KIRINYAGA COUNTY
HIV AND AIDS STRATEGIC PLAN

2014/2015 - 2018/2019

"Re-orienting HIV Response in a Devolved System of Government"

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National AIDS Control Council

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Acronyms and Abbreviations

ACSM	Advocacy, Communication and Social Mobilization
AIDS	Acquired Immuno Deficiency Syndrome
ART	Antiretroviral Treatment
BCC	Behaviour Change Communication
CASCO	County AIDS/STI Coordinator
CEC	County Executive Committee
CCC	Comprehensive Care Centre
CBO	Community Based Organisations
CDH	County Director for Health
CEC	County Executive Committee
CHMT	County Health Management Team
CHV	County Health Volunteers
CHVPE	County Health Volunteers Peer Educators
COBPAR	Community Based Program Activity Report
CRISSP	Central Kenya Region Response Intergration Strengthening and Sastainability Project
CSO	Civil Society Organizations
CU	Community Units
DIC	Drop In Centres
DHIS	District Health Information System
ECD	Early Childhood Development
eMTCT	Elimination of Mother to Child Transmission
FBO	Faith Based Organizations
FSW	Female Sex Workers
HCBC	Home and Community Based Care
HIV	Human Immuno-deficiency Virus
HIPORS	HIV Partner Reporting Online System
HPV	Human Papilloma Virus
HRBA	Human Rights Based Approach
HTS	HIV Testing Services
ICC	Inter-coordinating Committee
INGO	International Non-Governmental Organisation
IPD	In Patient Department
KAIS	Kenya AIDS Indicator Survey
KASF	Kenya AIDS Strategic Framework
KCASP	Kirinyaga County AIDS Strategic Plan
KCIDP	Kirinyaga County Integrated Development Plan
KHSSIP	Kirinyaga Health Sector Strategic and Investment Plan
KNASA	Kenya National AIDS Spending Assesment
KNBS	Kenya National Bureau of Statistics
M&E	Monitoring and evaluation
MARPS	Most at Risk Populations
MCA	Member of the County Assembly
MSM	Men having Sex with Men
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Program
NEPHAK	National Empowerment Network of People Living With HIV and AIDS in Kenya
NGOs	Non-Governmental Organizations
OPD	Out Patient Department

PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV
PPP	Public Private Partnership
PWD	People With Disability
PrEP	Pre Exposure Prophylaxis
RRI	Rapid Result Initiative
SCACC	Sub- County AIDS Control Committee
SDP	Service Delivery Point
STI	Sexually Transmitted Infections
TB	Tuberculosis
TOWA	Total War against HIV and AIDS
TWG	Technical Working Group
UON	University Of Nairobi
VCT	Voluntary Counselling and Testing
WAD	World AIDS Day

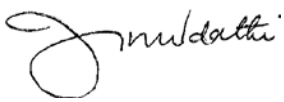
Foreword

Kirinyaga County is one of the 47 counties created through the devolved system of government by the constitution of Kenya 2010. The County, comprising of urban and rural populations, is ranked among the twenty nine medium HIV prevalence counties with a prevalence of 3.3%.[1] Although there is a notable decline in this prevalence, HIV continues to be a threat to health and overall development of the County. It remains one of the leading cause of mortality and morbidity[2] in the County hence the need for concerted efforts in reversing the trend.

The development of this Kirinyaga County HIV and AIDS Strategic Plan 2014/2015 – 2018/2019 demonstrates the County government's commitment in controlling the scourge. This strategic plan is aligned to the recently launched Kenya AIDS Strategic Framework 2014/2015 – 2018/2019, the Kenya HIV Prevention Roadmap and the Kirinyaga County Health Sector Strategic and Investment Plan. It is my sincere hope that through its implementation it will contribute to the recently endorsed Global Sustainable Development Goals.

In this regard, therefore, my Government is committed to facilitating achievement of the results articulated in this strategic plan through increasing domestic financing that includes enhancing private public partnership and in consultation with the County Assembly review the relevant by-laws to raise funds locally. HIV and AIDS will be a performance contracting indicator in the delivery of county services across sectors in the spirit of multi-sector response. Responding to HIV and AIDS will continue being a part of the County's planning and budgeting process through the County integrated Planning (CIDP) and the related County Medium Term Expenditure Framework (MTEF) budgeting process.

In so doing we will leverage on the achievements so far and continue to foster a unity of purpose and steer a multi-sector approach while engaging the local community towards making Kirinyaga a County Free of HIV and AIDS in the near future. I finally wish to reaffirm the County Government's commitment to its role in ensuring good health of its people.



H.E. Joseph Ndathi,
Governor

1 Kenya AIDS Strategic Framework 2014/2015- 2018/2019

2 Kirinyaga Health Sector Strategic and Investment plan 2014-2018

Preface

The Kirinyaga County HIV and AIDS strategic plan (KCASP) is the latest move by the County Department of Health Services with support from partners, as guided by National AIDS Control Council (NACC) to provide a strategic direction for the implementation and coordination of HIV and AIDS response in the County.

In developing the County HIV and AIDS strategic plan, the County relied on the Kenya AIDS Strategic Framework (KASF), Kirinyaga County Health Sector Strategic and Investment Plan (KHSSIP). In addition, it developed its structure in line with the devolved system of government by giving the County Government under the leadership of the Governor greater ownership and coordination in the control of HIV.

The strategic plan provides direction on the implementation, coordination and monitoring of HIV prevention, care and treatment services in Kirinyaga County. The KCASP's vision is "A County free of new HIV infections, stigma, discrimination and AIDS related deaths" with an overall goal to contribute to the KHSSIP objective of eliminating communicable condition through universal access to comprehensive HIV prevention, treatment and care.

Guided by the KASF the County has outlined its objectives as follows:

1. Reduce new HIV infections by 30%
2. Reduce AIDS related mortality by 10%
3. Reduce HIV related stigma and discrimination by 20%
4. Increase domestic financing of the HIV response to 10%

As a County we look forward to the engagement and contribution of all stakeholders: donors, development partners, INGOs, NGOs, Faith Based Organizations, private institutions and the community at large for technical, materials and financial support. This will enhance achievement of County specific, National and Global commitments. I seek to emphasize the need for continuous dialogue which will be key toward achieving this commitment

Ephraim Wambu Miano,
County Executive Committee Member for Health

Acknowledgement

We wish to acknowledge the contributions of various stakeholders and organizations whose passion, efforts, intellectual finesse and exceptional dedication put together this valuable document for Kirinyaga County.

The Kirinyaga County Government led by His Excellency the Governor Joseph Ndathi provided the opportunity, material support and overall support that kept the team focussed and working. We appreciate the County Executive Committee Member for Health; Ephraim Wambu Miano for his participation and contribution and especially for the support of the orientation meeting for the County and Sub-County health managers held at Nice Digital hotel, Mwea.

Their support to attend in person and providing leadership demonstrates their commitment towards realising the objectives of the HIV strategic plan.

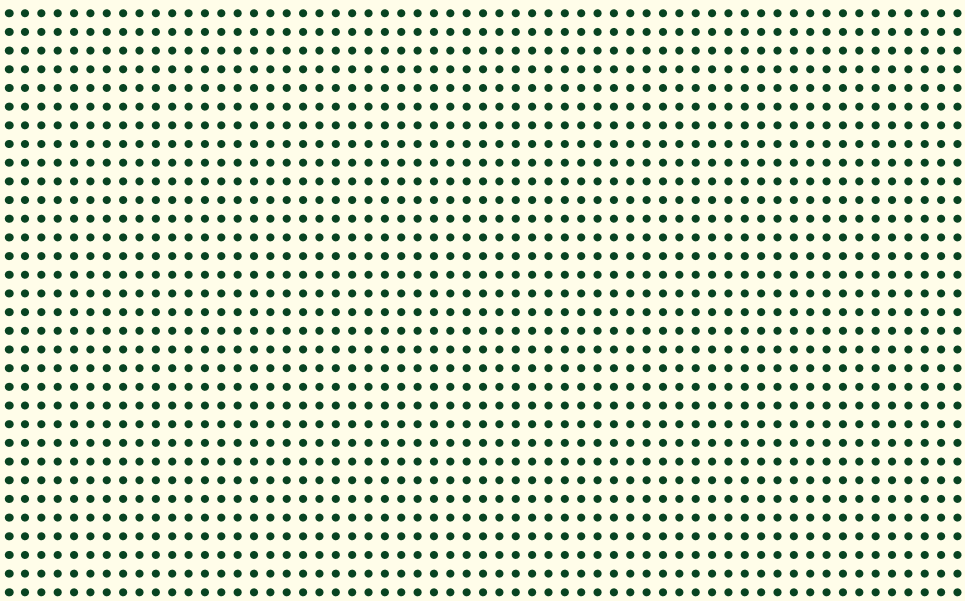
Thanks to the National AIDS Control Council for initiating the process of developing the Kirinyaga County AIDS strategic plan (KCASP) development through a multisector approach which commenced during the stakeholders KASF dissemination/roll out meeting on 19th-20th August 2015 in Thika. This was followed by a retreat for the technical team held from 21st March to 1st April 2016 in Kerugoya. The team came up with the zero draft copy of the KCASP.

Our gratitude goes to CRISSP/UON and the NACC Regional office for their technical support, and the drafting team for their dedication and selfless commitment through the process. We also acknowledge the National AIDS Control Council for their support in reviewing, editing and printing the document.

Dr. Esbon Gakuo
County Director of Health

01.

BACKGROUND OF THE COUNTY



BACKGROUND OF THE COUNTY

1.1: Geographical location

Kirinyaga County is one of the 47 Counties created under the Kenya constitution (2010). It is located between latitudes 0°1' and 0° 40' South and longitudes 37° and 38° East. It borders Embu County to the East and South, Murang'a County to the West and Nyeri to the north-west. It covers an area of 1,479.1Km^2 most of which lies on the southern slope of Mount Kenya, while the southern part (Mwea) are plains that are part of the Tana River basin. The County lies between 1,158 metres and 5,380 metres above sea level in the South and at the Peak of Mt. Kenya respectively. Mt. Kenya which lies on the northern side greatly influences the landscape of the County as well as other topographical features. The snow melting from the mountain forms the water tower for the rivers that drain in the County and other areas that lie south and west of the County.

1.2: Ecological Conditions

The County can be divided into three ecological zones; the lowland areas that fall between 1158 - 2000 metres above sea level, the midland areas that lie between 2000 - 3400 metres above sea level and the highland comprising areas falling between 3400 - 5380 metres above sea level. The lowland area is characterised by gentle rolling plains that cover most of Mwea constituency. The midland area includes Ndia, Gichugu and Kirinyaga Central constituencies. The highland area covers the upper areas of Ndia, Gichugu and Central constituencies and the whole of the mountain area.

The County is well endowed with a thick, indigenous forest covering 350.7 Km^2 and is inhabited by a variety of wildlife including elephants, buffaloes, monkeys, bushbucks and colourful birds while the lower parts of the forest zone provides grazing land for livestock. The rich flora and fauna within the forest coupled with mountain climbing are a great potential for tourist activities. The County has six major rivers namely; Sagana, Nyamindi, Rupingazi, Thiba, Rwamuthambi and Ragati, all of which drain into the Tana River. The water from these rivers has been harnessed through canals to support irrigation at the lower zones of the County especially in Mwea and also for domestic use through various water supply schemes.

Figure 1.1: Map of Kenya indicating location of Kirinyaga County

Source: KCIDP

1.3: Administrative and political units

Administratively, the County has 5 sub counties; Kirinyaga Central, Kirinyaga East, Kirinyaga West, Kirinyaga South and Mwea West (Kirinyaga North). The County has four constituencies and twenty wards.

Table 1.1: County Constituencies and Administrative Units

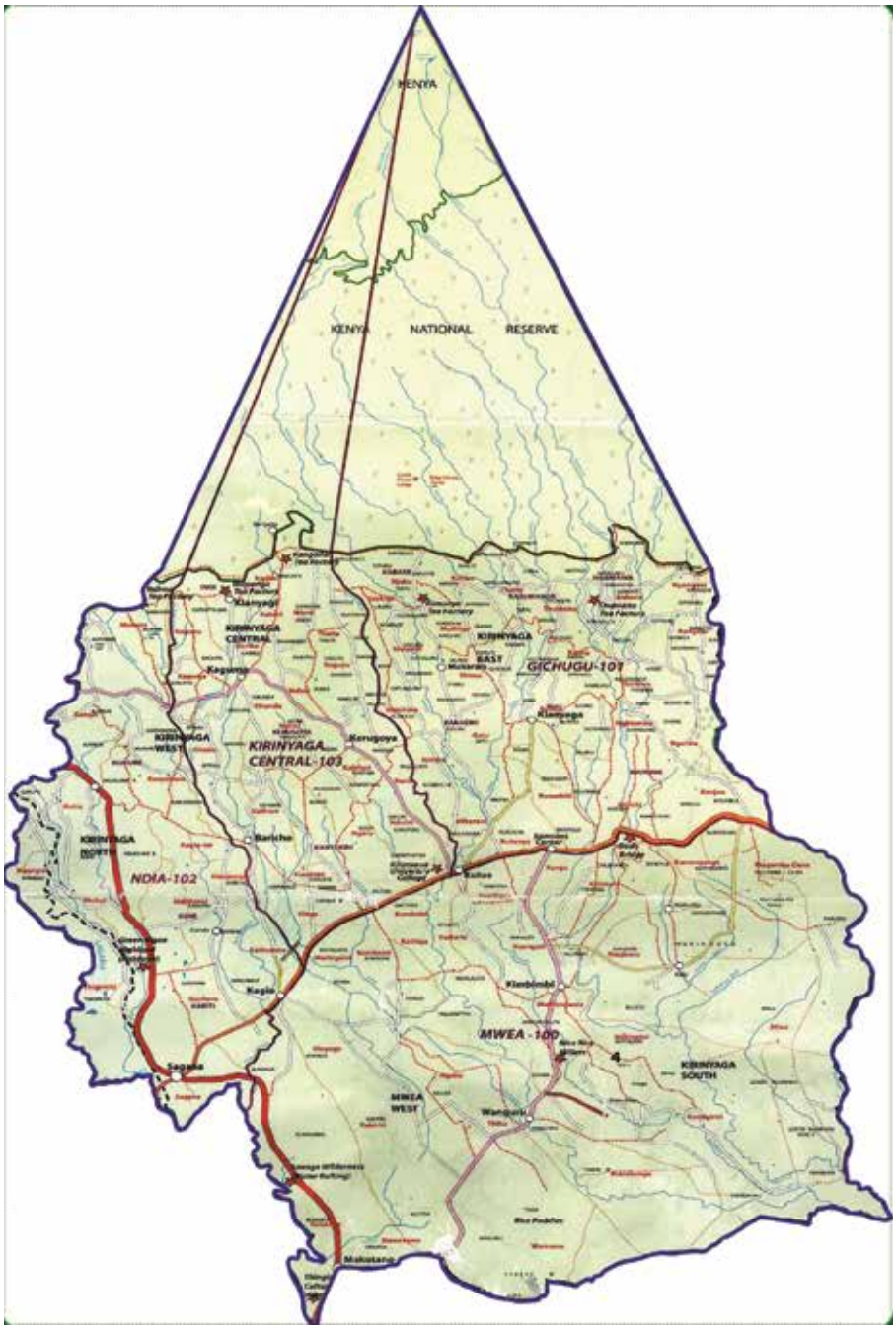
District	Area (km^2)	No. of Divisions	No. of Locations	No. of Sub-Locations
Kirinyaga West	211.3	3	8	16
Kirinyaga Central	173.6	3	5	18
Kirinyaga East	229.7	3	10	27
Mwea East	512.8	1	5	16
Mwea West	204	2	2	4
Forest Area	308.2	-	-	-
Total	**1435.6**	**12**	**30**	**81**

