds all players to clearly-defined objectives and results to ensure pooling and prudent utilization of resources towards the county HIV response.

To achieve this and more, BCHASP has set four broad objectives that are aligned to the Kenya AIDS Strategic Framework (KASF) as follows:

(i) Reduction of new infections by 75%.

(ii) Reduction of AIDS-related mortality by 25%.

(iii) Reduction of HIV stigma and discrimination by 50%.

(iv) Increasing domestic financing of the HIV response by 50%.

The objectives will be attained through implementation of the eight Strategic Directions (SDs) that are intended to lead to the measurable results and targets clearly defined in the M&E framework. Emerging risks will be mitigated and coordination strengthened for the achievement of the desired results.

Hon. Steve Kokonya,
CEC Member - Health, Bungoma County

Acknowledgements

The Bungoma County HIV and AIDS Strategic Plan (BCHASP) is the first document designed locally to guide the county's HIV response. It is aimed at guiding stakeholders in the planning, resource mobilization and intervention implementation. The strategic plan was accomplished through a consultative process involving key stakeholders in the HIV response who supported the process in various stages of its development. The Department of Health and Sanitation in the county would like to appreciate all the sectors and partners who contributed to the development of the document.

The commitment, technical support and overall stewardship from the National AIDS Control Council (NACC) is highly appreciated. We also appreciate NACC for providing the Kenya AIDS Strategic Framework that gave guidance to our technical working group.

We also thank the County Executive Committee Member for Health and Sanitation and the Chief Officer for the appointment of a dedicated technical working group and providing them with the necessary moral and financial support to develop this document. We appreciate the role played by many stakeholders including the civil society, the faith based organizations, PLHIV, government departments in the county, the private sector and key populations for their engagement and consultations.

We acknowledge the contributions of the various partners during the various stages of development of the document.

We also wish to acknowledge with deep gratitude the contribution of the BCHASP development taskforce members led by Mr Stephen Kathaka (Regional HIV Coordinator) NACC, Mr. Nickson Barasa (County AIDS and STI Coordinator), Mr Fred Wanyonyi (County AIDS Coordinator-NACC), Mr. David Makokha (Sub-County AIDS Control Coordinator-Webuye West), Ms Rose Mutende (ACU Coordinator Kibabii University), Ms. Betty Sitatii MoH SCASCO), Ms. Jeniffer Masai (M.O.H County RH Coordinator, Ms. Jentrix Namaemba (AMPATH Webuye Sub County Hospital), Ms. Rose Mayeku (Social Development Officer-Bungoma County Government) and Barnard Nyukuri (SCASCO (MoH) Sirisia) for their tireless efforts and dedication to the task.

We also thank the expert reviewers who provided valuable recommendations to improve the BCHASP.

Robert J. Simiyu
Chief Officer of health, Bungoma County

Executive Summary

The Bungoma County AIDS Strategic Plan (BCHASP) is a five-year plan developed to provide strategic guidance to inform the planning, coordination, implementation, monitoring and evaluation of the county multi-sectoral HIV and AIDS response.

The vision of BCHASP is "A county free from new HIV Infections, stigma, discrimination and AIDS related deaths." The goal of this strategic plan is: "To provide a leading role in HIV and AIDS prevention, care and treatment while mitigating on its socio-economic impacts."

With an adult HIV prevalence of 2.8%, and a total of 30,091 people living with HIV (Kenya HIV Profiles 2016), BCHASP seeks to address the various gaps identified by various HIV related studies in the country showing drivers of HIV epidemic across different counties.

Bungoma County has an estimated 27,780 adults and 2,311 children (0-14 year olds) living with HIV. In addition 4,143 young adults aged between 15-24 years, and 2,883 adolescents (10-19 years old) are living with HIV (KARPR 2016).

This strategic plan, therefore, seeks to address the HIV situation in Bungoma County and has been developed in line with the devolved governance framework as enshrined in the Constitution of Kenya (2010). The Constitution guarantees citizens the right to the highest attainable standard of healthcare, including HIV and AIDS services. This also works in harmony with the Bungoma County Integrated Development Plan (2013- 2017), and the Bungoma County Health Strategic and Investment Plan(2013 - 2017).

This plan provides for eight Strategic Directions, each with priority intervention areas:

1. **Strategic Direction One:** Aims at reducing new HIV infections by 75% by 2019 among adults and current mother to-child transmission rates to less than 5%.

2. **Strategic Direction Two:** Focuses on improving health outcomes and wellness of people living with HIV by providing linkage to care, increasing coverage of care and treatment, and scaling-up interventions to improve the quality of life and healthcare outcomes.

3. **Strategic Direction Three:** Provides the avenues for using a human rights based approach to facilitate access to services through removing barriers to access of HIV, SRH and rights information and services in public and private entities; reducing and monitoring stigma and discrimination, social exclusion and gender based violence; and improving access to legal and social justice and protection for PLHIV.

4. **Strategic Direction Four:** Aims at strengthening integration of community and health systems by improving access to and rational use of quality essential products and technologies for HIV prevention and treatment; strengthening the health service delivery system at the county level and also enhancing the community service delivery system in HIV prevention, treatment and care.

5. **Strategic Direction Five:** Is aimed at strengthening research, innovation and information management to meet the goals of this plan. This shall be achieved through allocation of resources and implementing a HIV research agenda informed by this strategic plan and also increase evidence based planning, programming and policy changes.

6. **Strategic Direction Six:** Focuses on promoting utilization of strategic information for research and monitoring and evaluation to enhance programming. This entails establishing a multi-sectoral and integrated real time HIV platform to provide for updates on HIV response accountability in the county; strengthening of the M&E capacity to effectively track the performance of the different goals of this plan and ensuring the efficiency of routine and non-routine monitoring systems to cater for the HIV situation in the county.

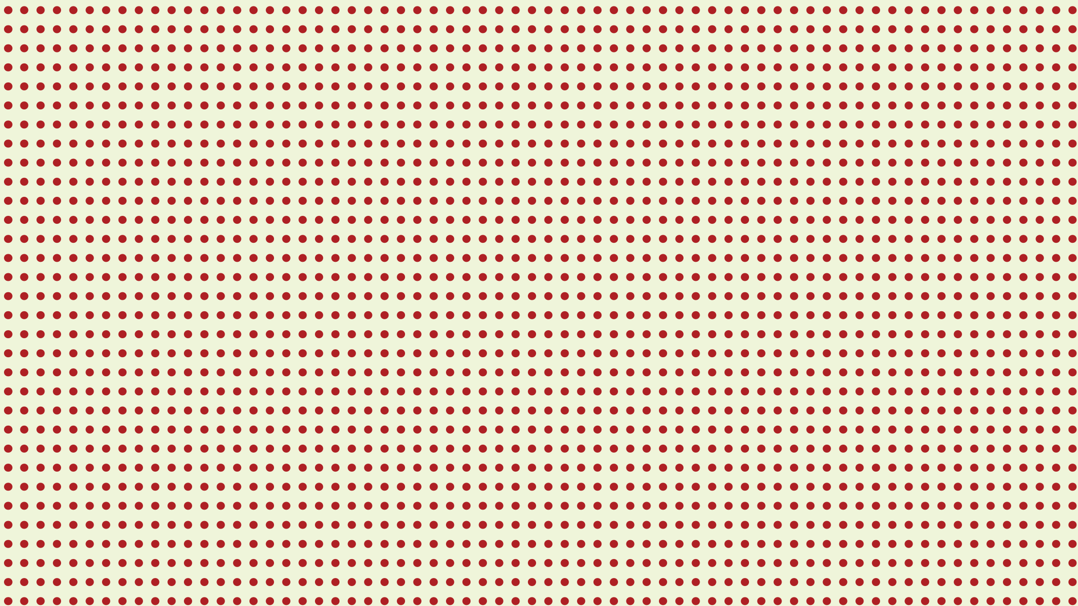
7. **Strategic Direction Seven:** Aims at increasing domestic financing for a sustainable HIV response in the county through maximizing the efficiency of existing delivery options and promoting innovative and sustainable domestic HIV financing options.

   The end result shall be a 50% increase in HIV financing from county resources.

8. **Strategic Direction Eight:** Promotes accountable leadership for the delivery of the BCHASP results by all sectors through building and sustaining a high level political and technical commitment for ownership of the HIV response and establishing a functional and competent HIV coordination mechanism in the county. It also promotes good governance practices and accountable leadership in a multi-sectoral approach for HIV response and an enabling policy, legal and regulatory framework.

01.

BACKGROUND ON COUNTY



Bungoma county lies between latitude 00 28' and latitude 10 30' North of the Equator, and longitude 340 20' East and 350 15' East of the Greenwich Meridian. The County covers an area of 3032.4 Km2. It borders the republic of Uganda to the North West, Trans-Nzoia County to the North-East, Kakamega County to the East and South East, and Busia County to the West and South West. The County is divided into 9 sub counties namely; Kanduyi, Bumula,Kabuchai, Sirisia, Webuye East, Webuye West, Tongaren, Kimilili and Mount Elgon. The sub counties are further divided into 45 wards.

Figure 1: Map on Bungoma County and her sub-counties.

The County boasts of a total population of 1,378,224 (673,133 males and 705,091 females) according to the 2009 population census (KNBS, 2010). As at 2015, the county's population projection was at 1,655,281 (808,449 males, 846,832 females) people. By the year 2017, the population is estimated to grow to 1,759,499 (859,350 males, 900,149 females) people, at a growth rate of 3.1% (KNBS Bungoma County Estimates, 2015).

Table 1: CIDP-Bungoma

Age group	Chapter 3:			2015 (Projections)			2017 (Projections)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	124,755	123,946	248,701	149,834	148,862	298,696	159,268	158,235	317,502
5-9	112,712	113,453	226,165	135,370	136,260	271,630	143,893	144,839	288,732
10-14	95,359	95,030	190,389	114,529	114,133	228,662	121,739	121,319	243,059
15-19	78,946	78,540	157,486	94,816	94,328	189,145	100,786	100,268	201,053
20-24	57,669	66,137	123,806	69,262	79,432	148,694	73,623	84,433	158,056
25-29	43,054	49,043	92,097	51,709	58,902	110,611	54,965	62,610	117,575
30-34	35,100	39,432	74,532	42,156	47,359	89,515	44,810	50,341	95,151
35-39	28, 921	30,689	59,610	34,735	36,858	71,593	36,922	39,179	76,101
40-44	21,431	23,880	45,311	25,739	28,680	54,420	27,360	30,486	57,846
45-49	19,936	21,948	41,884	23,944	26,360	50,304	25,451	28,020	53,471
50-54	15,031	16,549	31,580	18,053	19,876	37,928	19,189	21,127	40,316
55-59	11,239	12,653	23,892	13,498	15,197	28,695	14,348	16,153	30,502
60-64	8,262	9,343	17,605	9,923	11,221	21,144	10,548	11,928	22,475
65-69	5,951	7,005	12,956	7,147	8,413	15,560	7,597	8,943	16,540
70-74	4,851	5,625	10,476	5,826	6,756	12,582	6,193	7,181	13,374
75-79	3,602	4,267	7,869	4,326	5,125	9,451	4,598	5,447	10,046
80+	6,314	7,551	13,865	7,583	9,069	16,652	8,061	9,640	17,701
TOTAL	**673,133**	**705,091**	**1,378,224**	**808,449**	**846,832**	**1,655,281**	**859,350**	**900,149**	**1,759,499**

Bungoma County has a youthful population with the highest (75%) population being below 30 years. The ages 0-14 years comprise 48% of the total population, 15-24 ages 20%, while the population in the reproductive age comprise 43% of the total population. A youthful population is an indicator for critical need towards an increased investment in sustainable health care particularly youth friendly HIV and AIDS services. The urban centres with highest population in the county include Kimilili, Bungoma and Webuye which point towards a need for HIV and AIDS urban programmes. On the other hand, Kanduyi is recorded as a sub-county with the highest population density at 921 persons per square kilometre, followed by Kimilili, Webuye East, Kabuchai, Webuye West, Tongaren, Sirisia and Mt Elgon respectively.

