KISUMU COUNTY

HIV AND AIDS STRATEGIC PLAN

(2014/15 – 2018/19

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National AIDS Control Council

KISUMU COUNTY HIV AND AIDS STRATEGIC PLAN

(2014/15 – 2018/19

"Re-orienting HIV and AIDS response in a devolved system of Government"

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Table of Contents

Acronyms/Abbreviations v
Foreword viii
Preface ix
Acknowledgements x
Executive summary xi

CHAPTER 1: BACKGROUND 1
1.1 Location and Size of the County 1
1.2 Demography 1
1.3 Administrative/ Political units 2
1.4 Economic Activities 2
1.5 Religion and Traditional Culture 2
1.6 HIV Programme Planning and Coordination 2

CHAPTER 2: SITUATION ANALYSIS 3
2.1 National HIV burden 3
2.2 HIV Burden in Kisumu County 4
2.3 Treatment coverage 5
2.4 TB/HIV Co-infection 6
2. 5 Drivers of new HIV infections in Kisumu County 7
2.6 Strength, Weaknesses, Opportunities and Threats (SWOT) Analysis 8
2.7 HIV Financing 9

CHAPTER 3: RATIONALE, PURPOSE, ALIGNMENT TO OTHER KEY DOCUMENTS, STRATEGIC PLAN DEVELOPMENT PROCESS AND GUIDING PRINCIPLES 10
3.1 Rationale 10
3.2 Purpose of the KCASP 10
3.3 Alignment to other Key Documents 11
3.4 Process of developing the HIV Plan 11
3.4 Guiding principles 12

CHAPTER 4: VISION, MISSION, OBJECTIVES AND COUNTY STRATEGIC DIRECTIONS 13
4.1 Vision 13
4.2 Mission 13
4.3 Objectives of Kisumu County AIDS Strategic Plan 13
4.4 Kisumu County expected results by 2019 13
4.4 County Strategic Directions 15
4.4.1 Strategic Direction 1: Reducing new HIV infections 15
4.4.2 Strategic Direction 2: Improve Health Outcomes of PLHIV 19
4.4.3 Strategic Direction 3: Using a Human Rights Approaches to Facilitate Access to Service 22
4.4.4 Strategic Direction 4: Strengthening integration of Community and Health Systems 25
4.4.5 Strategic Direction 5: Strengthening Research, Innovation and Information Management to meet KCASP goals 29

4.4.6 Strategic Direction 6: Promote utilization of strategic information for research monitoring and evaluation to enhance programming 32
4.4.7 Strategic Direction 7: Increase Domestic Financing for Sustainable HIV Response 35
4.4.8 Strategic Direction 8: Promoting Accountable Leadership for delivery of the KCASP results by all Sectors 39

CHAPTER 5: IMPLEMENTATION ARRANGEMENTS 42
5.1 HIV Coordination structure for KCASP Delivery 42

CHAPTER 6: MONITORING & EVALUATION PLAN 43
6.1 M&E systems 43
6.2 Baseline Information 43
6.3 Indicators 43
6.4 KCASP Reviews 43
6.5 Data Flow and Archiving 44

CHAPTER 7: RISKS, MITIGATION, AND ASSUMPTIONS PLAN 45

CHAPTER 8: FINANCING OF THE KISUMU COUNTY HIV & AIDS PLAN 46
KCASP Results need (USD million) 47

CHAPTER 9: ANNEXES 48
Annex 1: The KCASP Development Process 49
Annex 2: Implementation plan 50
Annex 3: Results Framework 52
Annex 4: Leverage on Sectors for HIV prevention 62
Annex 5: References 64
Annex 6: Drafting and Technical Support Team members 65
a. Drafting team 65
b. Technical support team 65

Acronyms and abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ALHIV	Adolescents living with HIV
ANC	Antenatal Care
APHIA	AIDS Population & Health Integrated Assistance Programme
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Drugs
BCC	Behaviour Change Communication
CBO	Community Based Organization
COBPAR	Community Based Program Activity Reporting
CCC	Comprehensive Care Centre
CCM	Country Coordination Mechanism
CHEWs	Community Health Extension Workers
CHV	Community Health Volunteer
CHMT	County Health Management Team
CME	Continuous Medical Education
CSO	Civil Society Organization
DHIS	District Health Information System
DTC	District Technical Committee
EBI	Evidence Based Intervention
EGPAF	Elizabeth Glaser Paediatric AIDS Foundation
EID	Early Infant Diagnosis
EIMC	Early Infant Medical Circumcision
eMTCT	Elimination of Mother to Child Transmission
EPI	Expanded Program on Immunization
ETR	End Term Review
FBO	Faith Based Organization
FSW	Female Sex Worker
GBV	Gender Based Violence
GIZ	German International Development
HAPCA	HIV AIDS Prevention and Control Act
HBC	Home Based Care
HBTC	Home Based Testing and Counselling
HCBC	Home and Community Based Care
HCWs	Health Care Workers
HIPORS	HIV Partners Online Reporting System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPV	Human Papilloma virus
HRBA	Human Rights Based Approach
HTS	HIV Testing Services
IEC	Information, Education, and Communication
IGAD	Intergovernmental Authority on Development
IRDO	Impact Research and Development Organisation
IPC	Infection Prevention and Control
IPV	Intimate Partner Violence
KAIS	Kenya AIDS Indicator Survey
KASF	Kenya AIDS Strategic Framework
KCASP	Kisumu County AIDS Strategic Plan
KDHS	Kenya Demographic and Health Survey
KELIN	Kenya Legal Network
KEMRI	Kenya Medical Research Institute
KEPH	Kenya Essential Package for Health
KNASP	Kenya National AIDS Strategic Plan
KP	Key Populations
LMIS	Logistics Management Information System
MCA	Members of County Assembly
MDAs	Ministries, Departments and Agencies
M&E	Monitoring and Evaluation
MNCAH	Maternal Neonatal Child Adolescents Health
MoH	Ministry of Health
MoT	Mode of Transmission
MSM	Men who have Sex with Men
MTR	Mid-Term Review
NACC	National AIDS Control Council

NASCOP	National AIDS & STI Control Programme
NEPHAK	Network of People Living with AIDS in Kenya
NGO	Non-Governmental Organizations
NTSA	National Transport and Safety Authority
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PITC	Provider-initiated Testing and Counselling
PLHIV	People Living with HIV
PMS	Post Marketing Surveillance
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
PwD	People/Persons with Disabilities
PWID	People Who Inject Drugs
PHDP	Positive Health, Dignity and Prevention
RBM	Results Based Management
SACCO	Savings and Credit Cooperative Organization
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Worker
SWOT	Strength, Weakness, Opportunity and Threats
TB	Tuberculosis
TBA	Traditional Birth Attendants
TOWA	Total War against HIV and AIDS
TWG	Technical Working Group
TSC	Teachers Service Commission
TST	Technical Support Team
UNAIDS	United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organisation
WOFAK	Women Fighting AIDS in Kenya
YFS	Youth Friendly Services

Foreword

Significant progress has been made in the HIV response in Kenya with the national prevalence dropping to 6%. Kisumu County, however, continues to experience a prevalence rate of 19.3% which is much higher than the national average. HIV continues to contribute to high mortality rates thus burdening households and straining County Health and Community systems.

With this understanding, the Kisumu County AIDS Strategic Plan 2014/2015 – 2018/2019 exemplifies the firm commitment by my government, stakeholders and partners working in Kisumu to support County Health Services to deliver better health for all with a focus on cost effective and socially inclusive interventions to prevent and manage HIV and AIDS.

This County AIDS Strategic Plan focuses on leadership in the HIV response. It emphasizes an equitable HIV response in all sub counties and ensures no one is left behind. The county identifies main HIV driving factors that are linked to the various socio-economic activities including fishing along the beaches of Lake Victoria.

My government will continue to support and create an enabling environment to offer HIV services up to the household level. I encourage all stakeholders to work closely with my government and also commit to partner with the National Government's line ministries and departments to ensure the objectives of the plan that include; reduction in new HIV infections by 75%, reduction in AIDS related mortality by 25%, reduction in HIV related stigma and discrimination by 50% and increase in domestic financing of HIV response by 50% are achieved in the next 5 years. With this political will we shall strive to provide financial support to health services to ensure HIV integration in all sectors in this county in order to realize a county free of new HIV infections, stigma and AIDS related death.

HON. JACK RANGUMA.
The Governor, Kisumu County

Preface

In line with devolved governance structures, the country through NACC's leadership developed KASF to guide every county in formulating county specific HIV specific plan. In this regard, the Kisumu County stakeholders developed the Kisumu County AIDS Strategic Plan (KCASP) 2014/15-2018/19.

The plan promotes calibration of our efforts through effective prioritization of interventions. It focuses on effective evidence based interventions, which target priority and key populations while ensuring that all people are reached and stigma and discrimination are reduced for improved health outcomes.

The strategic plan recognizes the importance of a multi-sectoral response to HIV and outlines roles and expected actions from different sectors and actors. A coordination and governance structure led by the County Director for Health takes cognizance of devolved functions of health department, sub counties, health facilities and partners, and the need to strengthen stakeholder involvements for results.

The plan identifies several cross cutting areas of existing or potential strengths in HIV & AIDS response that require increased health department funding and partner support. The KCASP outlines an innovative leverage funding approach based in implementation of the HIV resource mobilization, increased access to HIV & AIDS care for those living with HIV and ultimately subsidize Kisumu County's future liability to HIV prevention and treatment.

The development of this plan was participatory, involving all key stakeholders in HIV response. It is my firm conviction that the implementation of this HIV & AIDS Strategic Plan will provide a roadmap for health services and ensure that the Health Department, assisted by implementing partners and other multisectoral stakeholders meets its constitutional mandate by providing integrated and high quality preventive, curative, rehabilitative and palliative health care services to her people. My department is, therefore, committed to work with the line ministries and departments of the National Government and partners in facilitating achievement of results articulated in this Strategic Plan. In doing so, we will build on the progress made so far through years of hard work, unity of purpose, courage and commitment to step up the momentum towards ending the AIDS pandemic.

HON. ELIZABETH OGAJA
County Executive Committee Member, Health Services

Acknowledgements

The Kisumu County HIV Strategic plan (KCASP) will provide direction to all stakeholders in the HIV and AIDS response. It draws on our past successes, lessons learnt and gives us the opportunity to provide the direction for our future. It emphasizes a multi-sectoral approach and accountability among partners and leverages on the opportunities presented by the devolved system of governance.

The development of this plan and the consensus building would not have been possible without the involvement of different stakeholders and partners. The Kisumu County Health Department acknowledges various individuals and organizations that assisted during the development process of this Kisumu County AIDS Strategic Plan (2014/15-2018/19). In particular, we thank the CECM for Health and the Chief Officer for Health in providing the necessary leadership in this process. We also acknowledge the enabling environment and the contributions that were provided by the County Assembly Committee for Health.

Special thanks go to all the Kisumu County Health Department staff who provided valuable insight, helpful suggestions and support during the development process. We would also like to acknowledge the following; KELIN, Maseno University, Kisumu County Budget Office, Impact RDO, NEPHAK, NASCOP and the NACC who put in tremendous effort as a drafting team for the Strategic plan. It is from these engagements that we have put forth a vision, setting us on a trajectory that will assure the achievement of our County HIV and AIDS goals.

The contribution of the National Government ministries and departments is immensely appreciated as they have gone a long way in providing technical assistance to the process.

It is also our humble pleasure to appreciate the National AIDS Control Council (NACC) for the support which include the development and printing of this Kisumu County AIDS & HIV Strategic Plan (KCASP) 2016 – 2018/2019.

DR. OJWANG' LUSI
Chief Officer Health, Kisumu County

Executive summary

Kisumu County is one of the 47 counties in Kenya. The county has a diverse background comprising of urban and rural set-ups as well as a rich ethnic, racial and cultural diversity. There are seven sub counties within Kisumu County where the major economic mainstay of the residents include: Fishing, Farming (rice and sugarcane growing) and Trade. With the prevalence rate of 19.3%, the county has been categorized among the 9 counties that account for 65% of new HIV infections in the country. Therefore, there is need to have a better understanding of the epidemiological, biomedical, social, economic, religious and cultural factors affecting the pattern of the epidemic in the county. This will enable provision of a strategic focus through prioritization to improve efficiency and Effectiveness in the HIV response.

Kisumu County AIDS Strategic Plan (KCASP) 2014/15-2018/19 is the guide for response to HIV at the county level. This document addresses the drivers of the HIV epidemic and builds on the past gains to achieve its goal of contributing to the country's vision 2030 through universal access to comprehensive HIV prevention, treatment and care. The KCASP is derived from the Kenya AIDS Strategic Framework (KASF) 2014/15-2018/19 which is the Strategic guide for the country's response to HIV epidemic at the national level. The vision is to have a county free of HIV infections, stigma and AIDS related deaths. This vision will be achieved through the following objectives;

- Reduction of new HIV infections by 75%.
- Reduction of AIDS related mortality by 25%.
- Reduction of HIV related stigma and discrimination by 50%.
- Increasing domestic financing of the HIV response to 50%.