Source: *KCIDP*

1.4: Demographic features

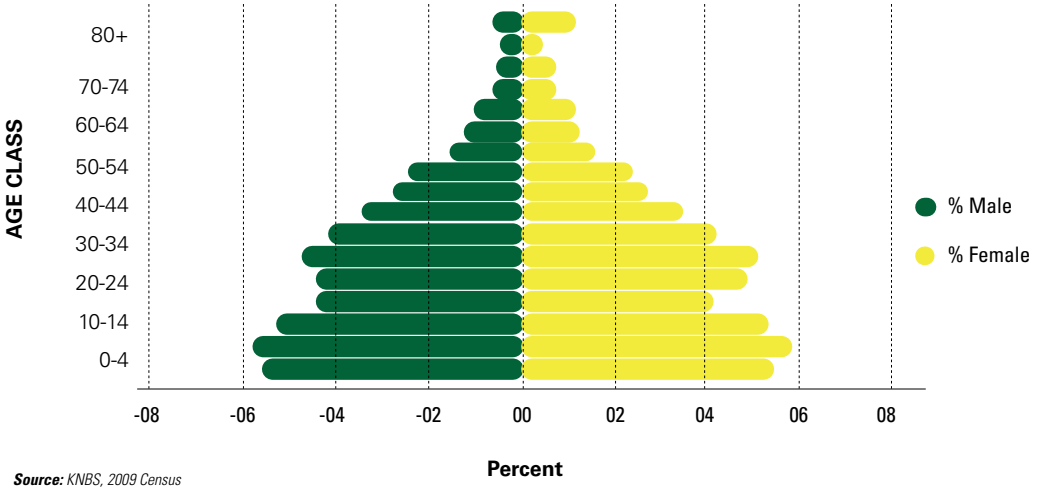
According to the Kenya Population and Housing Census 2009 report, Kirinyaga County had a population of 528,054 persons. This comprised of 260,630 males and 267,424 female. While 60.8 percent of the population was below the age of 30 years, 37.1 percent of them were below the age of 10 years. This indicates the importance of investing in their education and growth of the County to ensure availability of jobs.

Figure 1.2: Wards in the County



Source: *KCIDP*

Figure 1.3: Percentage population distribution across different age groups (2014 estimates)



Source: *KNBS, 2009 Census*

As a result of declining fertility rates among women, as shown by the highest percentage household size of 0-3 members at 55%, Kirinyaga County has a transitional population structure where the number of 0-14 year olds, constituting 33% of the total population, is declining and working age population of 15-64 year olds, constituting of 62% of the total population, is increasing.

Table 1.2: Population projection

Description		Population Estimates	Projected Population				
			2013	2014	2015	2016	2017
1	Total population		562,954	572034	581,260	590,635	600,161
2	Total Number of Households	3.4	165,575	168245	170959	173716	176518
3	Children under 1 year	2.29%	12,894	13102	13314	13528	13747
4	Children under 5 years	10.98%	61,826	62823	63836	64866	65912
5	Under 15 year population	33.16%	186,685	189695	192755	195864	199023
6	Women of child bearing age (15 – 49 Years)	26.92%	151,547	153991	156475	158999	161563
7	Estimated Number of Pregnant Women	2.29%	12,894	13102	13314	13528	13747
8	Estimated Number of Deliveries	2.29%	12,894	13102	13314	13528	13747
9	Estimated Live Births	2.29%	12,894	13102	13314	13528	13747
10	Total number of Adolescent (15-24)	17.9	100,792	102417	121973	105679	107453
11	Adults (25-59)	41.4	232,850	236606	281784	244141	248240
12	Elderly (60+)	7.6	42,628	43,315	51586	44695	45445

Data Source: *Projection from the Kenya Population Census, KBS. 2009.*

Kerugoya, Sagana and Wang'uru are the only towns in the County while Kagio and Kagumo comprise the urban centres. Wang'uru town has the highest population of 18,437; followed by Kerugoya (17,122) while Sagana is the least populated town with a population of 10,344. In the urban centres, Kagio has the highest population (3,512) while Kagumo has a population of 3,489.

The population of Wang'uru is highest because it has a lot of economic activities, mainly rice farming while Kerugoya town had long been the District administrative headquarters.

By sub-counties, Kirinyaga Central has the highest population while Kirinyaga North has the lowest.

Table 1.3: Kirinyaga population by sub-counties

No.	Sub County Units	Population				
		2009	2015	2016	2017	2018
1	Kirinyaga East	130,243	143,366	145,678	148,028	150,416
2	Kirinyaga West	99,515	109,542	111,309	113,104	114,928
3	Kirinyaga South	97,677	107,519	109,253	111,015	112,806
4	Kirinyaga North	87,267	96,057	97,606	99,190	100,780
5	Kirinyaga Central	113,355	124,776	126,89	128,834	130,912
	Total	**528,054**	**581,260**	**590,635**	**600,161**	**609,842**

***Data Source**: Projection from the Kenya Population Census, KBS. 2009.*

1.5: Economic conditions

Due to its well distributed rainfall and major rivers, the main economic activities in Kirinyaga County are agriculture-based and include rice farming, small scale tea farming, coffee farming, dairy farming and horticulture.

Tea is grown in Kirinyaga Central and Gichugu, and upper Ndia including the Nyayo tea zones. Rice is grown in lower Mwea. Under horticulture, farmers grow capsicum, tomatoes, french beans and cabbages much of which is sold in other markets like Nyeri, Muranga and Nairobi. Quarrying is also a key source of livelihood in the County especially in Kwavi around Sagana. Others include tree logging and charcoal burning.

1.6: Health situations

There are 202 health facilities in the County with a total bed capacity of 764 comprising of 109 public health institutions, 39 mission/ NGO institutions the largest one being Mwea Mission hospital and 54 private clinics. There are 3 level four facilities located in Kirinyaga Central, Gichugu and Mwea Constituencies. In addition there is one private hospital namely Mt. Kenya hospital located in Kerugoya town. In addition to these, there are 10 level three facilities, 45 level two facilities and 51 level one facilities which are spread all over the County. The doctor to population ratio is 1:36,339 and the average distance to the nearest health facility is 5 Km.

Table 1.4: Kirinyaga County Health Facilities Inventory (2015)

	Sub-County/ County	Hospitals					Primary Care HFs				
		Public	FBO	NGO	Private	Total Hospitals	Public	FBO	NGO	Private Nursing/ maternity homes	Private Clinics
1.	Kirinyaga Central	1	1	0	1	3	9	9	1	2	30
2.	Kirinyaga East	1	0	0	0	1	9	11	4	1	16
3.	Kirinyaga North	0	1	0	0	1	9	2	0	1	12
4.	Kirinyaga South	1	0	0	1	2	13	4	5	1	26
5.	Kirinyaga West	1	0	0	0	1	14	7	3	1	29
	Grand Total	**4**	**2**	**0**	**1**	**8**	**54**	**33**	**13**	**6**	**113**

***Source**: KCIDP*

Morbidity

The most prevalent diseases in the County are: flu at 38 percent, respiratory diseases at 36.9 percent, malaria at 21.6 percent, diarrhoea at 6 percent, and stomach ache at 2 percent. Malaria is however on an upward trend mostly due to stagnant water in the rice fields at Mwea irrigation scheme.

1.7: Education and Literacy levels.

The County has 348 ECD centres, 326 primary schools, 143 secondary schools and 29 tertiary institutions. There are 14,672 registered pupils in pre-school, 111,400 pupils in primary schools and 39,988 students in secondary schools. The teacher pupil ratio for Pre – school is 1:41, and 1:38 and 1:29 for Primary school and Secondary schools respectively.

The County has one public University (Kirinyaga University College) and one Private University namely TESCO College. There are 2 public colleges (AHITI Ndomba and Kamweti ATC), 11 Youth polytechnics (YP), 5 accredited colleges and 8 private non-accredited colleges.

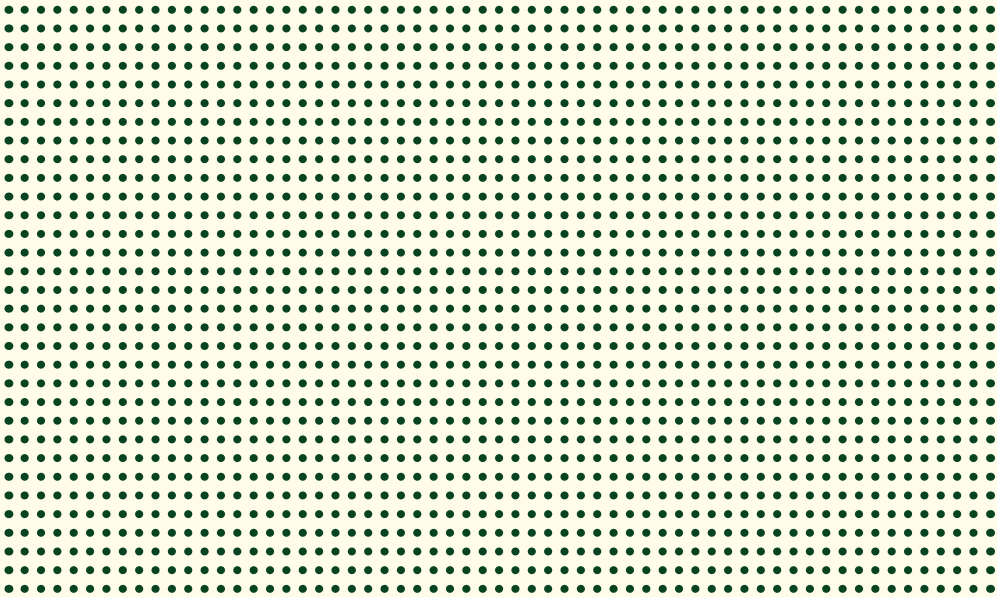
1.8: Infrastructural conditions

The total road network in the County is 1,109.11 Km, out of which 106.5 Km is bitumen, 462.05 Km is gravel and 540.5 Km is earth surfaced roads. The County has an established road network with 7 tarmac roads passing through it namely Makutano – Embu road, Kutus – Karatina road, Baricho road, Kiburu road, Kutus – Sagana road, Kutus – Kianyaga road and Kabare – Kimunye road. There is only a 5km of railway line and one railway station in the County though not in use. There is one airstrip located in Mwea constituency.

The mobile phone coverage stands at 99 percent while the number of fixed lines stands at 693 units. There are 5 sub- post offices and 14 cyber-cafes. There is also an increase in the usage of computers and internet in government offices, private businesses and homes due to availability portable modems and affordability of computers and laptops.

02.

SITUATION ANALYSIS



SITUATION ANALYSIS

Like any other County in Kenya, Kirinyaga County continues to face many challenges as a result of HIV and AIDS. According to the Kenya HIV County profile 2014, Kirinyaga County is classified as a medium HIV burden County with a prevalence rate of 3.3%. The male and female prevalence is 1.7% per cent and 4.8% per cent respectively. There are a total of 12,654 people living with HIV, of which 11,500 are adults and 1,154 are children. New annual adult infections in the County are estimated at 795 persons. HIV and AIDS mortality in the County was at 327 in adults and 49 for children in 2013. This has resulted is increasing number of widows, widowers and orphans. Of the total adults in need of ART (9,315), about 81% are currently receiving it. For the children, only 58 % of those in need are currently receiving the drugs. This calls for increased identification and ART provision to reduce AIDS related mortality.

Table 2.1: HIV and AIDS situation in Kirinyaga County

HIV adult prevalence	3.3%
Number of adults living with HIV	11500
Number of children living with HIV	1152
Adults in need of ART	9315
Adult receiving ART	7550
% Coverage on ART	81%
National ART coverage	79%
HIV and AIDS related mortality (2014)	327
Children in need of ART	1039
Children receiving ART	608
National ART coverage	42%
HIV and AIDS related mortality (2013)	49

***Sources**: Kenya HIV County Profiles 2014*

2.1: Priority populations for HIV in Kirinyaga County

As defined in KASF, priority population include the key population and the vulnerable population as discussed below.

(i) Key populations: They are considered as people who engage in risky sexual behaviour. Kirinyaga County has identified the following groups as key population: female sex workers (FSWs), Men having sex with Men (MSMs) and persons who inject drugs (PWID). These are explained as follows;

Table 2.2: Key populations

Female Sex Workers (FSW)	FSW exist in Kirinyaga and especially in the urban centres. Most are engaged in employment, business or on the farms but often engage in sex work to boost their income. Due to stigma, some pose as just customers in clubs while others engage in the vice in towns away from where they live. They go in the evening and return home early in the morning to avoid being discovered. Further, they don't use the traditional way where they wait for their "customers" on the streets but rather use their phones to arrange for their meetings. Their clients cut across the sectors but mostly involve those living away from spouses including the police, civil servants, business people etc.
Men who have Sex with Men (MSM)	This group of the population is known to exist in Kirinyaga County. They have however not come out in the public due to the stigma associated with it. There is one clinic in Mwea town that caters for this group only. It is known to have many clients most of them visiting at night. There are mobile facilities in other towns indicating their presence.
People who inject drugs (PWID)	There is increasing usage of drugs in the County mostly happening in schools and universities. While this information is not documented, there have been reported cases of persons injecting drugs

(ii) Vulnerable populations: This comprises of persons whose social context increases their vulnerability to HIV risks. The following

groups are identified as vulnerable groups in Kirinyaga County: Adolescents 10 – 24 years, truck drivers, PLWHIV, pregnant women and children living with HIV, persons in prison settings, Orphans, Street children and People With Disability.