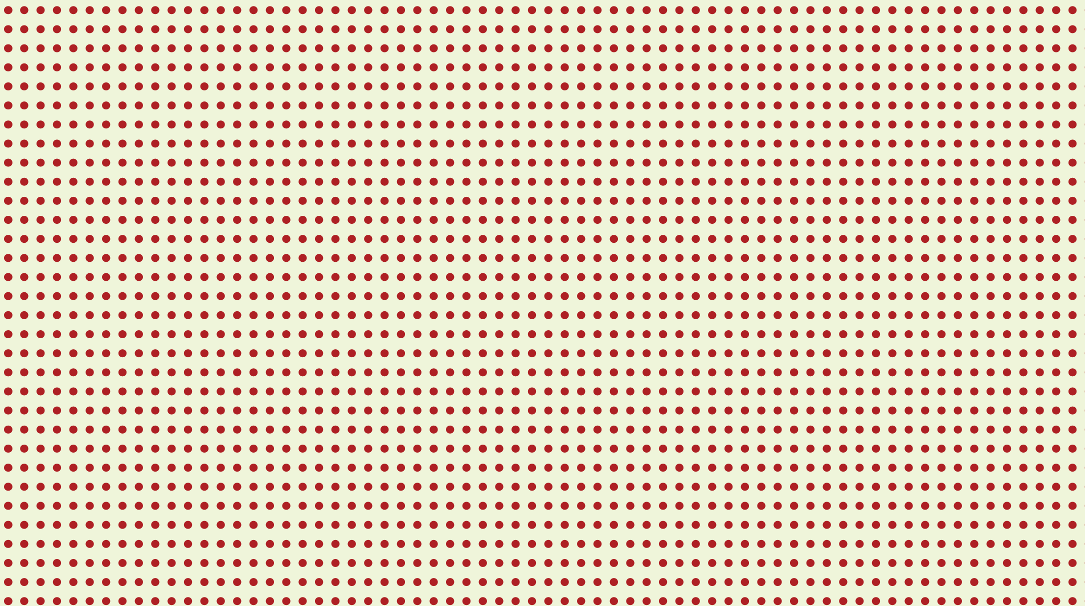
The main economic activities of the county are agriculture and trade. Other important economic activities in the county are tourism, industrial work and mining amongst others. The county performs relatively well in Youth Development Index (YDI), and Human Development Index slightly below the national averages (CIDP Bungoma, 2013-17). The estimated unemployment rate in the county is 36.7%.

According to SARAM 2013, the County has 136 health facilities of which 11 are hospitals, 4 nursing homes, 16 health centres, 78 dispensaries, 27 clinics and 134 community units which is a fair distribution of health facilities. However, the facilities have inadequate infrastructure, personnel, health products, health information, equipment and there is also limited financing towards health (CIDP Bungoma, 2013-17).According to KDHS 2014, 8.6% of the communities reside within a distance of 0-1 km of a health facility, 49.1% within 1.1-4.9 km of a health facility and 48.4% within 5 Kms or more.

Literacy rates are high at 81% with only 14.4 % of the population unable to read and write. However, there are community learning resource centres (258) in every sub-county to boost the reading culture. The County remains committed to keeping youth and young people in school as one of the means of averting HIV and AIDS.

02.

SITUATIONAL ANALYSIS



Kenya has made an immense progress in tackling the issue of HIV and AIDS. The prevalence has dropped to 2 percent points in the last 5 years. New HIV infections among children almost halved (NACC, 2014, 2015). Kenya recognizes that HIV and AIDS epidemic poses a serious threat to the development of the country and subsequently the counties. The Kenya AIDS Strategic Framework (2014/15-2018/19) marks a milestone towards HIV response from 'crisis management' to 'strategic and sustainable approach' for the nation. The framework is aligned to Kenya's Vision 2030, focusing on multi-sectoral planning, evidence based programming, and decentralized planning through a human rights perspective. The frameworks response to HIV and AIDS gives premise to geographical, population and intervention prioritization, feasibility and sustainability for impact.

2.1 (a) HIV Epidemic Analysis in the country

The HIV prevalence among Kenyan adults reached 5.6 % in 2012, down from 6.4% in 2008 (KDHS, 2008; KAIS, 2012). This was largely because of scale up of HIV treatment and care, and a reduction in new HIV infections. While adult prevalence has been on the decline, there has been a concern on the increasing new HIV infections among young people and adolescents. Adolescents and young people remain at a higher risk of HIV infection, with 29% of all new HIV infections reported coming from this group. The Kenyan epidemic is both generalized and concentrated. The prevalence of HIV among key populations is very high (MSM 18.2%, IDUs 18.3% and Sex Workers 29.3%) (IBBS, 2010). There are also notable regional variations with as low as 2% and as high as 27%.

2.1 (b) HIV Epidemic Analysis in the county

Bungoma County has an estimated 27,780 adults living with HIV and 2,311 children (0-14) living with HIV. In addition 4,143 young adults aged 15-24 years, and 2,883 adolescents (10-19 years old) are living with HIV (KARPR 2016). However, it is worth noting that there are variations in HIV prevalence by age, sex, and by type of population. The challenge of HIV and AIDS among key populations needs to be tackled in the County. While there is no sufficient data to account for Key population in the County, its proximity to Busia County, Malaba border, Kisumu City and Eldoret town calls for intensified interrogation of the issue. Generally, the current key population HIV prevalence in Kenya is estimated to be above 44%. It is imperative that deliberate measures should be put in place to tackle the new emerging hotspots.

Stigma hinders smooth HIV and AIDS interventions in Kenya. Bungoma County has a stigma index of 47% (NACC, 2014). Stigma and discrimination remains a barrier to accessing HIV prevention, treatment and care, and support services. There is need to intervene on stigma and discrimination affecting particularly PLHIV in the county, to contribute to evidence based advocacy, policy change and programme interventions as defined in the KASF 2014/15-2018/19.The estimated total number of health facilities in Bungoma County is 155. The PMTCT sites are 138 while there are 89 ART sites (DHIS, 2016). Access to ART programmes and health facilities remains a big challenge for many women and men particularly those living with HIV and AIDS. The average distance to the nearest health facility for the majority of the population is at 5km. According to KDHS 2014, only 21% of PLHIV delivered in a health facility. The county has low number of ART centres. Generally, skilled birth attendance and facility deliveries are low in the county (41%).

Comprehensive knowledge about HIV and AIDS among women of reproductive age is low (35%) in the County. Additionally, 65% of adolescents and young people lack comprehensive knowledge about mother to child transmission. This is important since sexual debut among young people is 17 years and there are14% reported cases of teenage pregnancies among those aged between 15-19 years (KDHS, 2014). The most affected areas are Bumula, Cheptais and Mt.Elgon. Adult support for condom use to prevent HIV and AIDS among teenagers and young adults is 71%, according to 2014, Kenya Demographic and Health Survey.

To improve HIV and AIDS programming in Bungoma County, it is important to scale up the coverage of HIV Testing Services. In the County, the percentage of women who have never tested is 23.4%, while 14% do not know where to go for HIV tests. About 43% of men have never tested for HIV in the County.

2.2 Drivers of new HIV infections

New HIV infections remain the greatest concern of the county. Some of the drivers of the new HIV infections identified include,early sexual debut among adolescents, alcohol and substance abuse, poor access to health care services, school dropouts,the issue of key populations and lacking data, poor social economic status among rural populations and urban settlers, truck drivers along major towns, environment around factory work, cross border migration, rampant HIV and AIDS stigma and discrimination and social cultural practices (unsafe traditional circumcision methods and domestic violence) that are retrogressive. The trans-Africa highway via Bungoma joining Kenya to Uganda through Malaba is a major commercial corridor for sex workers, MSM, traders, sugar industry workers, truck drivers and transiting refugees.

Table 1: Summary of HIV epidemic situation in Bungoma County

	Total	Adults	Children (0-14)
Adolescents and young people LHIV*			4527
Adolescents and young people LHIV*			7627 (15-24 years)
Adolescents and young people LHIV on care*			1734
Adolescents and young people LHIV on treatment*			1565
Adolescents and young people LHIV on care*			4384 (15-24 years)
Adolescents and young people LHIV on treatment*			3978 (15-24years)
Maternal Prophylaxis		53%	
HIV prevalence(female)	3.2%	4.0%	
HIV prevalence(Male)		2.4%	
PLHIV	31,186	26100	5086
On care male #		4939	904
On care female #		12,795	1031
%ART coverage		64%	32%
On ART	12122	10982	1140
New infections	176	83	93
Deaths due to HIV	1113	864	249
Need for PMTCT	1500	1500	-
Need for ART	20,740	17,164	3578

*Source: * CIDP –Bungoma County*

2.3 Priority Areas, Gaps, Challenges and Recommendation

The gap analysis for Bungoma County health service provision is based on the eight KASF Strategic Directions that promote the HIV service delivery in Kenya.

Table 2: Gaps and challenges

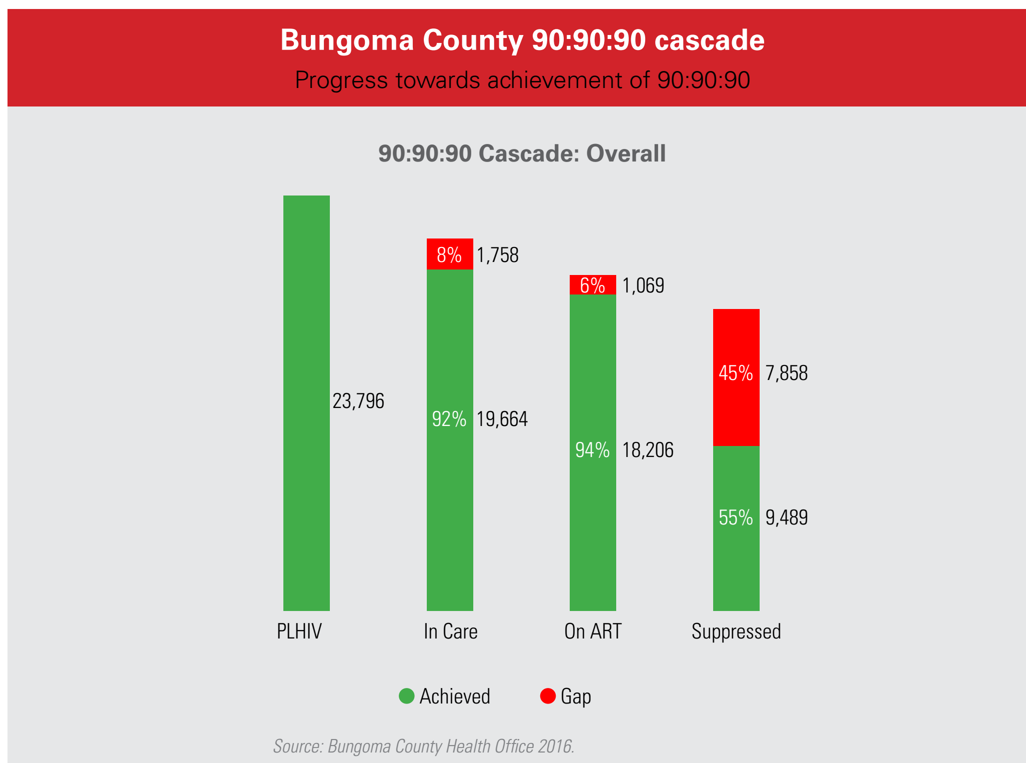
Strategic Direction	Gaps and Challenges Analysis
SD 1: Reducing new HIV infections	• High HIV infection among children. • New adult HIV infection. • Low ART coverage for children and adults. • ART coverage is taken up by partners. • Fewer ART centres. • Minimal integration of HIV and AIDS and other services. • Few skilled and facility deliveries for pregnant women, PLHIV. • Weak HIV programming for adolescents and young people. • Low knowledge on Comprehensive HIV and AIDS services.
SD2 : Improving health outcome for people living with HIV and AIDS	• 75% of those testing HIV positive delay before joining care treatment programme. • Low access to ART by HIV and AIDS clients. • Weak linkages to care. • Weak psychosocial support groups for adolescents and young people. • Lack of existing viral load labs and point of care CD4 equipment. • Delayed results turn around due to user facilities outside the county.
SD 3: Using human rights approach to facilitate access to services for PLHIV, key population and priority groups in all sectors	• No county specific HIV and AIDS policy/act. • Stigma among the Key Population, service providers, community. • Lack of commodities for KPs- lubricants, STI drugs, condoms, Ana scopes. • High staff turn over- KPs shy off from new staff. • KPs Drop- in Centres not established in the County. • Weak rights based approach in accessing comprehensive services for all. • High stigma index (47%).
SD 4: Strengthening integration of health and community system to inform the KASF	• Inadequate workforce trained on HIV response. • Inadequate health facilities ready to provide Kenya Essential Package of Health(KEPH). • Commodity management challenges. • Weak community level - AIDS competency. • Weak referral and linkage systems for HIV services.
SD 5: Strengthening research and innovation to inform the KASF goals	• Weak evidence based programming and policy. • Weak capacity to conduct HIV research.
SD 6: Promoting utilization of strategic information for research for M&E to enhance programming	• Migratory nature of key population making it difficult to track programmes. • MOH tools do not capture adolescent on care and ART. • Data on priority populations is lacking. • Weak M&E informational hub established in the county. • No county specific evaluations, reviews and surveys on key populations, PLHIV, women, young people and adolescents.
SD 7: Increasing domestic financing for sustainable HIV response	• Minimal resource allocation on HIV and AIDS programmes • % budget on HIV and AIDS.
SD 8: Promoting accountable leadership for delivery of KASF results by all sectors and actors	• Weak coordination on HIV and AIDS mechanism at the ward and community level. • Weak multi stakeholders coordination and involvement.