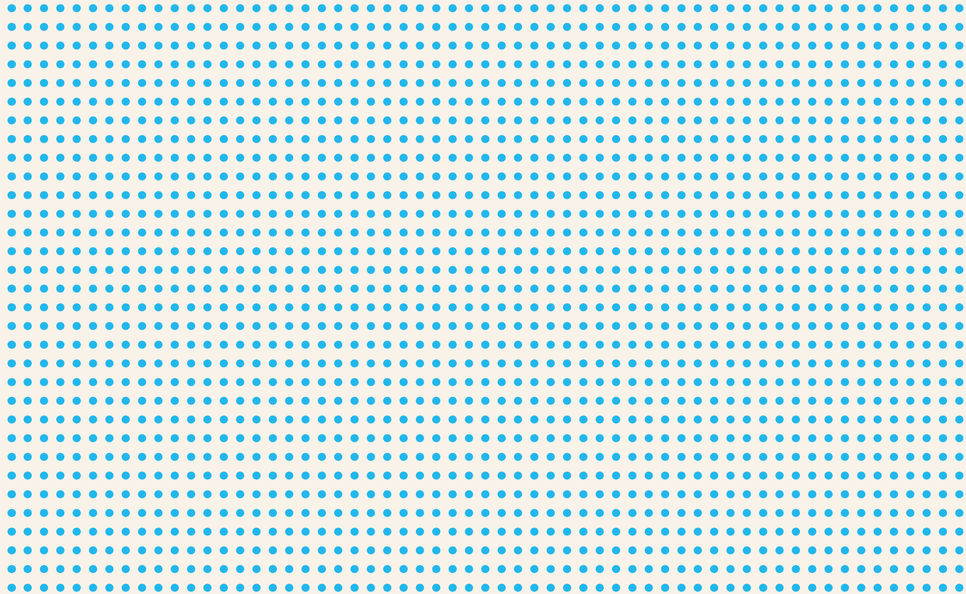
These objectives will be realised through the eight (8) strategic directions with support from the various HIV stakeholders implementing an array of programmes in Kisumu County with the coordination of the County Government.

This Strategic Plan is anchored on Kenya's Vision 2030 description of HIV and AIDS as "one of the greatest threats to socio-economic development". It marks a change in the approach of managing the response from doing "business as usual" to evidence and results-based multi-sectoral and decentralised planning. It is also aligned with the Constitution of Kenya 2010, which guarantees the policy environment for the national HIV and AIDS response, while also presenting a major paradigm shift in the governance and response which is county led and specific.

This document was developed through a consultative process that comprised of; the dissemination of the KASF, drafting, reviewing and validation.

01.

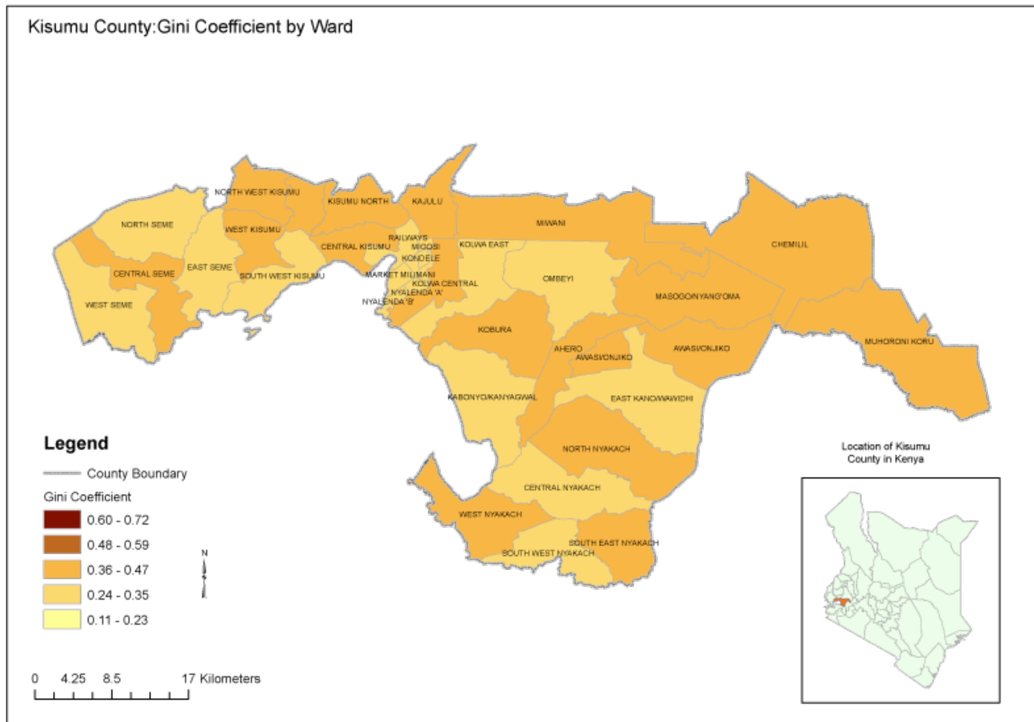
BACKGROUND



1.1 Location and Size of the County

Kisumu County lies on the western part of Kenya within longitudes 33° 20'E and 35° 20'E and latitudes 0° 20'South and 0° 50'south. The County borders Homa Bay County to the South, Nandi County to the North East, Kericho County to the East, Vihiga County to the North West and Siaya County to the West. The County covers a total land area of 2009.5 km^2 and another 567 km^2 covered by water (Kisumu County Integrated Development Plan, 2013/2014 – 2017/2018).

Figure 1.1: Map of Kisumu County Political Boundaries



Source: Kenya National Bureau of Statistics, 2010

1.2 Demography

The 2009 Population and Housing Census estimated Kisumu County's total population at 968,909 persons with 474,687 males and 494,222 females. The county's growth rate is estimated at 13.4 percent per annum and the total population is expected to increase from 968,909 in 2009 to 1,145,747 persons in 2017 (Kenya Population & Housing Census, 2009).

1.3 Administrative/ Political units

Kisumu County has seven sub-counties/ constituencies namely: Kisumu East, Kisumu West, Kisumu Central, Nyando, Seme, Nyakach and Muhoroni with a total of 35 wards each represented by an elected Member of the County Assembly.

Table 1:1: Kisumu County administrative units

S/NO	SUB COUNTY/CONSTITUENCY	NO. OF WARDS
1	Kisumu Central	6
2	Kisumu East	5
3	Kisumu West	5
4	Nyando	5
5	Muhoroni	5
6	Nyakach	5
7	Seme	4

1.4 Economic Activities

The economic growth and development of Kisumu County majorly depends on trade and agriculture which has been boosted by the presence of an international airport and Lake Victoria. Therefore, Kisumu serves as a potential business hub for Eastern Africa.

Other economic activities include; fishing, livestock rearing, sand harvesting and quarrying while tertiary services are boda boda and informal sector (jua kali). Tourism exhibits a high potential that is yet to be exploited in the county with various destinations dotted all over the county. Key examples include Kit Mikayi and the Impala Park in Kisumu.

1.5 Religion and Traditional Culture

Majority of Kisumu residents are Christians while others embrace religions such as Islam, African tradition and Hinduism.

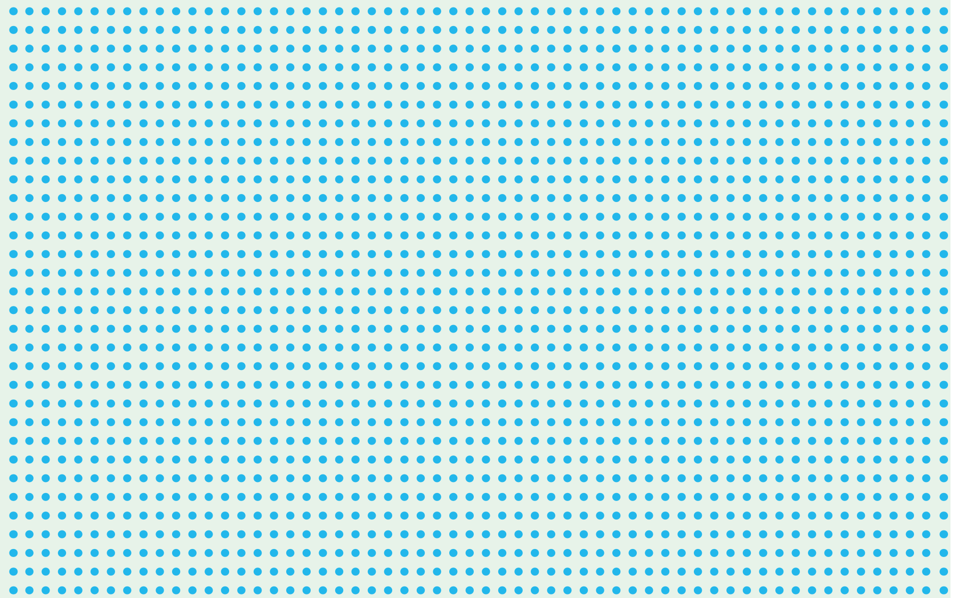
The local community is predominantly patriarchal, practices polygamy, wife inheritance and traditionally did not practice male circumcision. However, with emerging evidence of the benefits of medical male circumcision, they now embrace voluntary medical male circumcision as a strategy for HIV prevention.

1.6 HIV Programme Planning and Coordination

The coordination of HIV prevention in Kisumu County is multifaceted in nature where policy development, high level planning, resource mobilization as well as monitoring and evaluation are coordinated both at the National and County levels through the Ministry of Health agencies such as the National AIDS Control Council (NACC) and the National AIDS & STI Control Programme (NASCOP). Kisumu County has a vibrant civil society, public and private sector networks that carry out the implementation of HIV activities. The county government formulates and or adopts the national policies and guidelines customizing them to fit into the local context as required.

02.

SITUATION ANALYSIS



2.1 National HIV burden

Positive progress has been made in the response against HIV in Kenya with statistics showing a prevalence drop of 2% while new infections among children almost halved (KASF, 2014/15 – 2018/19). However, HIV continues to contribute to high mortality rates, burdening households and straining the national health systems. The HIV epidemic in the country is both generalized and concentrated in some populations such as the Key Populations. These are persons who are relatively at a higher risk of HIV transmission and acquisition on account of their behaviour or lifestyle, for instance men who have sex with men and persons injecting drugs. The national prevalence stands at 6.0%. In 2013, 1.6 million people were living with HIV in Kenya out of which 191,840 were children. 5.6% of males and 7.6% of females in Kenya are infected with HIV (Kenya HIV Estimates, 2014).

In Kenya, the Key Populations include men who have sex with men, people who inject drugs and sex workers (SW). The countrywide mapping conducted by NASCOP showed that the significance of key populations in the country is too critical to ignore as 33% of all new infections in the country are attributed to them (KMOT, 2009). According to Kenya AIDS Epidemic update of 2012 by NACC and NASCOP, HIV prevalence among KPs are high. For instance, prevalence in FSWs is (29.3%) with 4041 in Kisumu, PWID (18.3%)-424 and MSM-3019 (18.2%). HIV and AIDS affects productivity in all sectors including Agriculture, trade, transport and tourism (KAIS 2012).

It is also prudent to note that 65% of new infections occur in only nine (9) counties which include Kisumu. The MoT study of 2008 outlines the sources of new infections nationally as per the figure below.

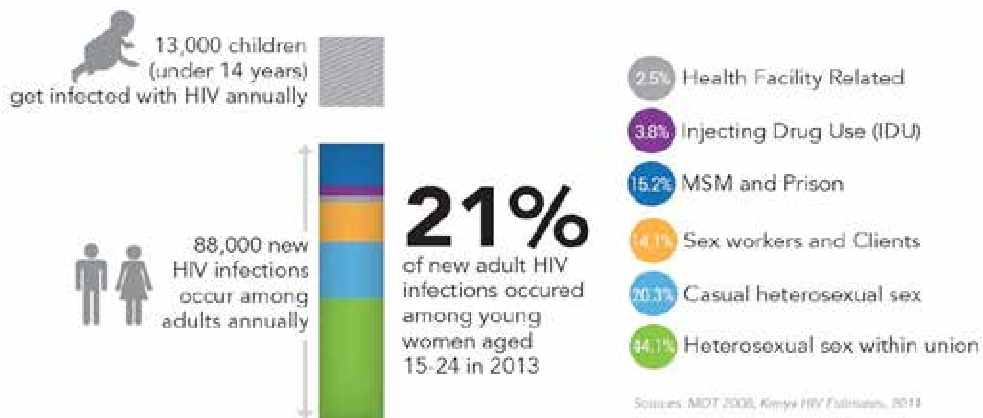


Figure 2.2: Source of new HIV infections in Kenya (Source: MoT, 2008; Kenya HIV Estimates, 2014)

2.2 HIV Burden in Kisumu County

General Population

Kisumu County, like most parts of the country, has made several gains in HIV and AIDS response. The biomedical, structural and behavioural interventions undertaken have resulted in a stabilization of the epidemic with the prevalence stabilizing at 19.3% (Kenya HIV Estimates, 2014).

Other gains include scaling up of ART coverage of 62,280 for adults and 6,881 among children, and PMTCT coverage of 86% of the targeted need (Kenya HIV Estimates, 2014). Support structures for persons infected and affected by HIV and AIDS have been established and community response strengthened through establishment of community units. The County Government continues to strengthen the entire spectrum of health service delivery through equipping health facilities and addressing human resource gaps. Despite the mentioned gains, HIV and AIDS epidemic remains a challenge for the County. With approximately 134,826 persons living with HIV (Kenya HIV Estimates, 2014), the County ranks 3rd in terms of HIV burden in the country. New adult annual HIV infection rate remains unacceptably high at 10,349 people in the County (Kisumu County HIV & AIDS Profile, 2014). Similarly, despite gains made on ANC and PMTCT, 2,296 new infections are registered in children 0-14 years annually (Kisumu County HIV & AIDS Profile, 2014).

According to the KDHS 2014, 70% of pregnant women delivered in health facilities. In 2014, out of the 24,906 positive HIV tests in Kisumu County 9,274 were below 24 years of age and constitute 37.2% of the total (DHIS 2016). This underlines the contribution of the young adults to the pandemic in Kisumu County.