Table 2.3: Vulnerable population

People with Disabilities (PWD)	PWD are especially vulnerable since they may be unable to protect themselves from rape or sexual exploitation. They lack access to HIV Information.
Truck drivers, Loaders, Brokers taxi drivers	As an agricultural County, many trucks visit the area to buy agricultural products on a daily basis. Brokers go around the farms identifying farmers with crops for harvesting or buying awaiting loading mostly at night. A number of them seek the services of sex workers.
OVCs	The County is a home to over 12,652 OVCs with an estimated 4,590 of them in child labour. They are at risk of missing on education opportunities as well as exploitation, including sexually by their guardians.
Street children	The number of street children is increasing within the towns in Kirinyaga. While some children come to the street during the day and go home at night, there are those in the streets full time. They are exploited sexually at night either by other people or by their "seniors". They are therefore at high risk to contracting HIV
Migrants	They are mostly the civil servants, police, businesspeople and teachers living away from their spouses. They are at risk of engaging in casual sex
Young women 15-24 years	They are at their sexual debut. They are either school dropout, in secondary schools, universities or colleges. Most of them engage in multiple experimental sexual activities mostly due to peer pressure. Newly circumcised men also engage in sex with them for their traditional "Kuhura mbiro" activity. Some also engage in transactional sex

2.2: Drivers of HIV in Kirinyaga County

While major steps have been undertaken to reduce new infections in the County, new infections are still being recorded. The main drivers of the HIV have been discussed as follows:

Migrant workers: Most of them work as civil servant like police, teachers, soldiers and health workers while others are in the private businesses. They live away from their families (spouses) and hence the possibility of engaging in casual sex.

Truck Drivers/Loaders: They flock the towns to collect agricultural produce to deliver to other towns. The County is also a stopover for many truck drivers on their transit to Meru, Nyeri, Nanyuki, Muranga and Nairobi. Prominent stop overs are Makutano, Sagana, Kibingoti, Kagio, Wanguru and other small markets on the highways. This has increased the number of sex workers who target the truck drivers. They contribute to the spread of the virus.

Boda boda riders: These are young men involved in ferrying passengers from one place to the other usually where there is no main public transport. They are classified as "well off" in the society due to their continuous income usually on a daily basis. They are known to demand "sex for a ride" especially to the cash strained young women and school going children.

Quarry workers: This is mainly in the Kwa VI area of Sagana. They are usually immigrants living away from their spouses. They live

in slum-like conditions with low incomes, education and standard of living. It is also in the same slums where illicit brews is made and consumed. The close-knit lifestyle provides an opportunity to access cheap casual sex

2.3: HIV and AIDS interventions in the County

A number of programs and activities have been undertaken and good progress has been realized in the fight against HIV and AIDS. This is as a result of the different activities/ programs that have been undertaken in the past. They include Community HIV testing, advocacy for HIV prevention, Syndrome Management of STIs and Opportunistic Diseases, Diagnostic Testing and Counseling (DTC), Voluntary Counselling and Testing (VCT), Prevention of Mother to Child Transmission of HIV and AIDS – PMTCT, Comprehensive Care Clinic (CCCs)/ART clinics, Blood Safety, Condom Promotion and Distribution, Care and Support of PLHIV (Psycho-social support groups), Home Based care for PLHIVs, Distribution of IEC materials and Enhanced Inter-Sectoral collaboration in HIV and AIDS control. Opening of new VCTs, CCCs and health facilities offering PMTCT have also been undertaken. Various partners have been instrumental in the fight against HIV. These include; NACC, UON/CRISPS, Kenya Redcross, Aphia plus, PSK.

2.4: SWOT ANALYSIS

To better understand and address the County HIV and AIDS situation it is important to understand the key strengths that the County possesses as well as the weakness within its structural system. Further, it is critical to identify the opportunities which the County can ride on as well as threats that may derail the achievement of the objectives. This analysis is discussed below.

Strengths

HIV and AIDS activities have been ongoing. Support from County Government has retained previous functional structures at the County and sub County level. There is also presence of civil society organisations (CBOs, FBOs, women groups, youth groups, PWD) whose capacity was built by NACC during TOWA poject. This offers a good entry to the community. High number of health facilities, good infrastructural facilities, OVC programmes etc.

Weakness

High levels of stigma and discrimination in the County is the highest cause of low uptake of HTS, and high ARVs defaulters. There has been inadequate funding for HIV activities and programmes. The County has also lacked County specific HIV Research that has hindered innovation and evidence based targeted interventions. While there has been supply of male condoms, the same has not been enough while female condoms have not been erratic. There has been weak coordination with the partners, CBOs, FBOs and NGOs each doing its own activities most of which is duplication. Referral mechanisms / escort services have been weak coupled with lack of defaulter tracing mechanisms and lack of effective home based care systems. Health workers have also been noted to have bad attitude resulting in poor services and self-stigmatisation. Generally, the setup of CCCs at the entrance of the health facility has been documented as major hindrance to seeking services from these facilities.

Opportunities

Presence of Kirinyaga University can be of assistance during research. Other helpful strategic partners include UON/CRISSPS, APHIA PLUS, Kenya Red Cross, CBOs, FBOs, youth groups, women groups. Implementation of community strategy offers an opportunity to scale up community based HIV interventions. There is also a

growing private sector comprising of financial institutions, horticulture and other untapped resources offering an opportunity for public private partnership in funding war against HIV. Presence of a clinic at Mwea serving MSM could be utilized to obtain more information on the operations, number and distribution of the MSM in order to extend the services to them. Provision of the Beyond Zero Van by the First Lady should go a long way in extending the services to the people especially in areas where the facilities are not available. Availability of food in the County gives it an opportunity to extend good nutritional support especially to the PLHIVs. This offers the much need nutritional requirements especially vegetables and fruits.

Threats

The biggest threat to the gains made in the fight against HIV is the exit of key partners thereby affecting sustainability of many programmes and projects. High ARVs defaulting puts to risk thousands of the PLHIV and may result in high mortality rates. Some patients have been known to hop from one clinic to the other and registering as new patients. This results in highly unreliable data. High stigma and discrimination is a major threat as well as the increased insecurity, drug abuse and consumption of illicit brews in the County. Other threats arise from the church/ faith doctrines on use of condoms and FGM.

Table 2.4: SWOT analysis

Strengths • Ongoing HIV and AIDS activities • Trained Staff • County Government Support • Existing structures at County and sub County levels • TOWA trained CBOs and FBOs • Partner support • Beyond Zero Clinic • Drop-in-Centres for KPs • Kenya Mentor mother Program	**Weaknesses** • Coordination challenges • Insufficient partner reports and double reporting • Lack of technical working groups • Skewed partner presence in the County • Erratic supply of HIV commodities • Inadequate infrastructure such as CCCs and youth friendly centres • Insufficient competent staff • Inaccessibility to health facilities in some areas • Reduced donor funding • Inadequate County specific HIV research
Opportunities • Devolution • Higher learning institutions- Potential to conduct HIV research • Rapidly growing and vibrant private sector- opportunity for PPP. • Implementation of the community strategy	**Threats** • Poor health seeking behaviour especially among men • Gender Based violence • Presence of Key Populations who act as bridge of infections into the general population • Alcohol and substance abuse among the youth

03.

PURPOSE, RATIONALE, STRATEGIC PLAN DEVELOPMENT PROCESS AND THE GUIDING PRINCIPLES

PURPOSE, RATIONALE, STRATEGIC PLAN DEVELOPMENT PROCESS AND THE GUIDING PRINCIPLES

3.1 Purpose

The purpose of the Kirinyaga County AIDS Strategic Plan is to guide in the development of a programme to address the HIV and AIDS issues in the County during the period 2014/15-2018/19. Further, the plan will help in the mobilization of resources for the programmes as well as setting the priority areas in dealing with the HIV pandemic in the County. The plan provides a strategic direction that will guide and inform the planning, coordination, implementation, monitoring and evaluation of the County multi-sectoral and decentralized HIV and AIDS response with the aim of achieving zero new infections, zero discrimination and zero AIDS related deaths. The plan articulates County priorities, results and targets that all stakeholders and partners will contribute to. The KCASP provides the basis for consolidating strategic partnerships and alliances especially with civil society organizations, public and private sector and development partners. The KCASP also establish the basis for the County to consolidate its efforts in developing sustainable financing mechanisms for HIV and AIDS response.

3.2 Rationale

In 2010, Kenya ushered in a new constitutional dispensation that created two levels of government, the National and the County governments. Among many functions that were transferred to the County Government is health that incorporates among others, management of the HIV and AIDS. In this regard the Kenya AIDS Strategic Framework (KASF) 2014 – 2018/2019 was developed and the function of each level of government outlined. Subsequent dissemination and roll out of the KASF to counties has provided a guideline for counties to develop their own specific HIV strategic plans based on the national framework.

HIV and AIDS response activities have been on-going in the County and there are systems and structures in place to coordinate the efforts of HIV response. The development of this KCASP provides an opportunity for the County to assess the activities undertaken in the past to determine and uphold the strengths, review the weaknesses, and seize the available opportunities while recognizing the threats to be addressed by the program. It will also provide a critical time to establish and re-orient its structure and operations within the devolved system of government.

Kirinyaga County (KHSSIP 2014 – 2018) singles out HIV and AIDS as associated with the leading causes of morbidity and mortality in the County, hence a priority intervention area. The KHSSIP provides the overall strategic direction for accelerating the attainment of universal health coverage 2014 – 2018. KCASP will therefore be implemented in line with the KHSSIP and County Integrated Development Plan (KCIDP). KCIDP acknowledges HIV and AIDS among the major challenges of development and suggests that preventive activities and support for those infected and affected be focused on at the community.

3.3 Development Process

KCASP is developed from KASF. KASF was prepared by NACC in consultation with stakeholders at national and county levels. The process of developing KCASP started with identification and training of 5 TOTs from the county to support the dissemination of KASF and thereafter lead the development of the plan. The TOT disseminated the KASF to 30 County stakeholders in a meeting held in Thika. During this meeting, a fifteen member drafting committee was nominated which

held its first meeting at the Deputy County Commissioner's office for planning purposes. The team comprised representatives of all the stakeholders. These include, NEPHAK, Youth, Community, County health department among others. They held discussions on 21-24 March 2016 at Roswam Hotel to prepare the draft plan which was presented to the CHMT for input. Inputs from this consultation were incorporated and a second draft was circulated to all stakeholders for further comments. The second draft was reviewed by a technical team facilitated by NACC on 17-18 June 2016, and comments given back to the drafting team to improve the document. The CEC health, CDH and the CHMT endorsed the final draft, which was then presented to the NACC for editing and graphic design as well as printing.

3.4 Guiding Principles

The following principles have been used as guide to the development of the strategic plan.

1. **Evidence-based programming:** the HIV program recognizes that there is a gap of information for effective programming and will undertake operational research in identified areas to inform innovation and interventions such as:

    - Understanding the influence and contribution of new infections by MSM and FSWs in Kirinyaga County given the agribusiness activities in the County.

    - Generate more information on HIV among the young adolescents and youth especially in schools and institutions of higher learning.

2. **Integrated HIV response** – the HIV program will target various identified key and vulnerable populations with deliberate program for HIV prevention and treatment. The sex workers, MSMs, truck drivers, migrant workers, quarry workers have been identified as vulnerable populations based on the economic activities they are engaged in which predisposes them to HIV. In addition, HIV and AIDS response activities will also be integrated in all health service delivery points.

3. **Efficient and effective HIV and AIDS response practices** – the HIV program will scale up the implementation of best practices HIV intervention that includes:

    - Kenya Mentor Mothers Program

    - Establish more Drop-in-Centres (DIC) for key populations

    - Reach the "under reached" using outreach mobile program that includes the Beyond Zero Mobile clinic to improve maternal and child health outcomes in relation to HIV & AIDS.

    - Formation of more support groups for PLHIV.

    - Lobby partners for support of CBO and FBO in HIV control. Education for life program

    - Health choices (Health choice 1 for 9-12 and Health choice 2 for 13-17)

    - Vocational training and youth resource centres

    - School health programs

    - Integrate HIV in all health care service provisions

    - Scale up skilled deliveries.

4. **Multi-sector HIV AIDS response–** the HIV program shall engage as many sectors and stakeholders in the County as possible to reach various target groups and these will include:

    - Institutions of higher learning (Universities) – so as to increase access to HIV prevention and treatment among the vulnerable population of 15 – 24 year girls and women through their institutions.

    - National Transport Authority – to reach the vulnerable drivers and touts in the public transport industry

    - Women, youth and other organized groups like the boda boda to increase access to HIV prevention and treatment services.

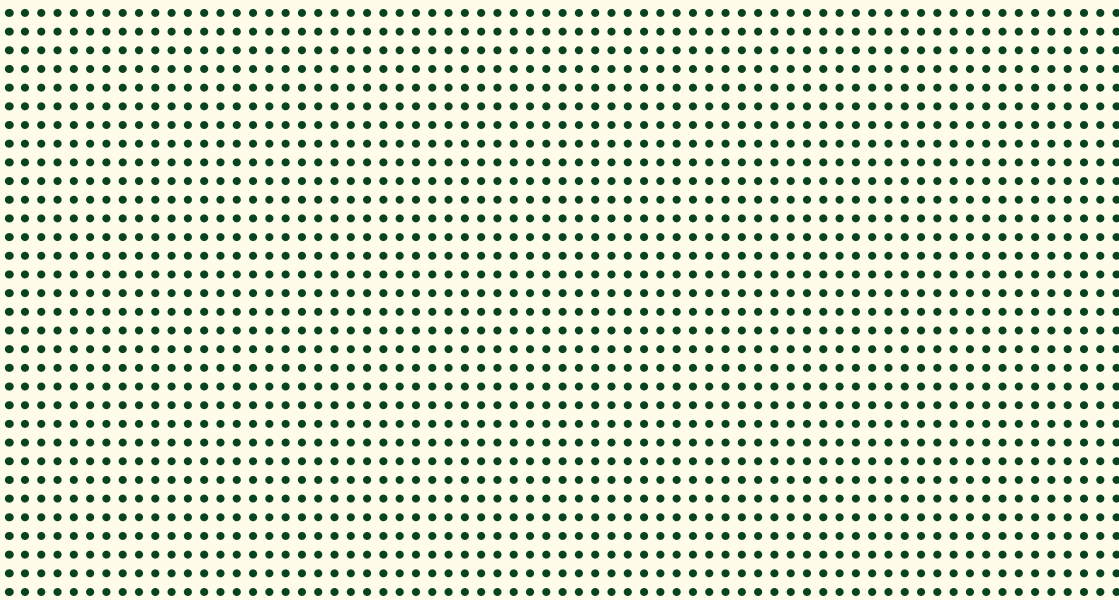
    - Key populations

5. **Governance and leadership in HIV and AIDS response** –the HIV program shall ride on the devolution of health services so as to re-orient and structure HIV and AIDS control in the County while strengthening the coordination of partners' efforts. The governance and leadership role will be provided by the County Government and other coordinating structures.