Key recommendations include:

- Improve access to uptake of HIV and AIDS integrated sexual and reproductive health services for girls and women.
- Improve education among young people to reduce sexual risks by delaying sexual debut.
- Keep girls in school to help delay sexual debut, pregnancy and early marriages.
- Promote and scale up universal access to voluntary medical male circumcision for HIV negative men and boys.
- Mobilize the community and peer support to create demand and increase women access to uptake of antenatal care as well as delivering in health facilities.
- Mobilize community and partners to scale up access to paediatric antiretroviral therapy.
- Promote strong county political and community leadership for a multi-sectoral HIV response.
- Mobilization of additional local resources to increase and sustain HIV response.
- Expanding HIV treatment programmes and increase community involvement in driving demand for increased uptake and adherence among both adults and children.
- Increasing social welfare services to HIV positive persons and others affected by HIV.
- Partner with digital service providers to provide information on HIV and AIDS management.
- Fast track implementation of work place policy on HIV and AIDS, Develop support policy for OVCs.

2.4 Morbidity and Mortality

According to SARAM 2013, the five most common diseases in order of prevalence in the County include; malarial fever (40%), respiratory tract infection (19%), skin diseases (7%), diarrhoea (4%) and typhoid (3%).



Source: Bungoma County Health Office 2016.

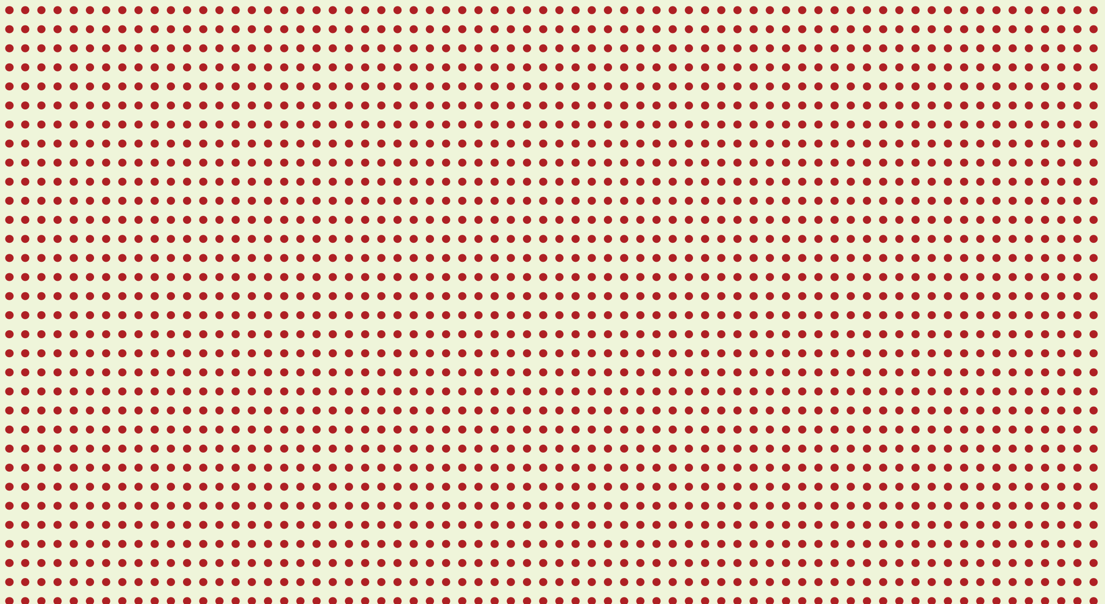
2.5 SWOT Analysis

Table 3: SWOT Analysis

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
Availability of skilled personnel	• Personnel not adequately trained on HIV issues thus lack capacity to conduct comprehensive HIV services. • Knowledge gaps amongst HCWs (capacity building).	• Utilization of ICT • Presence of partners support for trainings	• High personnel turn over
Increased awareness on HIV prevention measures	• Weak legislation on stigma and discrimination • Low disclosure rates • Low/poor health seeking behaviour in men	• Existence of networks of PLWA	• Limited behaviour change and approaches towards HIV prevention, care and treatment. • Alcohol and substance abuse among the general population and PLHIV • Presence of migrant populations
Presence of implementing partners supporting HIV and AIDS activities	• Limited financial resources for HIV programming • Parallel HIV reporting systems	• Supportive political environment • Untapped public private partnerships potential	• Inadequate stakeholder coordination mechanisms
Established supply chain of ARVs and other commodities from KEMSA	• Inadequate care and treatment centres	• Use of mobile HTS/ PMTCT services	• Erratic/inadequate supply of commodities
	• Inadequate data on OVCs in the county	• Cash transfer support program for OVCs	• Religious and social cultural practices towards HIV and AIDS
Presence of strong NACC structures in the county; CACCs	• Few sub County - AIDs Control Units (ACUs implementing HIV and AIDS workplace policy	• HIV and AIDS mainstreaming in all sectors	• Stigma at the workplace • Untrained sub ACU coordinators
Presence of functional psychosocial support groups at facility level	• Lack of sustainability mechanisms within support groups • Co-morbidities among PLHIV including NCDs leading to high mortality rates	• Availability of networks and national umbrella bodies such as NEPHAK and KENEPOTE	• Low identification of PLHIV in the community
Established community strategy system	• Inadequate community mobilization activities towards HIV response	• Using of innovation and best practice in HIV programming	• Inadequate financial support of Community Units.
Presence of networks for people living with HIV	• Lack of support for key population programs	• Establishment of Drop In Centres	• Poverty leading to rise in high risk behaviour e.g. prostitution • Presence of prison communities and other confined persons • Lack of a robust GBV programme
Presence and use of reporting tools	• Data quality challenges • Limited data demand and use at the lower level	• Presence of implementing partners	• Unreliable supply of reporting tools to the community
Accessibility to health services	• Lack of watertight mechanism of linkage/ referral of HIV positive clients • Low uptake of ANC services and number of deliveries conducted by skilled birth attendants • Lack youth/adolescent/ paediatric friendly services	• Existence of good physical infrastructure	

03.

RATIONALE & STRATEGIC PLAN DEVELOPMENT PROCESS



3.1 Rationale

The Bill of Rights in the Constitution of Kenya 2010, provides for the implementation of health services to the highest attainable standards. The BCHASP provides guidance for coordination and implementation of the HIV response; resource mobilization, allocation and accountability in the County.

This process ensures that the HIV response remains multisectoral and key institutions both at county and sub-county levels play their role in achieving the results aimed at reducing new HIV infections, putting more people on treatment and mitigating on the socio and economic impacts resulting from the HIV epidemic.

3.2 Process of Developing the BCHASP 2015-2019.

This plan was developed through in-depth analysis of available data and information in a highly participatory and consultative environment. The process was prompted by an end term review of the third Kenya National AIDS Strategic Plan III (KNASPIII) and the consequent development of Kenya AIDS Strategic Framework (KASF) that took into consideration the county-based governance structure. Through technical assistance from the NACC and partners, the County Department of Health initiated the process of developing the strategic plan based on identified intervention priorities and gaps. The Department took leadership of the process through formation of BCHASP working committees. Development of BCHASP 2015-2019 was a systematic and elaborate process that was informed by available evidence, extensive data and information and expert reviews and stakeholder participation. The process entailed the following key steps:

3.2.1: Development and dissemination of KASF to County players including health workers

Devolution ushered County governance in Kenya. The health function is largely devolved. To conform to the new reality, Bungoma County team participated in the development of KASF which took into consideration the new dispensation of health and HIV function. KASF further set new priorities guided by emerging evidences and HIV epidemiology. With assistance from NACC, NASCOP and other partners, KASF was disseminated widely among County players.

3.2.2: County HIV intervention gaps and priority identification

The step entailed participation by the Bungoma County teams in the process of end term review of KNASP III. From the process, the gaps in County HIV response were identified and prioritized. The review report was instrumental in guiding the BCHASP process.

3.2.3: Training of KASF County BCHASP Training of Trainers (TOTs)

The steps involved in identifying and training of County teams in KASF priorities are meant to enable them guide BCHASP development process. A team of 20 persons drawn from various sectors was trained.

3.2.4: Constitution of working groups and technical committees

The Drafting or the Technical Committee appointed by Bungoma County department of health undertook actual drafting together with organizing peer and technical review sessions.

3.2.5: Drafting process

The Drafting process involved review of the County priorities and gaps, consultations with health care workers, PLHIV, implementing

agencies and other stakeholders and consolidation and prioritization of the information collected. Drafters were selected in line with their expertise on various strategic directions.

3.2.6: Expert/peer review of the BCHASP draft

Sessions were held to review the draft document at various stages of development. These included review and validation of data and the related technical information, indicators, targets and costing among others.

3.2.7: Validation process

The draft document was subjected to validation by various groups and stakeholders including PLHIV, PWDS, religious and community leaders, youth groups, women groups, health care givers and representatives from public and private sectors. The views and recommendations were incorporated into the BCHASP draft.

3.3 Guiding Principles of BCHASP 2015-2019

1. Prioritization of evidence-based and result oriented interventions with clearly defined targets.

2. Efficiency, effectiveness and innovation. The BCHASP promotes the design and implementation of innovative HIV programmes that are efficient and effective.

3. Integration of service: The BCHASP promotes integration of services for efficient use of resources and attaining maximum results.

4. County ownership and partnership: All key stakeholders including the County, development partners, private sector and faith based organizations and communities of PLHIV were involved.
   All players are expected to align their efforts and resources to the envisioned BCHASP 2015-2019 targets.

5. Rights-based and gender transformative approaches: The BCHASP promotes HIV programmes that support the respect for human rights, advocates eradication of sexual and gender- based violence, stigma and discrimination.

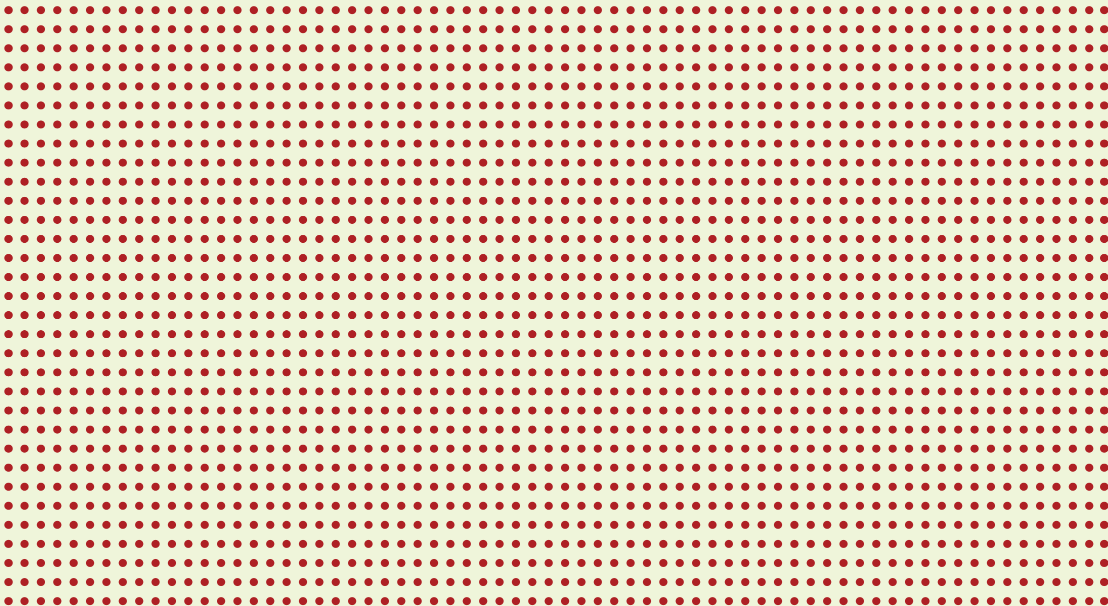
6. Multi-sectoral approach: BCHASP 2015-2019 strategic plan promotes County HIV response as everyone's business and calls upon different sectors to use their comparative advantages to combat HIV and AIDS in the County.