Table 2.2: Kisumu County HIV Profile

INDICATOR	CHILDREN	ADULTS	TOTALS
Estimated HIV prevalence	-	19.30%	
PLHIV	16,859	128,600	145,459
New Infections	2,296	10,682	12,891
Deaths due to HIV	1,040	3,406	4,446
Need for PMTCT	8,570	-	8,570
Health Facilities (Active)	-	-	199
ART Sites	122	122	122
PMTCT Sites	-	-	127
TB Treatment sites	-	-	126

Source: Kenya HIV Estimates, 2014; DHIS, 2016; Kisumu County HIV & AIDS Profile, 2014

Key Populations

Just like any other county, key populations are as well major drivers of new HIV infections in Kisumu County. The sex workers estimates stood at 4,041, MSMs at 3,019 (NASCOP Consensus Report 2013) and that of Persons Who Inject Drugs stood at 424 in Kisumu.

Priority Populations

These are populations whose social contexts increase their vulnerability to HIV. In Kisumu County, priority populations include adolescents, young people and women living in informal settlements. Other identified populations include truck drivers, street children, persons with disabilities and mobile workers, Boda boda operators etc.

The Adolescents and Young People Factor

Indicator	Total	Gap
Adolescents and Young people Living with HIV	35873	
Need for Identification	28698	
Identified for care	21211	7487
Need for treatment	25829	
On treatment	18109	7719
Viral suppression targets	23246	

There has been a growing concern about HIV and AIDS among the adolescents and young persons in Kenya and by extension the rest of Sub-Saharan Africa. The 'All IN' campaign launched by the President of the Republic of Kenya seeks to understand HIV epidemic among adolescents, avail data and tailor interventions that conform to their needs. Data reviewed from various sources (population based, KAIS, KDHS, County Estimates (modelled data and specific programs data) through Kenya Adolescents Assessment and Decision Makers tool (KAADM), a tool adopted from UNICEF, revealed that 6,800 females and 6,000 males of ages between 10-24 were living with HIV in 2016 in Kenya. HIV incidence was found to be higher, especially among the Most at Risks Adolescents (MARA) while uptake of treatment was significantly lower.

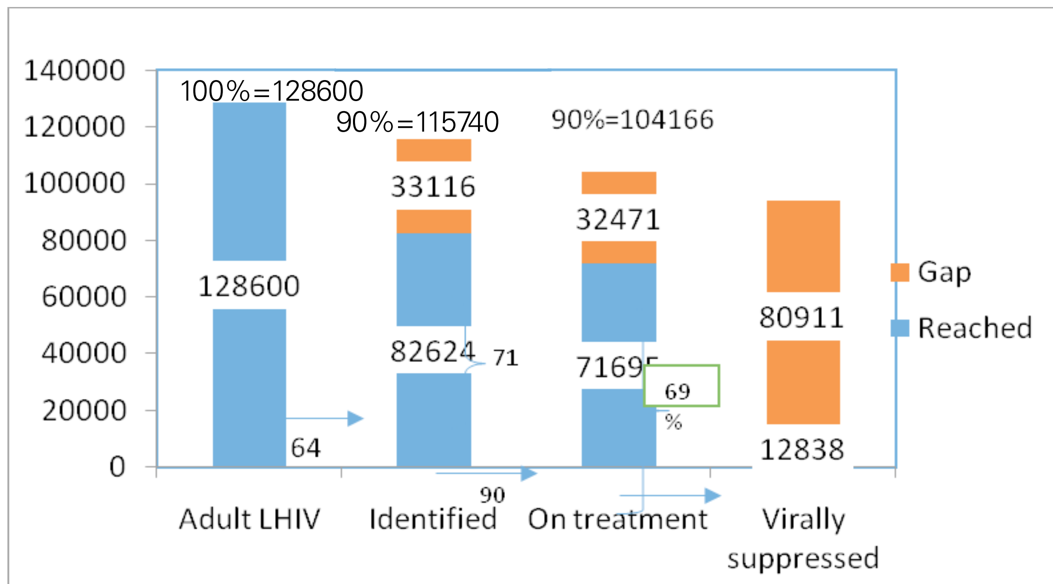
Note- The indicator Need for Treatment in table 2.4 above no longer applies in view of the current Test and Treat Guideline

2.3 Treatment coverage

In line with the 90–90–90 - ambitious treatment target to help end the AIDS epidemic (90% of all people living with HIV know their HIV status, 90% of all people with diagnosed HIV infection receive sustained antiretroviral therapy, 90% of all people receiving antiretroviral therapy have viral suppression), by September 2015 of the 128,600 (100%) estimated Adults Living with HIV the county had identified 82,624 (71%). Out of the 82,624, 71,695 (69%) were started on antiretroviral therapy and 12,838 (42%) of those on antiretroviral therapy were virally suppressed.

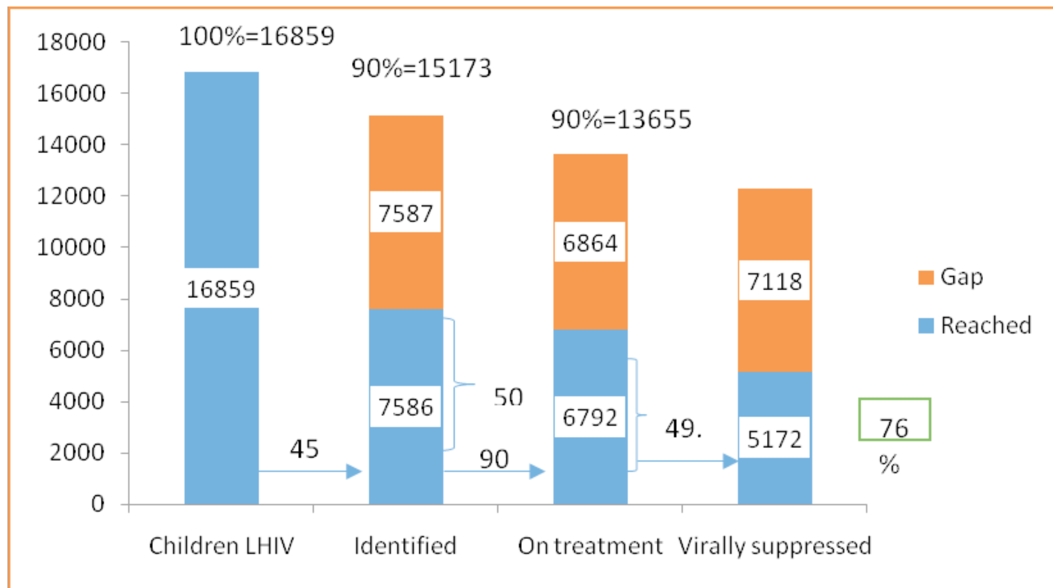
Of the 16,859 (100%) estimated children living with HIV, 7,586 (50%) were identified, 6,792 (49%) of whom were started on antiretroviral therapy (ART) and 5,172 (30%) of those on antiretroviral therapy were virally suppressed by September 2015. These are captured in the bar graphs below.

Figure 2.5: Adult HIV treatment in Kisumu County



(Source: NASCOP ACT Dashboard, 2015)

Figure 2.6: Children HIV treatment in Kisumu County



(Source: NASCOP ACT Dashboard, 2015)

2.4 TB/HIV Co-infection

The County HIV/TB co-infection rates are still at high levels although there has been a decrease in the past four years. TB/HIV co-infection in the County could be as a result of delayed HIV diagnosis, poor adherence to ART, better reporting and integration among other factors. The co-infection rates are shown below.

Table 2.3: TB/HIV co-infection rate in Kisumu County

YEAR	TB PATIENTS TESTED FOR HIV	TB/HIV PATIENTS	CO-INFECTION RATE
2012	3842	2607	68%
2013	3257	2210	68%
2014	3288	2106	64%
2015	2891	1826	63%

Source: TIBU, 2016

2. 5 Drivers of new HIV infections in Kisumu County

The Kisumu County has identified the following priority populations based on the susceptibility. This will enable a paradigm shift of focus from intervention to population as guided by the Kenya HIV Prevention and Revolution roadmap. They are shown in the table below.

Table 2.4: Drivers of HIV in Kisumu County

CATEGORY	DRIVER	JUSTIFICATION
Social factors	Sex workers (SW) and their clients	Have multiple sexual partners
	People Who Inject drugs (PWIDs)	Share syringes and other materials
	Truckers, Boda-boda Matatus (Drivers & conductors)	Have quick money and can offer free transport for sex
	Men who have sex with men (MSMs)	Multiple sex partners
	Fisher Folks	Many young boys living with a single widower (jaboya system).
	Informal settlements	Poverty and close proximity that allow sharing of partners
	Early sexual debut	Poor sexual knowledge that expose the partners to unprotected sex
	Intergenerational sex/ trans generational sex	Poverty and lifestyle
	Drug and substance abuse	Poverty and lifestyle
Cultural factors	Wife Inheritance/widows/widowers	The partners might have died of HIV and AIDS
	Non Circumcision	The predominant community is mainly uncircumcised.
	Multiple partners	Polygamy
	Cultural/religious practices	Some religions that discourage condom use or ART use.
Economic factors	Sugar cane plantation	Conducive environment for sex, migrant workers in plantations, availability of loose cash.
	Fishing Industry	Jaboya culture and sex for fish to sell
	Urban expulsion	Unemployment to many young people
	Transport sector	Highways with major stop overs, construction with many migrant workers
	Rice millers/ Rice farming	Availability of loose cash
	Inequitable distribution of social amenities and services	Sex for commodity

2.6 Strength, Weaknesses, Opportunities and Threats (SWOT) Analysis

Table 2.5: SWOT Analysis of Kisumu County HIV and AIDS program

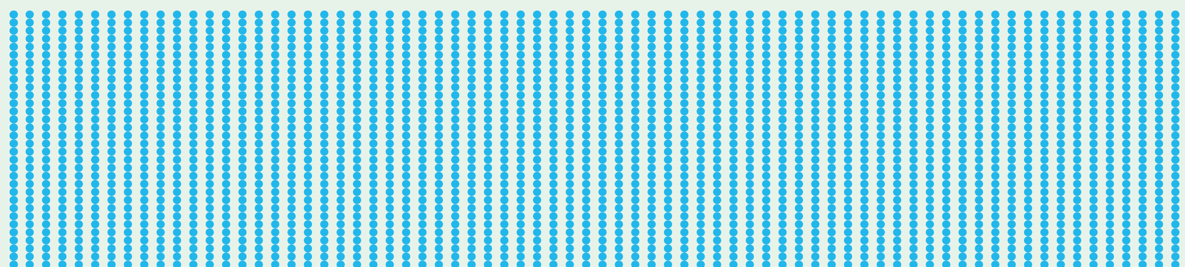
STRENGTH	WEAKNESS
• Existing Policies, standard operating procedures, guidelines, curriculum for training. • County Integrated Health Strategic Plan and an M&E framework in place. • Available Skilled Manpower. • Available County Health, HIV Statistics and Social-economic indicators e.g. No. Orphans (available data based on other health indicators). • Existing HIV delivery service structures, all levels and some sectors. • Public Private Partnership support available (ICAP, APHIA+, GIZ, FACES, WRP, AMPATH, EGPAF, IRDO, Health Strat, Kenya Red Cross, UNICEF, PS Kenya, KARP/KCCB. • Policy on Strengthening of National Government Service • Delivery and Coordination function at county level, through • Executive Order No. 3/2014	• Donor dependency in HIV programming. • Gaps in reporting, distribution and accountability of commodities. • Weak work place HIV interventions and policies. • Gaps in data collection tools supply. • Low staffing levels for management of restructured HIV services (County has employed substantial numbers). • No clear cut scheme of service for psychosocial counsellors.
OPPORTUNITIES	**THREATS**
• Integration of HIV services at all Health facilities. • Facilities at lower Kenya Essential Package for Health (KEPH) levels offering HTS services. • Existing supportive political structures. • School Health Programs. • ASRH program e.g. youth friendly services. • Partner support. • Existence of H.I.V Situation room.	• Sub optimal HIV status awareness. • No universal coverage for skilled birth attendants. • Late and low ANC visits. • Stigma among clients/patients still exist. • Under reporting of SGBV from the community. • Lack of awareness on availability and use of PEP services in the general population. • Increasing number key populations.

2.7 HIV Financing

The county has embraced program based budgeting where HIV and AIDS is a sub program. Prior to this, HIV funding have been integrated with other programs making it difficult to estimate the amount of money spent on HIV. Currently HIV program is donor dependent. However, the global situation has seen a shift in donor priorities to other emerging public challenges hence domestic funding for HIV is a key priority for the Kisumu County Health Department. With reference to Health Policy Project Report 2016, the county allocated Sh7.65 million for HIV services.

03

RATIONALE, PURPOSE, ALIGNMENT TO OTHER KEY DOCUMENTS, STRATEGIC PLAN DEVELOPMENT PROCESS AND GUIDING PRINCIPLES



3.1 Rationale

The Kenya Constitution 2010 introduced the devolved system of governance. This resulted into two levels of governments, the County Governments (47) and one National Government. Each of these levels of governments have their functions, some distinct, others concurrent and the rest overlapping. The health sector functions were devolved with County governments allocated the service delivery functions while the National government formulates policy, guidelines and training functions. The Kisumu County AIDS Strategic Plan provides an opportunity to respond to HIV within the local context and as provided for in the constitution.

