Republic of Kenya

Ministry of Health

GARISSA COUNTY

HIV and AIDS

STRATEGIC PLAN

2015/16 – 2018/19

maisha!
National AIDS Control Council

My County, My Responsibility

GARISSA COUNTY

HIV and AIDS STRATEGIC PLAN

2015/16 - 2018/19

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Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
CBO	Community-Based Organisation
COBPAR	Community Based Programme Activity Reporting
COH	Chief Officer, Health
EMTCT	Elimination of Mother-To-Child Transmission
FBO	Faith-Based Organisation
HAART	Highly Active Anti-Retroviral Therapy
HIV	Human Immuno-deficiency Virus
IBBS	Integrated Bio-Behavioural Surveillance
IEBC	Independent Electoral and Boundaries Commission
M&E	Monitoring and Evaluation
MARPs	Most At Risk Populations
MoH	Ministry of Health
MSM	Men who have Sex with Men
MVCT	Moonlight Voluntary Counseling and testing
NGO	Non-Governmental Organisation
NSP	Needle and Syringe exchange Programme
OPAHA	Organization of People Affected by HIV and AIDS
PITC	Provider-Initiated Testing and Counselling
PITC	Provider-Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
PTCT	Parent-To-Child Transmission
SCACC	Sub-County AIDS Coordinating Committee
SDGs	Sustainable Development Goals
SIMAHO	Sisters Maternity Home
SRH	Sexual and Reproductive Health
STI	Sexually-Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
UA	Universal Access
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

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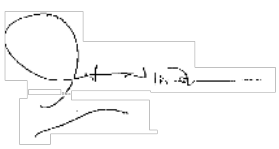
Foreword

HIV was first diagnosed in Kenya in 1984. By the end of 2014, a total of 1.6 million people were living with HIV in Kenya. The epidemic peaked in year 1995/6, with a national prevalence rate of 10.5%. Since then, there has been a steady decline in prevalence to 6.0% in 2014. The Kenya Vision 2030 aims to reduce this prevalence further to 2%, and zero new HIV infections.

In Garissa County, the HIV prevalence rate is estimated to be on the increase from the 1% average of the North Eastern region to approximately 2.1% of the County by 2014. There are an estimated 4,500 People living with HIV (PLHIV) in the County while the annual HIV incidence is estimated to be 200 people. This necessitates urgent and greater need for concerted and coordinated efforts among all the sectors to address the pandemic.

The Garissa County AIDS Strategic Plan 2015/16-2018/19 (GCASP) and the broader County Health Sector Strategic and Investment Plan 2013 - 2018 aims to achieve the Kenya AIDS Strategic Framework (KASF) objectives of; reducing new HIV infections, reducing HIV stigma and discrimination, reducing AIDS-related deaths, and increasing domestic financing. The development of the Garissa County AIDS Strategic Plan therefore reflects the County's ownership and support of the HIV and AIDS response.

My Government is committed to ensuring this Garissa County AIDS Strategic Plan guides Garissa County towards contributing and fulfilling the objectives of Universal Access (UA) and the attainment of the highest standard of health to all the residents of the County.



H.E Nadhif J. Adam

The Governor

County Government of Garissa

Preface

We are cognizant of the challenges posed by HIV and AIDS in Garissa County. In this regard, the County Government of Garissa in partnership with National AIDS Control Council and other Partners developed the Garissa County AIDS Strategic Plan to address the issues of the HIV pandemic in the County. The Plan identifies intervention areas for each of the eight Strategic Directions, in line with Kenya AIDS Strategic Framework 2014/15 – 2018/19. This Plan is useful for all sectors in the County.

The process of developing the Plan took a consultative and multi-sectoral approach which gathered contributions from key HIV stakeholders and the community in general. It involved workshops, focused group discussions, reviews of documents and validation meetings.

To ensure compatibility with the existing policies, GCASP is aligned to the County Integrated Development Plan, the Garissa County Health Sector Strategic and Investment Plan 2013 – 2018, the Kenya AIDS Strategic Framework 2014/2015 – 2018/2019 and Vision 2030. It further targets the implementation of Goal 3 of the Sustainable Development Goals - Good health and well-being. It is expected that this Plan will inform programming to all partners in the HIV and AIDS response in Garissa County.

Hon. Hubbie Hussein Al-Haji

CEC Member for Health Services

County Government of Garissa

Acknowledgements

The process of developing the GCASP was characterized by many challenges, key being non-availability of County-specific granulated HIV baseline data and limited financial resources. In spite of these bottlenecks, the process of developing the document was by and large a success.

We wish to acknowledge with deep gratitude the technical and financial assistance and contribution by various stakeholders and partners during the development process of this policy document. Specifically, we thank the National AIDS Control Council (NACC), the Garissa County's Department of Health Services, SIMAHO , Womankind-Kenya, and the Directorate of Economic Planning who played a vanguard role in the development of the GCASP.

Dr. Sofia Mohammed

Chief Officer – Department of Health Services

County Government of Garissa

Executive Summary

The Garissa County AIDS Strategic Plan (GCASP) 2015/16 – 2018/19 is the guide for the response to HIV and AIDS at the County level. The Plan addresses the drivers of the HIV epidemic and builds on achievements of the previous country strategic plans to achieve its goal and contribute to the attainment of the country's Vision 2030 through universal access to comprehensive HIV prevention, treatment and care.

GCASP is aligned to the Constitution of Kenya 2010, which envisions a new environment for the governance and management of the County HIV and AIDS response. It is premised in the County Integrated Development Plan (CIDP), County Health Sector Strategic and Investment Plan, KASF and Kenya's Vision 2030 which identifies HIV and AIDS as "one of the greatest threats to socio-economic development in the country in general".

The Plan marks a change in the approach of managing the County's HIV and AIDS response from being "business as usual" to an evidence and results-based approach in a multi-sectoral and decentralized planning. It provides strategic, policy, planning and implementation guidance and leadership for a coordinated multi-sectoral response to HIV and AIDS in the County.

CHAPTER 1

Background Information on the County

1.1 Location and size of Garissa County

Garissa County is one of the three counties in the North Eastern region of Kenya. It covers an area of 44,174.1km^2 and lies between latitude 10 58'N and 20 1' S and longitude 380 34'E and 410 32'E.

1.2 Population size and composition

The County has a total population of 699,534 people consisting of 375,985 males and 323,549 females as at 2012. The population is projected to increase to 785,976 and to 849,457 persons in 2015 and 2017 respectively (Source: CIDP-Garissa).

1.3 Physical and topographic features

Garissa County is basically flat and low-lying without hills, valleys or mountains. It rises from a low altitude of 20m to 400m above sea level. The major physical features are seasonal Laghas and the Tana River Basin on the western side. The River Tana has tremendous effect on the climate, settlement patterns and economic activities within the County. Given the arid nature of the County, there is great potential for expansion of agriculture through harnessing of River Tana and Laghas.

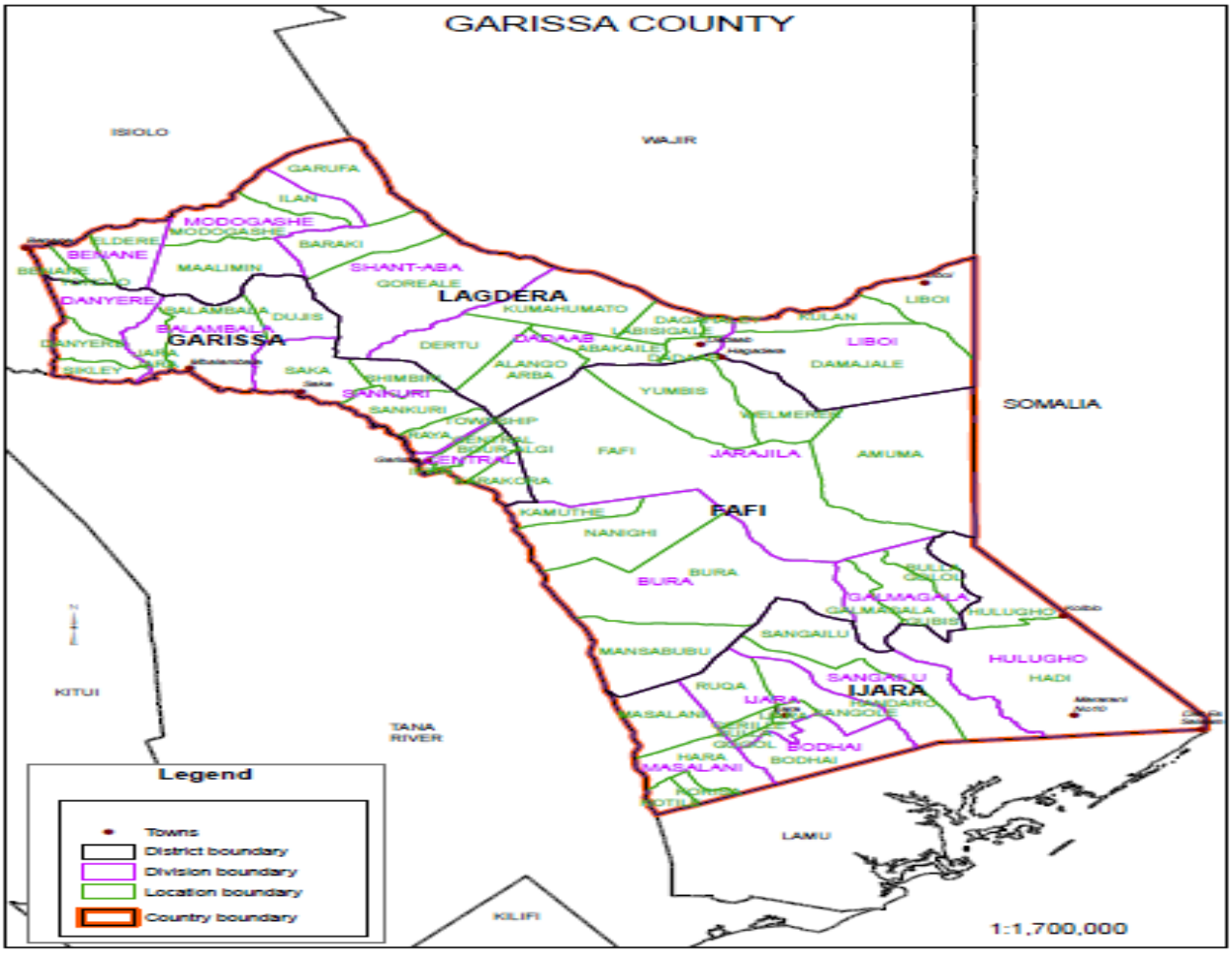


Figure 1.1: Location of Garissa County and its administrative divisions

1.4 Ecological and climatic conditions

Garissa County is principally a semi-arid area and receives an average rainfall of 275 mm per year.