6. **HIV response as an integral part of development**– the HIV program will form a major part of other developmental sectors such as transport, roads and house construction, industrialization among others so as to have healthy citizens who are free from HIV for a healthy and productive County.

04.

VISION, MISSION, GOALS, OBJECTIVES & COUNTY STRATEGIC DIRECTIONS



VISION, MISSION, GOALS, OBJECTIVES & COUNTY STRATEGIC DIRECTIONS

4.1 Vision

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

4.2: Mission

Promote access to HIV prevention services, care and mitigation support to all

4.3 Goal

Contribute to achieving vision 2030 through universal access to comprehensive HIV prevention, treatment and care

4.4 Objectives of the County

1. Reduce new HIV infections by 30%
2. Reduce AIDS related mortality by 10%
3. Reduce HIV related stigma and discrimination by 20%
4. Increase domestic financing of the HIV response to 10%

In line with the Kenya AIDS Strategic Framework, these objectives will be delivered through the following eight (8) strategic directions:

1. Reducing new HIV infections,
2. Improving health outcomes and wellness of all people living with HIV,
3. Using a human rights 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 Kirinyaga CASP goals,
6. Promoting utilization of strategic information for research, monitoring and evaluation (M&E) to enhance program,
7. Increasing domestic financing for a sustainable HIV response,
8. Promoting accountable leadership for delivery of the Kirinyaga CASP results by all sectors and actors

4.5 Strategic Directions

Strategic Direction 1:
Reducing new HIV infections

While the County has undertaken many interventions to combat HIV, the prevalence remains high at 3.3% with annual new infections of 795. About 40 % of the people do not know their HIV status presenting a major threat to the fight against HIV. Some of the activities undertaken include among others HTS, eMTCT and advocacy. The success of these activities is as a result of County commitment and support of development partners in addition to TOWA project. Exit by some donors is a major threat to sustainability of the success attained. While there has been provision of male condom, they are not enough while the female condoms are erratic. It has also been difficult to install condom dispensers/provide free condoms in bars, lodgings and guest houses because they argue that it impacts negatively on their condom sale business. In order to realise the objective to reduce new infections by 30%, various evidence based approaches have been identified. The owners of these businesses should include condoms in their basic package when offering services.

Table 4.1: New infections in the County

Strategic Direction 1: Reducing new HIV infections in Kirinyaga County					
KASF Objective: Reduce new HIV infections by 75%					
KCASP Results	**Key Activity**	**Sub activity / Intervention**	**Target Population**	**Geographical areas by County/ sub- County**	**Responsibility**
Reduce HIV infections by 30% from 795 to 556 by 2019	**Biomedical Interventions**				
	Increase access to HTS services to the key and vulnerable populations	Increase targeted PITC at service delivery points through targeted community based testing	High facility client with high index of suspicion such as Boda boda riders, men and flow farm workers	All the sub counties	CDH, CASCO, CACCs, Partners, Institutions of higher learning
		Introduce night "moonlight" testing	Men and FSWs		
		Integrate HTS in all health services.	Clients		
		Increase Partner testing	Partners of PLHIV		
		Undertake outreach and door to door HTS	Business community, schools and colleges		
	Provision of condoms	Ensure regular supply and distribution of condoms	Key and vulnerable populations		
	Intensify PMTCT to reduce MTCT	Prevention of new HIV infection among women	Pregnant women		
	Post Exposure Prophylaxis	Integrate FP services at the CCCs	SGBV survivors		
		Provide PEP to SGBV survivors			
		Decentralize and scale up PEP services to all health facilities	Health staff, SGBV survivors		
	Behavioural Interventions				
	Promote BCC messages in churches, youth forums, schools and Public barazas Life skills education and RH in institutions of learning	Promote condom use	General population	All sub counties	MoH, CASCO, County Director of Health
		Train community groups			
		Print and distribute IEC materials			
		Community sensitization on HTS			
		Conduct school health programs, talent days and tournaments			
		Campaigns against alcohol, drugs and substance abuse	General population	All sub counties	County Commissioner, community leaders NACADA, Institutions of Higher learning
	Structural Interventions				
	Increase services to the youths	Establish a youth friendly clinic	Adolescent and young persons	All sub counties	CDH, Partners, Gender, Culture & Social Services
	Install condom dispensers at strategic places e.g. boda boda sheds, key clubs	Procure and install condom dispensers at strategic places	General population		
	Provide lubricants	Provision of commodities (lubricants, condoms) visiting their clinic	MSM, FSW		

Strategic Direction 2: Improving Health Outcomes and Wellness of All People Living With HIV.

As at 2015, the County had 9315 adults and 1039 children in need of ART but only 81% of adult and 59% of the children were receiving it. While this is above the national average, a substantial number of the population did not receive the essential drugs. HIV and AIDS mortality was 327 for adults and 49 for children. The County continues to face various challenges in its endeavour to improve the well-being of PLHIV. There is poor linkage and referral system as well as non- adherence and high default rate. High stigma and discrimination continue to be a big impediment for people to seek heath care.

The County plans to scale up linkages within 3 months of HIV diagnosis to 90% for all age groups, scale up ART coverage to 90% as well as 90% 12 months retention for all age groups. There is need to increase the viral suppression to 90% on ART for all age groups. The following interventions have been considered to ensure a rise in the wellbeing of the PLHIV.

Strategic Direction 2: Improving Health Outcomes and Wellness of All People Living With HIV					
KASF Objective: Reduce AIDS related mortality by 25%					
KCASP Results	**Key Activity**	**Sub-Activity/**	**Target Population**	**Geographical areas by County/sub-County**	**Responsibility**
		Biomedical			
Reduce AIDS related mortality by 10% by Increasing ART coverage to 90% among children, adolescent and adults	Enrolment and Initiation of ART within 3 months of HIV diagnosis	Routine monitoring of CD4 to all pre- ART clients	PLHIV	All sub-counties	CDH/CASCO Partners
		Acquiring and distribution of commodities			
		Train 100 health care workers on new ART guidelines	Health Care provider		
		Provide 10000 basic care packs	PLHIV		
	Strengthen community psychosocial support services	Formation of 62 PMTCT psychosocial support	PM CT clients/ mentor mother/ social worker		CDH
		Formation of 62 adolescent psychosocial support	ALHIV/Youth champion/social worker		All Health workers/peer educators/CHVs ,CDH
		Formation of 62 discordant couples psychosocial support	Discordant couple/peer educators/social worker		Facility managers CDH
		Formation of 62 paediatric psychosocial support	Paid HIV/mentor mother/social worker		County Director/ partners/ social services department CACCs
	Increase treatment literacy	Provision of assorted I.E.C materials	Health Care provider		All Health workers/peer educators/ CHVs, CDH
	Nutritional support	Provision of food by prescription	Low BMI client		
		Provision of nutrition demonstration trays	Health Care provider		County Director/ partners/facility managers
	Strengthen HIV/ TB Collaboration	Initiation of ART for all TB clients Provision of IPT for all HIV clients	All clients/health care workers		CDH, Partners
		Conduct continuous TB screening for all HIV clients Conduct Gene Expert test for all suspects for co-infected			

Increased retention on ART at 12months to 90% in children, adolescents and adults	School health programmes (Strengthen health club networks and linkage, Teachers capacity building)	Training 300 teachers on HIV programmes areas	Teachers/health care providers	All sub-counties	CDH Partners
		Develop and disseminate youth friendly I.E.C materials	Youth/health care providers		
	Peer based advocacy (Identify and capacity build young champions, including the special groups)	Identify and capacity build young champions in schools	Teachers/Youths		CDH Partners
		Identify and capacity built champions for key populations	Champion key population		
	Management of opportunistic infections and non-communicable diseases (NCDs)	Identification and management of OI and NCDs infections	Clients		CDH and Partners Health care
	Follow-up and patient racking	Recruitment and sustenance of the peer educators/Mentor mothers/CHVs	Mentor mothers/peer educators/1chvs		CDH and Partners ,Social workers
		Regular maintenance of appointment diary and defaulter tracing monitoring	Mentor mothers/peer educators/1chvs		Health care provider

Strategic direction 3: Using human rights based approach to facilitate access to services.

According to national HIV and Stigma and discrimination index 2014, Kirinyaga County's HIV stigma index stands at 49.2%. It is classified among counties with the highest stigma index. Due to the stigma associated with HIV, many continue suffering without seeking medical care. Other PLHIV have resulted to seeking health services from distant health facilities some of which are in other counties. This reduces ability to follow-up, poor adherence as well as increasing number of defaulters on drugs. Other results include multiple enrolments in the CCCs, and high HIV related mortality rates.

Previous interventions have included outreaches, BCC interventions, HTS, and condom distribution. It is only by addressing the stigma that seeking services and addressing the HIV problem will be made easier. With the implementation of the County KCASP the intention is to reduce this HIV related stigma and discrimination to below 20%.

Strategic Direction 3: Using a human rights approach to facilitate access to services for PLHIV, key populations and other priority groups in all sectors					
KASF Objective: Reduce HIV related stigma and discrimination by 50%					
KCASP Results	**Key Activity**	**Sub-Activity**	**Target Population**	**Geographical areas by County/sub-County**	**Responsibility**
Reduce stigma and discrimination from 49.2% to <20%	Remove barriers to access of HIV, SRH and rights information and services in public and private entities	Train community groups on stigma and discrimination through education	General population	All sub counties	CEC, CDH
		Establish more functional DICs to offer HIV services to KP	PLHIV, KP		County Government, Partners
		Train Health care workers on HRBA	Health care workers		CDH, Partners, KERLIN, NCPWD
		Establish adolescents and youth friendly services	Partners working with young people, Department of health		CDH, Partners
		Sensitize forums for boys and men to promote gender equality	Boys & Men		CEC Gender, Culture & Sports CDH
		Intersectoral implementation of the County stigma and discrimination strategy	All sectors		CEC Gender , Culture & Sports CDH
		Establishment and implementation of AIDS control units in public sector	Public sector institutions		CDH, CACCs
		Facilitate access to SRH services	General Population		CDH
	Strengthen the existing and form more psychosocial support groups for PLHIV.	Form new psychosocial groups for PLHIV	PLHIV		MoH, Gender, Culture & Social Services
		Hold campaigns to sensitize the general population on anti-stigma and discrimination, gender violence , uptake of HIV services and prevention interventions	General population		CEC Health & Gender, Culture & Sports
	Legislation	Develop a County anti-stigma and discrimination policy and ensure implementation	General population		CEC Health & MCAs
		Establish a linkage and stigma and discrimination complaint system	General Population		CEC Health & MCAs
		Decentralize HIV tribunal or establish local arbitration mechanisms	PLHIV, OVCs, PLWD, SGBV survivors		HIV tribunal, CDH, County Commissioner

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

Community units continue to play a critical role in the management of HIV in the country. With recommended 5000 persons per community unit, Kirinyaga County should have at least 120 community units. To enhance health education, the County has trained 60 community units and hence falls short of the target by 60 community units. The County has a well spread network of health facilities across all the sub counties but lacks adequate trained Health workforce. This calls for recruitment of more staff to enhance service delivery at all the health facilities. The County has experienced situations where some partners are exiting from the County. This is affecting service provision as they are key in linking health services to the community.

Strategic Direction 4: Strengthening integration of health and community systems					
KASF Objectives : **Reduce new HIV infections by 75%** **Reduce AIDS related mortality by 50%** **Reduce HIV related stigma and discrimination by 50%** **Increase domestic financing of the HIV response to 50%**					
KCASP Result	**Key Activity**	**Sub Activity/Intervention**	**Target Population**	**Geographic areas by County/Sub County**	**Responsibilities**
Increase number of people in the community being tested and counselled from 60% to 80%	Integrate HIV services in community health units and Community testing mobilization	Creating community units where they are non-existent	General population	All sub Counties	CD Health, partners
		Identify CHEWS and CHVPEs for community testing			
		Recruitment of HTS counsellors Procurement and commodity security for HTS commodities			
		Capacity build existing community units and HCWs on HTS			
	Linking HIV positive clients to care and treatment	Conducting phone tracing/priority home visits for clients not linked to care and treatment	PLHIV	All Health Facilities	CDH, Partners
		Provide adequate referral M&E tools to Health facilities			
		Integration of HTS services in KEPH			
		Implementation of the referral directory in the community			
		Establishment of a facility-community referral desk			
	Ensure that HIV services are more accessible to key & vulnerable populations	Increase health facilities offering HIV services	KPs & Vulnerable populations	Health Facilities, MARPS Clinic community units	CD Health, partners
		Facilitate access to SRH and HIV services			
	HIV Related advocacy	Engage more CHVs on client advocacy in the facility on HIV and AIDS	Health Facility workers & CHW	Health Facilities, & community units	CD Health, Partners
		Align client follow up and peer support by using CHVs and CHEW			
Reduce HIV related mortality by 10%	Identification, linking and retention of PLHIV to ART services	Train HCWs, CHVPEs and CHVs on HCBC	Health Facilities,	All Sub Counties	CD Health, partners
		Provide CHVs and CHVPEs with Home based care kits			
		Facilitate logistics for the CHVs and CHVPEs			
		Facilitate access to SRH and HIV related services			
		Facilitate access to screening & management of non-communicable diseases			

Strategic direction 5: Strengthening Research and innovation to inform the KASF goals.

HIV & AIDS interventions in the County have been informed by national surveillance, KDHS and KAIS. There are research gaps in understanding drivers of the epidemic among different populations and translation of the result findings at the County level. There is need to establish a County research hub to document all HIV research to enhance implementation of evidence based HIV and AIDS programmes in order to leverage on skills of existing institutions of higher learning as well as operational research. There is need for establishing a research committee to evaluate the effectiveness of different interventions hence guiding the efforts of different stakeholders towards achieving a County free of HIV infections, stigma and AIDS related deaths. This will be addressed by development of the County research agenda, increasing funding for HIV/TB related research, stakeholder's involvement to develop the research agenda and multi sectoral joint planning to ensure the effectiveness and efficiency of the programmes.