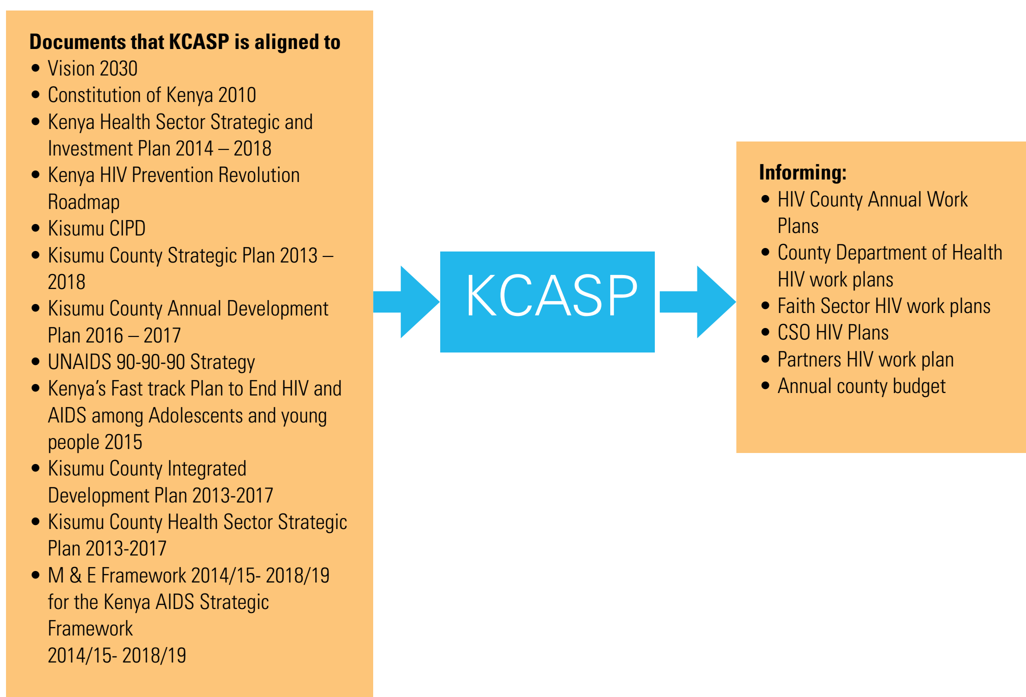
3.2 Purpose of the KCASP

The purpose of the Kisumu County AIDS Strategic Plan 2014/15 – 2018/19 is to:

- Define the results to be achieved in the next five years and offer broad strategic guidance to the county on the coordination and implementation of the HIV response.
- Guide for coordination and implementation of the HIV response.
- Act as a prioritization, resource mobilization, allocation and accountability tool.
- Ensure that HIV response remains multi – sectoral.
- To ensure synergy amongst the key institutions at the county level in implementing their mandate to achieve common results that are flexible enough to address micro effects of the HIV epidemic at the county level.

3.3 Alignment to other Key Documents

Figure 3.5: KCASP alignment and linkages



3.4 Process of developing the HIV Plan

The process of development of the Kisumu County HIV & AIDS Plan (KCASP) begun with the development and the dissemination of the Kenya AIDS Strategic Framework 2014/15 – 2018/19 and took the following stages:

- Development and Dissemination of the Kenya AIDS Strategic Plan (KASF) in Kisumu County with a multi sectoral audience.
- Appointment of the Kisumu County drafting team.
- Drafting of the Kisumu HIV & AIDS Strategic Plan.
- Review and Validation of Kisumu County HIV & AIDS Strategic Plan (KCASP).
- Costing of the Strategic Plan and launch.

A taskforce which comprised of members of CHMT, social services and other key partners drawn from NEPHAK, Impact RDO, KELIN, PSK, APHIAplus, NACC, County Budget Office and Maseno University was formed to spearhead the process of development of Kisumu County HIV Strategic Plan. The Technical review, conducted by a team of reviewers, was coordinated by the National AIDS Control Council.

3.5 Guiding principles

The development of the 2015-2019 KCASP has been informed by the lessons learnt from the KNASP III End Term Review as well as the strategic approach of the KASF. It is guided by the following guiding principles:

Multi sectoral approach: The document will strive to guide an approach to interventions enabling all communities and sectors to effectively contribute toward the vision and goals of the KCASP.

Non-discrimination: The County provides non discriminatory health services to all.

Universal access to services: The right to quality health services based on human rights approach.

Leadership and stewardship: Political leadership and stewardship of the county HIV & AIDS response and commitment to transparency, good governance and prudent management of financial and other resources at all levels of the response.

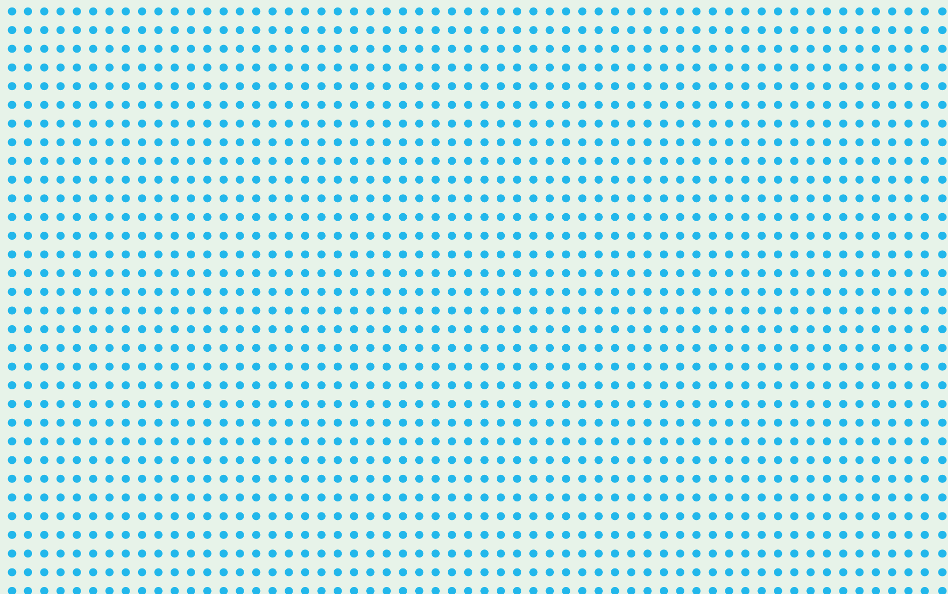
Meaningful Involvement of People Living with HIV: In an effort to reduce stigma and discrimination, the county mobilises and involves People Living with HIV.

Results-Oriented and Evidence-Based: The management and coordination of the HIV response in Kisumu county is evidence based and focused on measurable outcomes.

Accountability: The Strategic Plan strengthens accountability and use of available resources in management of HIV at all levels.

04

VISION, MISSION, OBJECTIVES AND COUNTY STRATEGIC DIRECTIONS



4.1 Vision

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

4.2 Mission

To provide focused leadership in HIV response through an all-inclusive multi sectoral collaboration and provision of integrated, accessible quality services.

4.3 Objectives of Kisumu County AIDS Strategic Plan

- Reduce new HIV infections by 75%.
- Reduce AIDS related mortality by 25 %.
- Reduce HIV related stigma and discrimination by 50%.
- Increase domestic financing of HIV response by 50%.

4.4 Kisumu County expected results by 2019

The Kisumu County HIV & AIDS Strategic Plan is a forward looking document and frames the County response in terms of what it should look like by the year 2019. Thus, the overall expected results for each Strategic Direction for the period are captured in the table below:

Table 4.1: Strategic directions and expected results by 2019

STRATEGIC DIRECTION	EXPECTED RESULTS BY 2019
Reducing new HIV infections	Reduced annual new HIV infections among adults by 75% Reduced HIV transmission rates from mother to child from 11% to less than 5%
Improving health outcomes and wellness of all people living with HIV	Increased linkage to care within 2 weeks of HIV diagnosis to 90% for children, adolescents and adults Increased ART coverage to 90% for children, adolescents and adults Increased retention on ART at 12 months to 90% children, adolescents and adults Increased viral suppression to 90% in children, adolescents and adults
Using a human right approach to facilitate access to services for PLHIV, key populations and other priority groups in all sector	Reduced self-reported stigma and discrimination related to HIV and AIDS by 50% Reduced levels of sexual and gender-based violence for PLHIV, key populations, women, men, boys and girls by 50% Increased protection of human rights and improved access to justice for PLHIV, key populations and other priority groups including women, boys and girls Reduced social exclusion for PLHIV, key populations, women, men, boys and girls by 50%
Strengthening integration of health and community systems	Improved health workforce for the HIV response at the county level by 40% Increased number of health facilities ready to provide KEPH-defined HIV and AIDS services from 67% to 90% Strengthened HIV commodity management through effective and efficient management of medicine and medical products Strengthened community-level AIDS competency
Strengthening research and innovation to inform the KCASP goals	Increased evidence-based planning, programming and policy changes by 50% Increased implementation of research on the identified CASP-related HIV priorities by 50% Increased capacity to conduct HIV research at county level by 10%
Promoting utilization of strategic information for research and monitoring and evaluation (M&E) to enhance programming	Increased availability of strategic information to inform HIV response at county level Planned evaluations, reviews and surveys implemented and results disseminated in timely manner M&E information hubs established at County Level and provide comprehensive information package on key KCASP Indicators for purposes of decision making
Increasing domestic financing for a sustainable HIV response	Increased domestic financing for HIV response to at least 50%
Promoting accountable leadership for delivery of the KCASP results by all sectors and actors	Good governance practices and accountable leadership entrenched for the multi-sectoral HIV and AIDS response at all levels. Effective and well-functioning stakeholder co-ordination and accountability mechanisms in place and fully operationalised at county levels An enabling policy, legal and regulatory framework for the multi-sectoral HIV and AIDS response strengthened and fully aligned to the Constitution of Kenya 2010.

4.4 County Strategic Directions

Table 4.2: County Strategic Directions

STRATEGIC DIRECTION AREA	SPECIFIC OBJECTIVE	
SDA 1: Reducing new HIV infections	To identify and target the priority populations for HIV services	
SDA 2: Improving health outcomes and well being of all people living with HIV	To improve HIV services for PLHIV	
SDA 3: Using a human rights based approach to facilitate services for PLHIV, key populations and other priority groups in all sectors	To increase equitable access to HIV services to PLHIV	
SDA 4: Strengthening integration of health services and community systems	To strengthen linkage between health services and community systems for HIV response	
SDA 5: Strengthening research and innovation to inform the Kisumu HIV County priorities	Provision of resources for research activities.	
SDA 6: Promoting the utilization of strategic information for research, monitoring and evaluation to enhance programming.	To strengthen monitoring and evaluation of the KCASP	
SDA 7: Increasing domestic financing for a sustainable HIV response.	To mobilize for resources for the implementation of the KCASP.	
SDA 8: Promoting accountable leadership for delivery of the KCASP	To strengthen the leadership and coordination of Kisumu County HIV & AIDS strategic plan.	

4.4.1 Strategic Direction 1: Reducing new HIV infections

HIV infection among adults is driven by multiple partnerships among heterosexual relations, high rates of discordance, low knowledge of HIV status among those who are HIV infected (50%) and low condom use coupled with low male circumcision of 66% (KAIS 2012). Concentrated epidemic is seen in populations of men who have sex with men (MSM), sex workers and their clients, prison populations and people who inject drugs contributing to a third of new HIV infections

	KEY INTERVENTION AREA
	Increase coverage of combination HIV prevention services, prioritize the population and identify the geographical location.
	Increase linkage and retention in ART
	Identify and remove barriers to HIV services through Human Rights Based Approach (HRBA).
	Strengthen HIV information education activities, establish more community units, increase outreach to those with limited access to health services.
	Promote the generation of HIV data and information.
	Promotion of consumption and utilization of data.
	Resource mobilization activities.
	Improving coordination, strengthen HIV advocacy and increase participation.

(MoT, 2008). Kisumu County also hosts other vulnerable populations such as fishing communities and long-distance truck drivers that exhibit heightened HIV risk. Early sexual debut remains a challenge among women and girls aged 15-24 at 32% with a prevalence of 4-6 times higher than boys of the same age.

To respond to the complex patterns of HIV epidemic, the county has set an ambitious path for evidence based bio-medical, behavioural and structural interventions.

Table 4.3: Interventions for reducing new HIV infections

STRATEGIC DIRECTION 1: REDUCING NEW HIV INFECTIONS				
KASF Objective	**KCASP Results**	**Key Activity**	**Sub-activity/ Intervention**	
Reduce new HIV infections by 75%	Reduced annual new HIV infections	Provide universal HIV testing services	Biomedical Conduct Targeted rapid results initiatives in HTS Behavioural Create awareness on HTS	
			Biomedical Eliminate Health sector HIV transmission Provide HTS commodities Behavioural Promote HTS among Health Care Workers. Structural Strengthen workplace protection policies	
		Provide innovative and evidence-informed HIV prevention, care and treatment services	Biomedical Sustain VMMC services provision Initiate Pre-exposure prophylaxis (PreP) Behavioural Conduct Risk reduction counselling and skills building Create community awareness on PEP Structural Train HCWs on VMMC	
			Biomedical Initiate Early infant male circumcision (EIMC) Behavioural Conduct Community sensitization on EIMC Structural Train HCWs of EIMC	
		Offer age and population appropriate HIV education	Biomedical Promote PEP utilization Scale up Alcohol screening and addiction support Offer Human Papilloma Virus screening and education Behavioural Conduct Community sensitization on PEP use Scale up harm reduction interventions Scale up Stigma reduction strategies Structural Set up rehabilitation centre	
			Biomedical Provide Condoms and lubricants Behavioural Conduct Condom promotion and social marketing Structural Procure and install Condom dispensers at strategic points	
			Behavioural Promote Peer to peer in schools and other institutions	
			Structural Conduct Health worker sensitization (CMEs)	
			Biomedical Promote Adherence support to client on ART Structural Recruit mentor mothers	

	Target population	Geographic areas	Responsibility
	General Population (Gen. pop), Key population (KPs)	County	Ministry of Health (MoH), Partners
	Health Care Workers (HCWs)	County	Partners, MoH
	General population, Key Populations	County	Partners, MoH
	Infants, General population, HCW	County	MoH, Partners
	General population, Key Populations	County	Ministry of Education (MoE), MoH, Partners
	Key and priority populations	County	Partners, MoH,
	Adolescents, KPs	County	MoH, Partners
	HCW	County	MoH, Partners
	Pregnant and breastfeeding mothers	County	MoH, Partners

STRATEGIC DIRECTION 1: REDUCING NEW HIV INFECTIONS				
		Provide universal STIs management	Biomedical Scale up STI screening and treatment in all health facilities Provide STIs management commodities Behavioural Conduct Risk reduction counselling and skills building	
	Reduced HIV transmission rate from mother to child from 11% to less than 5%	Provide Friendly eMTCT Services	Biomedical Deliver all four prongs of eMTCT at all facilities Structural Form peer support groups for psychosocial support services	
			Biomedical Integrate eMTCT with Maternal Neonatal Child Adolescents Health care (MNCAH) Behavioural Engage men on their role in eMTCT	
		Engage CHAs and CHVs to link community - facility interface	Structural Recruit more CHAs and CHVs	
			Structural Motivate CHVs by providing harmonized stipend scheme	
		Strengthen Early Infant Diagnosis (EID) infrastructure	Biomedical Integrate EID with Immunization services Structural Train HCWs on EID/ HEI	

4.4.2 Strategic Direction 2: Improve Health Outcomes of PLHIV

Kenya has embraced the UNAIDS 90-90-90 ambitious treatment target to help end the AIDS epidemic. By 2020, 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained ART and 90% of all people receiving ART will have viral suppression.