3.4 Public Participation

The Kenya Constitution 2010 stipulates that one of the functions of counties is "to encourage the involvement of communities and community organizations in the matters of the county government". Article 105(1) subsection (d) and Article 106 section (4) of the County Government Act 2012 provides for public participation in county planning processes. The preparation of this plan involved pre-drafting consultation with communities. The consultation strategy included public information and workshops and focused group discussions to encourage as much public engagement as possible. BCHASP 2015-2019 draft was widely circulated both in hard and soft copies to various stakeholders and players within and out of the county for their inputs. These included PLHIV, Persons with Disability, public and private sector players, youth groups, women groups and religious leaders among others.

04.

VISION, GOAL, OBJECTIVES AND STRATEGIC DIRECTIONS



a. Vision

A County free from New HIV Infections, Stigma, Discrimination and AIDS Related Deaths

b. Goal

To provide a leading role in HIV and AIDS Prevention, Care and Treatment while mitigating on its Socio-Economic Impacts

c. Objectives

1. To reduce new HIV infections by 75%.
2. To reduce AIDS related mortality by 50%.
3. To reduce HIV related stigma and discrimination by 50%.
4. To increase domestic financing of the HIV response in the County by 50%.

d. County Strategic Directions

1. Reducing new HIV infections.
2. Improving health outcomes and wellness of all people living with HIV.
3. Using a human right approach to facilitate access to services for PLHIV, key populations and other priority groups in all sectors.
4. Strengthening integration of health and community systems.
5. Strengthening research and innovation to inform the BCHASP goals.
6. Promoting utilization of strategic information for research and monitoring and evaluation (M&E) to enhance programming.
7. Increasing domestic financing for a sustainable HIV response.
8. Promote accountable leadership for delivery of BCHASP results by all sectors

Strategic Direction 1: Reducing new HIV infections

Introduction

The envisioned targets to achieve SD 1 are to reduce new adult infections by 75 % in the year 2020, and 90% by the year 2030. The county envisions reducing mother to child HIV transmission from 14% to less than 5% by 2020. Bungoma County estimates on the number of HIV positive cases as at 2015 was 4009 (DHIS, 2015). Higher positive cases have been recorded in Kanduyi and Kimilili. The drivers of new infections are cross border migration, adolescents and young people, key populations, long distance truck drivers and towns along the major highway (the great north road),lifestyles resulting from the rich agricultural economy and other social cultural factors like funeral ceremonies, traditional rites of passage ceremonies, wife/widow inheritance, polygamy, child labour and prostitution.

Strategic Direction 1: Reducing new HIV infections

KASF objective	BCHASP Results	Key Activity	Sub-Activity/ Intervention	
			Biomedical	
Reduce new HIV infections by 75%	• Increased HIV Testing Services from 46%to 90% in Bungoma County • Increased comprehensive knowledge of HIV services among women and men of reproductive age from 34% to 100%.	• Increase coverage of evidence based combination HIV prevention • Integration of HIV into other services • Promote linkages for HIV prevention through integration with other routine health service delivery/areas • Promote information on comprehensive HIV services and linkage to other services for all through community based awareness campaigns • Strengthen and establish youth friendly service delivery points	• Innovative HIV testing and counselling (HTC) models • Prep programme for selected priority populations • Scale up STI management in all facilities • Offer HTS service provision in community and facilities • Screen and manage HPV among FSW/MSM and Hepatitis B and C for People Who Inject Drugs • Provide key commodities • Link comprehensive HIV prevention messages, HTS, Prep, pep, condoms services with immunisation, reproductive health, maternal, neonatal and child health • Offer appropriate comprehensive information on family planning and services to women of reproductive age living with HIV • Scale up facility based PITC and ensure linkage to care • Ensure HTS and TB service points account for linkage to prevention care and treatment	
	• Increased to 90% from 21% of all positive pregnant mothers accessing PMTCT and delivering in health facilities /skilled delivery	• Ensure all pregnant women attend ANC services interlinked with HTC • Enrol and retain all HIV positive lactating women/children on ART • Deliver all 4 prongs of eMTCT at 100% in health facilities in the county	• Monitored ART/ANC service delivery programme • Integrate early infant diagnosis of HIV with immunisation • Offer comprehensive HIV services to young women, provide family planning services to all women of reproductive age • Integrate eMTCT with MNCH	

	Behavioural	Structural	Target Population	Geographic areas by County/sub- county	Responsibility
	• Behaviour change programme using specific interpersonal tools and techniques e.g. Brail • Peer to Peer outreach in school and out of school • Implement Evidence Based Intervention • Intensify condom programme • Use peer educators, community health workers/volunteers to offer integrated HIV prevention messages with other programme areas • Identify and retain high risk individuals for regular HTS and screening	• Engage men on their role in HIV prevention and EMTCT • Roll out campaign against SGVs • Use CHWs to increase access to HTC services • Advocate for early and safe male circumcision • Capacity building for staff on provision on Key Population friendly services • Implementation of stigma reduction campaigns through local structures, social media and other forums • Engage community leaders, religious leaders, HIV networks, political leaders for HIV prevention knowledge interventions • Deliver door to door and community based testing	• General population Vulnerable and Key Populations, Men of reproductive age, young people/ adolescent • CHWs, community leaders, faith based leaders, peer educators private sector	• Kimilili, • Tongaren, • Webuye West • Webuye East • Mt. Elgon • Kanduyi • Sirisia • Kabuchai • Bumula	County Health Department, NASCOP, NACC, Implementing Partners, Ministry of Education and all other departments
	• Male involvement in ANC services. • Strengthen and expand mentor mothers programmes in the county • Empower community units with reproductive health messages on PMTCT. • HIV and RCH education in schools and community • 2qEstablish support groups of pregnant women and other psychosocial support services	• Advocate on early antenatal clinic attendance • Engage men in HIV prevention and eMTCT. • Formation of new and strengthen the existing adolescent and young people psychosocial support groups • Promote age appropriate comprehensive sexuality education and AIDS among young people	Pregnant women, men and children		County Health Department, NASCOP, NACC, FBOs, CSOs, Private Partners

Strategic Direction 2: Improving Health Outcomes and Wellness of all people living with HIV

Introduction

The set targets for SD 2 are to increase linkage of over 90% diagnosis, increase ART coverage to 90%, increase ART retention to 90% and increase viral suppression to 90% of clients on ART. The targets apply to children, adolescents and adults.

SD 2: Improving health outcomes and wellness of people living with HIV

KASF objective	BCHASP Results	Key Activity	Sub-Activity/Intervention		
			Biomedical	Behavioural	
Reduce AIDS related mortality by 25%	Increased the percentage of children ART coverage from 57% to 90%	• Integrate HTC and care treatment services in maternal, neonatal and child health settings	• Provide ART services to all the infected children. • Timely identification, linkage treatment and retention in care	• Strengthen nutritional support.	
	To put 3,676 adolescents and young people on ART	• Establish adolescent youth friendly ART integrated programmes • offer HPV screening, education and counselling • Establish a TWG and resource centre on adolescent and youth friendly services	• Offer age appropriate contraception's, condoms and microbicides	• Parents follow up as index clients for children testing • Offer peer to peer outreach in schools and out of schools • Implement evidence based interventions (sister to sister, family matters programme)	
	Increased adult ART treatment from 64% to 90% percent.	• To put 17,164 adults on ART treatment	• Provide ART services to eligible infected adults • Strengthen facility and community linkages through referrals	• Implement/ strengthen PSSGs for keypopulation, young people, PLHIV, and general populations and other vulnerable groups	
	Strengthen the capacity of all county health workers in 144 health facilities in 9 sub-counties to monitor quality of care on ART	• Continuous training of health care workers on patient management • Training of health workers on EMR		• Initiate and strengthen peer support strategies for PLHIV	

As per KAIS 2012, adults in need of ART in Bungoma County were 17,164 while those actively receiving ART were 10,982. County ART adult coverage was 64% which is lower than national coverage of 79%. There are 864 annual reported deaths due to AIDS related complications.

Structural	Target Population	Geographic areas by County/sub- county	Responsibility
• Provide care givers /CHWs with education on ART • Dissemination of paediatric ART guidelines/public education and education care givers	• Children • Adolescents/young people • Care givers • Health care workers • Community	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central(Kabuchai) • Bumula	• Ministry of Health,NACCand implementing partners • Youth and adolescents advocates
• HIV and RCH education in schools	• Adolescents and young people , learning institutions, rehabilitationcentres, and juvenile institutions	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	• Ministry of Health and implementing partners • Youth and adolescents advocates
• Health system strengthening for Public private sector referrals • Public education and education of care givers	• Adults • Key populations • PWD • Truck drivers • All vulnerable populations	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	• County Government, NASCOP, NACC, Partners
• Health system strengthening on laboratory protocols • Strengthen laboratory referral networks • Strengthen MOU between the referral lab to improve on the turnaround time. • Promote age and population specific treatment education in community and other non-health based facilities.	• Health care workers	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	• CDH, NASCOP, NACC, Partners

Strategic Direction 3: Using a Human Rights Based Approach to facilitate access to services for PLHIV, Key Populations and other priority groups in all sectors

Introduction

The envisioned targets are reduced self-reported stigma and discrimination related to HIV and AIDS by 50%, reduced levels of sexual and gender-based violence for PLHIV and key populations (MSM, FSW,IDUs, long distance truck drivers) by 50%, increased protection of human rights and improved access to justice for PLHIV, key populations and other priority groups (youths , PLWD). These include women, boys and girls and reduced social exclusion for PLHIV and key populations (MSM, FSW,IDUs, long distance truck drivers).

SD 3: Using a human rights based approach to facilitate services for PLHIV, key populations and other priority groups in all sectors

KASF objective	BCHASP Results	Key Activity	Sub-Activity/Intervention		
			Biomedical	Behavioural	
Reduce HIV related stigma and discrimination by 50%	Reduced HIV related stigma and discrimination from 47% to 24%	• All sectors to review and adopt existing policies to protect PLHIV, vulnerable and key population • Establish, support and strengthen interest/support groups • TWG on a Human Right Based Approach to HIV services established. • Strengthen capacity of health work force on right based approach to HTS • Roll out media campaigns • Address community harmful gender norms and negative stereo type that are a barrier to addressing HIV, SRH, and rights information	Monitor and report comprehensive HTS services	• Condom promotion • Promote education and sensitization within sectors • Implement Positive Health Dignity and Prevention • Support groups through Psychosocial support services and use • Prevention with positives approach • Promote evidence based interventions	
	600 health workers trained on HRBA to HIV services	• Training of health workers	Training of Health workers on HRBA to HIV services		
	9 County health facilities offering child,key population and other group friendly services.	• Build the capacity of health care providers and community leaders on stigma reduction and non-discrimination.	Training of Health workers on HRBA to HIV services	• Sensitize HRBA to HIV services • Sensitization of community leaders and stakeholders on stigma and non-discrimination	

Human rights are universal legal guarantees protecting individuals and groups against actions and omissions which interfere with fundamental freedoms and entitlements. National values and principles of governance articulated in Article 10 of the Constitution of Kenya expressly incorporate human rights and bond all state organs, state officers, public officers and all persons when they interpret the constitution, enact laws and make or implement public policy decisions.