Given the arid nature of the County, temperatures are generally high throughout the year and range from 20^0C to 38^0C. The average temperature is however 360C. The hottest months are September and January to March, while the months of April to August are relatively cooler. The humidity averages 60 g/m^3 in the morning and 55 g/m^3 in the afternoon. An average of 9.5 hours of sunshine is received per day.

1.5 Administrative and political units

Garissa County has seven sub-counties which include: Fafi, Garissa town, Ijara, Hulugho, Lagdera, Balambala and Dadaab. There are, however, six constituencies in the County.

Table 1.1: Garissa County administrative units and the sizes

S/ No.	Admini-strative\unit	Area (Km^2)	Divisions	Locations
1	Garissa	2,538.5	3	10
2	Balambala	3,049.2	4	12
3	Lagdera	6,519	3	10
4	Dadaab	6,781	3	12
5	Fafi	15,469	3	12
6	Ijara	6,709.6	4	11
7	Hulugho	3,107.8	3	16
Total		**44,174.1**	**23**	**83**

Source: IEBC, 2012

1.6 Health access (facilities and personnel)

Garissa County has a total of 126 health facilities. Out of these, 68 are Level Two facilities, seven are Level Four, 21 are private clinics, 19 are Level Three facilities and one is a Level Five facility located in Garissa Town. There are also three Non-Governmental Organization dispensaries and five mission health facilities which are included in the above figure. Good health care services are mostly available in the urban areas. The average distance to the nearest health facility is 35Km. Most of the health facilities are along the river where there are settlements. The number of trained health personnel is also very low with the doctor-population ratio being currently 1:41,538 while the nurse-population ratio is 1:2,453.

1.6.1 Morbidity

The five most prevalent diseases in Garissa County are malaria, upper respiratory tract infections, urinary tract infections, diarrhoeal diseases and flu; with a prevalence of 46.6%, 5.2%, 6.6%, 2.75% and 3.7% respectively. HIV and AIDS prevalence rate is low at 2.1% compared to 6% at the national level. This, however, is a sharp increase from 1 percent recorded during the Kenya Demographic Health Survey 2014. This rise can be attributed to, among other reasons, the fact that only 10 percent of the population has comprehensive knowledge on HIV prevention as per the Multiple Indicator Cluster Survey (MICS) of 2007.

1.6.2 Nutrition status

The prevalence of wasting in Garissa County among children 6 - 59 months is 8.85% (weight for height of less than - 2 SD . On the other hand, the prevalence rate of underweight children is 26.8% in the County. The prevalence rate of stunting in the County is 38.6% (KDHS, 2008-2009). These can be attributed to continued food insecurity in the region with a majority of the population relying on relief food, which is basically pulses and rice.

1.6.3 Immunization coverage

The vaccination coverage in Garissa County is 62 %. This is attributed to the inaccessibility of the area, long distances to health facilities and poor road network.

1.6.4 Access to family planning services

The County has a very low contraceptive acceptance rate which stands at 4%. The low contraceptive use is attributed to the cultural and religious practices which prohibit family planning. It is also compounded by the long distances to health facilities, which currently stand at an average of 35km.

1.7 Education and literacy

1.7.1 Pre-school education

Garissa County has 184 Early Childhood Development Education (ECDE) centres with a total enrollment of 24,091 consisting of 13,285 boys and 10,806 girls. There are 229 teachers hence a teacher-pupil ratio of 1:105. The pre-school net enrollment rate is 9.6% and the completion rate is 89.34 percent while the retention rate is 11 percent. This is due to the nomadic lifestyle of the people. In addition to formal schooling there are also Madarasa where young children are taught religious studies.

1.7.2 Primary education

The County has 131 primary schools with a total enrollment rate of 41,474 consisting of 24,939 boys and 16,535 girls. The enrollment rate is low in the County. There are 672 teachers, giving a teacher-pupil ratio of 1:61. The primary school net enrollment rate is 23.5% while the completion rate is 62.7%. The transition rate stands at 58.3%. This is due to the nomadic lifestyle of the people and early marriages among the girl child.

1.7.3 Literacy

The proportion of the population that is able to read stands at 39.75% while that of the population who cannot read and write is 57.9%. On average, the literacy level in the County is 8.2%. Men are more literate than women.

1.7.4 Secondary education

The County has 18 secondary schools with a total enrollment of 6,580 students with 4,774 boys and 1,806 girls. This represents 4% of the secondary school-age population. The teacher-student ratio stands at 1:36. The secondary school net enrollment rate is 3.50 percent and the completion rate is 77%.

1.7.5 Tertiary education

Public and private university campuses are being set up in the town. There is one Science and Technology Institute, North Eastern Technical Training Institute, one Kenya Medical Training College and one Teachers Training College; all located in Garissa town. The County also has three youth polytechnics; one each in Bura East, Dadaab and Garissa. In addition, there are numerous private accredited and non-accredited colleges.

1.8 Beliefs and practices

The Somali people have practised Islam for such a long time that many Somali customs are derived from this religion. Islamic influence is manifested in the Somali way of dressing.

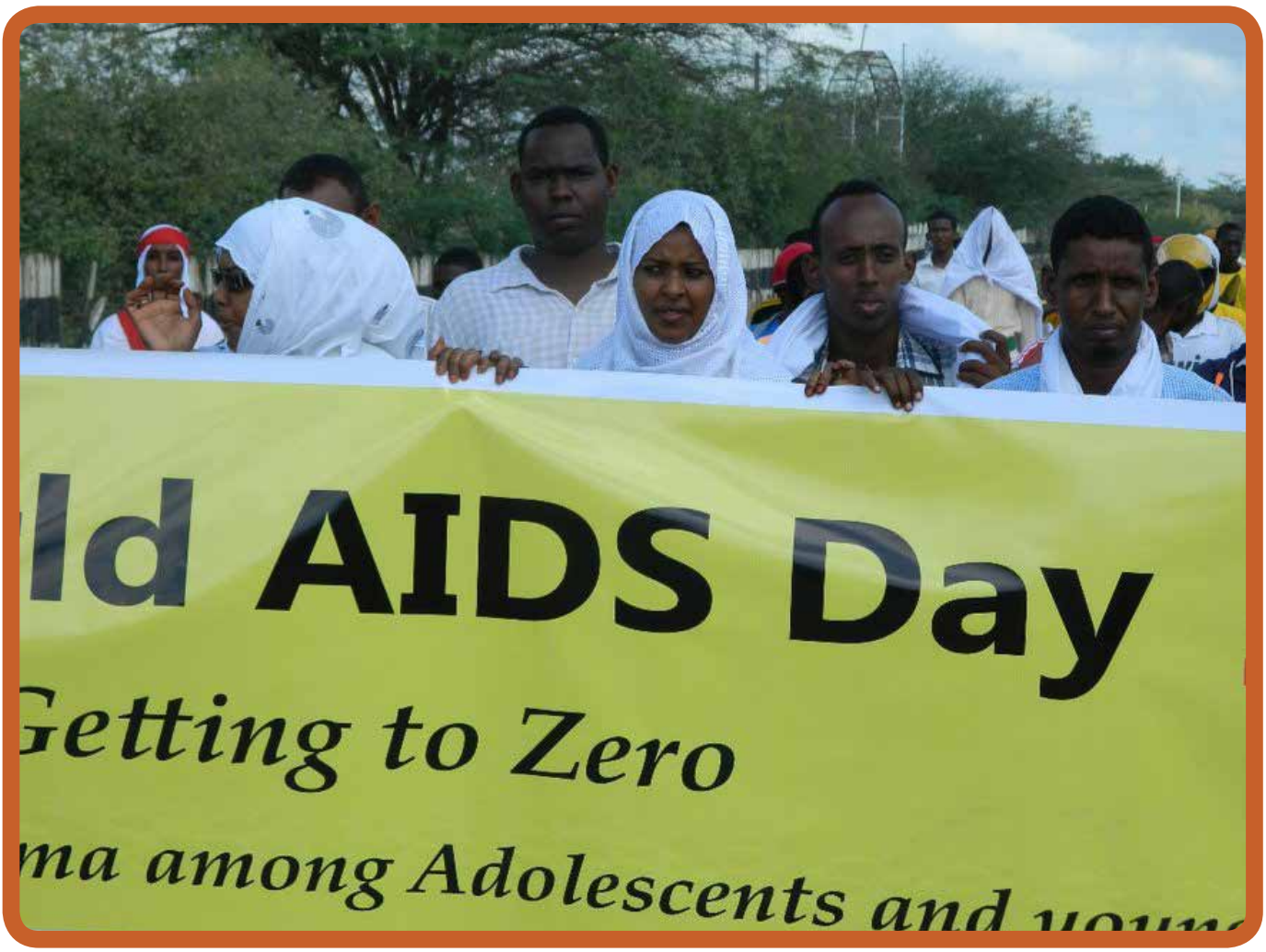
Polygamy is widely practised among the Somali. Traditionally, the women's role was to take care of their homes and their husbands, while men watched over their camel flocks. The Somali practise a nomadic pastoralist way of life; keeping herds of camels, sheep, indigenous cattle and goats.

Today, many of the Somali live away from their native home of North Eastern region, residing in almost every major town in Kenya where they engage in business and trade. However, they still maintain their close kinship.

1.9 Evolution of HIV and AIDS response

Historically, the ethnic Somalis in Garissa have been largely isolated from other regions in Kenya, both culturally and geographically. One benefit of this isolation was that their traditional Islamic practices, nomadic pastoral lifestyle, and remote location kept them relatively untouched by the HIV epidemic affecting the rest of the country. But in recent years, new technology such as mobile phones, increasing road traffic between Garissa and the rest of the country, shifting cultural practices and norms, and population changes have collectively influenced the way the local population interacts.