The county health systems face varied challenges in the delivery and promotion of services ranging from identification, linkages to care, retention and viral suppression. There is inadequate and unequal access to health services and human resource. Additionally, services to PLHIV are characterized by poor referral and tracking, weak commodity and supply chain as well as inadequate skills and infrastructure for information management systems. Lower coverage of ART among

	General population	County	MoH, Partners
	Children and pregnant women living with HIV	County	MoH, Partners
	Couples	County	MoH, Partners
	General population	County	MoH, Partners
	CHVs and County Government	County	MoH, Partners
	HCW	County	MoH, Partners

children implies retention of a heavy reservoir of HIV in the general population. Improper co-ordination between health and other sectors such as education, legal and social services lowers quality of care delivered to clients. Reduction in loss in the cascade of care and treatment require clear detection of determinants and points of loss of patients and resolve them at service delivery points and County levels by recognizing need to focus on different population based on age, sex and sexual activity. This includes focusing on their geographical location, situation and challenges in the cascade of care, treatment and reason for loss or attrition. Some of the barriers in HIV access and linkage to care in Kisumu County include; Distance of health facilities, inadequate human resource and the practice of alternative medicine among other things.

Table 4.4: Interventions for improving health outcomes and wellness of people living with HIV

STRATEGIC DIRECTION 2: IMPROVING HEALTH OUTCOMES AND WELLNESS OF PEOPLE LIVING WITH HIV		
KASF objective	**KCASP Results**	**Key Activity**
Reduce AIDS related mortality by 25 %	Increased linkage to care within two weeks of HIV diagnosis to 90% for children, adolescents and adults	Improve patient referral and patient management system and infrastructure
		Develop County specific adolescent and youth initiatives in line with the Fast track plan
		Integrate services at the health facilities
		Mobilize the community and peer support to create demand for and increase women's access to uptake to ANC as well as delivery in health facilities
Reduce HIV related stigma and discrimination by 50%	Increased sexual education, HIV knowledge in children, adolescents and adults	Provide stigma reduction interventions
		Encourage discussion between parents and adolescents on sexual matters and HIV
		Enhance test and treat services with continuous treatment literacy
	Increased retention on ART at 12 months to 90% in children, adolescent and adults	Put in place mechanisms for retention to care e.g. support groups and promotion of adherence
	Improved viral load monitoring	Improve efficiency and effectiveness of quality laboratory services for viral loads
	Increased quality service delivery	Employ quality improvement mechanisms in the treatment outcomes

	Sub-Activity/ Intervention	Target Population	Geographic areas	Responsibility
	Biomedical Scale-up HTC coverage Mobilize the community to seek health services Provide commodities for HIV testing	General population	County	MoH, Partners
	Structural Provide care givers with HIV education literacy and empowerment Scale-up integrated youth friendly services	Youths and Adolescents in and out of school	County	MoH and Youth department, MoE, Partners
	Structural Create Drop in Centres Cascade integrated HIV trainings on HCWs to serve KPs	Key and priority Populations	County	MoH, Partners
	Behavioural Strengthen facility and community linkages with inter and intra facility referral protocols and linkage strategies	General population	County	MoH, Partners
	Behavioural Strengthen peer support groups to increase demand and access to care Structural Scale up M.O.E program for HIV education and treatment	General population, KPs	County	MoE, partners, MoH
	Structural Implement evidence based interventions (EBI) Develop IEC materials on parent–child dialogue	Parents and Adolescents	County	Health Promotion officer, NACC
	Structural Customize standardized guidelines for disclosure by and to adolescents living with HIV			
	Behavioural Utilize peer support and networks of people living with HIV Promote Public education and education of care givers Structural Conduct enhanced defaulter tracing mechanism (with focus boarding schools)	Adolescents, General Population TSC, MoE, KPs	County	MoE, MoH, Partners
	Structural Set up two more viral load testing labs Establish effective laboratory networks on viral load monitoring	Health facilities	County	MoH, Partners
	Structural Capacity build the HCWs Develop and implement surveillance plans, protocols and periodic surveys	HCWs	County	MoH, Partners

4.4.3 Strategic Direction 3: Using a Human Rights Approaches to Facilitate Access to Service

The policy environment of HIV response is defined by the constitution of Kenya 2010 which establishes a right to the highest attainable standard of health. Article 27 of the constitution out-laws discrimination on the basis of one's health status. However the Kenya stigma index Survey 2014 reported stigma and discrimination at over 45% nationally while Kisumu County recorded 34.9% stigma.

PLHIV face stigma and discrimination in their families and within structures and institutions in which they seek services. Employment related discrimination has been documented.

Some of the challenges and gaps experienced in accessing care for PLHIV in Kisumu County include;

- Lack of data on barrier to health access disaggregated by population, geographical and public/private entities.

- Lack of awareness on the rights as provided for in the current Kenya constitution and legal (Policy framework) that would provide an enabling environment for service delivery.

- Inadequate measures to minimize social

Table 4.5: Interventions to facilitate access to services using human rights approaches

STRATEGIC DIRECTION 3: USING A HUMAN RIGHTS APPROACHES TO FACILITATE ACCESS TO SERVICES			
KASF Objective	**KCASP Results**	**Key Activity**	
Reduce HIV related stigma and discrimination by 50%	Reduced barriers to access of HIV, SRH, rights information and services in public and private entities	Advocacy to community and stakeholders	
	Reduced level of sexual and gender based violence by 50%.	Formulate laws and policies to stop SGBV	

exclusion, Stigma and Discrimination

• Limited awareness and use of the HIV and AIDS Tribunal.

Kenya expects to reduce self-reported stigma and discrimination related to HIV and AIDS by 50%. It's also expected to reduce sexual and gender-based violence for PLHIV, Key population, women, men, boys and girls by 50% by 2019.

To achieve the targets on the reduction in percentage levels of discrimination, GBV and exclusion (respectively), Kisumu County will put in place the following interventions;

• Remove barriers to access of HIV, SRH, rights information and services in public and private entities.

• Improve County legal and policy environment for protection and promotion of rights of PLHIV and key population.

• Reduce and monitor stigma and discrimination, Social exclusion and GBV.

• Improve access to legal and social justice for protection from stigma and discrimination in both public and private sectors including schools and colleges.

	Sub-Activity/Intervention	Target Population	Geographic areas	Responsibility
	Behavioural Sensitize the police, gate keepers, health care, CUs, CHVs, paralegal, workers, judiciary, county assembly on health rights **Structural** Develop health care charter for the health care workers and clients Display and actualization of Stigma free messages in schools Establish sensitization systems within the Police department, for healthcare workers, teachers , gate keepers, judiciary, county assembly on health rights Adopt and use the National HIV and AIDS workplace policy- Train and deploy Kenya sign language, Braille interpreters at the facilities Translate information, Education and communication (IEC) materials into local dialect Advocate for economic empowerment, vocational training and cash transfers	KP, PLHIV, PwD, OVC, Youth, ALHIV and Young women	County	KP, Implementing partners, MOH-KP department, NEPHAK WOFAK, KELIN, CUC, MoE, FICE, KENEPOTE
	Behavioural Facilitate campaign to reduce stigma and discrimination, to reduce GBV, and promote uptake of HIV services through the media and other public/ community forums, chief barazas Advocate for male involvement in HIV and SRH programmes Sensitize community groups on treatment literacy, existing bills (HAPCA - HIV & AIDS Prevention Control Act), HIV Tribunal, work place policy and Constitution) Structural Improving access to legal, social justice and protection from stigma and discrimination in public and private sector	PLHIV, Gen. pop.	County	Partners, MoE, Children's Department

STRATEGIC DIRECTION 3: USING A HUMAN RIGHTS APPROACHES TO FACILITATE ACCESS TO SERVICES			
Reduce HIV related stigma and discrimination by 50%	Increased knowledge, recovery centres and integrated HIV services	Educate, monitor and evaluate stigma, discrimination and GBV	
	HIV policies formed and implemented	Formulate and implement of SGBV policies	

4.4.4 Strategic Direction 4: Strengthening integration of Community and Health Systems

Kisumu County has 190 community units that seek to interlink with the main health provision facilities. In 2006, the Ministry of Health through its National Health Sector Strategic Plan II 2005-2010 came up with a Community Health Strategy (CHS) to re-vitalize the primary healthcare (PHC) concept. This is implemented by both state and non-state actors. Kisumu County has found various gaps in the CHS which leads to weakened community mobilization, poor referral or linkage networks and weak specific disease follow up and supportive initiatives such as provision of psychosocial support, defaulter tracing and other community health interventions. In total, the County has the following health facilities:

- 1 Level Five facility
- 25 Level Four facilities
- 127 Health centres and Dispensaries
- 50 Private facilities

Kenya has just revised its Community Strategy as the vehicle for community interventions in collaboration with both state and non-state actors. Integration of the community and health systems is necessary towards ensuring a well functional health system. Community systems play a critical role in HIV prevention, care, treatment and support. Their roles include referrals and linkages to care and treatment services and enhancement of the treatment literacy. Kisumu County will strengthen community mobilization and Home and Community Based Care (HCBC). There is need to build the capacity of all players and other civil societies to play these roles including gender and human rights mainstreaming.

	Behavioural Educate the community on legal issues Structural Advocate for integrated adolescent friendly HIV services Establish more youth friendly centres at service/intervention centres Advocate for more GBV recovery services at each sub-county	Adolescents PLHIV, key pop and other priority group women boys and girls	County	MoH, Children's department, County government, Partners
	Behavioural Sensitize and disseminate to beneficiaries, guardians, caregivers, health care workers on child protection policies and sexual offences Acts Structural Formulation of guidelines and policies to stop GBV	OVC, Young women, men, Elderly and PwD	County	Children's department, Partners

Table 4.6: Status of Community Units in Kisumu County

SUB COUNTIES	COMMUNITY UNITS (CU)	CU DEFICITS	CHVS
Kisumu East	34	3	512
Kisumu West	24	4	303
Nyakach	39	0	390
Nyando	36	0	410
Muhoroni	29	6	260
Seme	28	0	264
County total	190	13	2139

Through a number of interventions, this Strategic Direction aims at;

- Providing a competent, motivated and adequately staffed health workforce.
- Strengthening Health Service Delivery Systems and linkages.
- Strengthening Community service delivery System for provision and uptake of HIV Services.
- Strengthening supply chain systems.

Table 4.7: Interventions to strengthening integration of health and community systems

STRATEGIC DIRECTION 4: STRENGTHEN INTEGRATION OF HEALTH AND COMMUNITY SYSTEM			
KASF objective	**KCASP Results**	**Key Activity**	
Improve health workforce for HIV response by 40%	Motivated and competent health workforce	Conduct Continuous Professional Development (CPD) Annual HR gap analysis and appraisals	
Increase number of facilities offering KEPH defined HIV and AIDS services from 63% to 90%.	Strengthened Health Service Delivery Systems and linkages	Enhance referral and linkage services between community and facility	
Strengthen community level AIDS competency	Strengthened community service delivery system for provision and uptake of HIV services	Community sensitization and integrating HIV services into community units	
Strengthen HIV commodity management	Community resource accountability Strengthened supply chain system	Capacity build the community on resources management.	

Sub-Activity/Intervention areas	Target Population	Geographic areas	Responsibility
Behavioural Create incentives for health workforce through rewards. Structural Hiring and rational deployment of staff Training and capacity building of staff on HIV response, life skills and citizenship obligations Harmonize staff remuneration and promotions	County Health Workforce	All Sub Counties	County public service board, MoH
Behavioural Enhance/Expansion of peer led strategies in all the health facilities such as mentor mothers Promote community support groups linkages Structural Scale up and upgrade all Health facilities to offer integrated KEPH services Conduct periodic review of community reporting tools such as referral cards, COBPAR etc.	Peer and Support groups, M &E DHIS departments	All Sub Counties	County Government, NACC, Partners
Behavioural Enhance community involvement and participation for sustainability and ownership of service delivery Structural Establish financial kitty to support community volunteers Strengthen the SCACCs coordination of the HIV response Enhance periodic updates on new trends on HIV for CHEWs and CHVs	General population, Community Health Service providers	All sub Counties	MoH, NACC, Partners
Structural To strengthen HIV commodity management e.g. condoms	Community Health Service providers	All sub Counties	County government, CHVs, CHEWS
Biomedical Distribute and service HIV diagnostic equipment and adopt new technologies e.g. point of care CD4, self-testing Structural Ensure quality HIV commodity management in terms of; procurement, appropriate prescription, supply , storage and surveillance	Community (General population), Community Health Service Providers	All Sub Counties	County MoH, KEMSA and Partners

4.4.5 Strategic Direction 5: Strengthening Research, Innovation and Information Management to meet KCASP goals

Research is the backbone on which all strategic directions and intervention are built. It should be guided by relevance, multidisciplinary and credible outcomes.