	Target Population	Geographic areas by County/sub- county	Responsibility
Structural			
• Sensitise law and policy makers on need to come up with policies that prohibit stigma and discrimination and support access to treatment and care • Implement stigma reduction campaigns • Sensitize and Engage communities in • Stigma reduction awareness • Mid-term and end term review of policies that impact on HIV • The TWG to establish contact with the HIV tribunal in order to replicate the same at the county level • Protect rights and empower key and vulnerable population • Provide friendly HTS services • Promote uptake of HIV prep and pep among survivor of SGBV and rape	Health workers, Key populations, special or vulnerable populations PLHIV, youth, adolescents, young mothers, private sectors, workplace populations, schools and learning institutions, political class, religious sectors, business population, media	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	CDH, NASCOP, NACC, Partners
• Implement innovative approaches to provide PLWD with HIV services and programs including access to IEC materials.	Health workers, CHVs	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	CDH, NASCOP, NACC, Partners
• Improve the existing paediatric facilities to make them child friendly	General public, schools	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	CDH, NASCOP, NACC, Partners

KASF objective	BCHASP Results	Key Activity	Sub-Activity/Intervention		
			Biomedical	Behavioural	
Reduce HIV related stigma and discrimination by 50%	9Model youth friendly services established.	Establish youth friendly services.	Training of Health workers on HRBA to HIV services	Sensitize HRBA to HIV services Sensitization of community leaders and stakeholders on stigma and non-discrimination	
	Bungoma County HIV prevention and control policy in place.	Drafting and enactment of HIV policy			

Strategic Direction 4: Strengthening Integration of Health and Community Systems

Introduction

Targeted outcomes under this strategic direction are to improve health workforce for HIV response by 40%, increase number of health facilities ready to provide KEPH-defined HIV and AIDS services from 6%(DHIS,2015) to 90%, strengthen HIV commodity management, strengthen Community-level AIDS competency.

SD 4:Strengthening integration of health services and community systems

KASF objective	BCHASP Results	Key Activity	Sub-Activity/ Intervention		
			Biomedical	Behavioural	
• Improve Health workforce for the HIV response at both county and National level by 40% • Increase number of health facilities ready to provide KEPH-defined HIV and AIDS services from 67% to 90%	Increase health workforce for HIV response by 40%	• Hiring and training health workers on HIV services • Integrate and improve capacity in HIV management and leadership in general pre-service and in-service healthtraining.	Strengthen HIV commodity management system	Promote a friendly health care workforce	

	Target Population	Geographic areas by County/sub- county	Responsibility
Structural			
Establish youth friendly HIV services including the integration within the youth empowerment centres	Health workers, CHVs, Partners working with youth	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	CDH, NASCOP, NACC, Partners
Domesticate the national policies and legal framework for county specific policies and laws	MCAs, law enforcement agencies, opinion leaders, PLHIV	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	National Police Service, Ministry of Interior, Civil Society,CDH, NASCOP, NACC, Partners

	Target Population	Geographic areas by County/sub- county	Responsibility
Structural			
Develop and implement a staff retention policy taking into account the additional burden of HIV.	Health workers, CHVs, Community	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	CDH, NASCOP, NACC, Partners

KASF objective	BCHASP Results	Key Activity	Sub-Activity/ Intervention		
			Biomedical	Behavioural	
	Increase number of health facilities ready to provide KEPH-defined HIV and AIDS services from 6% to 50%	Strengthening the capacity of 50 facilities to offer minimum KEPH –defined HIV and AIDS services	Strengthen HIV commodity management system	Promote a friendly health care workforce	

Strategic Direction 5: Strengthening Research and Innovation to inform the KASF goals

Introduction

Targeted outcomes for this strategic direction are increased evidence-based planning, programming and policy changes by 50%, increased implementation of research on the identified KASF-related HIV priorities by 50%, increased capacity to conduct HIV research by 10%.

SD 5: Strengthening research and innovation to inform the Bungoma HIV strategic plan

KASF objective	BCHASP Results	Key Activity	Sub-Activity/ Intervention		
			Biological	Behavioural	
• Reduce new HIV infections by 75% • Reduce AIDS related mortality by 25% • Reduce HIV related stigma and discrimination by 50%	• Vital data on drivers of new HIV infection and high mortality rates in Bungoma County is available by 2018 • Data and information on determinant of stigma and discrimination in Bungoma County available	• Undertake operational research and information management on key populations, Interests groups, youth adolescents and PLHIV • Undertake a study on stigma and sexual and gender based violence • Determine stigma and discrimination on key outcomes including HTC uptake, enrolment and retention in care.	To conduct research/ study on alcohol and drug use, bodaboda sector, sex workers, Men having sex with men, other priority groups and its impact on HIV and AIDS	Map the key and vulnerable populations in different sub counties for appropriate prevention and treatment services	

	Structural	Target Population	Geographic areas by County/sub- county	Responsibility
	• Equipping existing facilities with KEPH-defined HIV and AIDS. • Deployment of staff • Upgrade facility infrastructure to meet basic standards for HIV services	Dispensaries, health centres, clinics, hospitals, nursing homes	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	CDH, NASCOP, NACC, Partners

There is good reported progress on biomedical, behavioural and structural research on HIV. Kenya has pioneered socio behavioural and epidemiologic studies amongst different populations at risk such as the Key Populations of MSM, Sex Workers and PWIDs and adolescents. Studies such as KAIS and MOT provide valuable information for programmes and research.

	Structural	Target Population	Geographic areas by County/sub- county	Responsibility
	Establish a Research Evaluation and Monitoring Unit (REMU)	Boda boda, youth, young people and adolescents, children Living with HIV, key populations, priority populations, clients on CCC and ART programme	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South (Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula • Webuye West	CDH, NASCOP, NACC, Partners

KASF objective	BCHASP Results	Key Activity	Sub-Activity/ Intervention		
			Biological	**Behavioural**	
• Reduce new HIV infections by 75% • Reduce AIDS related mortality by 25% • Reduce HIV related stigma and discrimination by 50%	• Vital data on drivers of new HIV infection and high mortality rates in Bungoma County is available by 2018 • Data and information on determinant of stigma and discrimination in Bungoma County available	• Undertake operational research and information management on key populations, Interests groups, youth adolescents and PLHIV • Undertake a study on stigma and sexual and gender based violence • Determine of stigma and discrimination on key outcomes including HTC uptake, enrolment and retention in care.	To conduct research/ study on alcohol and drug use, bodaboda sector, sex workers, Men having sex with men, other priority groups and its impact on HIV and AIDS	Map the key and vulnerable populations in different sub counties for appropriate prevention and treatment services	

Structural	Target Population	Geographic areas by County/sub- county	Responsibility
• Conduct operational research on available data from DHIS and partners	Health facilities	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	CDH, NASCOP, NACC, Partners
• Determine impact of stigma and discrimination at HTS service points. • Increased evidence based programming for ART services	Community	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula, Webuye West	County Government, research institutions and partners, CDH, NASCOP, NACC, Partners
Undertake a study on cultural factors that influence spread of HIV in the county	Community	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	County Government, research institutions and partners CDH, NASCOP, NACC, Partners

Strategic Direction 6: Promote Utilization of Strategic Information for Monitoring and Evaluation

Introduction

Bungoma County's response to the evolving HIV epidemic is largely influenced by strong commitment to availing quality data in a timely manner for effective evidence-informed decision making. The Constitution of Kenya requires participation of the people in decision making; transparency and Accountability as recognized by this strategic plan. This plan will be informed by various data sources which will provide trends in HIV prevalence and incidences. This document will strengthen coordination, ownership and data use for evidence based planning and decision making.

The Bungoma County HIV and AIDS Strategic plan expects to contribute to achievement of the following results by 2019

- Increased availability of strategic information to inform HIV response at national and county level.
- Planned evaluations, reviews and surveys implemented and results disseminated in a timely manner at county level.
- M&E Information Hubs established at county level and providing comprehensive information package on key BCHASP indicators for decision making.

These results will be tracked by a national M&E Framework. To achieve these results, the following key M&E intervention areas have been proposed.

SD 6: Promoting the utilization of strategic information for research, monitoring and evaluation to enhance programming

KASF objective	BCHASP Results	Key Activity	Sub-Activity/ Intervention	
			Structural	
• Reduce new HIV infections by 75% • Reduce AIDS related mortality by 25% • Reduce HIV related stigma and discrimination by 50%	HIV County data is available for programming and informed decision making	• Enforce timely comprehensive routine and non-routine monitoring systems for quality HIV data	• Undertake routine supervision and monitoring	
	Quality data is available.	• Implement the KASF evaluation agenda and monitoring and evaluation framework 2014/2015 – 2018/2019 • Conduct review meetings	• Print and distribute M&E tools for collection of HIV data • Disseminate and build capacity of the M&E framework and evaluation agenda to relevant staff according to local context	

Priority Intervention areas

- Implement a unified and functional M & E framework.
- Strengthen M & E capacity to effectively track BCHASP performance and HIV dynamics in the County.
- Strengthen synergies between HIV research and other disease and development areas.
- Ensure harmonized, timely and comprehensive routine and non- routine monitoring systems to provide quality HIV data as per county and sector priority information needs.
- Establish multi- sectoral and integrated real time HIV platform to provide updates on HIV epidemic response accountability at county and national level.

The SD provides a renewed focus on improving data quality, demand and use for effective decision making through proactive tracking of progress at all levels of service delivery. Its set targets are to increase availability of strategic information to inform HIV response, plan evaluations, reviews and surveys of HIV programs, disseminate information and establish information hubs.

	Target Population	Geographic areas by County/sub- county	Responsibility
	Health facilities, implementing partners and private sector	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	County government,CDH CACCs, NACC, CASCO
	CHIRO, programme officers, HTS counsellors, CHU, Laboratory, research centres, sentinel surveillance centre and other implementing partner	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	CoCDH, NASCOP, NACC, Partners national government

Strategic Direction 7: Increasing Domestic Financing for Sustainable HIV and AIDS Response

Introduction

The dwindling of resources for HIV response demands smarter investments for every shilling to priority areas that produce efficiently high impacts. The Bungoma County HIV and AIDS Strategic plan will contribute to increased domestic financing for HIV and AIDS response to 50% by 2019 through the following priority interventions; Maximize efficiency by refocusing our existing efforts to deliver better results to Bungoma County residents within current funding levels and align the HIV and AIDS response with local situation.

7.3 Align current HIV investment to BCHASP priorities

Bungoma County will optimize HIV and AIDS investment by aligning government and development partners funding to BCHASP priorities. Domestic investment will be in the form of

SD 7: Increasing domestic financing for a sustainable HIV response

KASF objective	BCHASP Results	Key Activity
• Increase domestic financing of the HIV response to 50%	Policy on HIV financing is put in place.	Review existing health policies to align to HIV financing agenda and provide recommendations
	Increased domestic financing	Rollout fundraising campaign drives

allocation from the national level towards the HIV and AIDS sector at the county. Mechanisms shall be put in place to collate the investments from the government and development partners at the county level to realize value for money invested. Components in the health sector and other key sectors in the county such as education, agriculture, social development and youth affairs shall ensure that HIV and AIDS activities are incorporated in their plans and budgets. The allocation will also be used for HIV and AIDS research and coordinating HIV and AIDS at the national and county levels.

The target is to increase domestic financing of HIV activities by 50%. Currently the public sector contributes 17% of financing for HIV response in Kenya.

Sub-Activity/Intervention		Target Population	Geographic areas by County/sub- county	Responsibility
Behavioural	**Structural**			
	• Policy paper on increasing domestic funding of HIV activities approved and implemented by the County Executive Committee	Policy makers, Finance department	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	CDH, NASCOP, NACC, Partners
	• Undertake a mapping of HIV partners' representation in Bungoma and lobby for support • Develop a web platform within Bungoma County portal • Strategically position NACC within the county resource mobilization committee and investment committee • Generate donor data base	Implementing partners, Donor, County budgeting committee, National government, NASCOP, health Research institutions	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South (Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	CDH, NASCOP, NACC, Partners

Strategic Direction 8: Promoting Accountable Leadership for delivery of KASF Results by all Sectors and Actors

Introduction

The SD inculcates good governance, accountable leadership, and multi-sectoral co-ordination and enabling policy, legal and regulatory framework in HIV response at all levels including county level. The SD is hinged on the provisions of the Constitution of Kenya 2010.