In 2002, just one bus used to travel between Nairobi and Garissa per day. By 2008, that number had increased to 30. Undoubtedly, this increase in communication and interaction between the County and other areas of Kenya has brought improvements in access to goods and services and medical care. However, this may also have contributed to an increase in HIV prevalence as evidenced by KDHS (2003) report where, zero cases of HIV were reported in the former NEP. In 2007, the HIV prevalence rate had increased to 1.3% (KAIS 2007) throughout the region. The current average prevalence rate of the County is 2.1%.



CHAPTER 2

Situational Analysis

The HIV prevalence in the County is estimated to be on the increase from the 1 percent average of the region to approximately 2.1 percent. There are estimated more than 5,000 PLHIV and the incidence rate is at around 200 new HIV infections annually.

HIV indicator		Number /%	Data Source
Total population		699,534	KNBS 2009
HIV adult prevalence		2.1%	Kenya HIV Estimates, 2014
Adults	Living with HIV	3,300	
	New HIV infections (annually)	116	
	HIV-related deaths	521	
	Receiving ART (CD4 Count < 350)	786	
	Need for ART	1,649	
	ART Coverage	48%	
Children	Living with HIV	1,075	
	New HIV infections (annually)	14	
	HIV-related deaths	69	
	Receiving ART	73	
	Need for ART	755	
	ART Coverage	10%	
Orphans and Vulnerable Children (OVC) beneficiaries	Households with an orphan	8,532	
	Poor households with an orphan	4,181	
	Cash transfer beneficiary households	1,687	

2.1 Risk factors and vulnerabilities

Garissa is considered to be a county of low HIV prevalence but at a high risk of the spread of HIV infection. The reasons behind this are several; protracted armed conflicts, the extremely low socio-political and economic status of women, huge numbers of people displaced externally (refugees), the poor social and public health infrastructure and the emergence of sex work practices.

2.1.1 Condom use and knowledge on HIV and AIDS

Condoms are available through MoH clinics, pharmacies as well as in the shops with high uptake in the community among vulnerable groups. However, there is high stigma attached to condom use. Abstinence Fasting and Marriage (AFM) has been proposed as an accepted Islamic HIV prevention approach.

According to KDHS 2014, the County is among the counties with the least knowledge of modes of HIV spread.

2.1.2 Priority populations

Risk of HIV is not equal for all populations in Garissa County. Among the priority populations who disproportionately contribute a high number include; sex workers (Conventional, Transactional, Divorces, Serial Monogamy), refugees population, taxi and truck drivers, tea and miraa sellers, migrant workers (public servants, disciplined forces, traders, development agencies workers), schools and college population, out-of-school youths, Vulnerable and Marginalized Groups (VMG) and PLHIV. These populations require targeted interventions as appropriate.

2.1.2.1 Key Populations

There is evidence of increased sex work in urban towns of the County. Studies conducted by APHIA-plus (Sexual Network Survey, 2008) in Garissa indicated that 22 percent of men have practised transactional sex as have 35 percent of the women.

Other than the conventional sex work practices, transactional sex among the miraa/khat women, divorces and tea girls has emerged as a risk factor. This includes the Keja syndrome where a group of young men hire a house and have sex with one female sex worker.

2.1.2.2 Mobile populations (refugees, truck drivers and migrant workers/traders)

Mobility is tied to the spread of HIV in a number of ways. It can encourage or make people vulnerable to high-risk sexual behaviour; makes people more difficult to reach, whether for prevention education, condom provision, HIV testing, or post-infection treatment and care; and migrants' social networks create opportunities for sexual networking.

According to an IOM brief, there are currently an estimated 350,000 people displaced by conflict from the neighboring Somalia living in the Dadaab camps within the County. Though UNHCR through its implementing partners has a health component in the camps, the programmes do not comprehensively address the HIV and AIDS response in a coordinated approach and as per the national and county HIV and AIDS plans.

International experience provides evidence of spread of HIV along main transport routes. Truck drivers transiting through Garissa County destined to the refugee camps or northern counties are among the vulnerable groups in the County.

High level of mobility among migrant workers who include pastoralists, disciplined forces, public servants and development agencies workers also creates spatial fluid households and families, predisposing them to HIV.

CHAPTER 3

Rationale and Strategic Plan Development Process

3.1 Rationale

The GCASP is designed to guide the County's response to HIV and AIDS. It serves as a guide for a wide range of stakeholder involvement in the response to HIV and AIDS prevention, care and treatment in the County. It assists stakeholders to develop their own specific strategic plans so that all initiatives in the County can be harmonized to maximize efficiency and effectiveness.

The plan is based on analysis of the limited available data and takes into account the resource constraints of the County in both human and financial terms. It identifies clear priority areas where increased attention is likely to have the greatest impact on HIV and AIDS in the County.

Finally, it recognizes that HIV and AIDS is a development issue and requires a broad multi-sectoral response that addresses the complex web of underlying causal factors as well as its equally complex consequences.

3.2 Development process

The planning for the 2015 – 2019 Garissa County AIDS Strategic Plan featured a participatory and broad-based, multi-partner process. A multi-sectoral consultation workshops took place in June and September 2015 to solicit inputs and feedback from civil society, government, bilateral and multilateral organizations. A drafting committee of ten members was responsible for obtaining stakeholder-specific inputs and consolidating these into the work plan. A consensus workshop was held in April 2016 to agree on the strategies, programme priorities and coverage targets identified. The final plan was launched by the County leadership.

CHAPTER 4

Vision, Goal, Objectives and Strategic Directions

Vision

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

Goal

Reduce HIV prevalence to less than 1% by enhancing prevention, treatment, care and support by 2020.

Objectives

The Garissa County Strategic Plan sets the objectives to be achieved by the end of the plan implementation period as:

1. **To reduce new HIV infections by 75%.**
2. **To reduce AIDS-related mortality by 25%.**
3. **To reduce HIV related stigma and discrimination by 60%.**
4. **To increase domestic financing of the HIV response to 5%.**

Specific Objectives

Specifically, the plan is intended to achieve the following:

1. To strengthen linkage between health services and community systems for HIV response.
2. To undertake a holistic HIV prevention strategy to the target population.
3. To increase equitable access and utilization of HIV services to the general population, the marginalized and priority population of Sex Workers, PLHIV, Youths and People Living with Disabilities.
4. To strengthen monitoring and evaluation of HIV and AIDS services in the County.
5. To mobilize resources for the implementation, sustainability and ownership of the HIV and AIDS Strategic Plan.
6. To conduct operational and basic HIV research for planning and decision making.
7. To inculcate a strong leadership and coordination, ownership and sustainability structure on HIV and AIDS response in the County.

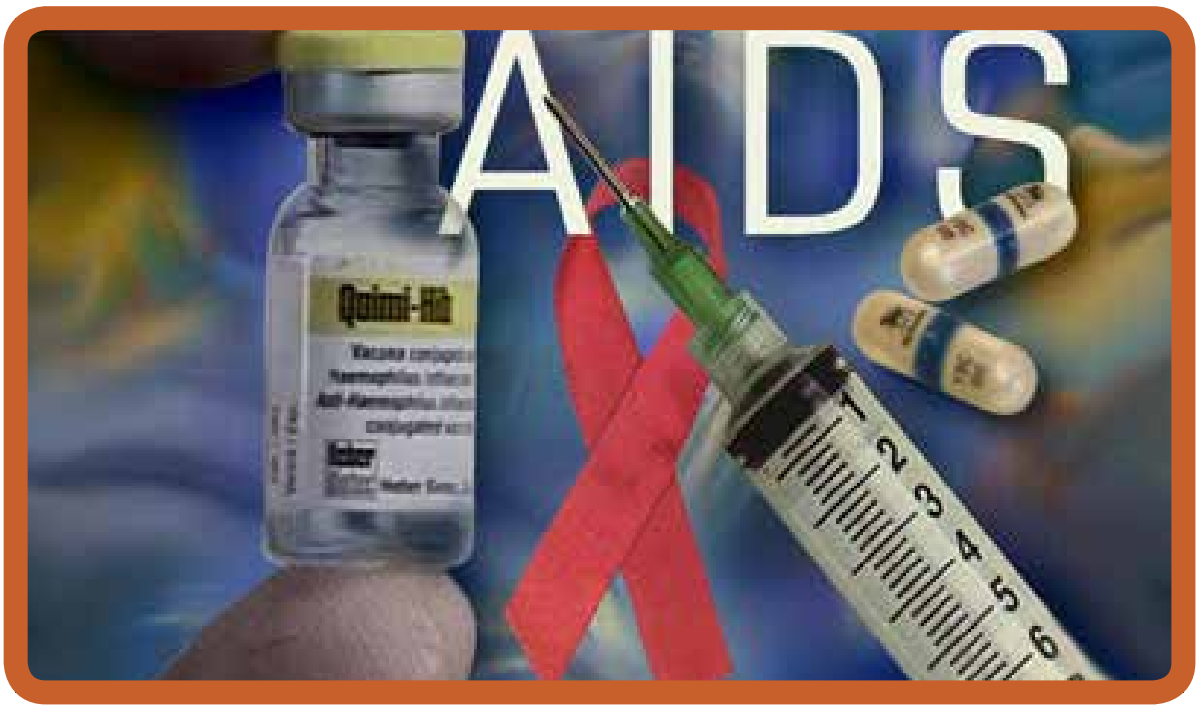
4.4 Alignment with County and National Policy Frameworks

The GCASP is aligned to various policy frameworks to ensure its contribution to overall human development and achievement of sub-county, county and national health policy objectives. These include: The Constitution of Kenya 2010, Kenya Vision 2030, Kenya Health Policy 2014 - 2030, Garissa County Integrated Development Plan 2013 - 2017, Kenya AIDS Strategic Framework, Kenya HIV Revolutionary roadmap, Kenya's Fast Track to end HIV among the Young People, and the Kenya Community Health Strategy

4.5 The GCASP guiding principles

The Garissa County AIDS Strategic Plan is anchored on core guiding and implementation principles. These include:

1. County ownership and partnership - All HIV stakeholders including the government, development partners and the private sector.
2. Commitment and financing of the response.
3. Non-discrimination on HIV status, stigma reduction and meaningful involvement of PLHIV.
4. A rights-based and culturally-sensitive approach.
5. A multi-sectoral but coordinated mechanism.
6. Evidence-based and accountability for results



Strategic Directions

Strategic Direction 1

4.6 County Strategic Directions (SDs)

In line with the Kenya AIDS Strategic Framework strategic directions, the Garissa County HIV and AIDS Strategic Plan outlines the results and activities to be carried out, granulated into target population and the geographical area within the County.