Resource mobilization and allocation for HIV research fund and capacity for HIV research in the county is still limited, hence the need to lobby and advocate for a research fund to be established.

Research and innovation to generate timely evidence to inform scale up of policy, programs and intervention that can improve health outcomes for Kisumu County will form a critical component of this strategy. A Kisumu county research agenda will be developed to guide prioritization and coordination of HIV and AIDS research at the county level.

Key intervention areas for the strategic direction.

- Coordination of research activities.
- Implementation of research agenda.
- Research Funding.

Expected results by 2019

- Increased evidence - based planning and programming and policy changes.
- Increased implementation of research on the identified HIV priority areas.
- Increased capacity to conduct HIV research at county level.
- Increased funding for HIV research.

Table 4.8: Interventions to strengthen research, innovation

STRATEGIC DIRECTION 5: STRENGTHENING RESEARCH,			
KASF objective	**KCASP Results**	**Key Activity**	
Increase capacity to conduct HIV research at county level by 10%	Increased evidence - based planning and programming	Coordinate research activities	
	Increased capacity to conduct HIV research at county level	Coordinate research activities	
		Implement the research agenda	
		Conduct county baseline surveys on HIV prevalence, GBV, stigma index	
	Increased funding for HIV research	Develop a research fund	

and information management to meet KCASP Goals

INNOVATION AND INFORMATION MANAGEMENT TO MEET KCASP GOALS				
	Sub-Activity/ Intervention	**Target Population**	**Geographic areas by County/sub- county**	**Responsibility**
	Structural Formation of a Kisumu County Research Committee Strengthen coordination of research institutions and other interested partners Develop the county research agenda Coordinating, tracking and utilization of existing research findings to influence policy or action	Research Stakeholders Research institutions and other interested partners Research committee	County	County Government, Research Committee
	Structural Capacity build the research teams on conducting researches and scientific writing	Research Teams	County	Research Committee, Research Institutions & NACC
	Monitor ethical committees to facilitate quality HIV research	Research Stakeholders	County	County government
	Conduct county baseline surveys on HIV prevalence, GBV, stigma index	Researchers, research institutions and teams	County	Research Committee, Research Institutions
	Disseminate research outcomes to support HIV Programming Disaggregate the baseline surveys to sub-county level to enable program projections and evaluation	Researchers, research institutions and teams	County	County government Research Institutions
	Develop a county Research financing plan	Research committee	County	County government
	Lobby and advocate for research financing	County Government, Research Institutions, Corporate bodies and other agencies	County	MoH

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

HIV response is largely influenced by strong leadership commitment, availability of accurate and timely data for effective evidence based decision making. This, therefore, calls for the need to strengthen M&E capacity at all levels. Monitoring and Evaluation of multi sectoral response to HIV and AIDS continue to rely on a variety of systems: data sources routine, periodic collection and collation systems which are supported and maintained by various stakeholders. The achievement in HIV programme monitoring has, however, not been without challenges. The M&E system is faced with gaps in strategic approach on co- ordination, ownership and meaningful data use for decision and planning among various stakeholders, various levels and sectors.

The analytical capabilities at the county and sub county levels are weak and will need to be strengthened to effectively address the strategic data needs at these levels.

Routine and non-routine M&E systems are in place though infrastructure and personnel is a challenge.

Table 4.9: Interventions to promote utilization of strategic information for research monitoring and evaluation to

Strategic Direction 6: Promote utilization of strategic information for research monitoring and evaluation to enhance programming KASF objective :Promote utilization of strategic information for research M&E to enhance programming			
KCASP Results	**Key Activity**	**Sub-Activity/Intervention**	
Increased availability of strategic information to inform HIV prevention at County level	Set up M&E infrastructure.	Structural Establish a county HIV web portal Operationalize use of HIV situation Room Procurement of M&E equipment Develop electronic support supervision tool for HIV program	
	Conduct capacity development	Structural Conduct M&E capacity assessment in terms of personnel, infrastructure, guidelines, tools and Standard Operating Procedures Train managers and front line health workers in Basic M&E to enhance data use for action Train health managers and partners on situation room Train service providers managers on DHIS	
	Generate, prepare and present HIV M&E reports	Assess availability of HIV information at facility and community level Prepare annual HIV/TB report. Dissemination of annual HIV/TB report Develop County HIV fact sheet.	
	Conduct supportive supervisions	Structural Conduct mentorship, on job training and coaching within facilities on M&E tools Conduct HIV program support supervision.	
Planned evaluations reviews and surveys implemented and results disseminated in timely manner	Operationalize costed county M&E plan to guide and inform M&E activities	Structural Mobilize resources for M&E activities	

Incomplete retrospective data entry in the available EMRs in the county derailing point of care use.

HIV M&E information products are available and have continued to provide strategic information for informed program planning, implementation and Evaluation. However, these are generated from several disjointed platforms.

Need to improve data quality focusing on the dimensions of timeliness, completeness, completeness, accuracy, precision and reliability.

Inadequate funding for M&E activities at County and Sub County levels.

As the routine M&E systems become more accessible, a renewed focus on improving data quality, demand and use at all levels will be given priority. This will, therefore, require adequate funding for M&E activities, ownership and support for HIV M&E systems including capacity development, support system for data collection and collation to DHIS2.

To achieve this, the following recommended actions will be undertaken during the implementation period.

enhance programming

Target Population	Geographic areas	Responsibility
M&E department staff	County	County government
CHMTs, SCHMTs & HMTs	County and sub counties	NACC, County government
Facilities and institutions offering HIV Care services	County	MoH
Facilities and institutions offering HIV Care services	County, Sub County and facilities	MoH/ NACC
CHMT, SCHMT	County	NACC/MoH

Strategic Direction 6: Promote utilization of strategic information for research monitoring and evaluation to enhance programming KASF objective :Promote utilization of strategic information for research M&E to enhance programming			
Planned evaluations reviews and surveys implemented and results disseminated in timely manner	Conduct data verification and data quality reviews	Structural Actualize KHQIF Carry out Data Quality Assessments quarterly	
	Print tools	Structural Procure, print and distribute data capture tools to enhance reporting	
	Train Health care workers on DHIS2 and other related platforms HITS system and HIPORS	Structural Train staff on online data transmission Increase access to online data platforms	
	Conduct M&E Stakeholders review meetings	Structural Hold County Annual and quarterly review meetings Hold quarterly M&E meetings with stakeholders	
	Hold annual HIV and AIDS conference	Structural Plan and source for funding to hold conference	
	Form County and Sub County M&E Committees	Structural Strengthen Kisumu County TWG Provide mentorship, on job training and coaching on M&E issues and support supervision	

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

4.4.7.1 County health budget allocation

The County Health department was allocated approximately (KSh2,127,099,629) in the financial year 2014/2015. Most of these funds were consumed by recurrent expenditure (93%) with 145,900,000 (7%) utilized for development.

Table 4.10: County health budget allocation trend

Financial Year	Allocation (Kshs)	Recurrent Expenditure (Kshs)	Development (Kshs)	Allocation for HIV
2016/2017	2,567,888,768	2,305,688,768	262,200,000	Integrated in overall county Health budget (Plans to cost per program area)
2015/ 2016	2,369,701,000	2,127,990,000	241,711,000	Integrated in overall county Health budget
2014/ 2015	2,127,099,629	1,981,199,579	145,900,000	Integrated in overall county Health budget

Source; Kisumu County budget 2016/2017, 2015/2016, 2014/2015

	Health Care Workers Source documents at facility level and DHIS2	County	CHMT/SCHMT Partners
	County Health Department	County	NACC, MoH
	Health workers and other stakeholders	County	MoH/ Partners
	Health workers and other stakeholders	County	NACC, Partners MoH
	Health workers and other stakeholders	County	NACC/Partners MoH
	Technical working groups	County	NACC, partners MoH

Although there is no specific allocation for HIV, the County government spends money on personnel emoluments and HIV commodities.

4.4.7.2 Sustainable Financing of HIV

The national HIV response continues to experience diminishing funding from the traditional development partners. In addition, the rebasing of the economy in 2014 has implications for HIV response. In the near future, the country will not be able to procure HIV commodities at a subsidized rate. This will translate to a trickling down effect to county governments. While the KCASP is not a strategy of the health department, the majority of the directly attributable costs are incurred within the health sector. This calls for the county government to explore innovative and sustainable alternative sources of funds. Research on expedient strategies on generation of funds must be commenced with speed.

The KCASP thus seeks to:

- Maximize efficiency of existing delivery options for increased value and results within existing resources.
- Promote innovative and sustainable domestic HIV financing options.
- Align HIV resources/ investments to KCASP priorities.

Table 4.11: Interventions to increase domestic financing for sustainable HIV response in Kisumu County

Strategic direction 7: Increase domestic financing for sustainable HIV response **KASF Objective Increase domestic financing for HIV response to 50%**			
KCASP Results	Key activities	Sub activities	
Increased domestic financing for sustainable HIV response	Create HIV specific budget line in County Health department expenditure.	Promote resource allocation that has the greatest impact on achieving the Strategy objectives. Map out development partners in the county (Location of operation and their interventions) to minimize duplication of efforts. Promote existing funding mechanisms for livelihood programs, e.g. cash transfers, affordable credit, grants for capacity building etc.	
	Promote innovative and sustainable domestic HIV financing options	Initiate Community Based Health care Financing (CBHF) Contribute 3% of the county health budget to HIV specific interventions Establish a HIV budget line in the Health allocation Initiate Public Private Partnerships(PPP) for HIV response Appeal to philanthropists within the county to support the HIV intervention Undertake charitable events e.g. marathons, charity walk etc. for purposes of resource mobilization within the county Apportion interests from dormant funds (unclaimed assets) to HIV response. Encourage organized informal sector contribution Tax holiday for individuals and corporate in HIV philanthropic involvement County to encourage financing of HIV initiatives by legislating rebate on county taxes for traders	
	Align HIV resources/ investments to KCASP priorities	Track government allocations towards HIV response to the different County government departments Engage county assembly to consider HIV as an added parameter in resource allocation Facilitate implementation of deliberate measures to unblock the financial, human, infrastructural, institutional, and structural bottlenecks that impact absorption capacity to financing HIV programmes Facilitate quantification of county HIV resource needs Facilitate planning by reporting contribution to KCASP annually	

	Responsibility
	CEC Health Services, National Government Departments (Youth & Gender), Children's Department, CHMT, Partners
	CEC Health, CEC Finance, CHMT, Partners, Chair health Committee, CHTC, National treasury
	CEC Health Services, CHMT, Partners, Chair Health, Committee – County Assembly

4.4.8 Strategic Direction 8: Promoting Accountable Leadership for delivery of the KCASP results by all Sectors

Accountable leadership and good governance is critical for effective and efficient HIV response. There is need to provide an enabling policy environment that will include county partnership with the Ministry of Interior and coordination, members of National Assembly and Principal Secretaries of National government line ministries to promote accountable leadership and governance. The county has thus identified key areas for intervention as indicated below;

Key intervention areas:

- Provision of an enabling policy and legal regulatory framework through formulation/ adoption and implementation of relevant

Table 4.12: Interventions to promote accountable leadership for delivery of the KCASP results by all sectors

Strategic Direction 8: Promoting Accountable Leadership for Delivery of the KCASP results by all Sectors			
KASF objective	KCASP Results	Key Activity	
Enhance stakeholder coordination and accountability.	Good governance practice and accountable leadership entrenched for the multi-sectoral HIV and AIDS response for the county	Involve all stakeholders in HIV planning and programming	
		Create a structured network of County HIV response	
Enable policy legal and regulatory frame work for multi-sectoral HIV&AIDS response	An enabling policy, legal regulatory framework for the multi-sectoral HIV and AIDS response strengthened and fully aligned to the Constitution of Kenya 2010	Implement National HIV and AIDS Law	
Promote good governance practices and accountable leadership for HIV & AIDS response at all levels	Effective and well functioning stakeholder co-ordination and accountability mechanisms in place and fully operationalized at the county level	Capacity building of HIV service providers by County Government and partners on emerging trends. Monitoring & Evaluation	

policies and laws.

- Establishment and strengthening of the coordination architecture.
- Provision of oversight.

The expected results by 2019 are:

Good governance practice and accountable leadership entrenched for the multi-sectoral HIV and AIDS response for the county.

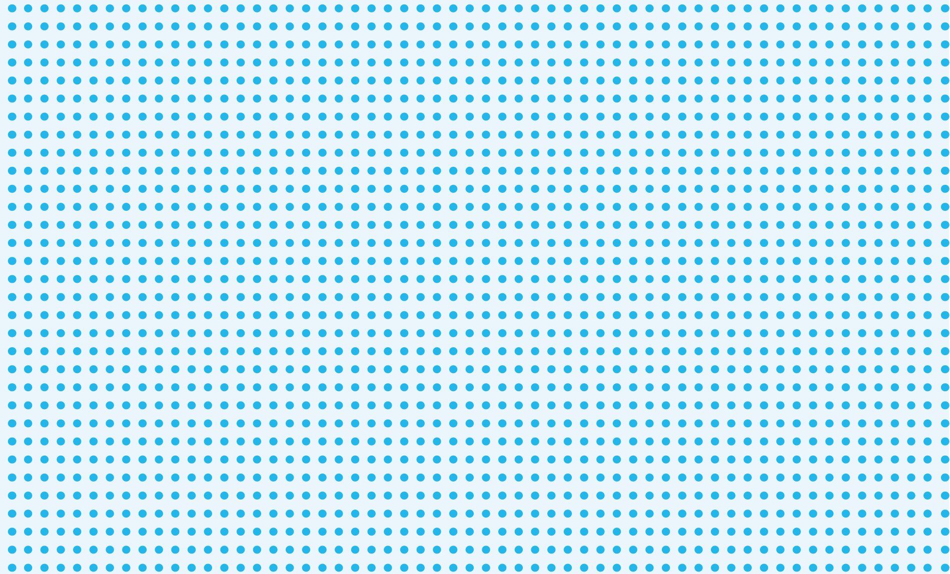
An enabling policy, legal regulatory framework for the multi-sectoral HIV and AIDS response strengthened and fully aligned to the Constitution of Kenya 2010.