Strategic direction 5: Strengthening Research and innovation to inform the KASF goals KASF Objectives : Reduce new HIV infections by 75% Reduce AIDS related mortality by 50% Reduce HIV related stigma and discrimination by 50% Increase domestic financing of the HIV response to 50%					
KCASP Results	**Key Activity**	**Sub-Activity/**	**Target Population**	**Geographic areas by County/sub- County**	**Responsibility**
Increased availability of evidence-based information to inform planning, programming and policy formulation for HIV response at the County level	Increase evidence based planning, programming and policy changes	Establish information resource centres at the County level	Health workers, learning institutions, community, partners	All sub counties	County Government, institutions of Higher learning, partners NACC, NASCOP, Research institutions
Increased implementation of Research on the identified KCASP related HIV priorities	Strengthen the Research implementation at County/Sub-County/facility	Resource mobilization for research activities			
		Strengthen documentation, reporting and dissemination of research projects			
		Collaboration with learning institution to conduct research projects			
Increased capacity to conduct HIV research at County/Sub-County level	Strengthen the capacity of staff	Establish research centres at County			
		Identify key areas for Research (refer to the research plan)			
		Establish research committee			
		Engage public participation in setting the research agenda			
		Initiate and strengthen multisectoral collaboration in driving the research agenda			
		Conduct operational/ cost effectiveness/ Efficiency research on key identified areas/ emerging issues			
		Train health care workers to conduct research project			
		Train health care workers on proposal development			

Strategic Direction 6: Promoting Utilization of Strategic Information for Research and Monitoring and Evaluation (M/E) to enhance programming

Availability of data to support decision making is key in the fight against HIV in Kirinyaga County. An effective data collection, transmission and analysis are important to inform policy formulation, planning and implementation. Kirinyaga County collects two sets of HIV data: at health facility level and community level. The Health facility data is collected through Health Records Officer with support of data clerks stationed at health facilities. The data is then fed into the District Health Information System 2 on a monthly basis. This forms the DHIS data set. The other set of data is collected through COBPAR with the support of NACC where community based HIV data is collected from CBOs, NGOs and other stakeholders implementing community based HIV activities. The data is forwarded through the CACCs who submit to the regional HIV coordinators for verification before being entered into the national database.

The high stigma and discrimination has seen huge movements of patients to other counties especially Nyeri and Muranga counties and hence their missing information. Other patients are reported to have been registered in multiple facilities resulting in duplication of data. In this case, the true reflection of the data on HIV is highly compromised. Other challenges in data collection, monitoring and reporting include: Inadequate reporting tools, limited resources to conduct data review meeting, inaccurate data collection, and limited number of facilities that have been automated through the Electronic Medical Register (EMR).

Strategic Direction 6: Promoting Utilization of Strategic Information for Research and Monitoring and Evaluation to enhance programming

KASF Objectives : **Reduce new HIV infections by 75%**
Reduce AIDS related mortality by 50%
Reduce HIV related stigma and discrimination by 50%
Increase domestic financing of the HIV response to 50%

KCASP Results	Key Activity	Sub-Activity	Target Population	Geographic areas by County/sub- County	Responsibility
Increased availability of strategic information to inform HIV response at the County level	Strengthening of M & E capacity to effectively track CASF performance and HIV epidemic dynamics at all levels	Establish an integrated M&E Committee.	Health workers, policy makers, CACCs, stakeholders/ partners	All sub counties	CDH, NACC, Partners , NASCOP
		Recruitment for additional 10 M&E officers			
		Train 100 health workers on new HMIS tools			
		Supportive supervisory field visits and mentorship visits			
		Formation M/E Technical Working Group and networking			
	Develop a monitoring and evaluation framework	Conduct periodic M&E meetings			
		Undertake mid - term and end tem review of the KCASP	Stakeholders		County government, NACC, Partners , NASCOP
Establish M/E information Hubs to provide comprehensive information package on CASF indicators for decision making	Establishment of an integrated multi-sectoral HIV platform for provision of HIV updates	Develop an inventory of HIV partners, implementers and their activities.	CACCs, Department of social services, partners		
		Establish an integrated M&E hub			
Well -coordinated Planned evaluation, Reviews, Surveys and dissemination on HIV programming	Ensure harmonisation and accurate, timely and comprehensive of non-routine and routine monitoring system	Conduct data quality audits	CACC, SCASCOs, partners		County government, partners
		Conduct facility/community monthly meetings to discuss analysed/submitted reports	Facilities, community units		Partners, CDH
		Develop biannual County health bulletin	Stakeholders		County government, NACC, NASCOP

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

At the national level, international organisations finance about 68% of AIDS response. The results of the financial crisis in Europe brought with it a substantial decline in the international financing of the health sector. At the County level, only about 20% of HIV funds came from the National government while rest came from donors.

Funding from NACC has mainly been used to support community activities including the World AIDS Day commemoration every year, support to the CACC to undertake supervision, office running and transport operating costs. The County Government pays for the salaries of health workers engaged in HIV response activities, pays allowances and transport incurred by the staff during supervision. Other partners include KEMSA for the supply of key commodities like the condoms, IEC materials, ART and other activity based funding for activities.

Decline in funding requires that the County continuously increases financing for HIV programs to ensure their sustainability as donor financing declines and others exit. The following interventions have been suggested to increase County HIV financing.

Strategic Direction 7: Increasing domestic financing for sustainable HIV response.					
KASF Objectives : Reduce new HIV infections by 75% Reduce AIDS related mortality by 50% Reduce HIV related stigma and discrimination by 50% Increase domestic financing of the HIV response to 50%					
KCASP Result	**Key Activity**	**Sub Activity/Intervention**	**Target Population**	**Geographical areas by County/Sub County**	**Responsibility**
Increase domestic financing for HIV response by 10% from 6m to 6.6m	Lobbying for resources/ funds	Set up a County HIV committee to ensure HIV programmes and services are included in the County budgets	Stakeholders	All sub-counties	CEC Health, CDH, NACC
		Present a policy paper in the County assembly to support HIV financing	County assembly		County HIV committee, CDH
		Promote innovative and sustainable domestic HIV financing options e.g. Marathons, charity walks, games, and dinners	Partners, stakeholders , well wishers		County Assembly, CEC Health, Partners
		Initiate IGAs for economic support to PLHIVS / OVCs	Stakeholders		County government, partners
		Mapping of HIV partners	Stakeholders		
		Strengthen Public/private partnerships.	Stakeholders		
		Establish County HIV trust fund	Stakeholders , County assembly		

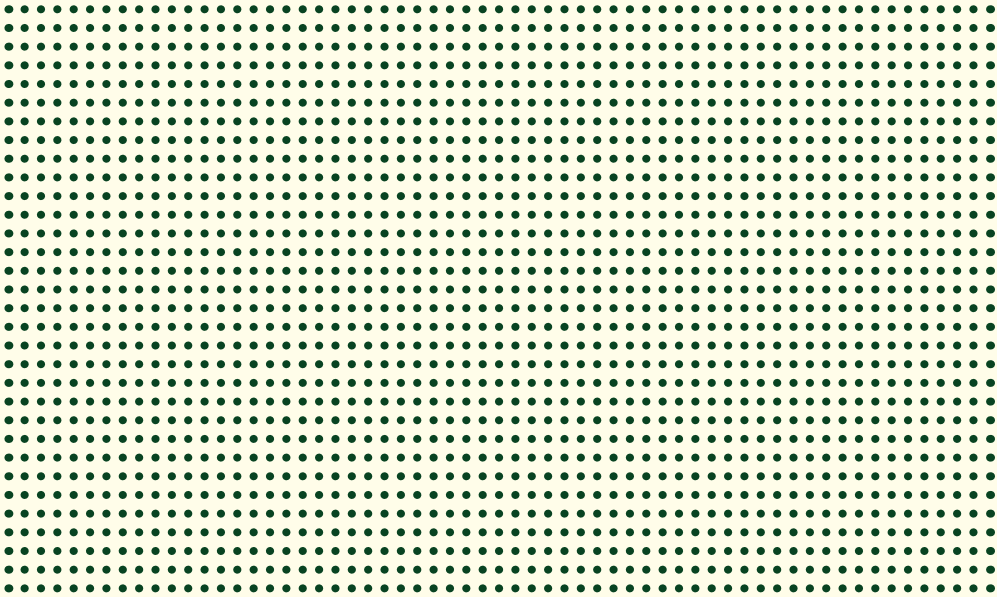
Strategic Direction 8: Promote accountable leadership for delivery of KASF results by all sectors and actors

To achieve the objectives of the KCASP, there is need for transparent, accountable and all-inclusive government. Involvement of all the stakeholders including the NGOs, civil society, PLHIV and the general community is key. It is important that all the elected leaders have the political will and provide leadership on HIV response. As per the KCASP proposed structure, the Governor is required to spearhead delivery of services to address HIV and AIDS burden. Under the Governor there shall be other structures such as the County Executive Committee, the County HIV Committee, County HIV ICC, County HIV Coordination Unit, County KASF monitoring committee and Sub County / Constituency HIV Committees.

Strategic Direction 8: Promote accountable leadership for delivery of KASF results by all sectors and actors					
KASF Objectives : Reduce new HIV infections by 75% Reduce AIDS related mortality by 50% Reduce HIV related stigma and discrimination by 50% Increase domestic financing of the HIV response to 50%					
KCASP Result	**Key Activity**	**Sub Activity/Intervention**	**Target Population**	**Geographic areas by County/ Sub County**	**Responsibility**
KCASP is developed and implemented	Disseminate and roll out the KCASP	Print 150 copies of the KCASP and disseminate to all stakeholders	Stakeholders	All sub-counties	County government, CDH, NACC
KCASP is well coordinated and progress monitored	Establish a functional HIV coordination mechanism.	Constitute County HIV committee (CHC) and hold quarterly meetings	Stakeholders		CEC health, CDH, NACC Chairs County assembly health and finance committees
		Constitute County HIV coordinating committee	Stakeholders		CEC Health, CDH, County government, NACC, Partners
		Constitute County M&E committee and hold quarterly meetings			
		Constitute County HIV ICC and hold quarterly meetings			
		Constitute Sub counties HIV Committee and hold monthly meetings			
	Develop and strengthen multi-sector accountability for KCASP results	Design a multi-sectoral County HIV and AIDS response performance management plan to coordinate, monitor and evaluate performance of the County HIV and AIDS control programmes.	Political leaders, stakeholders , County assembly , PLHIV		County government, Partners, CDH, networks of PLHIV
		Lobby for political commitments on HIV programmes in the County.			
		Sensitize County leaders on HIV coordination, implementation and resource mobilization.			
		Promote HIV champions			
		Establishing high level political partnerships for resource mobilization.			

05.

IMPLEMENTATION ARRANGEMENT

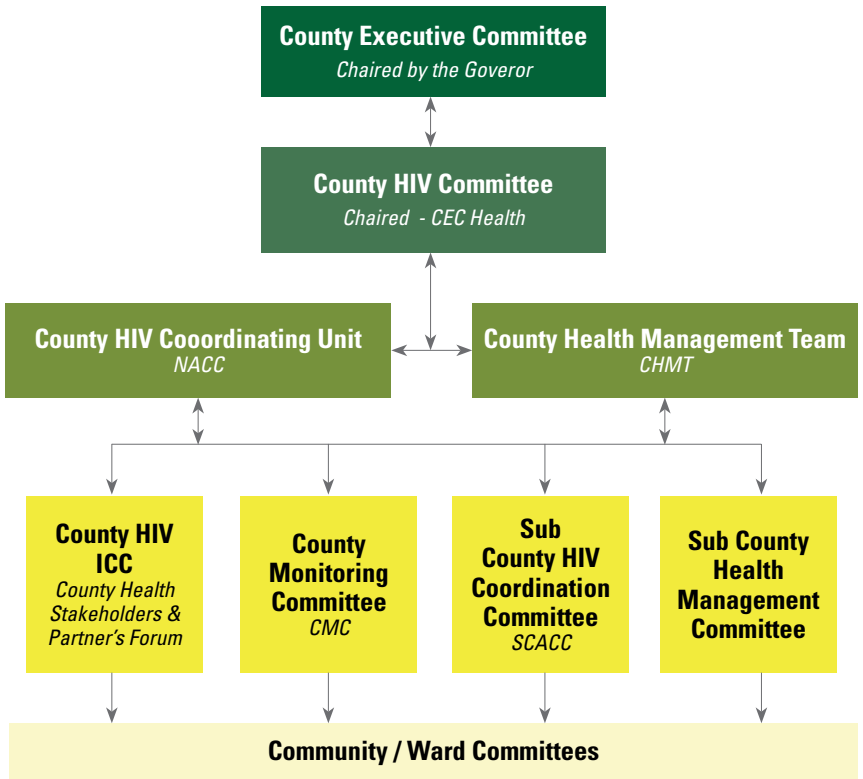


IMPLEMENTATION OF KCASP

Under the Constitution 2010, Health functions and resources were devolved to the counties. The KCASP recognizes that the County is responsible for implementation of HIV services and programmes in a multi- sectoral set up. The County Government is the link between the County HIV committee, sub-counties HIV committees, implementers, PLHIV and special interest groups hence the need to provide a strategic communication framework to coordinate the efforts of all stakeholders.

As indicated under Figure 5.1, the County will have six committees.

Figure 5.1: County HIV Coordination Structure



County Executive Committee

The **County Executive Committee** will be chaired by the Governor. It shall oversee the implementation of the County HIV legislation. it will spearhead prioritization of resource allocation to address HIV burden in Kirinyaga County. It shall lobby for HIV resources from development partners

County HIV Committee

It shall be accountable to the Governor for the performance of their functions relating to HIV. It shall be responsible to identify the gaps in HIV matters in the County. It will be responsible for developing proposals to solicit funds from development partners.

Membership

It shall be chaired by the Health CEC with the NACC RHC as the secretary. Other members include; County commissioner, Representatives of County assembly (from health, budget, planning committees), Chief Officer health, Director health, Director social services, director planning and finance, Representative of PLHIV, Representative of private sector, CACCs (2) sub-counties, Faith communities-(1), CASCO, Partners (2).

The County HIV committee shall:

- Hold meetings on a quarterly basis to review implementation of the KCASP
- Responsible for the effective delivery of the HIV response at the County level through periodic review and monitoring of the KCASP.
- Approve the County HIV targets and plan
- Review and present County HIV Budget
- Set the County HIV agenda

County HIV Coordination Unit

This will be the responsibility of the NACC Secretariat at the County level. The unit shall coordinate the day to day implementation of the KASF at the County level. It will work closely with the County Health Management Team and the various line ministries and department at the County level.

The HIV coordination unit shall

- Ensure Quarterly County ICC HIV meetings are held and follow through on County ICC HIV actions
- Regular engagement of all state and non-state actors within the County in planning, prioritization, implementation, monitoring, and evaluation of HIV and AIDS programmes.
- Strengthening linkages and networking among stakeholders and providing technical assistance, facilitation, support for KCASP delivery
- Monitor County Legislation to ensure all Bills are HIV compliant

Monitoring & Evaluation Committee

The committee shall consist of persons with M&E expertise drawn from across all sectors and partners- public, private and civil society including key affected population and PLHIV in the County. The role of the Monitoring and Evaluation Committee shall include;

- Ensuring that all tools and materials for data collection are available for use at all times.
- Reviewing and analyzing data received at the County level
- Building the capacity of health workers on data collection and transmission.
- Ensuring the data collection, quality control, consolidation, interpretation and dissemination.
- Ensure the preparation and publication of County Department of Health newsletter on a bi-annual basis for dissemination of health articles, data and human interest stories including HIV.