The interventions on this Strategic Direction will raise public awareness on HIV and AIDS, and STI prevention and control. It will also ensure universal access to behaviour change communication on HIV, especially targeting priority populations.

Table 4.1: Interventions towards reducing new HIV infections

STRATEGIC DIRECTION 1: REDUCING NEW HIV INFECTIONS						
KASF Objective	**CASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographical areas by sub-county**	**Respons-ibility**
Reduce new HIV infections by 75%	Prevent new HIV infection by 75%	Peer education/ BCC	Create awareness and sensitization	Men and women aged 15-24 years	All sub-counties	NACC
			Promote safe cultural / religious practices (ear-piercing, circumcision, burning skin)	Traditional circumcisers and healers	All sub-counties	MoH-Garissa, CDH
			Radio programmes	General population-(targeted messages)	All sub-counties	NACC
		Up-scale HTS	Conduct community-based outreach HTC	General population	All sub-counties	MoH-Garissa CDH/CASCO
			Conduct routine HTC campaigns (door-to-door and MVCT)	General population	Garissa Sub-County	MoH-Garissa, CASCO
			HTC promotion including prisons and other institutions	Institutions	All sub-counties	NACC
			Health system strengthening through training on HTC	Health care workers/care givers	All sub-counties	MoH - Garissa CASCO
			Create demand for Premarital counselling and testing	Women and men of reproductive age	All sub-counties	MoH - Garissa CASCONACC
			Strengthen and institutionalize PITC in clinics	Healthcare service clients	All sub-counties	CASCO

KASF Objective	CASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographical areas by sub-county	Respons-ibility
Reduce new HIV infections by 75%	Prevent new HIV infection by 75%	Scale-up EMTCT and elimination of pediatric HIV	Strengthen and scaling up integration of PMTCT (ANC/ MAT/PNC)	Health care workers/care givers	All sub-counties	MoH - Garissa
			Enrollment of all HIV-positive mothers to care and treatment	HIV-positive pregnant mothers	All sub-counties	CASCO
			Provision of adequate HAART	HIV-positive pregnant mothers	All sub-counties	CASCO
			Testing all pregnant and lactating mothers for HIV	Pregnant mothers	All sub-counties	CASCO
			Test all partners	Couples	All sub-counties	CASCO
			Conduct EID to all HIV-exposed infants	HIV-exposed infants	All sub-counties	CASCO
		Provide ART and PEP services	Increase number of ART sites to at least 20 from 18	Existing health facilities	All sub-counties	COH
			Supplying of ART and PEP	CCCs / PMTCT Sites	All sub-counties	COH
			Capacity building of health workers on ART	Health care workers/care givers	All sub-counties	COH, CASCO
			Provision of reporting tools	CCCs/ PEP/ PMTCT sites	All sub-counties	CASCO
			Provide HAART for discordant couples	CCCs/ PEP/ PMTCT sites	All sub-counties	CASCO
		Safe blood transfusion	Health system strengthening training of health workers.	Health care workers	All sub-counties	NBTC
			Upgrade satellite BTCs to become fully fledged	Central Sites	GCRH	Garissa County Government
		Health system strengthening	Training health care workers on HTC, infection prevention, PMTCT, blood safety, PWP, PEP, ART	Health care workers	Garissa County	MoH - Garissa CASCO NACC
			Strengthen institutional capacity to offer HIV and AIDs Care	Laboratories	All sub-counties	MoH/ CASCO
		Introduction of HIV school programmes	Increase access on sexuality, reproductive health services and stigma reduction for teachers in schools	Teachers	All sub-counties	MoH/ Ministry of Education
			Up-scale ACU- mainstreaming HIV units in institution of higher learning	Institutions	All sub-counties	NACC
			Offer peer-to-peer outreach in schools and outside schools	Youth in and out of school	All sub-counties	MoH/ Ministry of education

KASF Objective	CASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographical areas by sub-county	Respons-ibility
Reduce new HIV infections by 75%	Prevent new HIV infection by 75%	Promotion of condom use	Condom promotion among Key and Priority Populations	Key and Priority Populations	Vulnerable population/ sexually active within Garissa County	MoH-Garissa CASCO/ NACC
			Fix condom dispensers to toilets/bars and hotspot areas	HIV hotspot areas	Garissa County	MoH-Garissa CASCO/ NACC
			Support the use of condom among PLHIV	PLHIV	All sub-counties	MoH - Garissa CASCO/ NACC

4.6.2 Strategic Direction 2

Persons infected and affected by HIV should be covered under existing programmes. Stronger linkages and referral system between HIV and related services will be encouraged under this strategy. It also ensures and maintains the quality and sustainability of treatment, care and support services for PLHIV.

Table 4.2: Interventions for improving health outcomes and wellness of all PLHIV

STRATEGIC DIRECTION 2: IMPROVING HEALTH OUTCOMES AND WELLNESS OF ALL PEOPLE LIVING WITH HIV						
KASF Objective	**CASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographical areas by sub-county**	**Responsibility**
Reduce AIDS-related mortality by 25%	Increased access to diagnosis and reduced risk of HIV transmission	Upgrade the County laboratory infrastructure and equip the HIV service delivery points with lab equipment and reagents	Conduct need assessment in County laboratories	All health facilities	All sub-counties	MoH - lab coordinator/ COH
			Procure HIV laboratory equipment and reagents	All health facilities	All sub-counties	MoH - lab coordinator/ COH
			Improve laboratory infrastructure and skills	All health facilities	All sub-counties	MoH -lab coordinator/ COH
			Provide screening and diagnostic equipment for TB, malnutrition, opportunistic infections together with those for HIV	All health facilities	All sub-counties	MoH - COH
Reduce AIDS-related mortality by 25%	Improved referral management system and increased integration of services	Strengthen facility and community linkages with inter- and intra-facility referral protocols and link strategies for PLWHIV	Strengthen facility and community linkages with inter- and intra-facility referral protocols and link strategies for PLWHIV	Community and health facilities	All sub-counties	MoH Community Strategy focal person
			Integrate and strengthen referral system on the general streamline of service delivery	Health care workers	All sub-counties	MoH - Referral Coordinator
			Support improved linkages and functioning referrals and feedback mechanisms through public and private service providers	private public health care workers	All sub-counties	MoH - Referral coordinator
			Identification of gaps in facility and community linkages	Community and health facilities	All sub-counties	MoH - Referral coordinator

KASF Objective	CASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographical areas by sub-county	Respons-ibility
Reduce AIDS-related mortality by 25%	Improved referral management system and increased integration of services	Strengthen facility and community linkages with inter- and intra-facility referral protocols and link strategies for PLWHIV	Capacity building of community health workers, volunteers	Health care workers, community volunteers	All sub-counties	MoH - Referral coordinator
	Increased retention on ART	Monitoring and follow-up of clients	Monitor adults and children on treatment and follow-up	Health care workers/care givers	All sub-counties	MoH - Garissa
			Improve adherence support	HIV-positive pregnant mothers	All sub-counties	CASCO
			Monitor viral load on HIV patients	HIV-positive pregnant mothers	All sub-counties	CASCO
			Reduce turnaround time for results and feedback	Pregnant mothers	All sub-counties	CASCO

4.6.3 Strategic Direction 3

Stigma and discrimination are barriers to uptake of HIV services. This Strategic Direction provides ways to ensure equitable access to health services among priority populations.

Table 4.3: Interventions towards using a human rights-based approach to facilitate access to services for PLHIV, Key Populations and other priority groups in all sectors

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						
KASF Objective	**CASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographical areas by sub-county**	**Responsibility**
Reduce HIV-related stigma and discrimination by 50%	Reduced self and social HIV related stigma and discrimination by 50% and increase protection of human rights	Sensitise law and policy makers on the need to enact laws, regulations and policies that prohibit discrimination and support access to HIV prevention, treatment, care and support	Formulation of policies to protect rights of PLHIV and other vulnerable groups	HIV-positive pregnant mothers	Garissa County	National HIV tribunal/ County Assembly
			Form County HIV tribunal to address stigma and discrimination, and sexual or/and gender-based violence on PLHIV	HIV-positive pregnant mothers	Garissa County	National HIV tribunal/ County Assembly
			Strengthen PLHIV support groups to advocate environment-friendly for protection of PLHIV	Pregnant mothers	Garissa County	MoH - Garissa CASCO NACC
			Capacity-building of healthcare staff on stigma reduction	Couples	All health facilities	CASCO NACC
			Involvement of religious leaders, peer educators, community leaders, education institutions, media engagement, Islamic perspective on love and support, PLHIV and key populations in stigma reduction advocacy activities	HIV-exposed infants	Garissa County	MoH - Garissa CASCO NACC
			Conduct annual County Stigma Index Survey	Existing health facilities	All sub-counties	MoH – Garissa NACC

4.6.4 Strategic Direction 4

HIV, being a chronic condition, requires functional support systems both at the community and health facility levels.