Effective and well-functioning stakeholder co-ordination and accountability mechanisms in place and fully operationalised at the county level.

	Sub-Activity/Intervention	Target Population	Geographic areas	Responsibility
	Structural Governor to provide an annual state of the county address on HIV Identification of active stakeholders and promote structured dialogue. Advocate for elected leadership to allocate resources for HIV response at the county.	Public & private sector leadership	County	County government
	Establish/Operationalise/Strengthen county HIV Coordination units: County HIV Committee, Inter Agency Coordination Committee (ICC), SCACC Map HIV implementing partners in Kisumu County Encourage PLHIV to form support groups and patient platforms	Public & private sector leadership	County	County government, NACC, SCACC
	Domesticate/ customize national policies to reflect county priorities.	County Leadership	County	County government
	Training of Health Care Providers Benchmarking of HIV programming Conduct annual, Mid-term and end term reviews Strengthen M&E reporting framework for government and partners.	Public and Private Leadership	County	County government

05

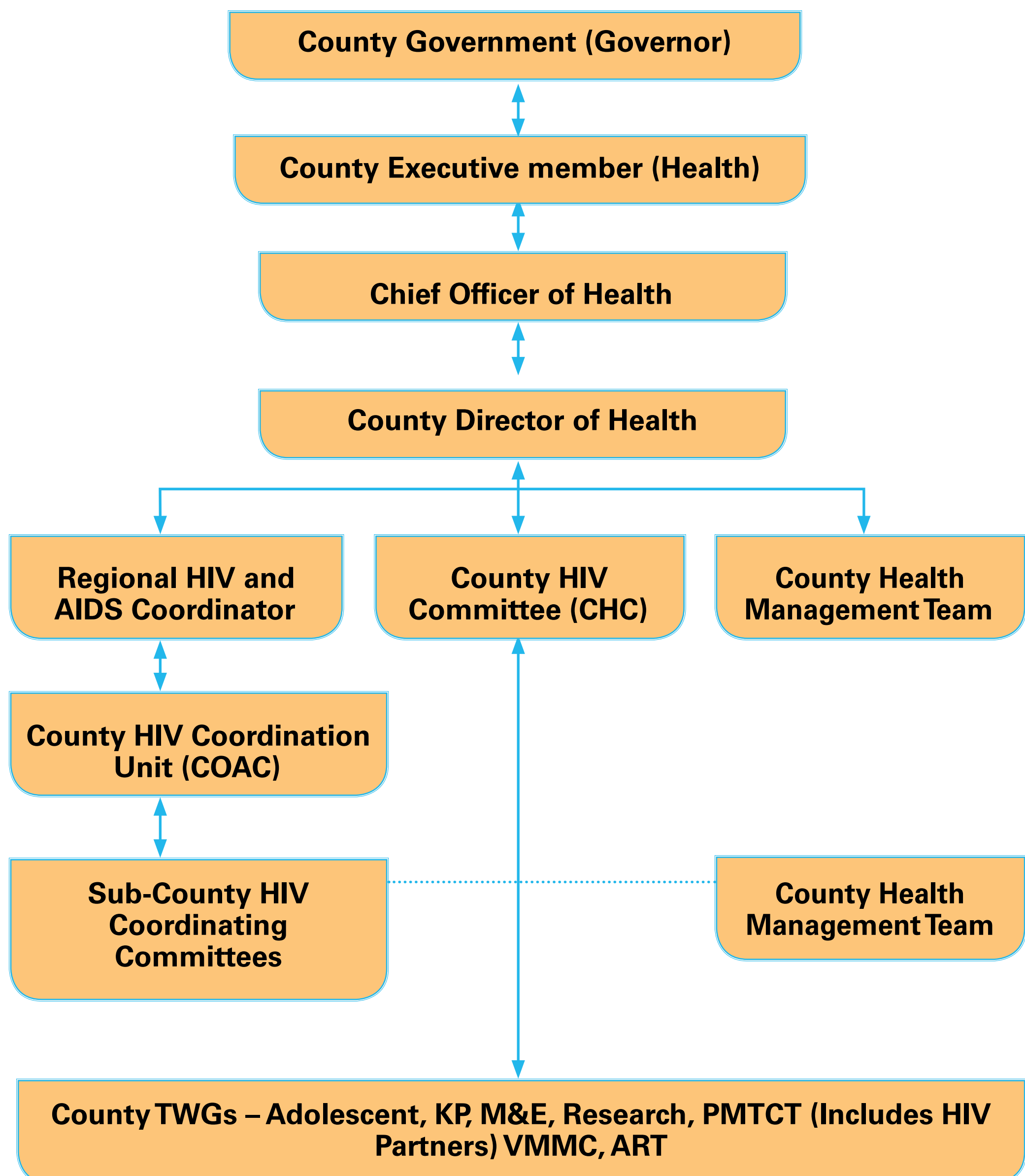
IMPLEMENTATION ARRANGEMENTS



5.1 HIV Coordination structure for KCASP Delivery

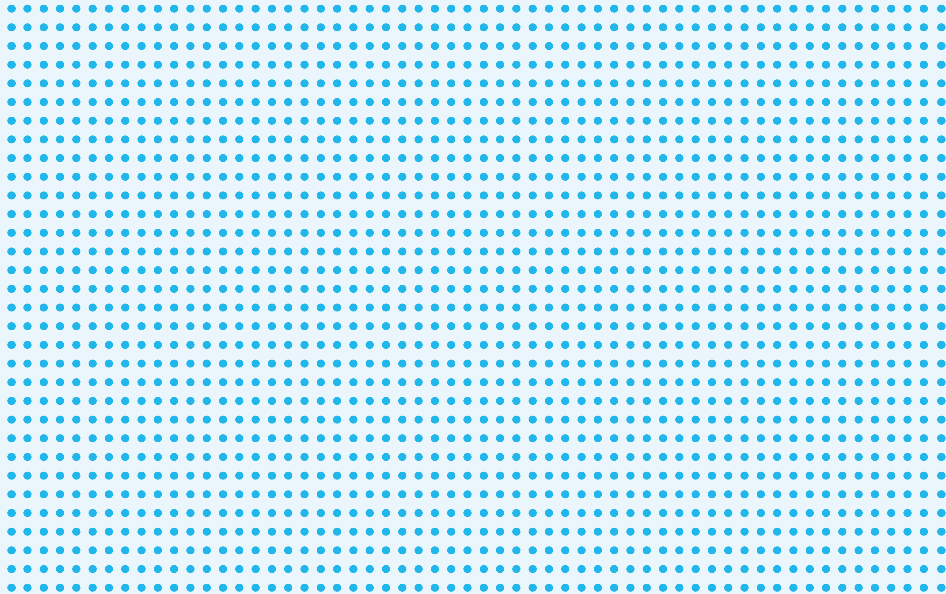
The multisectoral county response will be managed by various structures at different levels. Each level will be mandated with different tasks and roles in the delivery of the strategic plan. The coordination infrastructure of the KCASP will be an all-inclusive one. This infrastructure will be coordinated at different levels as shown in the organogram below;

Figure 5.6: Kisumu County Coordination infrastructure for KCASP Delivery
The roles of these committees will be indicated in their terms of reference after formation.



06

MONITORING & EVALUATION PLAN



6.1 M&E systems

Monitoring and Evaluation is an essential component of programmatic success. However, there exists gaps or challenges in M&E systems in Kisumu County, more so, in the areas of HIV prevention, human rights and mitigation. Other challenges identified, include lack of agreed standardized and disaggregated indicators for adolescents and young people, inadequate tools and guidance on monitoring behaviour and human rights interventions, limited capacity in M&E, as well as data quality issues. A district health information system (DHIS) exists for purposes of tracking interventions in the health sector. Data collection for community based intervention, work place and social protection programs use the COBPAR, Workplace reporting tools and social protection reports respectively, albeit with major technical challenges.

6.2 Baseline Information

Given that this strategic plan proposes to decrease the number of new HIV infections, baseline data will be used to set mid and end term targets for the County. For those indicators where County specific baseline data is not available, the KCASP will be guided by National Data. Therefore, there is need to conduct county specific surveys.

6.3 Indicators

Monitoring at County level will be based on an established core set of indicators against the strategic directions of the Plan. These indicators will be sufficient to provide an indication of effectiveness of the county response at a glance. All primary data contributing institutions will be expected to submit required data to appropriate subsystem. The focus will largely be on inputs, processes and outputs. The county will also rely on outcome and impact level data from national surveys for some of the indicators.

6.4 KCASP Reviews

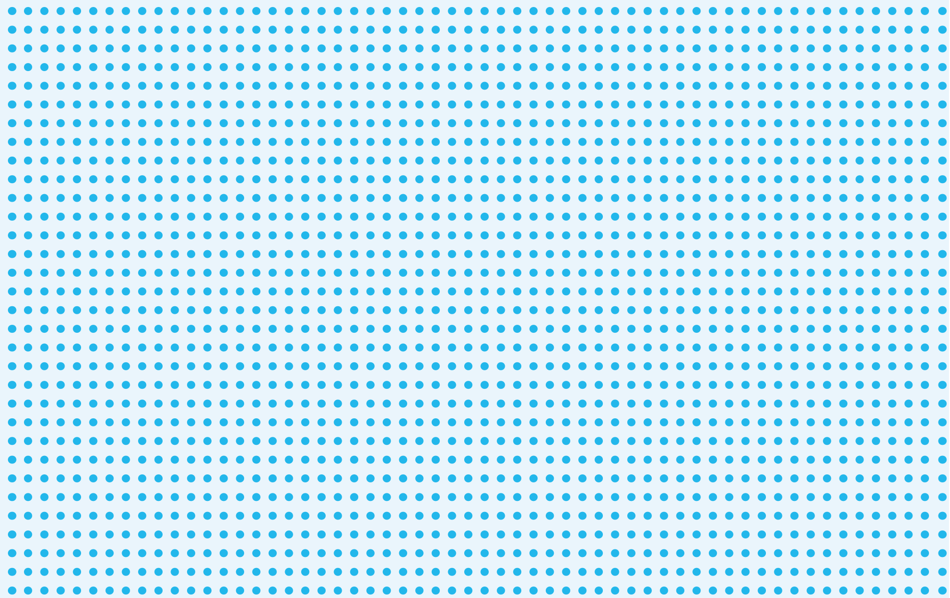
Given the multi-sectoral nature of HIV response, there are varied data sources from diverse stakeholders hence the need for quarterly and bi-annual stakeholders data review forums. Midterm and end term reviews of the plan will be conducted in 2017 and 2019 respectively, led by the KASF/ KCASP M&E committee, with the support of consultants. These reviews will examine accomplishments against expected results over the first two years, as well as at the end of the plan period. These will be important opportunities to review plan strategies and indicators and where necessary make evidence based adjustments to the interventions.

6.5 Data Flow and Archiving

Data from different subsystems will be consolidated into the County M & E systems. The county will consolidate information from all the existing subsystems at the county level which will feed into the National System. Data from different actors will be collected using the existing data collection tools for each sector/actor.

07.

RISKS, MITIGATION, AND ASSUMPTIONS PLAN



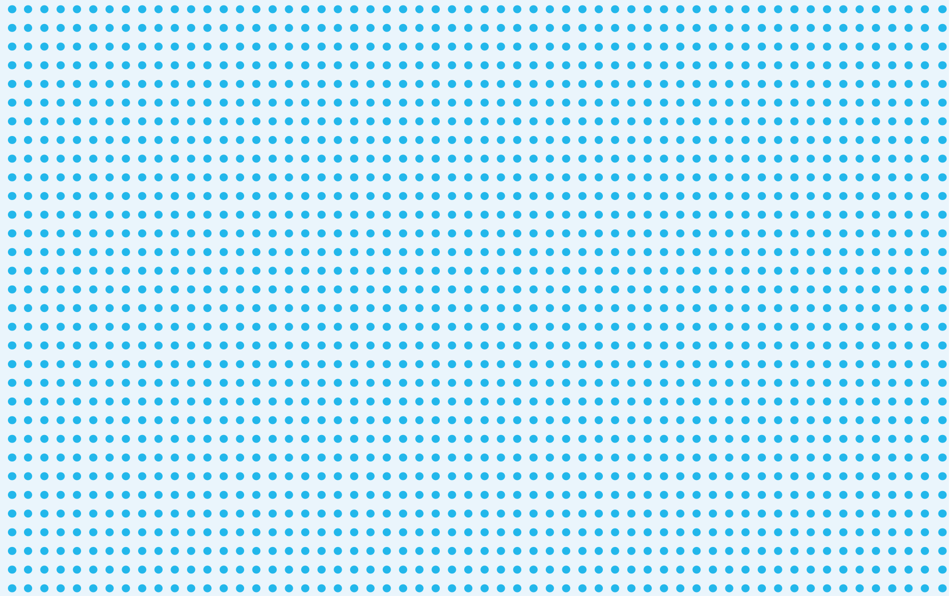
The actualization of KCASP will depend on various factors and challenges are expected that may hinder or disrupt proper implementation. They include availability of resources, leadership and governance among others. However, mitigation plans have been put in place to ensure that the plan is well implemented.