The County HIV ICC Committee:

This shall be accountable to the County governor for the performance of their functions and the exercise of their powers on matters relating to HIV. This shall be the primary forum for deliberating on HIV issues in the County. It shall be chaired by the CEC health and the NACC County HIV coordinator will be the secretary. It will comprise

of senior representatives in the County government, civil society, private sector and development partner, various Stakeholder Working Groups representing the various constituencies e.g. CSOs, FBOs, Youth, PwD, and PLHIV. The committee will convene at least four meetings annually to report on KCASP implementation progress, planned activities and future priority areas

Roles

- Ensure linkages, harmonization, coordination and resource mobilization and allocation, and tracking of progress of HIV programmes within sub counties
- Facilitate information sharing within and across partners in the County
- Reviewing programmes and projects supporting KCASP implementation
- Responsible for the effective delivery of the HIV response at the County level.
- Oversee the development of a collaborative and comprehensive strategy to rollout KCASP and subsequently monitor its implementation.

Sub-County/Constituency HIV committees

There will be four (4) constituency/sub-County committees in Kirinyaga County. The chair will be elected at the first meeting where SCACCs are secretaries to the committee. It shall comprise of the; National government official at the sub County level- deputy County commissioner; One person nominated from among the active civil society organization; Representative of PLHIV; Representative of PWD; One person representing interest of women; Representative of youth; SCACC; Sub-County MOH

Roles

- Stakeholder mobilization to respond to HIV issues in the community
- Monitor community response to HIV issues and submit biannual reports to HIV committee
- Receive and disseminate appropriate national and county policies, guidelines and strategies on HIV and AIDS.
- Ensure linkages, harmonization, coordination and resource mobilization and allocation, and tracking of progress AIDS programmes within sub counties
- Facilitate information sharing within and across partners in the County

06.

RESEARCH, MONITORING AND EVALUATION OF THE PLAN

RESEARCH, MONITORING AND EVALUATION OF THE PLAN

6.1: Monitoring plan

Monitoring and evaluation of the implementation of the KCASP and assessment of the outcome is essential based on the availability of accurate, relevant and timely data. This will influence decision making on HIV related issues at various levels.

Health facilities, both public and private, shall submit data to the sub County on monthly basis while community units and CSOs will report through the link facility. The sub-County health system delivery indicators' data will be captured in the DHIS while the community system indicators shall be reported through the COBPAR.

Similarly, the County shall use the logistical management information system (LMIS) to track the supply chain for pharmaceuticals and other health commodities to the health facilities. This LMIS shall provide data related to HIV commodities stocks and supply to the health facilities.

The County plans to develop a County integrated information system, which will facilitate interaction between sub-counties and County levels. This system shall be used to report on the KCASP biomedical indicators. In addition, the County shall build the capacity of the HRIOs including provision of necessary infrastructure.

The monitoring and evaluation shall involve:

- Development, dissemination and distribution of data collection and reporting tools
- Data collection at service delivery point at facility and community level.
- Data compilation and analyses at facility and management level
- Data validation at all management levels
- Data dissemination to management, stakeholders and community.
- Feedback mechanism and supportive supervision.

The HIV M&E system is primarily divided into health facility-based and non- facility-based, or community-based, components of monitoring and evaluating the County HIV response.

The County will utilize the following essential components to ensure a functional M & E system

a) Establish a KCASP Monitoring Committee with clear Terms of Reference

b) Invest in Human capacity, recruit and capacity build existing M & E staff for facility and community based systems

c) Establish and strengthen Technical Working Groups (TWGs) (i.e. KP, PMTCT, Adolescents and young People, HIV commodities, Acceleration of Care and Treatment (ACT),Research)

d) Annual Costed County HIV M & E work plan

e) Routine HIV program Monitoring- Strengthen Standard Operating Procedures (SOPs) guiding data collection and management

f) Routine reporting of community based activities and develop uniform reporting tools.

g) Survey and surveillance- The County will benefit from national surveys and surveillance (KDHS, KAIS, MoT) in tracking some indicators.

h) County HIV Database- The situation room will be used to generate data consolidated from different subsystems to include DHIS, HMIS,COBPAR,

i) Support supervision and data auditing- Quarterly support supervision and data audits in facility and community based M & E Systems

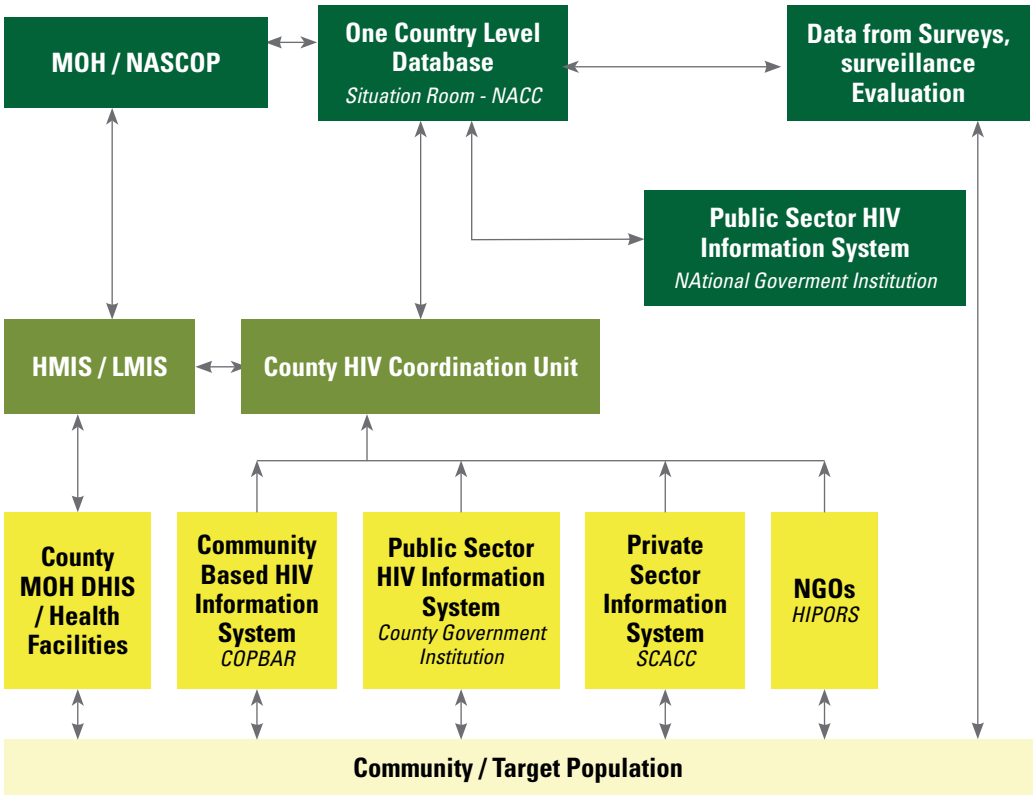
j) HIV Research- the Research TWG will develop better coordinating mechanism for HIV research in the County to be adopted by partners and learning institutions in conducting HIV research in the County.

k) Data Dissemination and use- The M & E Committee will develop data dissemination mechanisms to ensure all stakeholders have access to the most up-to date information available that can inform program decisions. The information products will include quarterly HIV reports, dashboards and KCASP indicators snapshot.

l) Midterm and End term review-There will be a midterm and end term review of the KCASP.

Fig. 6.1: Unified M&E System for Information and Data flow.

The figure below show the unified HIV response information system the County will employ to receive data from sub systems used at different data collection points. This data will then be consolidated, analysed and various products derived for decision-making and research.



6.2: Data Collection

1. **Community Level/ Target Population:** The data collected is passed to various sectors e.g. public sector, private sector, NGOs (HIPORS) and health facilities. This data includes condom distribution; number of PLHIV supported HTS etc.

2. **Facility Level:** The data collected is mainly as a result of interventions from healthcare workers. These interventions include HTS, HIV care & treatment among others. This data is summarized and submitted to the sub County level.

3. **Sub County Level:** Summarized data from the facility and community level is verified and entered into the DHIS, and other databases as appropriate.

4. **County Level:** Validated data from the sub County is submitted for review and onward submission to the national level. There may be other data sources such as research/ survey findings/ reports.

5. **National Level:** The data collected informs decision-making and policy formulation thus the need for quality data.

Evaluations
To assess the effectiveness, impact and sustainability of KCASP, mid-term, end-term and programmatic evaluations shall be conducted.

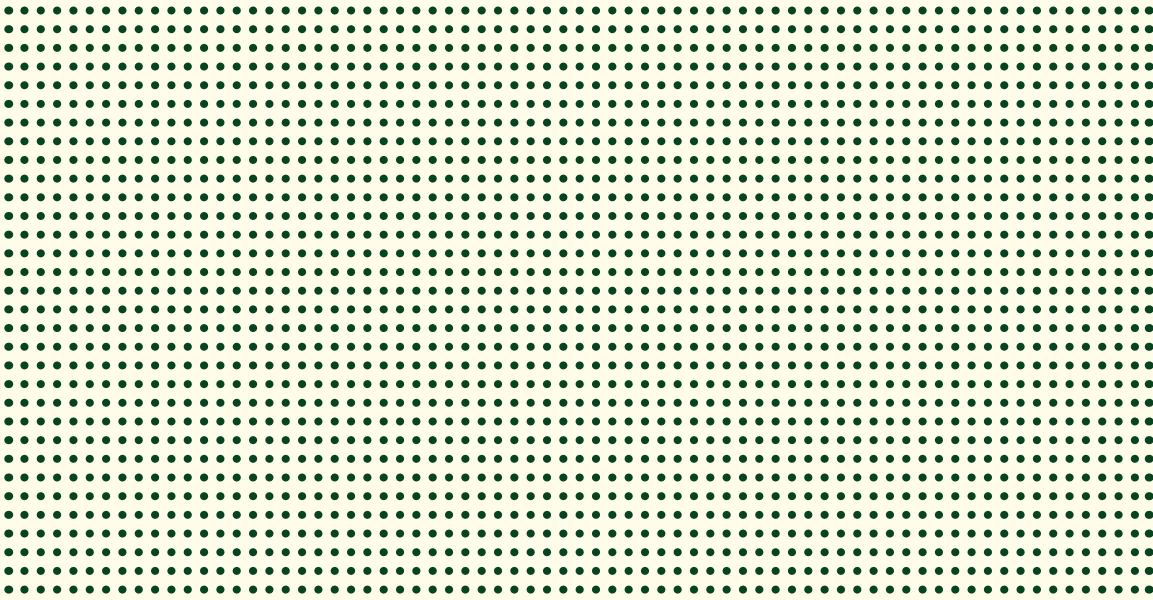
Programme Evaluation
Programme evaluation shall be used to establish the effectiveness and efficiency of the various HIV programmes. An evaluation agenda for KCASP will be developed to come up with programme-specific assessments during the period of KCASP implementation.

Mid-Term Evaluation of KCASP
Mid-term evaluation is expected towards end of 2017 and shall be undertaken by external independent experts. The evaluation shall assess the relevance, effectiveness, and efficiency of the strategic plan. A detailed evaluation protocol shall be developed to ascertain the achievements against what was planned.

End-Term Evaluation of KCASP
End term evaluation shall be conducted by independent experts and who will focus on the extent to which the KCASP expected outcome and related impact have been achieved over the implementation period. The evaluation shall be conducted in 2019, and the outcome shall inform the development of the next strategic plan.

07.

RISK AND MITIGATION PLAN



RISK AND MITIGATION PLAN

Risk Category	Risk Name	Status	Probability (1-5)	Impact (1-5)	Risk Average score	Response	Responsibility	When
Political	Lack of political goodwill	Inactive –No monitoring in place	3	3	3	Sensitization and awareness	CDH	Continuous
	Low knowledge level of leaders	Active – risk not being actively monitored	4	4	4	Sensitization of the leaders on HIV and sustainable financing	COH/ NACC	Continuous
	Low prioritization of the HIV agenda and activities	Active- risk is being actively monitored	3	3	3	Lobby for leaders' commitment and continued prioritization of the HIV agenda	COH, NACC, Partners	Continuous
Environmental	Rising number of informal settlements	Active- risk is being actively monitored	3	3	3	Community sensitization and empowerment	CDH, NACC, Dept. of Interior Coordination	Continuous
	Migrant workers	Active- risk is being actively monitored	2	2	2	Awareness, sensitization and develop/ implement work place policy	CDH, NACC	Continuous
	Alcohol and drug substance abuse	Active- risk is being actively monitored	3	3	3	Awareness and sensitization	CDH, NACC	Continuous
	SGBV	Active- risk is being actively monitored	2	2	2	Community sensitization	Religious leaders, National & County Government	Continuous
Technological	Low implementers' capacity	Active- risk is being actively monitored	3	3	3	Capacity assessment, capacity building	CDH	Continuous
Economical	Unequal distribution of financial resources	Active- risk is being actively monitored	3	3	3	Empower the youth on resource mobilization and income generation	County Government	Continuous
	Inadequate financial resources for HIV related activities	Active- risk is being actively monitored	4	4	4	Lobby for more resources from the County Government, explore innovative financing,	COH, County Government, NACC	Continuous
Legislative	Weak legislation favourable for HIV related issues	Active- risk is not being actively monitored	4	4	4	Customize and operationalize the HIV prevention and control act 2006 and other related Bills	NACC, CDH	Continuous
Leadership	Poor governance, weak partnership framework	Active – risk not being actively monitored	3	3	3	Entrench good governance and strengthen multi-sectoral approach for delivering KCASP results	CEC, NACC	Continuous

ANNEXES

Annex 1: Results Framework

Strategic Direction 1: Reducing new HIV infections								
KASF Objective		**Key activity**	**Indicators**	**Baseline**	**Source**	**Mid Term target**	**End term target**	**Responsibility**
Reduce new HIV infections by 75%		Scale up HTS	Percentage of population tested for HIV	60%	KAIS 2012	75%	80%	CDH Partners
		Scale up blood donation from 9457 units & Promotion of blood safety and donor notification	proportion of blood donors notified of their HIV results	TBD	NBTS	80%	100%	CDH, Partners
		Promotion of condom use and related commodities	Number of condoms supplied	908,343	DHIS 2013/14	1,500,000	2,000,000	CASCO, SCACCs, CSOs, Partners
		Legislate in the County assembly for all lodges and hotels to include condoms in their basic room package	Percentage of hotels and lodges with condoms in their basic room package	0%	DHIS	50%	90%	CDH, County assembly, Partners
		PEP and Occupational safety	Number of health facilities providing PEP services	126	CDH	132	140	CDH, Partners
		DICs increased from 1 to 3	Number of established and functional DICs	1	DHIS	2	3	CDH, Partners, networks of PLHIV, Networks of key populations
		establish youth and PWD friendly HIV services	Number of facilities offering PWD and youth friendly services	2	DHIS	6	9	CDH, partners
			Establish Adolescent TWG to spearhead the fastrack plan and convene quarterly meetings	0	DHIS	1	2	CDH, Partners, NACC
		Scale up HIV information among adolescents and young people	Percentage of adolescents with comprehensive HIV knowledge	54%	FastTrack plan	70%	86%	CDH, Partners, NACC
		Provide HIV services in institutions of learning	Percentage of adolescents 15-19 And young people 20-24 who know their HIV status	50% 80%	Fast track plan	70% 90%	90% 99%	CDH, Partners, Institutions of learning