Table 4.4: Interventions for strengthening integration of health and community systems

STRATEGIC DIRECTION 4: STRENGTHENING INTEGRATION OF HEALTH AND COMMUNITY SYSTEMS						
KASF Objective	**CASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographical areas by sub-county**	**Responsibility**
Improved health workforce for HIV response at all levels by 40%	Improved capacities, motivation and adequacy of health care workers	Promote and support innovative in-service learning approaches for health workers	On-the- job training for diagnosis, comprehensive care and support, referral and management	Health care workers	All sub-counties	CASCO NACC
			Leverage opportunity through creation of synergies with health, systems, community and other sectors for HIV prevention.	Health Workers, Community Health Committees.	All sub-counties	CASCO NACC
		Advocate to prioritize rural health workers' career advancement, giving promotion preference to those who have done extended rural service	Provide continuous regular and specialized trainings to enhance career progression.	Health care workers,	All sub-counties	Chief Officer Health
Increase number of health facilities ready to provide KEPH-defined HIV services	Improve linkages between the community and service providers	Conduct outreach service to facilitate linkages between the community and service providers Provide mobile health facilities to the hard-to-reach areas	Provide integrated HIV activities in all health facilities.	Health care workers,	All sub-counties	CASCO NACC CASCO NACC MoH - Sub County
			Conduct integrated HIV counselling and testing services to the community		All sub-counties	CASCO NACC MoH - Sub County
			Regular supply of HIV commodities across the health facilities and at the community level.	Health facilities, community	All sub-counties	CASCO NACC MOH – Sub-county

KASF Objective	CASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographical areas by sub-county	Respons-ibility
Increase number of health facilities ready to provide KEPH-defined HIV services	Improve linkages between the community and service providers	Provide ART and PEP services	Strengthen linkages between the cCmmunity Units and health facilities.	CHEWs, Community Health Committees, Facility Health Committees	All sub-counties	CASCO County Focal person - Community Unit
			Strengthen referral system between the community and the health facilities through CHVs.	CHEWs, Community Health Committees, Facility Health Committees, CHVs	All sub-counties	CASCO County Focal person - Community Unit
Strengthened community level AIDS comp-etency	Evidence-based reporting	Implement community health strategy	Strengthen integration of HIV component in CUs. Roll out of COBPAR tool.	CHEWs, Community Health Committees Facility Health Committees	All sub-counties	CASCO NACC County Focal person - Community Unit SCACC
			Conduct quarterly support supervision of community units.	CHEWs, Community Health Committees, CHVs.	All sub-counties	CASCO County Focal person - Community Unit
			Strengthen governance structure at community and health facility level, through training, quarterly meetings and provision of resources.	Community Health Committees, Facility Management Committee	All sub-counties	CASCO, County Focal person - Community Unit SCMOH

4.6.5 Strategic Direction 5

Research findings need to form the basis for the HIV and AIDS response. The County capacity in conducting researches is limited. This Strategic Direction identifies the basic researches and surveys at the county level to inform planning and operationalization of activities, but largely relying on the established national structures.

Table 4.5: Interventions towards strengthening research and innovation to inform KASF goals

STRATEGIC DIRECTION 5: STRENGTHENING RESEARCH AND INNOVATION TO INFORM THE KASF GOALS						
KASF Objective	**CASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographical areas by sub-county**	**Respons-ibility**
Increase evidence-based planning, programming and policy changes by 50%	Increased evidence-based planning, programming and policy changes by 25%	Develop County HIV research agenda	Establish research working group. Prioritize research questions.	HIV/AIDS Partners	All sub-counties	CASCO NASCOP NACC
		Conduct operational research on behaviuor change, care and support, condom use	Mobilize and lobby for resources to conduct the research.	HIV and AIDS Partners	All sub-counties	CASCO NASCOP NACC
			Conduct operational research on HIV and AIDS targeted areas	Health workers	All sub-counties	NACC
Increased capacity to conduct HIV research at country and county levels by 10%	Increase capacity to conduct HIV research at county level	Empower health care workers on HIV research methodologies	Training on HIV research.. Mentorship on HIV research.. O—the-job training of health care workers on HIV research...	Community, Key Population at risk	All sub-counties	CASCO NASCOP NACC
Increased evidence-based planning programming and policy changes	Increased evidence based planning, programming and policy changes	Disseminate HIV research findings to all the stakeholders in the sub-countie.	Mobilize and lobby for resources to disseminate the findings of the research.	Community members All sub-counties	All sub-counties	CEC health CO-Health County Budget office NASCOP NACC
			Establish research committees to identify county research priorities and disseminate findings.	Community leaders, health care workers, health managers, academic audience.	County level	NACC CASCO Research committee
		Use data for decision making	Implementation of the findings.	Community leaders, health workers, HIV and AIDS partners	All sub-counties	NACC CASCO

KASF Objective	CASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographical areas by sub-county	Respons-ibility
Increased evidence-based planning programming and policy changes	Increased evidence based planning, programming and policy changes	Initiate joint planning, monitoring and evaluation	Conduct annual joint stakeholders planning meetings.	Community Leaders, Health workers and partners.	County level.	CASCO County Focal person - Community Unit
			Initiate quarterly M & E mechanism to track performance.	Community leaders (MCAs), research institution, health partners.	County level.	NACC CASCO
		Strengthen coordination among related sectors	Conduct stakeholders mapping.		County level	CASCO, NACC
			Conduct quarterly stakeholders meeting/ operationalie HIV- ICC at the County level	County level	County level	CEC - Health, CASCO NACC
			Establish inter-agency coordination committee	County level	County level	CEC - Health, CASCO NACC

4.4.6 Strategic Direction 6

This Strategic Direction looks at how evidence-based information on the implementation of the interventions suggested is collected, collated, analyzed and presented or reported to inform the HIV and AIDS programming and coordination in the County.

Table 4.6: Interventions for promoting utilization of strategic information for research, monitoring and evaluation to enhance programming

STRATEGIC DIRECTION 6: PROMOTING UTILIZATION OF STRATEGIC INFORMATION FOR RESEARCH, MONITORING AND EVALUATION (M&E) TO ENHANCE PROGRAMMING						
KASF Objective	**CASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographical areas by sub-county**	**Responsibility**
Increase availability of strategic information to inform HIV response at national and county levels	Improved access to strategic information	Develop County M&E framework in line with KASF M&E Framework	Constitute and operationalize the CASP M&E Committee.. Establish County situation room /dash board..	Health partners, MOH	Garissa County	NACC CASCO
			Report activities based on M&E indicators.	HIV and AIDS Health partners, health facilities	All sub-counties	CASCO NACC
			Harmonization of reporting tools.	Health partners MoH	Garissa County	CASCO NAC CHRIO
Plan evaluations, reviews and surveys implemented and results disseminated in a timely manner		Tracking programmes implemented in each sub-county or ward to ensure County HIV and AIDS activities are coordinated within the CASP	Conduct quarterly joint stakeholders meeting.	MoH, health partners	All sub-counties	CHC CASCO NACC
			Conduct periodic monitoring and facilitative supervisory site visits in the County.		All sub-counties	CASCO NACC MoH - Sub County
			Reporting and reviewing of activities/data submitted by stakeholders.	MoH, health partners	All sub-counties	CASCO NACC CHC

4.4.7 Strategic Direction 7

The HIV and AIDS response has largely been funded by donors. A small percentage of the financial resources have been from the Government. Donors are now withdrawing their support mainly from the low HIV-prevalence areas and focusing on the high burden regions. This leaves Garissa County to find solutions on how to finance the response through domestic innovative approaches.

Table 4.7: Interventions towards increasing domestic financing for HIV response

STRATEGIC DIRECTION 7: INCREASE DOMESTIC FINANCING FOR HIV RESPONSE						
KASF Objective	**CASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographical areas by sub-county**	**Responsibility**
Increase domestic financing of HIV response to 50%	Result to be defined after costing of strategy	Allocate at least 5% of the County health sector budget to HIV and AIDS response	Lobbying through CEC - Health for allocation of HIV/ AIDS resources in health budget.	CEC for health, County Assembly Health Committee (MCAs)	Garissa County	Chief Officer- Health CEC-Health NACC
			Enactment of a county law to allocate at least 5% of County Health Sector Budget to HIV and AIDS response.	Governor, County Assembly Health Committee	Garissa County	Chief Officer Health, CEC Health, County Assembly Speaker NACC
		Lobby the private sector to support HIV activities	Mapping of key HIV potential implementing partners.	Health partners and donors	All sub-counties	CASCO NACC Office of the Governor
			Dissemination of HIV gaps analysis to the potential partners for support.	Community leaders, Health partners and Donors	All sub-counties	CASCO NACC CHC
			Institutionalizing the MOUs for implementation.	Health partners and Donors	All sub-counties	CO – Health CDH NACC CASCO
		Review the County secretarial plans to determine the opportunity available and lobby for inclusion	Conduct joint planning at the County level.	Community leaders, health partners and MoH	Garissa County	CASCO CDH NACC
			Lobby for inclusion of HIV activities in the county-integrated plans and annual County development plan.	Directorate of Economic Planning	Garissa County	CASCO NACC County Economic Planning Office
		Develop a funding dashboard detailing all funds incoming to the County on HIV utilization	Mapping of potential funds meant for HIV activities.	County level	County level	CEC - Health, CASCO NACC

KASF Objective	CASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographical areas by sub-county	Respons-ibility
Increase domestic financing of HIV response to 50%	Result to be defined after costing of strategy	Develop a funding dashboard detailing all funds incoming to the County on HIV utilization	Conduct stakeholder forum of potential funders to lobby for funds and commitment.	Health partners, coop orate bodies, private sectors	Garissa County	CASCO NACC Chief officer -Health
		Engage health facility in- charges on optimal utilization of health facilities funds for specific HIV activities	Support health facility in-charges during planning and budgeting for incorporation of HIV activities.	Health facility in-charges	All sub-counties	SC - MoH Facility I/C

Strategic Direction 8

This Strategic Direction addresses the HIV and AIDS County ownership mechanisms. It establishes the requisite structural, legal and programmatic infrastructures for proper coordination and alignment of all the key implementers in the County. It ensures accountability by all and brings on board the County leadership to support the response.