The challenges reported on the deliverables of the SD include ownership, community participation, stakeholder engagement, coordinated development partner support and leadership capacity development processes.

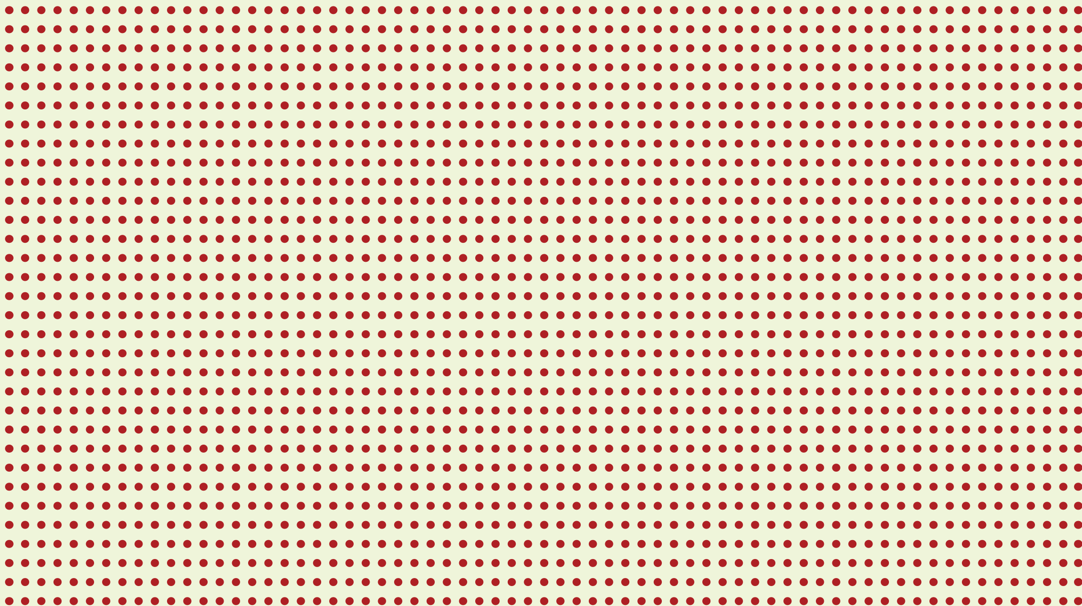
SD 8: Promoting accountable leadership for delivery of the Bungoma County HIV strategic plan

KASF objective	BCHASP Results	Key Activity	Sub-Activity/Intervention Structural
• Reduce new HIV infections by 75% • Reduce AIDS related mortality by 25% • Reduce HIV related stigma and discrimination by 50% • Increase domestic financing of the HIV response to 50%	BCHASP is in place and being implemented	Disseminate and roll out the BCHASP	• Print 5000 copies of the BCHASP
			• Disseminate BCHASP to the County Executive Committee and other stakeholders in the county
	Quarterly stakeholder forums constituted and functional	Develop terms of reference for HIV co-ordination mechanism at the county and sub-county	• Conduct quarterly meetings by stakeholders • Share the roles and mandate of different stakeholders/actors • Develop a stakeholders data base
	County CASP monitoring committee constituted	Constituency committee meet regularly and report	• Support and build the capacity of constituency monitoring committees • Receive quarterly progress reports from stakeholders and working groups • Develop road maps for implementation of the CASP.

Target Population	Geographic areas (County)	Responsibility
Health departments, partners	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	CDH, NASCOP, NACC, Partners
Health departments, partners	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	CDH, NASCOP, NACC, Partners
Health departments, partners		CDH, NASCOP, NACC, Partners
Health departments, partners	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	CDH, NASCOP, NACC, Partners
Health departments, partners	• Kimilili • Bungoma North (Tongaren) • Webuye West • Webuye East • Mt. Elgon • Bungoma South(Kanduyi) • Bungoma West (Sirisia) • Bungoma Central (Kabuchai) • Bumula	CDH, NASCOP, NACC, Partners

05.

IMPLEMENTATION ARRANGEMENTS



5.1 HIV Response and Implementation in the County

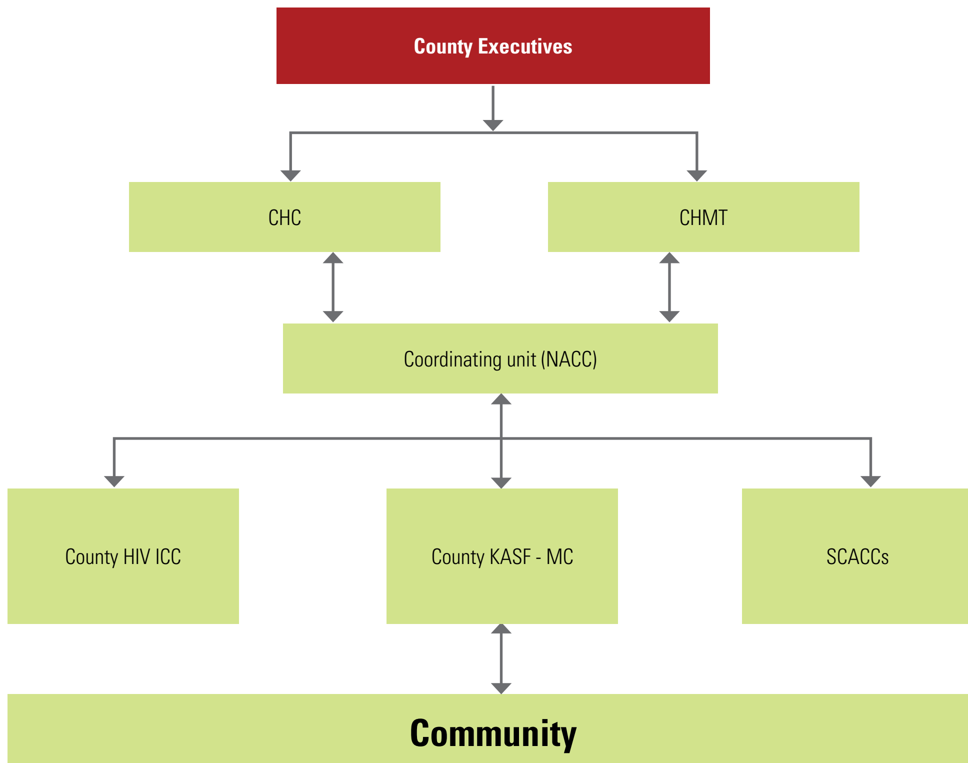
The implementation of this County Strategic Plan on HIV and AIDS is structured and managed accordingly to facilitate the participation and involvement of relevant stakeholders from government, civil society and private sector and development partners. Strong governance and coordination of the County AIDS Programmes by the County HIV Committee and the Department of Health's, CHMT, will ensure harmonization and alignment of all stakeholders involved in the HIV and AIDS response.

5.2 Coordination of HIV response.

The overall coordination of the response in the County is vested upon the executives, led by the Governor. In order to ensure a harmonized and coordinated response, a County HIV Committee (CHC) is established to be the highest decision-making organ in the County regarding the HIV and AIDS response. This organ, in line with CHMT, will efficiently inform the executives on the progress in the County.

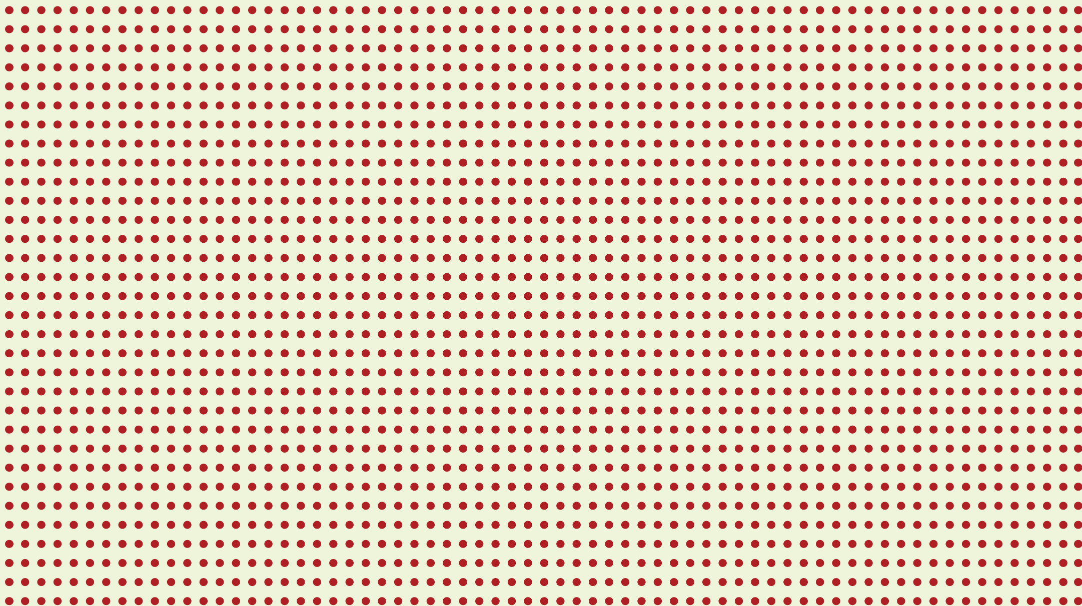
Reports from the community and implementers will be received via the subset structures of County KASF Monitoring Committee (KASF - MC), HIV Inter–agency Coordination Committee (HIV – ICC) and through the Sub-County AIDS Coordination Committees (SCACCs).The NACC will establish a County Coordination Unit whose functions will be the secretariat to the CHC.

Figure 5.1: County Coordination Unit Organogram



06.

MONITORING AND EVALUATION OF PLAN



The implementation of the Bungoma County AIDS Strategic Plan will be monitored and evaluated by the County CASP monitoring committee.

Information gathered from county HIV and AIDS monitoring and evaluation programmes will be used to:

(a) Ensure HIV and AIDS prevention programmes achieve high levels of accountability and efficiency.

(b) Informed decision making on County and National HIV response.

(c) For the purpose of reporting on national HIV M&E commitments such as DHIS, HIPORS and COBPAR.

6.1 Monitoring and evaluation process

Monitoring and evaluation will be utilizing a process which is able to capture and evaluate various levels of programme implementation. All stakeholders involved in the response are contributors to the various indicators and are equally responsible for ensuring that they are regularly monitored .The NACC Secretariat and BCHASP Monitoring Committee is given the responsibility to monitor and evaluate the overall HIV and AIDS implementation.

6.2 Data collection

The NACC Secretariat will work with the Bungoma County Department of Health and civil society organizations to conduct monitoring and evaluation of HIV related interventions in the County.

6.3 Monitoring and reporting structure

A Technical Working Group on Monitoring and Evaluation (BCHASP-M&E) chaired by the CASCO is proposed to lead on the HIV programme performance reviews. This will provide an Opportunity for strengthening of the Secretariat's own technical capacity as well as those of the relevant organizations. The intention of the performance reviews is to evaluate progress based on coverage, effectiveness and sustainability of programmes.

The frequency of the county level HIV programme review should be every 3 months. The review will be conducted with government and civil society organizations responding to HIV at the county level. The progress report of the M&E committee will be presented to the CHC.

6.3.1 Annual progress report

An annual progress report shall be prepared by the CHC and forwarded to the County Executive Committee member for Health for onward transmission to the-Governor .This will form part of the annual state-of-the county progress report presented to the County Assembly.