		Scale up eMTCT activities in all health facilities	Number of pregnant women who know their HIV status	1314	DHIS	1449	1612	CDH, Partners
			Percentage of pregnant and lactating mothers receiving HAART	85%	DHIS	90%	95%	CDH, Partners
			Percentage of HIV exposed infants with negative result from positive pregnant and lactating mothers	85%	DHIS	90%	100%	CDH, Partners
Strategic Direction 2: Improving Health outcomes and wellness of all people living with HIV								
KASF Objective		**Key activity**	**Indicators**	**Baseline**	**Source**	**Mid Term target**	**End term target**	**Responsibility**
Reduce AIDS related mortality by 25%		Strengthening referral and linkage to care and treatment including Home based care	Number of HIV positive clients linked to care within 3 months	342	DHIS	598	726	CDH, Partners, County Government, KEMSA
		Integrate CCCs in all health facilities	Percentage of facilities with integrated CCCs.	13%	DHIS	50%	80%	
		Increase uptake of ART	Percentage of eligible HIV clients on ARVs	97%	DHIS	98%	99%	
		Build capacity of health care workers on paediatric HIV management	Percentage of paediatric patients enrolled and retained on care	60%	DHIS	70%	85%	
		Monitoring and follow-up of clients enrolled	Number of HIV positive adults and children retained on treatment 12 months after initiation of ART	2830	DHIS	3830	6000	
		Train CCC social workers on HIV care management for OVCs	Number of social workers trained	20	DHIS	30	60	
		Biometric registration of ART patients to eliminate double registration and defaulting	Percentage of ART patients biometrically registered	0%	DHIS	50%	90%	
		Early initiation to ARVs	Percentage of HIV (+ ve) clients with viral load suppression at 12 months after initiation of ARVs	80%	DHIS	90%	99%	
		Screening all HIV clients for TB	Percentage of HIV clients screened for TB	80%	DHIS	90%	99%	
		Strengthen Laboratory surveillance systems & Pharmaco vigilance	Proportion of viral load results received on time	82%	DHIS	90%	100%	

Strategic Direction 3; Using a human rights approach to facilitate access to services for PLHIV, Key populations and other priority groups in all sectors								
KASF Objective		**Key activity**	**Indicators**	**Baseline**	**Source**	**Midterm Target**	**End term Target**	**Responsibility**
Reduce HIV related stigma and discrimination by 50%		Sensitizing service providers on stigma and discrimination	Percentage of women and men aged 15-49years expressing accepting attitudes towards PLHIV	38%	Stigma index	50%	80%	CDH, Networks of PLHIV, networks of Key populations, County government, HIV Tribunal
		Strengthen and build the capacity of PLHIV support groups on PWP	Percentage of support groups established and that remain active	20%	COBPAR	60%	90%	
		Community training on human rights as relates to HIV & SGBV	Percentage of community dialogue days held as relates to HIV & SGBV	30%	COBPAR	60%	90%	
		Train Key Populations on HR	No of quarterly sessions held with key populations	1	COBPAR	2	3	
		Train teachers and law enforcers	Percentage of PHLIV who experience sexual and GBV	60%	COBPAR	40%	20%	
		Packaging preventive HIV programs for key populations	Number of program developed for KP	1	COBPAR	3	4	
		Devolve HIV tribunal	Percentage of cases received and resolved by the HIV tribunal	0%	COBPAR	30%	60%	HIV Tribunal, CDH, Networks of PLHIV and key populations

Strategic direction 4. Strengthening integration of health and community systems								
KASF objective	**KCASP result**	**Key activity**	**Indicators**	**Baseline**	**Source**	**Midterm target**	**End term target**	**Responsibility**
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%**	Improved Health care workforce for HIV response by 40%	training the Health Workforce in HIV and AIDS response	No of Health workers trained on HIV and AIDS response	612	DHIS	734	978	CDH, Partners , County Government
	Increased number of health facilities ready to provide KEPH defined HIV and AIDS services	Scale up the number of health facilities providing KEPH defined HIV and AIDS services	Percentage of health facilities providing early infant diagnosis	40%	DHIS	60%	90%	
	Strengthened HIV commodity management through effective and efficient management of medicines and medical products	Scheduled Procurement and distribution of test kits and laboratory reagents	Percentage of HIV testing health facilities that report stock outs at least once in 3months	10%	DHIS	5%	0%	
		Continuous Quality improvement	Percentage of functional QIC	56%	DHIS	70%	86%	
	Strengthened community level AIDS competency	Strengthen Community Strategy and training on Community level HIV module	Number of community units implementing AIDS competence guidelines	21	DHIS, COBPAR	30	41	
			Percentage of CU offering HIV services including HBC	10%	DHIS	30%	50%	
		Adolescents and young people reached with HIV information	Percentage of schools and institutions with HIV programs	30%	Public Sector Reporting	70%	985	County government, Ministry of education, partners, institutions of learning
		Workplace programs established with comprehensive HIV and wellness programs	Percentage Workplace programs	20%	Public Sector Reporting	50%	70%	County government, partners, FKE

Strategic Direction 5; Strengthening Research, innovation and information management to inform KASF goals								
KASF objective	**KCASP result**	**Key activity**	**Indicators**	**Baseline**	**Source**	**Midterm target**	**End term target**	**Responsibility**
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%**	Increase capacity to conduct HIV research at County level by 10%	Investing in the County capacity for sound research	Number of health workers trained on research/ scientific writing	0	County Department of Health	30	60	CDH, Partners, County Government , NACC, Institutions of higher learning
		Undertake an annual stigma index	Report on stigma index available and in use to reduce stigma and discrimination	0	Stigma Index	0	1	
	Increased implementation of research on identified County related HIV priorities by 50%	Identify County HIV research priorities	Percentage of planned research conducted in line with County HIV agenda	0%	County Department of Health	5%	10%	
		Establish a research hub	Research hub established and in use	0	County Department of Health	1	1	
	Increased evidence based planning, programming, budgeting and policy changes by 50%	dissemination and translation of research findings to inform programming identification and implementation of high impact research priorities, innovative programming and capacity strengthening to conduct research	proportion of research reports disseminated to inform policy, planning and programming	0%	County Department of Health	25%	50%	

Strategic Direction 6; Promote utilisation of strategic information for research and monitoring and evaluation to enhance programming								
KASF objective	**KCASP result**	**Key activity**	**Indicators**	**Baseline**	**Source**	**Midterm target**	**End term target**	**Responsibility**
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%**	Increased availability of strategic information to inform HIV response at all levels Strengthening M&E systems in the department	Harmonize timely comprehensive routine and non-routine monitoring systems to provide quality HIV data	Number of complete reports submitted	4	County Department of Health	4	4	CDH, partners
	Planned evaluations, reviews, service implemented and results disseminated in a timely manner	Strengthen M&E activities	Number of planned M&E meetings , surveys, DQAs Held	4	County Department of Health	6	8	CDH, partners
	Comprehensive information package on key KCASP indicators provided for decision making	Investments in health information strengthening	Number of timely , complete reports received	4	County Department of Health	4	4	CDH, partners
	M&E information hub established at County level	Establish multi-sectoral and integrated real time HIV platform to provide updates on HIV epidemic response accountability at all levels	functional County Dash Board	0	County Department of Health	1	1	County Government, NACC, Partners

Strategic Direction 7; Increasing domestic financing for a sustainable HIV response								
KASF objective	**KCASP result**	**Key activity**	**Indicators**	**Baseline**	**Source**	**Midterm target**	**End term Target**	**Responsibility**
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%**	Increase domestic financing to 10%	Promote allocative efficiency and effective use of available resources	County Government financing to HIV	2,700,000	County Budget	5,000,000	10,000,000	County Government , County assembly
		Joint planning, budgeting and joint performance monitoring and evaluation between all stakeholders in the County	Percentage of HIV funding coming from private and households	30%	KNASA	35%	40%	County government, partners, FKE
		mobilizing funds from key stakeholders towards KCASP priorities	Funds allocation to KCASP priorities		County Budget	30%	40%	County government, partners
		Promote innovative and sustainable domestic HIV financing options e.g. Marathons, charity walks, games, and dinners	Percentage of resources mobilized against the HIV budget	6%	KNASA	7%	10%	County government, partners
		Undertake mapping of HIV partners to identify gaps	Inventory of HIV partners per sub-County and intervention area	-	Stake holder Inventory	-	-	County government, partners

Strategic Direction 8: Promoting Accountable leadership for delivery of KASF Results by all sectors and actors								
KASF objective	**KCASP result**	**Key activity**	**Indicator**	**Baseline**	**Source**	**Midterm target**	**End term target**	**Responsibility**
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%**	80% of partners and stakeholders reached with the KCASP	Print 150 copies of KCASP and disseminate to the County executive and County assembly and stakeholders	Percentage of partners and stakeholders using the KCASP to implement HIV activities	0	HIPORS	60%	80%	County government, Partners, NACC
	An enabling legal and regulatory framework for multisectoral HIV response fully aligned to the Constitution of Kenya 2010	Developing a County policy and legal framework for HIV response	Number policies and legal frameworks developed	0	County Department of Health	1	1	County Government, County assembly
	Create an enabling environment for multi-sectoral response	Stakeholder engagement and involvement	Number of stakeholder forums held	0	County Department of Health	4	6	County government, partners
		Establishing a functional HIV coordinating mechanism at all levels	Number of functional HIV committees at the sub-County	4	County Department of Health	4	4	CDH
			County HIV committee in place and meeting quarterly	0	Minutes	3	4	County government, NACC
			Establish County HIV ICC and hold quarterly meetings	0	County Department of Health	2	4	County government, partners, NACC
			Effective and well-functioning stakeholder coordination and accountability mechanism in place and fully operationalized at all levels	0	HIPORS	6	8	County Government , partners, NACC
			Number of MDAs with sector specific HIV plans and work place programs	3	Public sector reporting	7	12	County government, Institutions of learning, NACC
			HIV reported quarterly as an indicator in the County performance contract	0	PC Report	3	4	County government, NACC
	Good governance practices and accountable leadership entrenched for the multi sectoral HIV and AIDS at all levels		Number of advocacy meetings held with key stakeholders	2	Minutes	3	4	CDH, partners
			World AIDS day budgeted for and commmemorated in the county	1	report	1	1	CDH, partners, NACC

Annex 2

KIRINYAGA CASP BUDGET (KSHS)					
Strategic Direction 1: Reducing new HIV infections					
KCASP results	**Key activity**	**Indicators**	**Year 1**	**Year 2**	**Year 3**
Reduced annual new HIV infections by 30%	Scale up HTS	Number of population tested for HIV	523,134,000	664,464,375	720,193,200
	Scale up blood donation from 9457 units & Promotion of blood safety and donor notification	Number of blood donors notified of their HIV results	14,185,500	15,000,000	16,500,000
	Promotion of condom use and related commodities	Number of condoms supplied	5,613,560	9,270,000	12,360,000
	Legislate in the County assembly for all lodges and hotels to include condoms in their basic room package	Number of hotels and lodges with condoms in their basic room package	500,000	300,000	200,000
	PEP and Occupational safety	Number of health facilities providing PEP services	27,902,700	29,231,400	31,003,000
	DICs increased from 1 to 3	Number of established and functional DICs	3,000,000	6,000,000	9,000,000
	Establish youth and PWD friendly HIV services	Number of facilities offering PWD and youth friendly services	6,000,000	18,000,000	27,000,000
		Establish Adolescent TWG to spearhead the fastrack plan and convene quartely meetings	0	350,000	700,000
	Scale up HIV information among adolescents and young people	Number of adolescents with comprehensive HIV knowledge	10,176,207	11,429,184	14,277,280
	Provide HIV services in institutions of learning	Number of adolescents 15-19	45,740,250	55,482,000	72,531,450
		Young people 20-24 who know their HIV status	73,184,400	71,334,000	79,784,595
Reduced HIV transmission rates from mother to child from 6.3 % to less than 2 %	Scale up eMTCT activities in all health facilities	Number of pregnant women who know their HIV status	2,571,498	2,835,693	3,154,684
		Number of pregnant and lactating mothers receiving HAART	2,185,773	2,552,124	2,996,950
		Number of HIV exposed infants with negative result from positive pregnant and-lactating mothers	1,857,907	2,296,911	2,996,950
Subtotal			**716,051,796**	**888,545,687**	**992,698,109**
Program management costs 7.4%	_	_	53,703,885	66,640,927	74,452,358
Total			**769,755,680**	**955,186,613**	**1,067,150,467**

Strategic Direction 2: Improving Health outcomes and wellness of all people living with HIV					
KCASP results	**Key activity**	**Indicators**	**Year 1**	**Year 2**	**Year 3**
Attain 90% linkage to care after HIV diagnosis	Strengthening referral and linkage to care and treatment including Home based care	Number of HIV positive clients linked to care within 3 months	19,761,786	34,554,234	41,950,458
% of health facilities offering ART	Integrate CCCs in all health facilities	Number of facilities with integrated CCCs.	3,018,534	11,609,748	18,575,597
90% ART coverage	Increase uptake of ART	Number of eligible HIV clients on ARVs	522,101,186	527,483,672	532,866,159
	Build capacity of health care workers on paediatric HIV management	Number of paediatric patients enrolled and retained on care	1,219,994	1,423,326	1,728,325
90 % retention at 12 months	Monitoring and follow-up of clients enrolled	Number of HIV positive adults and children retained on treatment 12 months after initiation of ART	5,538,310	7,495,310	11,742,000
	Train CCC social workers on HIV care management for OVCs	Number of social workers trained	1,000,000	1,500,000	3,000,000
ICT utilised in ART adherence	Biometric registration of ART patients to eliminate double registration and defaulting	Number of ART patients biometrically registered	0	100,000	180,000
Attain 90% viral suppression	Early initiation to ARVs	Number of HIV (+ ve) clients with viral load suppression at 12 months after initiation of ARVs	49,275,200	55,434,600	60,978,060
Reduce AIDS related mortality by 10%	Screening all HIV clients for TB	Number of HIV clients screened for TB	49,275,200	55,434,600	60,978,060
	Strengthen Laboratory surveillance systems & Pharmaco vigilance	Number of viral load results received on time	200,000	300,000	500,000
Subtotal			**651,390,210**	**695,335,490**	**732,498,658**
Program management costs 7.4%	_	_	48,854,266	52,150,162	54,937,399
Total			**700,244,476**	**747,485,652**	**787,436,057**