Table 4.8: Interventions for promoting accountable leadership for delivery of the KASF results by all sectors and actors

STRATEGIC DIRECTION 8: PROMOTING ACCOUNTABLE LEADERSHIP FOR DELIVERY OF THE KASF RESULTS BY ALL SECTORS AND ACTORS						
KASF Objective	**CASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographical areas by sub-county**	**Respons-ibility**
Effective and well-functioning stakeholder coordination and accountability mechanisms in place and fully operationalized at county level	Effective and functional structures	Establish and operationalize the County HIV Committee (CHC), County ICC and CASP monitoring Committeee	Constitute and operationalize the County HIV Committee (CHC), County ICC and CASP monitoring Committee.	Health stakeholders Health partners	Garissa County	CEC – Health
		Develop programmatic and financial reporting systems for presentation to the County leadership	Submission of program and financial reports to the CHC.	HIV implementing partners	Garissa County	CEC-Health NACC
			Provide biannual feedback on program and financial reports.	HIV implementing partners	Garissa County	CEC-Health NACC
		Mobilize political and policy level support targeting County leadership	Sensitization meeting of the county leadership on HIV situation in the County.	GVN, MPs, MCAs, First Lady-County	Garissa County and sub-counties	NACC CASCO
To create an enabling policy, legal and regulatory framework for multi-sectoral HIV and AIDS response	An enabling policy environment put in place	Lobby and monitor the development and operationalization of legislation and policy on HIV and AIDS in the County	Sensitizing the MCAs to support legislation on HIV and AIDS.	County Assembly Health Committee	Garissa County	CEC-Health County Assembly Clerk NACC Civil Society Private Sector
			Provide technical support to the House Committee on Health in the development of HIV bills	County HIV Committee County Assembly Health Committee	Garissa County	CEC-Health County HIV and AIDS Coordinator
			Monitor the progress of HIV-specific bills and provide continuous feedback and guidance	County Assembly Health Committee	Garissa County	County HIV and AIDS Coordinator
			Mapping of potential funds meant for HIV activities.	County Assembly Health Committee	Garissa County	CEC-Health County HIV/AIDS Coordinator

CHAPTER 5

Implementation Arrangements

The Constitution of Kenya 2010 created devolved governance at the county level, which has changed the overall national governance structure and necessitated the development of a more complex and dynamic coordination and management structure for the HIV and AIDS response.

The coordination framework elaborated below aligns with various legislative instruments that define different levels of coordination and service delivery in devolved governance to the lowest possible administrative level. The framework aims at achieving the following goals:

(a) Ensuring that defined mandates, roles and responsibilities of institutions, sectors and stakeholders at different levels in devolved systems are not repeated.

(b) Providing a platform for all public sector and non-state actors to implement GCASP at all levels of HIV programming.

(c) Reducing potential conflicts between and among stakeholders at different levels of GCASP implementation structure.

(d) Ensuring accountability for performance, resources and results by all implementing partners at various levels.

(e) Ensuring effective implementation of GCASP.

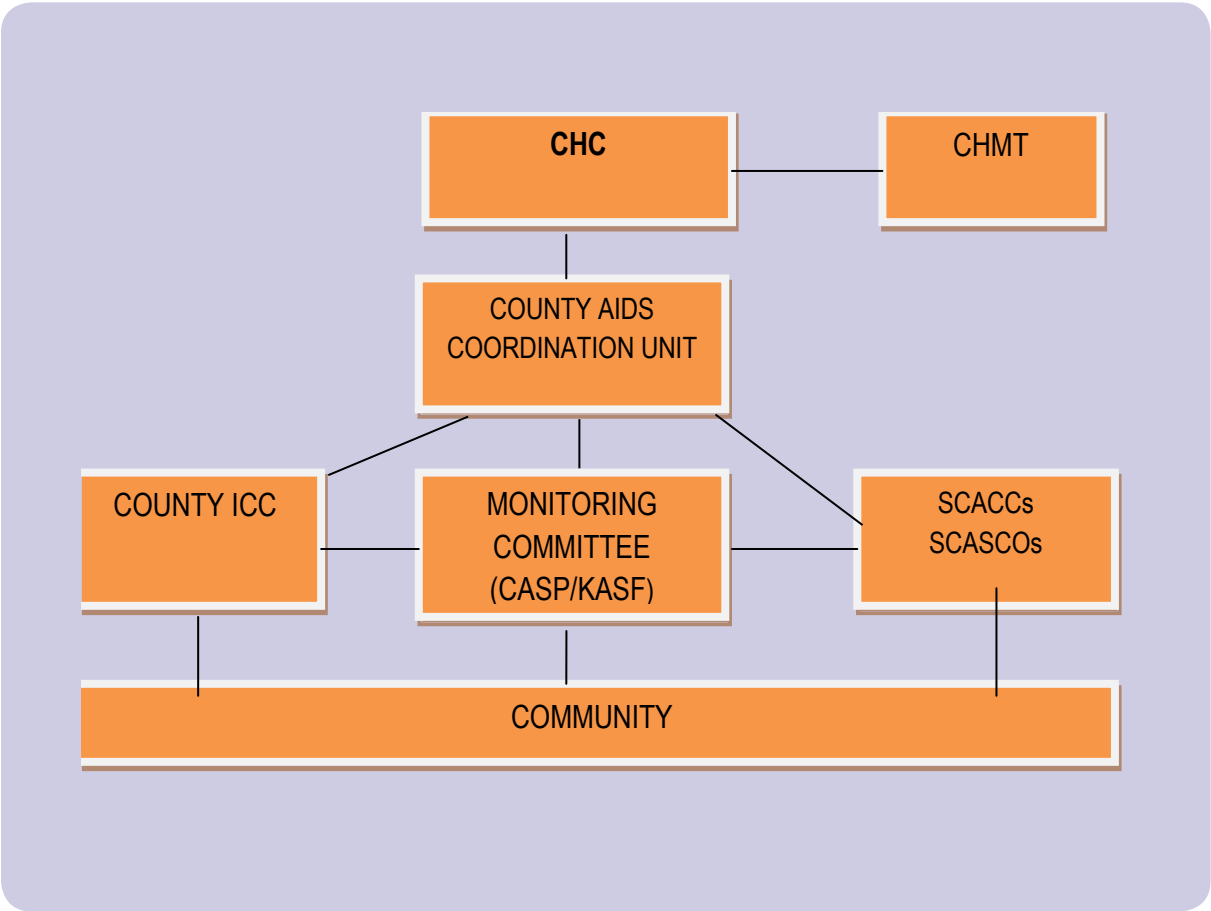


Figure 5.1: The structural arrangement for HIV response

Roles

1. The County HIV Committee (CHC) will be chaired by CEC Health. This is the highest decision-making organ in relation to the HIV and AIDS response in the County. It is comprised of selected county heads of departments/divisions.
2. The County HIV Coordination Unit is the NACC (regional) office. It is the secretariat.
3. County Inter-Agency Committee (ICC) is a forum of all the HIV implementers in the County. The forum will be convened through the CHC periodically for feedback on the HIV response in the County.
4. CASP M&E Committee is the technical arm of the CHC.
5. SCACCs and SCASCOs are the grassroot structures in touch with the community and implementers.

CHAPTER 6

Research, Monitoring and Evaluation of the Plan

6.1 Overview of M&E

The overall purpose of monitoring and evaluation (M&E) is to track activities and indicators of the County Strategic Plan implementation. It is a process of ensuring that resources are spent as planned within the framework of strategic plan projections and budgets; and that activities take place as planned within the specific timeframes to realize the stated strategic objectives. Evaluation is defined as periodic assessment of the relevance, performance, efficiency, effectiveness and impact of the activities.

Monitoring the strategic plan will help to determine whether the implementation is on track and establish the need for any adjustment in light of the changes in interventions. This plan will be implemented through a results framework (see annexure) to provide key inputs into the GCASP M&E system. Specifically, key activities, expected outcomes, performance indicators, projected timelines, responsibility and projected cost is indicated for all the interventions suggested.

6.2 Monitoring mechanism

6.2.1 Institutionalization of the County AIDS Strategic Plan

The individual strategies have clearly defined activities with specific timelines for implementation. For ease of monitoring, the Garissa CASP is aligned to the KASF objectives and strategies and national M&E indicators. The realization of the strategic plan will feed into the overall objectives of the KASF and Kenya Vision 2030.

6.2.2 Supervision

The CASP monitoring committee will carry out supervision of the overall Plan implementation and prepare quarterly reports. This will require the cooperation of all stakeholders. Findings from the supervision missions will be presented to the CHC and follow-up actions discussed. The CHC will ensure prompt submission of the reports to the relevant persons.

6.2.3 Activity assessments

County ICC meetings to review progress will be held bi-annually with representatives from the various HIV stakeholders. This will keep the planned activities and outputs on track during implementation, and enable the stakeholders to identify and take necessary actions to address emerging challenges. This will give the ICC a chance to interrogate what is being done.

6.3 Evaluation

The Plan will be subjected to two evaluations, Mid-term Evaluation and Review; and Final Evaluation. The evaluations will be done using an indicator monitoring tool under the guidance of a strategic planning expert.

6.3.1 Mid-term Evaluation and Review (MER)

The purpose of the Mid-term Evaluation and Review (MER) will be to assess the extent to which the Plan is meeting its implementation objectives and timelines. The MER will be carried out in 2017 after an internal evaluation which will provide an opportunity to:

(i) Establish the extent to which the strategy has realized the planned objectives and expected results.

(ii) Assess management and coordination strategy and the extent to which these structures support effective implementation of the strategy. This will include the extent to which key stakeholders have been involved in implementation.

(iii) Assess the strategy outcomes in the community in terms of efficiency, effectiveness, relevance and sustainability.

(iv) Identify and document key lessons learnt and best practices that can be used for advocacy to influence relevant policies and practices.

(v) Give recommendations on ways of addressing identified gaps and advise on possible areas that need to be changed in the remaining strategy period to ensure realization of the objectives.

6.3.2 Final evaluation

The purpose of the Final Evaluation for the Strategic Plan 2015 - 2019, expected to be carried out at the end of 2019, will be to address the following issues:

1. Establish the extent to which the County has realized the planned objectives and expected results.
2. Assess the County's outcome in terms sustainability of programmes.
3. Identify and document key lessons learnt and best practices that can be used for advocacy to influence relevant policies and practices as well as for replication in new programmes.

6.4 Reporting and information dissemination

Reporting the progress of implementation will be critical in adjusting strategic directions and measuring performance. Progress reports will be made on quarterly basis. The reports will outline in summary from projected targets, achievements, facilitating factors and challenges. The reports will be prepared and submitted by the monitoring committee through the CHC to Garissa County Government. Issues that will require policy interventions will be forwarded to the national government while those that require local intervention can be forwarded to relevant County authorities.

CHAPTER 7

Risk and Mitigation Plan

The implementation of the plan is bound to risks and challenges as tabulated below.