6.3.2 Mid-term review

A mid-term review of the implementation of the Strategic Plan is planned to take place in 2017/18. It will review progress made in the first two years. The review will be discussed in a joint stakeholder meeting, with the aim of reaching consensus on: Progress made in the implementation of the response as agreed in the current Strategic Plan and the direction and scope of future implementation of the response to HIV and AIDS

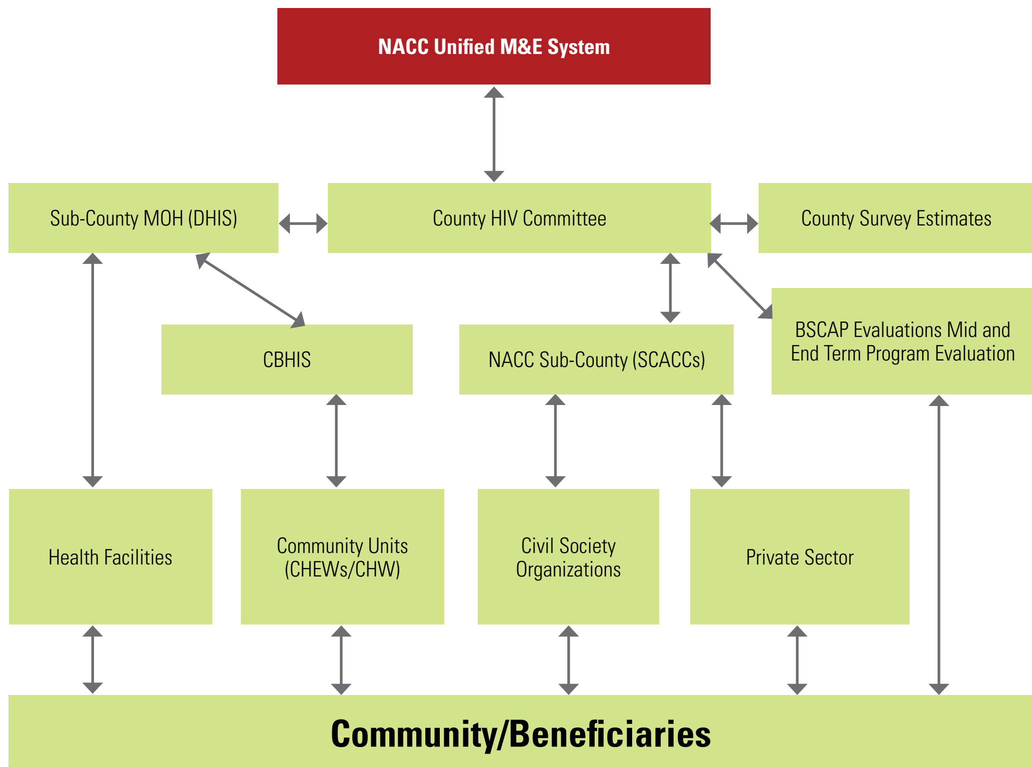
6.3.3 Final review and impact evaluation

A final evaluation of the Plan will take place in the second half of 2019. The final evaluation will assess whether expected results and targets have been achieved, through the analysis of

available data to measure outcome or impact, and a comparison with baseline values for these core indicators.The final evaluation will not only assess effectiveness of individual programmes and of the overall national response, but will also take into consideration the quality and efficiency of Programmes and interventions.

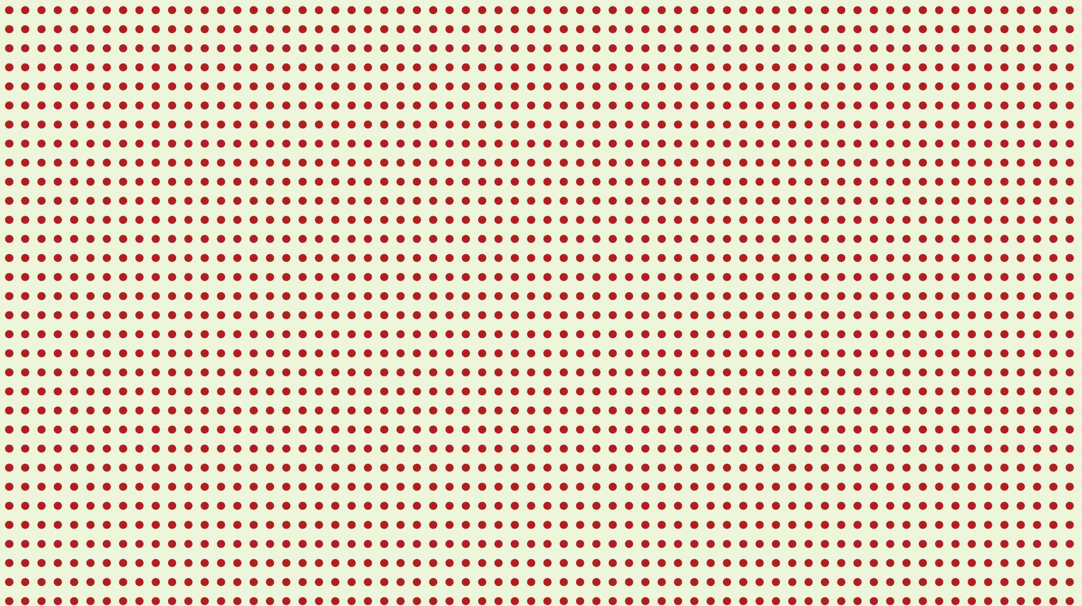
6.3.4 HIV and AIDS research

Monitoring and evaluation of the County Strategic Plan will also require data collected through research, including regular surveys. Research compliments monitoring and evaluation by building a knowledge base which will guide the response.



07.

RISKS AND MITIGATION PLAN

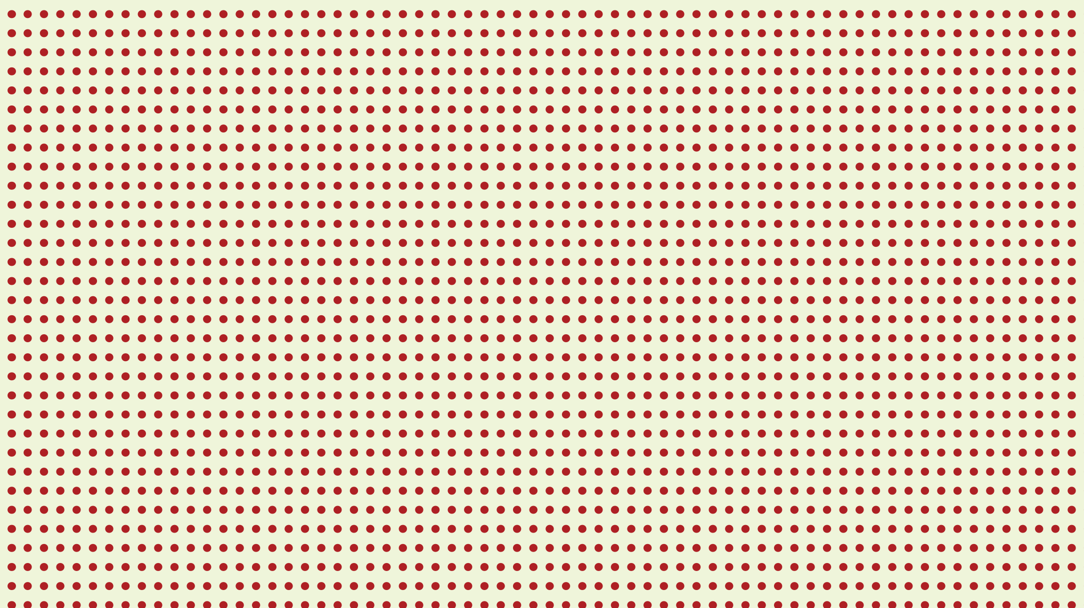


It is most likely that implementation of BCHASP (2015-2019) will proceed without interruptions. However, probable risks will be assessed and mitigated through a continuous process. The County HIV committee (CHC) will constantly report to the County Health Ministry, NACC, NASCOP and other implementing partners on identified risks so as to bring mitigation measures.

Risk Category	Risks	Status	Mitigation	Responsibility	when
Political	Disruption of planned implementation	Medium	Put in place sustainability strategies for interventions like enough stock of ARVs and other commodities	KEMSA, County Government, NASCOP, NACC	Y1
Operational	Inefficient implementation of planned activities		Efficiency and effectiveness studies not yet in place	County Government	Y1
Social Cultural	High Society/cultural religions stigma will affect programming HIV Environment for PLHIV and other vulnerable populations	High	Continuous engagement of Community and religious leaders using NACC interfaith and other committed Community Educational	County Government National Government NACC Implementing Partners	Continuous
Systems	Weak systems to address commodity stock outs and guarantee inter and intra-County redistribution	High	Work with KEMSA, NASCOP, NACC and County Health to strengthen HIV and health commodity forecasting, supply and distribution to avert stock outs	KEMSA, County Government, MoH, NASCOP, NACC	Y1
	Weak service delivery supervision system to guarantee quality, efficiency and effectiveness	Medium	Strengthened routine, non-routine and ad hoc supervision to all service delivery facilities	County Health Department, NASCOP, MoH	Continuous
Legislation	A legal, policy environment for HIV programming and BCHASP implementation that is not conducive	High	Flag out, amend or repeal laws, clauses that impinge BCHASP implementation and initiate supportive laws and policies	County Government, County Assembly, Law, Reform, NACC CSOS	FY1
Human Resource and staffing	Inadequate staffing at all cadres of HIV and Health Service delivery Inadequate prudent utilization of available resources	High Medium	Undertake staffing assessment and initiate process of ensuring minimum staffing at all cadres of Health and HIV service delivery	County Health Department, MoH, NASCOP, NACC, Implementing partners	Y1
Financial	Low resources allocation to the HIV sub-sector especially for key structural behavioural interventions such as stigma reduction	High	Lobby increased resource allocation to support implementation of targets set under BCHASP	County Government County Assembly, NACC, NASCOP, CSOs	Fy1
			Initiate local resource mobilization strategies through an elaborate PPP Strategy, among others	County Government, County Assembly, NACC, NASCOP, Private sector, CSOs	FY1

08.

ANNEXES



Results Framework

Strategic Direction 1: Reducing new HIV infections

KASF objective	BCHASP Results	Key Activity
Reduce new HIV infections by 75%	Increased Percentage of persons with knowledge of their HIV status from 46% to 90%	Increase coverage of evidence based combination HIV prevention
		Integration of HIV into other services
		Promote linkages for HIV prevention through integration with other routine health service delivery/areas
	Increase comprehensive knowledge of HIV services among women and men of reproductive age from 34% to 100%.	Promote information on comprehensive HIV services and linkage to other services for all through community based awareness campaigns
		Strengthen and establish youth friendly service delivery points
	Increase to 90% from 21% all positive pregnant mothers to access PMTCT and delivering in health facilities /skilled delivery	Ensure all pregnant women attend ANC services interlinked with HTC
		Enrol and retain all HIV positive lactating women/ children on ART
	Deliver all 4 prongs of eMTCT at 100% in health facilities in the county	Offer comprehensive HIV services to young women, provide family planning services to all women of reproductive age
		Integrate eMTCT with MNCH

Indicators	Baseline	Mid Term Target	End Term Target	Responsibility
Percentage of new adult HIV infections disaggregated by age and gender % of young women and men ages 15-25 who are HIV infected % of child infections from HIV infected women Estimated annual numbers of new infections from Key populations. % of adolescents 10-24 years having correct knowledge on how HIV is transmitted.	46% 3.2% 5.2% 400 64%	70% 3.0% 5.0% 300 70%	90% 2.5% 3% 200 75%	CDH, NASCOP, NACC, Partners
Number of health facilities which have integrated HIV into other services	9	18	36	CDH, NASCOP, NACC, Partners
Percentage increase of HIV prevention through integration with other routine health service delivery/areas	34%	70%	90%	CDH, NASCOP, NACC, Partners
Percentage increase in the number of women and men of reproductive age with comprehensive knowledge of HIV services	34%	65%	100%	CDH, NASCOP, NACC, Partners
No. of youth friendly service delivery points strengthened and established	1	18	36	CDH, NASCOP, NACC, Partners
Percentage increase of pregnant women who attend ANC services interlinked with HTC	21%	70%	90%	CDH, NASCOP, NACC, Partners
Percentage of HIV positive lactating women/children enrolled and retained on ART	21%	70%	90%	CDH, NASCOP, NACC, Partners
Percentage increase of women of reproductive age accessing family planning services	21%	70%	100%	CDH, NASCOP, NACC, Partners
Number of health facilities integrating eMTCT with MNCH	9	18	36	CDH, NASCOP, NACC, Partners