Strategic Direction 3; Using a human rights approach to facilitate access to services for PLHIV, Key populations and other priority groups in all sectors					
KCASP results	**Key activity**	**Indicators**	**Year 1**	**Year 2**	**Year 3**
Reduce self reported stigma and discrimination related to HIV to below 20%	Sensitizing service providers on stigma and discrimination	Number of women and men aged 15-49years expressing accepting attitudes towards PLHIV	23,704,573	31,190,228	49,904,365
	Strengthen and build the capacity of PLHIV support groups on PWP	Number of support groups established and that remain active	1,071,200	3,213,600	4,820,400
	Community training on human rights as relates to HIV & SGBV	Number of community dialogue days held as relates to HIV & SGBV	1,500,000	3,000,000	4,500,000
	Train Key Populations on HR	Number of quarterly sessions held with key populations	600,000	1,200,000	1,800,000
Reduce levels of sexual and gender based violence for people living with HIV, key populations , women, men, boys and girls by 50%	Train teachers and law enforcers	Number of PHLIV who experience sexual and GBV	500,000	1,000,000	1,500,000
Increase protection of human rights , and improved access to justice for people living with HIV , key populations and other priority groups	Packaging preventive HIV programs for key populations	Number of program developed for KP	1,500,000	4,500,000	6,000,000
	Devolve HIV tribunal	Number of cases received and resolved by the HIV tribunal	0	500,000	1,000,000
Subtotal			**28,875,773**	**44,603,828**	**69,524,765**
Program management costs 7.4%			2,165,683	3,345,287	5,214,357
Total			**31,041,456**	**47,949,115**	**74,739,123**

Strategic direction 4. Strengthening integration of health and community systems					
KCASP result	**Key activity**	**Indicators**	**Year 1**	**Year 2**	**Year 3**
Improved Health care workforce for HIV response by 40%	Training the Health Workforce in HIV and AIDS response	Number of Health workers trained on HIV and AIDS response	30,600,000	36,700,000	48,900,000
Increased number of health facilities ready to provide KEPH defined HIV and AIDS services	Scale up the number of health facilities providing KEPH defined HIV and AIDS services	Number of health facilities providing early infant diagnosis	3,795,014	5,692,522	8,538,782
Strengthened HIV commodity management through effective and efficient management of medicines and medical products	Scheduled Procurement and distribution of test kits and laboratory reagents	Number of HIV testing health facilities that report stock outs at least once in 3months	100,000	100,000	100,000
	Continuous Quality improvement	Number of functional QIC	16,968,000	21,210,000	26,058,000
Strengthened community level AIDS competency	Strengthen Community Strategy and training on Community level HIV module	Number of community units implementing AIDS competence guidelines	1,050,000	1,500,000	2,050,000
		Number of CU offering HIV services including HBC	42,000	180,000	410,000
	Adolescents and young people reached with HIV information	Number of schools and institutions with HIV programs	3,693,168	8,617,392	11,695,032
	Workplace programs established with comprehensive HIV and wellness programs	Number Workplace programs	1,000,000	2,500,000	3,500,000
Subtotal			**57,248,182**	**76,499,914**	**101,251,814**
Program management costs 7.4%			4,293,614	5,737,494	7,593,886
Total			**61,541,796**	**82,237,407**	**108,845,700**

Strategic Direction 5; Strengthening Research, innovation and information management to inform KASF goals					
KCASP result	**Key activity**	**Indicators**	**Year 1**	**Year 2**	**Year 3**
Increase capacity to conduct HIV research at County level by 10%	Investing in the County capacity for sound research	Number of health workers trained on research/ scientific writing	0	1,500,000	3,000,000
	Undertake a annual stigma index	Report on stigma index available and in use to reduce stigma and discrimination	0	0	500,000
Increased implementation of research on identified County related HIV priorities by 50%	Identify County HIV research priorities	Number of planned research conducted in line with County HIV agenda	0	250,000	500,000
	Establish a research hub	Research hub established and in use	0	5,000,000	1,000,000
Increased evidence based planning, programming, budgeting and policy changes by 50%	Dissemination and translation of research findings to inform programming	Number of research reports disseminated to inform policy, planning and programming	0	1,000,000	1,500,000
	Identification and implementation of high impact research priorities, innovative programming and capacity strengthening to conduct research	Number of prioritized research reports disseminated	100,000	100,000	100,000
Subtotal			**100,000**	**7,850,000**	**6,600,000**
Program management costs 7.4%	_	_	7,500	588,750	495,000
Total			**107,500**	**8,438,750**	**7,095,000**

Strategic Direction 6; Promote utilization of strategic information for research and monitoring and evaluation to enhance programming					
KCASP result	**Key activity**	**Indicators**	**Year 1**	**Year 2**	**Year 3**
Increased availability of strategic information to inform HIV response at all levels	Harmonize timely comprehensive routine and non routine monitoring systems to provide quality HIV data	Number of complete reports submitted	400,000	400,000	400,000
Planned evaluations, reviews, service implemented and results disseminated in a timely manner	Strengthen M&E activities	Number of planned M&E meetings , surveys, DQAs Held	1,600,000	2,400,000	3,200,000
Comprehensive information package on key KCASP indicators provided for decision making	Investments in health information strengthening	Number of timely , complete reports received	400,000	400,000	400,000
M&E information hub established at County level	Establish multi-sectoral and integrated real time HIV platform to provide updates on HIV epidemic response accountability at all levels	Functional County Dash Board	0	500,000	200,000
Subtotal			**2,400,000**	**3,700,000**	**4,200,000**
Program management costs 7.4%	–	–	180,000	277,500	315,000
Total			**2,580,000**	**3,977,500**	**4,515,000**

Strategic Direction 7; Increasing domestic financing for a sustainable HIV response					
KCASP result	**Key activity**	**Indicators**	**Year 1**	**Year 2**	**Year 3**
increase domestic financing to 10%	Promote allocative efficiency and effective use of available resources	Amount of County Government financing to HIV	500,000	500,000	500,000
	Joint planning, budgeting and joint performance monitoring and evaluation between all stakeholders in the County	Amount of HIV funding coming from private and households	600,000	600,000	600,000
	Mobilizing funds from key stakeholders towards KCASP priorities	Amount of funds allocation to KCASP priorities	360,000	360,000	360,000
	Promote innovative and sustainable domestic HIV financing options eg. Marathons, charity walks, games, and dinners	Amount of resources mobilized against the HIV budget	2,000,000	2,000,000	2,000,000
	Undertake mapping of HIV partners to identify gaps	Inventory of HIV partners per sub-county and intervention area	-	-	-
Subtotal			**3,460,000**	**3,460,000**	**3,460,000**
Program management costs 7.4%			259,500	259,500	259,500
Total			**3,719,500**	**3,719,500**	**3,719,500**

Strategic Direction 8; Promote Accountable leadership for delivery of KASF results by all sectors and actors					
KCASP result	**Key activity**	**Indicator**	**Year 1**	**Year 2**	**Year 3**
80% of partners and stakeholders reached with the KCASP	Print 150 copies of KCASP and disseminate to the County executive and county assembly and stakeholders	Number of partners and stakeholders using the KCASP to implement HIV activities	45,000	100,000	150,000
An enabling legal and regulatory framework for multisectoral HIV response fully aligned to the Constitution of Kenya 2010	Developing a County policy and legal framework for HIV response	Number of policies and legal frameworks developed	1,000,000	15,000,000	18,000,000
	Stakeholder engagement and involvement	Number of stakeholder forums held	0	600,000	900,000
Create an enabling environment for multi- sectoral	Establishing a functional HIV coordinating mechanism at all levels	Number of functional HIV committees at the sub-county	3,600,000	3,600,000	3,600,000
		County HIV committee in place and meeting quarterly	0	450,000	600,000
		Establish county HIV ICC and hold quarterly meetings	0	300,000	300,000
		Effective and well functioning stakeholder coordination and accountability mechanism in place and fully operationalized at all levels	0	900,000	1,200,000
		Number of MDAs with sector specific HIV plans and work place programs	1,500,000	3,500,000	6,000,000
		HIV reported quartely as an indicator in the County performance contract	0	150,000	200,000
		Number of advocacy meetings held with key stakeholders	400,000	600,000	800,000
Subtotal			1,900,000	5,450,000	8,500,000
Program management costs 7.4%	–	–	142,500	408,750	637,500
Total			**2,042,500**	**5,858,750**	**9,137,500**
Grand Total			**1,571,032,909**	**1,854,853,288**	**2,062,638,347**

SUMMARY	Year 1	Year 2	Year 3
Strategic Direction 1 sub-total	769,755,680	955,186,613	1,067,150,467
Strategic Direction 2 sub-total	700,244,476	747,485,652	787,436,057
Strategic Direction 3 sub-total	31,041,456	47,949,115	74,739,123
Strategic Direction 4 sub-total	61,541,796	82,237,407	108,845,700
Strategic Direction 5 sub-total	107,500	8,438,750	7,095,000
Strategic Direction 6 sub-total	2,580,000	3,977,500	4,515,000
Strategic Direction 7 sub-total	3,719,500	3,719,500	3,719,500
Strategic Direction 8 sub-total	2,042,500	5,858,750	9,137,500
Total (KSHS.)	**1,571,032,909**	**1,854,853,288**	**2,062,638,347**

Annex 3: Implementation plan

Strategic Area	Activities	2016				2017				2018			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
SD 1: Reducing new HIV infections	Scale up mobile and moonlight VCT services in the hotspot areas	X	X	X	X	X	X	X	X	X	X	X	X
	Scale up and strengthen existing youth friendly services	X				X				X			
	County Government to allocate more resources for recruiting, training and retaining HTS service providers	X				X				X			
	Training of healthcare providers, integrated supervision and mentorship to maximize enrolment and retention of PLHIV eligible for ART under the treatment as prevention strategy	X	X	X	X	X	X	X	X	X	X	X	X
	Integration of early infant diagnosis with other immunization service	X	X	X	X	X	X	X	X	X	X	X	X
	Carry out Community sensitization on the importance of eMTCT	X	X	X	X	X	X	X	X	X	X	X	X
	Increase outreaches targeting KPs based on geographical location	X			X	X			X	X			X
	Prioritization and scaling up of combination prevention interventions for vulnerable youth and key populations	X	X	X	X	X	X	X	X	X	X	X	X
	Scale up and operationalize Gender-Based recovery centres				X				X				X
	Conduct a baseline survey on GBV				X								
	Strengthen linkage and referral between HIV testing and enrolment to care and treatment	X	X	X	X	X	X	X	X	X	X	X	X
	Strengthen procurement, distribution and management of essential commodities and equipment	X	X	X	X	X	X	X	X	X	X	X	X
	Develop targeted IEC and BCC messages for the different subpopulations Improve the community-based HIV M&E system												

SD 2: Improving Health Outcomes and wellness of PLHIV	Increase the number of health facilities offering ART centres												
	Improve the coordination of joint interventions between health facilities and community-based organizations through the County health management team			X									
	Integration of early infant diagnosis with other immunization services	X	X	X	X	X	X	X	X	X	X	X	X
	Improvement of the existing CCI to make them child friendly				X				X				X
	Training of healthcare providers, integrated supervision and mentorship to maximize enrolment and retention of PLHIV eligible for ART under the treatment.	X	X	X	X	X	X	X	X	X	X	X	X
	Scale up and establish a viable rehabilitation Centre for alcohol and drug addicts				X				X				X
	Establish a HIV referral laboratory in Kirinyaga County.			X									
	Develop innovative approaches for integrate the use of ICT in HIV services especially increasing adherence to ART.			X									
	Support partners to implement the minimum package for PWP activities	X	X	X	X	X	X	X	X	X	X	X	X
SD 3: Using Human Rights based approach to facilitate access to services	Scale up and operationalize Gender-Based recovery centres		X										
	Capacity building and mentorship for enhanced documentation		X										
	Sensitize PLHIV and the community on the legal rights.			X				X				X	
	Decentralize the functions of the HIV tribunal to the Counties			X				X				X	
	Train more paralegal on the HIV and AIDS issues				X								
	Empower vulnerable girls and women for active participation in the HIV response.	X	X	X	X	X	X	X	X	X	X	X	X
	Create an enabling legislative framework to encourage roll out of intervention				X								
SD 4: Strengthening integration of community and health system	Strengthen Human Resource planning to improve, recruitment, equitable deployment, training, supervision, mentorship and better working conditions of healthcare workers.		X				X				X		
	Adoption and implementation of Kenya HIV Quality Improvement Framework (KHQIF) as well as implementation of health workforce	X											
	County Government to allocate more resources for recruiting, training and retaining HTS service providers.				X				X				X
	Establish more community health units	X	X	X	X	X	X	X	X	X	X	X	X
	Integrate HIV information and education as part of the school health program.			X									

SD 5: Strengthening Research, Innovation and Information Management to meet the KCASP	Form the County Monitoring Unit to coordinate research, monitoring and evaluation activities.	X											
	Allocate sufficient funds for drugs and lab reagents	X				X				X			
	Develop a County HIV research agenda through a consultative process to complement the National HIV Agenda				X								
	Strengthen utilization of routine data source for planning and decision making.	X	X	X	X	X	X	X	X	X	X	X	X
SD 6: Promoting utilization of strategic information for research monitoring and evaluation	Improve the community-based HIV M&E system and monitoring	X	X	X	X	X	X	X	X	X	X	X	X
	County and Sub-County health management team members will participate in the Sub-County OVC committee in charge of overseeing OVC service provision.	X				X				X			
	Strengthen inter-agency collaboration in OVC management.	X	X	X	X	X	X	X	X	X	X	X	X
	Prepare and publish a County Department of Health Newsletter.			X			X			X			X
SD 7: Increasing domestic financing for sustainable HIV response.	Prioritization of high impact and cost-effective interventions				X								
	Promote Public-Private Partnerships in health services.				X				X				X
	Lobby for increased domestic funding.				X				X				X
	Undertake a mapping of HIV partner's representation in Kirinyaga to identify gap areas.	X											
SD 8: Promote accountable leadership for delivery of the KCASP results by all sectors	Build and sustain high-level political commitment for strengthened County ownership of HIV response to be led by the governor	X											
	Sensitize members of the County assembly and the public to incorporate HIV activities during public participation forum during the County budget process	X											
	Hold a meeting to disseminate the KCASP to the Kirinyaga County Executive Committee					X							
	Form the County HIV coordination unit					X							
	Hold a meeting to disseminate the KCASP to the private sector for enhancing private public partnership for HIV services in Kirinyaga					X							
	Support Sub County / Constituency HIV committees	X	X	X	X	X	X	X	X	X	X	X	X
	Commemorate WAD				X				X				X

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Notes


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National AIDS Control Council


University of Nairobi
CRISS Project


The Global Fund
To Fight AIDS, Tuberculosis and Malaria