Table 7.1: Risk and mitigation in GCASP implementation

Risk Category	Risk Name	Level of Risk	Response	Responsibility	When
Programmes	Prioritization of HIV	High	Lobby for HIV prioritization in the County	CEC	Annual
	Insecurity	High	Factor in the budget	Regional Coordinator	As arises
	Flooding	High	Factor in the budget	County Government	As arises
Operational	Lack of expertise	Medium	Continually engage in capacity development	CHC	Annually
Technological	Lack of skills	Medium	Continually upgrade equipment in accordance with the ICT trends.	CHC	Annually
Political/ Legislation	Lack of political goodwill	High	Enhance working relationship with the political leadership	CHC	Annually
Culture	HIV Stigma	High	Undertake change management initiatives	CHC	Quarterly
Financial	Inadequate financing	High	Lobby for increased funding	CEC	Annual

Annexes

This section outlines the results framework of each of the eight strategic directions, the resources needed to implement the strategic plan, reference literature and the list of drafters and reviewers

Annex 1: Results Framework

STRATEGIC DIRECTION 1: REDUCING NEW HIV INFECTIONS							
KASF Objective	**CASP Results**	**Key Activity**	**Indicators**	**Baseline (year 2014)**	**Mid-Term Target**	**End-Term Target**	**Respons-ibility**
Reduce new HIV infections by 75%	Prevent new HIV infection by 75%	Peer education/BCC	Percentage of women and men aged 15-24 years reached with BCC information.	55%	70%	90%	NACC/CASCO
			Percentage of HIV education forums conducted in and out of school	TBD	6%	12%	NACC
			Number of youth-friendly centers established.	0	1	1	COH
		Up-scale HTC services	Number and Percentage of People Counselled and tested for HIV and who received their test results	68,036 (9%)	235,715 (30%)	458,379 (50%)	NACC/CASCO/ NASCOP
			Number of partners reached with HTS services	908	2,000	5,000	NACC/CASCO/ NASCOP
			Percentage of health workers trained on HTS	6%	24%	36%	CASCO
		Scale-up EMTCT	Number and Percentage of ANC mothers done PMTCT	16,208 (57%)	22,847 (75%)	30,776 (90%)	NACC/CASCO/ NASCOP
			Percentage of HIV-positive pregnant mothers enrolled in care and treatment	43%	60%	80%	CASCO
			Percentage of infants exposed and given preventive ARVs	43%	60%	80%	CASCO
			Percentage of EID done	34%	60%	80%	CASCO
		Provide ART and PEP services	Percentage of people diagnosed with HIV who were linked to care services	80%	85%	>90%	CASCO
			Number of active HIV-positive clients on care and treatment	1,170	2,041	3,088	CASCO
			Percentage of health facilities offering ARV/PEP services	10%	13%	15%	CASCO
			Percentage of HIV exposed individuals requiring PEP	84%	(100%)	(100%)	CASCO

KASF Objective	CASP Results	Key Activity	Indicators	Baseline (year 2014)	Mid-Term Target	End-Term Target	Respons-ibility
Reduce new HIV infections by 75%	Prevent new HIV infection by 75%		Percentage of individuals offered PEP services	100%	100%	100%	CASCO
		Safe blood transfusion	Percentage of health workers trained on blood safety.	16%	48%	96%	NBTC
			Percentage of blood screened for HIV	100%	100%	100%	NBTC
			Number of ELIZA machine installed.	0	1	1	COH
		Health system strengthening	Percentage of health workers trained on HIV-related courses.	25%	60%	80%	COH, CDH, CASCO, NACC
			Percentage of health facilities providing HIV-integrated services	75%	83%	83%	COH/CASCO
			Percentage of health facilities implementing universal precautions to prevent HIV infections	83%	83%	83%	CASCO
		Introduction of HIV school programmes	Percentage of school-going children aged between 10 - 24 years reached with HIV information	40%	60%	80%	CASCO/ County health education officer, NACC
		Promotion of condom use	Number of condoms dispensed	38,355	60,000	100,000	CASCO , NACC
			Percentage of MARPS/ descendants reached	29%	50%	100%	CASCO , NACC

STRATEGIC DIRECTION 2 IMPROVING HEALTH OUTCOMES AND WELLNESS OF PEOPLE LIVING WITH HIV							
KASF Objective	**CASP Results**	**Key Activity**	**Indicators**	**Baseline (year 2014)**	**Mid-Term Target**	**End-Term Target**	**Respons-ibility**
Reduce AIDS-related mortality by 25%	Increased access to diagnosis and reduced risk of HIV transmission	Upgrade the County laboratory infrastructure and equip the HIV service delivery points with lab equipments and reagent	Percentage of laboratory equipment and reagents purchased for HIV	20%	50%	80%	COH, County Director Health/CASCO/ County Lab Focal Person
			Percentage of laboratories offering HIV service	10%	15%	25%	County Director Health/CASCO/ County Lab Focal Person
			No of screening and diagnostic equipment for TB, malnutrition, opportunistic infections together with those for HIV purchased	20	50	80	County Director Health/CASCO/ County Lab Focal Person
		Improve referral management system	Percentage of facility and community linked with inter- and intra-facility referral protocols and linkage strategies	60%	85%	90%	Community strategy focal person

KASF Objective	CASP Results	Key Activity	Indicators	Baseline (year 2014)	Mid-Term Target	End-Term Target	Respons-ibility
Reduce AIDS-related mortality by 25%	Improved referral management system and increased integration of services	Improve referral management system	Number of health workers, community health workers and volunteers trained on HIV referral	0	100	200	Community Strategy coordinator, CASCO, SCACC
		Increase retention on ART	Percentage of people diagnosed HIV positive linked to care within 3 months	85%	90%	100%	Community Strategy coordinator, CASCO, SCACC, SCASCO
			Percentage of people living with HIV (PLHIV) receiving HIV care services	12%	40%	60%	CASCO, NACC
			Number and percentage of adults and children enrolled in HIV care and eligible for cotrimoxazole prophylaxis currently receiving cotrimoxazole	73% (240)	85%	90%	CASCO
			Number and Percentage of eligible clients newly initiated on highly active ART in the last 12 months	72% (251)	85%	90%	CASCO
			Percentage of adults and children currently receiving ART among all eligible people living with HIV (using national criteria)	72%	85%	90%	CASCO
	Increased retention on ART		Percentage of TB/HIV co-infected clients who are receiving ARTs	71%	85%	90%	CASCO
			Percentage of HIV patients screened for TB	87%	93%	100%	CASCO
			Percentage of adults and children with HIV known to be on treatment 12 months after initiation of anti-retroviral therapy (24 months, 36 months, 60 months)	84%	90%	>90%	CASCO
			Percentage of ART patients with undetectable viral load at 12 months after initiation of ART	0%	4%	12%	CASCO
			Percentage of people on ART tested for viral load who have a suppressed viral load in the reporting period	20%	60%	80%	CASCO

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							
KASF Objective	**CASP Results**	**Key Activity**	**Indicators**	**Baseline (year 2014)**	**Mid-Term Target**	**End-Term Target**	**Respons-ibility**
Reduce HIV-related stigma and discrimi-nation by 50%	Reduced self and social HIV related stigma and discrimination by 50% and increase protection of human rights	Sensitise law and policy makers on the need to enact laws, regulations and policies that prohibit discrimination and support access to HIV prevention, treatment, care and support	Percentage of PLHIV who self-reported that they experienced discrimination and/or stigma due to their HIV status	60%	60%	80%	CHC, NACC
			Percentage of women and men ages 15 – 49 expressing accepting attitudes towards people living with HIV	20%	60%	80%	CHC
			Percentage of ever married or partnered women and men ages 15 – 49 who experienced sexual and/ or gender-based violence	60%	40%	20%	CHC
			Percentage of young people aged 15–24 who experienced sexual and/or gender-based violence	60%	60%	0%	MoE
			Percentage of PLHIV who experienced sexual and/or gender-based violence	80%	30%	0%	OPAHA, NEPHAK
			Percentage of PLHIV ages 15 – 49 who experienced sexual and/ or gender-based violence	80%	30%	0%	OPAHA, NEPHAK
			Number of laws, regulations, and policies reviewed or enacted at county level that impact reporting on the HIV response positively	0	1	1	CEC – Health, County Assembly House Committee on Health, NACC

STRATEGIC DIRECTION 4: STRENGTHENING INTEGRATION OF HEALTH AND COMMUNITY SYSTEMS							
KASF Objective	**CASP Results**	**Key Activity**	**Indicators**	**Baseline (year 2014)**	**Mid-Term Target**	**End-Term Target**	**Respons-ibility**
Improve health workforce for HIV response at all levels by 40% Increase number of health facilities ready to provide KEPH-defined HIV services	Improved capacities, motivation and adequacy of health care workers	Promote and support innovative in-service learning approaches for health workers	Percentage of health workers who have received in- service HIV training	50%	70%	80%	NASCOP/ CASCO
		Advocate to prioritize rural health workers career advancement, giving promotion preference to those who have performed extended rural service	Percentage of health workers who have progressed from one education level to the other	20%	30%	40%	Chief officer - Health
		Improve linkages between the community and service providers	Percentage of community units established and operationalized	34%	85%	100%	County CU focal person
		Implement community health strategy	Percentage of community units implementing AIDS competency guidelines	34%	85%	100%	County CU focal person, NACC
	Improved linkages between the community and service providers		Percentage of Community Health Units given training on HIV module	34%	85%	100%	County CU focal person, NACC
			Number of Community Health Workers reporting on HIV programmes	1,020	2,550	3,000	County CU focal person, SCACC