Strategic Direction 2: Improving Health Outcomes for PLHIV

KASF objective	BCHASP Results	Key Activity	Indicators
Reduce AIDS related mortality to 25%	Increase the percentage of children ART coverage from 57% to 90%	Integrate HTC and care treatment services in maternal, neonatal and child health settings	% of children receiving ART
	To put 3,676 adolescents and young people on ART	Establish adolescent youth friendly ART integrated programme	No. of adolescent youth receiving ART.
		Establish a TWG and resource centre on adolescent and youth friendly services	No of resource centres established/TWG
	To scale up adult ART treatment from 64% to 90%	To put 17,164 adults on ART treatment	% of adults put on ART
	Strengthen the capacity of all county health workers in 144 health facilities in 9 sub-counties to monitor quality of care	Continuous training of health care workers on patient management Training of health workers on EMR	% of health care workers trained in patient management

Strategic Direction 3: Using HRBA to facilitate access to services for PLHIV, key population and other priority groups in all sector

KASF objective	BCHASP Results	Key Activity	Indicators
Reduce HIV related stigma and discrimination by 50%	Reduce HIV related stigma and discrimination from 47% to 24%	All sectors to review and adopt existing policies to protect PLHIV, vulnerable and key population	Percentage of sectors reviewing and adopting existing policies to protect PLHIV, vulnerable and key populations
		Establish, support and strengthen 450 interest/support groups	Number of interests groups/ support established, supported and strengthened
		TWG on a Human Right Based Approach to HIV services established.	Establishment of TWG at County and Sub-County level
		Strengthen capacity of health work force on right based approach to HTS	Number of health care workers capacity build on right based approach on HTS
		Roll out media campaigns to address community harmful gender norms and negative stereo type that are a barrier to addressing HIV, SRH, and rights information	Number of media campaign rolled out to address community harmful gender norms and negative stereo type
	600 health workers trained on HRBA to HIV services	Training of health workers	No of Trained Health workers on HRBA to HIV services
	9 county health facilities offering Paediatric and key population friendly services. .	Build the capacity health care providers and community leaders on stigma reduction and non-discrimination.	No of Trained Health workers/community leaders on stigma / discrimination
	9 Model youth friendly service centres established.	Establish youth friendly service centres.	No of youth friendly centres established
	Bungoma County HIV prevention and control policy in place.	Drafting and enactment of HIV policy	No of HIV policies drafted and enacted

	Baseline	Mid Term Target	End Term Target	Responsibility
	57%	70%	90%	CDH, NASCOP, NACC, Partners
	5543	7500	9219	CDH, NASCOP, NACC, Partners
	0	5	9	CDH, NASCOP, NACC, Partners
	64%	75%	90%	CDH, NASCOP, NACC, Partners
	6.3%	12.5%	25%	CDH, NASCOP, NACC, Partners

	Baseline	Mid Term Target	End Term Target	Responsibility
	47%	35%	24%	CDH, NASCOP, NACC, Partners
	*150	300	450	CDH, NASCOP, NACC, Partners
	0	5	10	CDH, NASCOP, NACC, Partners
	0	50	150	CDH, NASCOP, NACC, Partners
	0	9	18	CDH, NASCOP, NACC, Partners
	0	300	600	CDH, NASCOP, NACC, Partners
	0	300	600	CDH, NASCOP, NACC, Partners
	0	9	18	CDH, NASCOP, NACC, Partners
	0	1	1	CDH, NASCOP, NACC, Partners

Strategic Direction 4: Strengthening Integration of health and community systems.

KASF objective	BCHASP Results	Key Activity	Indicators
Improve Health workforce for the HIV response at county level by 40%	Increase health workforce for HIV response by 40%.	• Hiring and Training health workers on HIV services • Integrate and improve capacity in HIV management and leadership in general pre-service and in-service health training.	Percentage increase of health care workers (hired) and trained
Increase number of health facilities ready to provide KEPH-defined HIV and AIDS services from 67% to 90%	Increase number of health facilities ready to provide KEPH-defined HIV and AIDS services from 6% to 50%	• Strengthening the capacity of 50 facilities to offer minimum KEPH –defined HIV and AIDS services	Percentage of health facilities offering minimum KEPH

Strategic Direction 5: Strengthening Research and Innovation to inform on the BCHASP

KASF objective	BCHASP Results	Key Activity	Indicators
• Reduce new HIV infections by 75% • Reduce AIDS related mortality by 25% • Reduce HIV related stigma and discrimination by 50% • Increase domestic financing of the HIV response to 50%	• Vital data on drivers of new HIV infection and high mortality rates in Bungoma County • Data and information on determinant of stigma in Bungoma county available	• Undertake operational research and information management on key populations, youth adolescents and PLHIV • Establish and /or strengthen a research ethical unit	• No of researches done targeting the vulnerable/key populations and other priority populations • Number of research ethical units established and /or strengthened.
		• Undertake a study on stigma and sexual and gender based violence	• No of stigma studies carried out among PLHIV, Key populations
			• Determination of stigma and discrimination on key outcomes

Strategic Direction 6: Promoting the utilization of strategic information for research, monitoring and evaluation to enhance programming

KASF objective	BCHASP Results	Key Activity	Indicators
• Reduce new HIV infections by 75% • Reduce AIDS related mortality by 25% • Reduce HIV related stigma and discrimination by 50%	HIV County data is available for programming and informed decision making	• Enforce timely comprehensive routine and non-routine monitoring systems for quality HIV data • Provide update of HIV response from key players in the county • Print and distribute M&E tools for collection of HIV data • Build the capacity of the M&E personnel to help monitor KASF implementation	• Number of routine supervisory visits done on HIV data systems personnel • Percentage ofplanned M&E products generated at the county • Percentage of health facilities having access of M&E tools for collection of HIV data printed and distributed • Number of Capacity building meetings held targeting HIV related M&E Personnel

	Baseline	Mid Term Target	End Term Target	Responsibility
	-	20%	40%	CDH, NASCOP, NACC, Partners
	67%	75%	90%	CDH, NASCOP, NACC, Partners

	Baseline	Mid Term Target	End Term Target	Responsibility
	0 0	2 1	5 1	CDH, NASCOP, NACC, Partners
	0	2	4	CDH, NASCOP, NACC, Partners
	0	1	1	CDH, NASCOP, NACC, Partners

	Baseline	Mid Term Target	End Term Target	Responsibility
	4per year TBD TBD TBD	10 50% 50% 10	20 100% 100% 20	CDH, NASCOP, NACC, Partners

Strategic Direction 7: Increasing domestic financing for a sustainable HIV response

KASF objective	BCHASP Results	Key Activity	Indicators
1.Increase domestic financing of the HIV response to 50%	Policy on HIV financing is put in place	1 a)Review existing health policies to align to HIV financing agenda and provide recommendations 1b)Policy paper on increasing domestic funding of HIV activities approved and implemented by the County Executive Committee • Undertake a mapping of HIV partners' representation in Bungoma and lobby for support • Strategically position NACC within the county resource mobilization committee and investment committee	• Percentage of health policies aligned to HIV financing agenda in the County • Number of periodic mapping of HIV implementers done. • % of HIV related Committees in the County that NACC is represented

Strategic Direction 8: Promoting accountable leadership for delivery of the Bungoma County HIV strategic plan

KASF objective	BCHASP Results	Key Activity	Indicators
• Reduce new HIV infections by 75% • Reduce AIDS related mortality by 25% • Reduce HIV related stigma and discrimination by 50% • Increase domestic financing of the HIV response to 50%	• BCHASP is in place and being implemented • County HIV multi-sectoral coordination structure established	• Disseminate and roll out the BCHASP • Disseminate BCHASP to the County Executive Committee and other stakeholders in the county • Establish andstrengthen functional and competentHIV coordination Mechanism	• Number of BCHASP Copies disseminated and rolled out to general public • % of BCHASP Copies disseminated and rolled out County Executive Committee • % of HIV coordination meetings held and documented at county

	Baseline	Mid Term Target	End Term Target	Responsibility
	TBD	50%	100%	CDH, NASCOP, NACC, Partners
	TBD	1	2.	
	TBD	50%	100%	

	Baseline	Mid Term Target	End Term Target	Responsibility
	TBD	100		NACC, NASCOP COUNTY GOVERNMENT
	TBD	50%	100%	
	TBD	2	4	

Annex 2

Resource Requirement for BCHASP (Millions)

Strategic Directions	Specific BCHASP Intervention Areas	% of Resource Dedicated for the strategy	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019	Total
SD1	HIV Prevention	25.99%	4.84	5.52	6.23	6.97	7.55	31.10
SD2	Treatment and Care	53.37%	9.95	10.88	11.36	11.57	11.43	55.18
SD3	Social inclusion, human rights and gender	4.00%	0.75	0.97	1.21	1.46	1.74	6.12
SD4	Health systems	6.35%	1.18	1.07	0.88	0.79	0.41	4.33
	Community systems	3.65%	0.68	0.61	0.50	0.45	0.24	2.49
SD5	Research	0.49%	0.09	0.10	0.11	0.12	0.13	0.56
SD6	Monitoring and evaluation	1.84%	0.34	0.35	0.34	0.32	0.29	1.63
SD7 & SD8	Leadership, governance and Resource Allocation	3.94%	0.73	0.75	0.73	0.68	0.62	3.51
	Supply chain management	0.37%	0.07	0.08	0.09	0.09	0.10	0.42
	Grand Total	**100.00%**	**18.64**	**20.32**	**21.44**	**22.45**	**22.49**	**105.34**

Annex 3: References & Operational Documents

References

1. Bungoma County Health Strategic Plan 2014

2. Bungoma County Integrated Development Plan (2013- 2017)

3. HIV and AIDS Prevention and Control Act, 2006

4. KASF – Kenya AIDS Strategic Framework

5. KNBS (Kenya) 2008-2009 Kenya Demographic and Health Survey 2008-09 Preliminary report. Calverton, Maryland, KNBS, NACC, NASCOP, NPHLS, KMRI, ICF Macro September 2009

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12. NACC; 2009. Kenya National AIDS Strategic Plan, 2009-2013-Delivering on universal access to services

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12. NACC; 2009. Kenya National AIDS Strategic Plan, 2009-2013-Delivering on universal access to services

13. NASCOP (2012). Guidelines for Prevention of Mother to Child Transmission (PMTCT) of HIV and AIDS in Kenya, 4th edition. (Update on current guidelines)

14. NASCOP (2013), Kenya AIDS Indicator Survey 2012. Nairobi: NASCOP (NASCOP, 2009)

15. The Constitution of Kenya, 2010

16. UNAIDS (2014) 90-90-90 an ambitious treatment target to help end the AIDS epidemic, UNAIDS112

Operational Documents

1. The Kenya HIV Prevention Roadmap

2. HIV program network

3. HIV estimates and County profiles

4. Kenya AIDs epidemic report 2012

5. Strategic Framework towards Elimination of Mother to Child Transmission of HIV and Keeping Mothers Alive 2012-2015.

6. A Strategic Framework for Engagement of the First Lady in HIV Control and Promotion of Maternal, New-born and Child Health in Kenya 2013-2017.

7. National Guidelines for HIV Testing and Counselling and Prevention with Positives.

8. Guidelines on use of antiretroviral drugs in treating and preventing HIV, Rapid advice, 2014.

9. Kenya Quality Model for Health 2009. Kenya HIV Quality Improvement Framework.

Annex 4: List of Drafting and Technical Review Teams

County Drafting Team

1. Steven Kathaka - NACC Regional HIV Coordinator
2. Mr. Nickson O. Barasa - County AIDS and STI Coordinator
3. Fred Wanyonyi- County HIV Coordinator
4. David Makokha –Sub County HIV Coordinator Webuye East.
5. Ms Rose Mutende- ACU Coordinator Kibabii University
6. Ms. Betty Sitatii- MoH SCASCO
7. Ms.Jeniffer Masai- MoH County RH Coordinator
8. Ms.Jentrix Namaemba-AMPATH
9. Barnard Nyukuri -MoH
10. Ms Rose Mayeku

County Review Team

1. Nelly Komonyo- Consultant
2. Steven Kathaka -MPH, NACC Regional HIV Coordinator
3. Norton Sang- Consultant
4. Lilian Kayaro-FHOK

HARAMBEE

maisha!
National AIDS Control Council