STRATEGIC DIRECTION 5: STRENGTHENING RESEARCH AND INNOVATION TO INFORM THE KASF GOALS							
KASF Objective	**CASP Results**	**Key Activity**	**Indicators**	**Baseline (year 2014)**	**Mid-Term Target**	**End-Term Target**	**Respons-ibility**
Increase evidence-based planning, programming and policy changes by 50% Increase capacity to conduct HIV research at country and county levels by 10% Increase evidence-based planning programming and policy changes	Increased evidence-based planning, programming and policy changes by 25%	Conduct operational population-based sero-prevalence studies/ research on behaviour change, care and support, condom use	Number of prioritized biomedical and behavioural researches conducted	0	1	3	NASCOP/ NACC/CASCO
			Number of people trained in HIV-related research	0	10	50	NASCOP/ NACC/CASCO
			Proportion of research reports available to public	0	1/1	2/3	NASCOP/ NACC/CASCO
		Implement community health strategy	Number of research findings disseminated to inform policy, planning and programme	2	4	8	NASCOP/ NACC/CASCO
	Increased capacity to conduct HIV research at county level	Disseminate HIV research findings to all the stakeholders in the sub-counties.	Number of research findings disseminated to inform policy, planning and programme	2	4	8	NASCOP/ NACC/CASCO
	Increased evidence based planning, programming and policy changes	Use data for decision making	Number of joint planning meetings on HIV/AIDs research conducted at county level	0	2	4	NASCOP/ NACC/CASCO
		Initiate joint planning, monitoring and evaluation of HIV/AIDs research	Number of joint M&E activities on HIV/AIDs research conducted at county level	0	2	4	NASCOP/ NACC/CASCO
		Strengthen coordination and collaboration on HIV/AIDS research among related sectors	Number of stakeholders meetings/workshops on HIV/AIDS research held	0	2	4	NASCOP/ NACC/CASCO

STRATEGIC DIRECTION 6: PROMOTING UTILIZATION OF STRATEGIC INFORMATION FOR RESEARCH AND MONITORING AND EVALUATION (M&E) TO ENHANCE PROGRAMMING							
KASF Objective	**CASP Results**	**Key Activity**	**Indicators**	**Baseline (year 2014)**	**Mid-Term Target**	**End-Term Target**	**Respons-ibility**
Increase availability of strategic information to inform HIV response at national and county levels	Improved access to strategic information	Develop county M & E framework in line with national government.	Number of M & E framework developed in line with national government.	0	1	1	CASP M&E Committee, CASCO, NAC
		Quarterly meeting by KASF monitoring committee on feedback provision	Percentage of KASF reports disseminated at county levels	0%	80%	100%	CASP M&E Committee, CASCO, NACC
			Percentage of sub counties submitting timely, complete, and accurate reports based on targets set in the HIV Plan.	41%	60%	80%	CASP M&E Committee, CASCO, NACC, SCACC

STRATEGIC DIRECTION 7: INCREASING DOMESTIC FINANCING FOR A SUSTAINABLE HIV RESPONSE							
KASF Objective	**CASP Results**	**Key Activity**	**Indicators**	**Baseline (year 2014)**	**Mid-Term Target**	**End-Term Target**	**Respons-ibility**
Increase domestic financing of HIV response to 50%	Result to be defined after costing of strategy	Mobilize resources from the county government.	Percentage of County government funding out of the total for the HIV response	0%	1%	2%	Office the Governor, CEC-Health, COH
			Percentage of HIV domestic funding coming from the public sector	0%	1%	1%	Office the Governor, CEC-Health, COH
		Facilitate the private sector response to HIV through collaboration agreements for support for testing kits, data collection and support supervision	Percentage of HIV domestic funding coming from private sector, including households	0%	1%	1%	Office the Governor, CEC-Health, COH
		Review the county sectorial plans to determine the opportunity available and lobby for inclusion.	Number of county sectorial plans reviewed.	1	4	9	CASP M&E Committee, NACC

KASF Objective	CASP Results	Key Activity	Indicators	Baseline (year 2014)	Mid-Term Target	End-Term Target	Respons-ibility
Increase domestic financing of HIV response to 50%	Result to be defined after costing of strategy	Develop a funding dashboard detailing all funds incoming to the County on HIV utilization	Number of county sectorial plans with HIV/ AIDS activities included.	1	1	1	CASP M&E Committee, NACC, County Secretary
		Hold high level meetings with policy makers to advocate for utilization of health facilities funds for specific HIV activities	Proportion of funds allocated to the CASP strategic direction by the partners.	0	1/8	3/8	CASP M&E Committee, NACC,
			Number of high level meetings held with the policy makers.	1	4	4	Office of the Governor, NACC, CEC-Health, COH, CDH

STRATEGIC DIRECTION 8: PROMOTING ACCOUNTABLE LEADERSHIP FOR DELIVERY OF THE KASF RESULTS BY ALL SECTORS AND ACTORS							
KASF Objective	**CASP Results**	**Key Activity**	**Indicators**	**Baseline (year 2014)**	**Mid-Term Target**	**End-Term Target**	**Respons-ibility**
Effective and well-functioning stakeholder coordination and accountability mechanisms in place and fully operationalized at county level	Effective and functional structures	Establish and operationalize the County HIV coordination committee	HIV coordination committee established and operational	0	1	1	CEC – Health NACC/ CASCO
		Mobilize political and policy level support targeting County leadership; Governor, MPs, MCAs, First Lady	Number of meetings held to mobilize support on HIV activities	2	4	4	CEC - Health, NACC/ CASCO/COH
		Lobby and monitor the development and operationalization of legislative and policy on HIV and AIDS in the County	Number of planned policy, legal and guidelines developed or reviewed	0	1	1	CEC-Health, NACC
		Develop programmatic and financial reporting systems for presentation to the CHC , Governor and County Assembly	Number of reports on programmatic and financial reports submitted.	0	4	8	NACC/ CASCO

Annex 2: Resource needs

Resource requirements for the Garissa County's response to HIV and AIDS include human, financial, and infrastructure resources.

i. Human resources

"Human resources" are the staff required for programme planning, implementation, and management as well as staff for monitoring and evaluation at all levels and in every participating/ partner institution. Each programme which is planned, carried out, monitored and evaluated has distinct human resource needs which vary in skill, knowledge, and number from programme to programme. To ensure efficient use of resources, each programme determines its minimum staff requirements. Programme development, in turn, builds these human resource needs into programme plans.

Every person has the potential to realize his/her role as an adaptive, transformative and social being, who is capable of managing his/herself to achieve a full, balanced and sustainable life. In view of this, human resources should be prepared through a planned work-related programme. In addition to effective competency-based staff recruitment and placement, a good personnel plan includes regular opportunities for capacity building, a clear career path, a competitive standard of compensation, as well as establishment and maintenance of a good working environment.

Specifically, in connection with human resource management related to HIV and AIDS, serious attention must be given to gender equality, meaningful involvement of people living with HIV, as well as appropriateness of personnel management and development of staff knowledge (social and technical) about the field of HIV and AIDS.

ii. Financial resources

The implementation of 2015/16 – 2018/19 County AIDS Strategic Plan will require significant financial resources. Funding sources for the AIDS programme include national and local (County) budgets, private sector, community institutions, as well as international partners. Contributions of importance are not limited to financial resource. The monetary value of in-kind contributions can also be quantified and counted as financial contribution.

For example, a community-based activity may provide personnel or facilities for an activity either of which, if purchased, would be of significant expenses. National and international private sector bodies can join in the response by implementing AIDS programmes of benefit to the County or can contribute to community effort as an activity in their corporate social responsibility programme.

iii. Commodities and infrastructure

Commodities and infrastructure include (1) service sites, (2) supplies and materials for prevention, (3) supplies and materials for surveillance, (4) supplies and materials for care, support and treatment, (5) materials for information, education, communication, as well as other supplies and materials to support the AIDS response.

Overall, Garissa County will require the following amounts in financing the response to HIV and AIDS within the period 2015-2019. This is as per the County HIV Resource need costing tool (NACC).

Resource Needs (Millions of Kenyan Shillings)					
	2015	**2016**	**2017**	**2018**	**2019**
ART	KSh42	KSh52	KSh63	KSh73	KSh84
PMTCT	KSh0	KSh0	KSh0	KSh0	KSh1
HTC	KSh18	KSh22	KSh26	KSh30	KSh35
VMMC	KSh1	KSh1	KSh1	KSh1	KSh1
Condoms	KSh1	KSh5	KSh6	KSh6	KSh7
Key populations	KSh1	KSh1	KSh1	KSh2	KSh2
Behavior change	KSh17	KSh21	KSh25	KSh30	KSh34
Medical services	KSh0	KSh0	KSh0	KSh0	KSh0
OVC	KSh15	KSh17	KSh17	KSh17	KSh17
Program support	KSh15	KSh19	KSh22	KSh25	KSh28
Total	**KSh110**	**KSh138**	**KSh161**	**KSh185**	**KSh209**

Annex 3: References

1. Kenya Demographic Health Survey 2014
2. Monitoring and Evaluation
3. HIV and AIDS in Kenya 2014 Factsheet
4. HIV Estimates 2014
5. Kenya AIDS Indicator Survey 2012
6. Kenya AIDS Strategic Framework
7. Kenya HIV County Profiles
8. Kenya Vision 2030
9. Kenya National AIDS spending assessment report for the financial years 2009/10 – 2011/12
10. Kenya HIV Prevention Revolution Roadmap
11. National HIV and AIDS Monitoring, Evaluation and Research Framework 2009/10 – 2012/13
12. The Constitution of Kenya 2010
13. Kenya HIV and AIDS Research Agenda
14. County Integrated Development Plan

Annex 4: List of Drafting and Technical Review Teams

County Drafting Team

1.	Anthony Njuguna	– Sub-county Health Records and Information, Garissa Sub-county
2.	Aden Hussein	– Sub-county Public Health Nurse, Garissa Sub-county
3.	Benard Kirui	– Health Records and Information, Garissa County
4.	Noor Sheikh	– County Aids and STI Control Officer, Garissa County
5.	Romano Noor	– SIMAHO
6.	Antony Njoroge	– SIMAHO
7.	Ibrahim Mohamed	– Garissa County Interim HIV and AIDS Coordinator
8.	Sahara Aden	– Garissa County Nursing Officer/ Deputy CASCO
9.	Mohamed Omar	– Dadaab CACC Coordinator
10.	Alex Kiilu	– Economic Planning

Technical Review Team

1.	Mwanjama Omari	– Regional HIV Coordinator, NACC
2.	Rohin Onyango	– Research, M&E Expert, Africa Capacity Alliance (ACA)
3.	Daniel Mwisunji	– Programme Cordinator, ACA
4.	Hannington Onyango	– Programme Officer, NACC

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