Table 7:1: Risks, Mitigation, and assumptions plan

Risk Category	Risk Name	Status	Probability	Impact	Response	Assumptions	Responsibility	When
Technological	Partners/ Implementers lacking technical capacity	Active - risk is being actively monitored	Medium	High	Mitigate - budget moneys for training	All necessary technological structures and capacity will be available or provided	CEC Health Services, Partners	Y1
Political	Inconsistent and insufficient political good will	Passive - risk to be actively monitored	Low	Medium	Reduce - by constantly engaging the political leadership	There will be political support and the 2017 elections will be peaceful	CEC Health Services	2017 and Continuous
Operational	Inconsistent and inadequate supply of HIV commodities Financing	Active - Being monitored Active-Donor support	High High	High High	Reduce – by implementing the pull system of commodity and have emergency funds to replenish the supplies Mitigate-County HIV specific budget allocation	All HIV commodities will be supplied without delay Adequate County HIV financial support	CEC Health Services, Partners	Continuous
Legislation	Inadequate legislation to support KP and vulnerable groups	Active	High	High	Lobby (legislation) support from the KCASP	Policies will be formulated that support KP and vulnerable groups	County Assembly and CEC Health	Continuous

08.

FINANCING OF THE KISUMU COUNTY HIV & AIDS PLAN



The finances to implement the KCASP have been estimated with the view of achieving the best within a resource constrained setting. The county resource needs for this strategic plan period was estimated from KASF 2014/15-2018/19 that used Stover Resource Model. The model utilizes EPI and program data to form the baselines, and projects the resource needs over a period of time. The key element used in the calculations by this model is the HIV burden represented by the number of PLHIV in the county compared to that of the Nation.

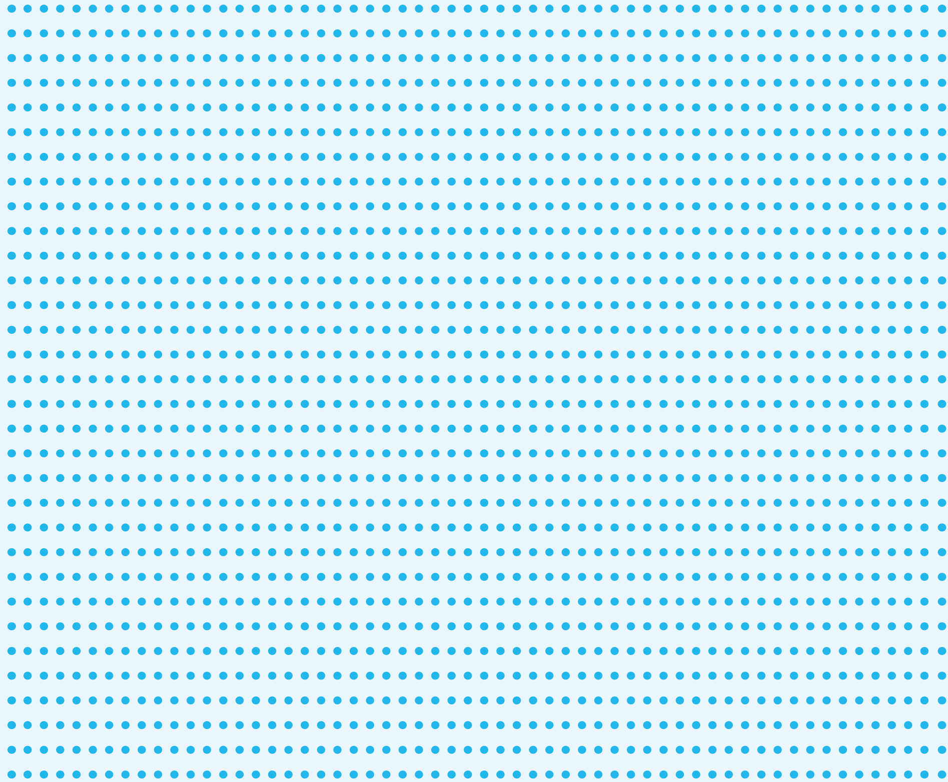
Table 8.1: KCASP Resource need (USD millions)

Strategic Directions	Specific KCASP Intervention Areas	% of resource dedicated for the strategy	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019	Total
SD1	HIV Prevention	25.00%	20.145	22.94	25.89	28.97	31.38	129.33
SD2	Treatment and Care	53.00%	42.707	46.70	48.78	49.67	49.05	236.91
SD3	Social inclusion, human rights and gender	7.00%	5.641	7.33	9.12	11.06	13.15	46.29
SD4	Health systems	3.00%	2.417	2.19	1.79	1.61	0.84	8.85
	Community systems	3.00%	2.417	2.18	1.79	1.61	0.84	8.83
SD5	Research	1.00%	0.806	0.91	1.00	1.07	1.12	4.91
SD6	Monitoring and evaluation	2.00%	1.612	1.63	1.59	1.50	1.35	7.68
SD7 & SD8	Leadership, Governance and Resource Allocation	5.00%	4.029	4.09	3.99	3.75	3.38	19.24
	Supply chain management	1.00%	0.806	0.91	1.00	1.07	1.12	4.91
	Grand Total	**100.00%**	**80.58**	**88.88**	**94.95**	**100.30**	**102.24**	**466.95**

Source: NACC, 2014

09.

ANNEXES



Annexes

Annex 1: The KCASP development process

ACTIVITY	DATE	MEMBERS INVOLVED
KASF Dissemination for Kisumu County	24th – 25th September 2015	Multisectoral Stakeholders
Appointment of Kisumu County drafting team	6th November 2015	CEC - Health Services County Director – Health Services
Planning meetings for the drafting of the KCASP	23rd January 2016 2nd March 2016 15th March 2016	Drafting team members County Director – Health Services
Drafting of the Kisumu County AIDS Strategic Plan	21st – 24th March 2016	Drafting team members
Review of the Kisumu CASP Zero Draft	9th – 10th June 2016	TST members Drafting team members
Validation of the reviewed Kisumu CASP document	TBD	Drafting team members Technical Support Team members Multisectoral stakeholders

Annex 2: Implementation plan

KEY ACTIVITY	2014/15	2015/16	2016/17	2017/18	2018/19
Provide universal HIV testing services	√	√	√	√	√
Provide innovative and evidence-informed HIV prevention, care and treatment services	√	√	√	√	√
Offer age and population appropriate HIV education	√	√	√	√	√
Provide universal STIs management	√	√	√	√	√
Provide friendly eMTCT Services	√	√	√	√	√
Utilize CHAs and CHVs to link community - facility interface			√	√	√
Strengthen Early Infant Diagnosis (EID) infrastructure	√	√	√	√	√
Improve patient referral and patient management system and infrastructure		√	√	√	√
Develop County specific adolescent and youth initiatives in line with the Fast track plan		√	√	√	√
Integrate services at the health facilities	√	√	√	√	√
Mobilize the community and peer support to create demand for and increase women's access to uptake of ANC as well as delivery in health facilities	√	√	√	√	√
Develop County specific stigma reduction interventions		√			
Encourage discussion between parents and adolescents on sexual matters and HIV	√	√	√	√	√
Enhance PRE ART services e.g. treatment literacy	√	√	√	√	√
Establish mechanisms for retention to care e.g. support groups and promotion of adherence		√			
Improve efficiency and effectiveness of quality laboratory services for viral loads	√	√	√	√	√
Employ quality improvement mechanisms in the treatment outcomes	√	√	√	√	√
Advocacy to community and stakeholders.			√	√	√
Formulate laws and policies			√		
Monitor and evaluate stigma, discrimination and GBV	√	√	√	√	√
Conduct county baseline surveys on HIV prevalence, GBV, stigma index			√		
Conduct Continuous Professional Development (CPD)	√	√	√	√	√

Enhance referral and linkage services between community and facility		√	√	√	√
Community sensitization and integrating HIV services into community units	√	√	√	√	√
Coordinate research activities			√		
Implement the research agenda			√		
Develop a research fund			√		
Set up M&E infrastructure			√		
Generate, Prepare and present HIV M&E reports		√	√	√	√
Conduct supportive supervisions			√	√	√
Develop county M&E costed plan to guide and inform M&E activities			√		
Conduct data verification and data quality reviews		√	√	√	√
Print data tools		√	√	√	√
Train DHIS2 and other related platforms HITS system and HIPORS			√		
Conduct M&E stakeholders review meetings			√	√	√
Form County and Sub County M&E Committees				√	
Support transmission of M&E products Maximize efficiency of existing delivery options for increased value and results within existing resources		√	√	√	√
Promote innovative and sustainable domestic HIV financing options			√	√	√
Align HIV resources/ investments to KCASP priorities		√			
Involve all stakeholders in HIV planning and programming			√	√	√
Create a structured network of County HIV response		√			
Capacity building of partners on emerging trends and innovations		√	√	√	√

Annex 3: Results Framework

STRATEGIC DIRECTION 1: REDUCE NEW HIV AND TB INFECTIONS			
KCASP Results	**Service Delivery Area**	**Indicators**	
Reduce new HIV infection in adults and children by 80%	Key population	Annual Number of new adult HIV infections	
		Annual Number of new child HIV infections	
		Annual number of new infections from Key population (sex workers, MSM, prison population, PWID)	
		Number of syringes distributed per person who injects drugs by the needle and syringe program	
		% of FSW reporting the use of condom during penetrative sex with their most recent client	
		% of men reporting the use of a condom the last time they had anal sex with a male partner	
	Adolescent programme	% of young women and men aged 15-2 4 who have had sexual intercourse before age 15	
		% of schools that provide life skills based HIV education	
	HTS	Percentage of the population counselled and tested	
	PEP	Number of Health facilities providing PEP services	
	General Population	% of people aged 15-49 who had sexual intercourse with more than one partner in the last 12 months	
		% of people aged 15-49 who had sexual intercourse with more than one partner in the last 12 months and reported condom use during the last sexual intercourse	
	PMTCT	Number of pregnant women attending ANC whose male partner was tested for HIV	
		Number and % of infants born to HIV infected women starting on Cotrimoxazole prophylaxis within 2 months of birth	
		Number and % of infants born to HIV infected women who receive DNA- PCR test for HIV within 2 months of birth.	
		Number and % of pregnant women who know their HIV status (1ST ANC Visit).	
		% of HIV positive women who receive antiretroviral to reduce risk of mother to child transmission (ANC-PMCT).	
		% of health facilities providing EID.	
		% of clients who finished four ANC visits.	

Baseline	Data Source	Mid Term Target	End Term Target
10,682	County Estimate 2013	4807	9613
2,296	County Estimate 2013	995	1989
4199	MoT study (2008)	3149	2099
0	Partner data	0	0
66%	PBS	70%	75%
20%	IBBF	25%	30%
4%	County Estimate 2013	2%	1%
20%	County MoE records	30%	40%
74%	DHIS - 2015	85%	90%
122	DHIS	160	201
2.8%	KAIS 2012	2%	1%
14%	KAIS 2012	20%	25%
2,618 (0.3%)	DHIS 2015	50%	87%
97%	DHIS	100%	100%
3786/3213x100=118%	DHIS 731/711	100%	100%
92%	DHIS	100%	100%
95%	DHIS 2015	100%	100%
98%	DHIS 2015	100%	100%
55%	DHIS 2015	70%	80%

STRATEGIC DIRECTION 2: IMPROVING HEALTH OUTCOMES AND WELLNESS OF PEOPLE LIVING WITH HIV			
KCASP Results	**Service Delivery Area**	**Indicators**	
Reduce AIDS related mortality by 30%	HIS	Annual number of HIV related deaths (Adults)	
	HIS	Annual number of HIV related deaths (children)	
	ART Program	% of people diagnosed HIV positive linked with care within 3 months. Percentage of PLHIV receiving HIV care services. Number and percentage of adults and children enrolled in HIV care and eligible for Cotrimoxazole prophylaxis currently receiving Cotrimoxazole prophylaxis.	
	PMCT Program	Number and % of eligible clients newly initiated on highly active ART in the last 12 months.	
	ART Program	Percentage of adults and children currently receiving ART among all eligible people living with HIV (using national criteria). Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (24 months, 36 months, 60 months).	
	HIV/TB Co morbidity	Percentage of TB/HIV co-infected clients who are receiving ARTs. Percentage of HIV patients screened for TB.	
		Percentage of ART patients with an undetectable viral load at 12 months after initiation of ART	
		Percentage of people on ART tested for viral load who have a suppressed viral load in the reporting period	
	Capacity building	Percentage of health facilities providing HIV care and treatment services	
		Percentage of health facilities implementing continuous quality improvement activities according to MoH standardized protocols	
		Number of health facilities providing care and treatment according to MoH standardized protocols	

Baseline	Data source	Midterm Target	End Term Target
2,861	County Estimate 2013	358	715
1,040	County Estimate 2013	125	250
82.2%	DHIS Oct-Dec 15	85%	90%
66.4%	DHIS 2015	85%	90%
89026 (66.4%)	DHIS 2015	90%	90%
5343 (98%)	DHIS 2015	4030 (90%)	8061 (90%)
60%	DHIS 2015	75%	90%
86% (822/960=86)	DHIS 2015	90%	90%
86%	12 month cohort	90%	90%
	DHIS	90%	90%
92%	TIBU 2015	96%	100%
92%	DHIS	90%	100%
44%	HIMS	75%	90%
377,159 (42%)	NASCOP Report Dec 2015	60%	75%
97.6%	RHIS	98%	100%
40%	RHIS	60%	80%
124	RHIS	130	140

STRATEGIC DIRECTION 3: USING A HUMAN RIGHTS APPROACHES TO FACILITATE ACCESS TO SERVICES		
KCASP Results	Service Delivery Area	Indicators
Reduced barriers to access of HIV and AIDS and SRH services in public and private entities OYOLA Reduced level of sexual and gender-based violence (SGBV) by 50% Increased knowledge, recovery centres and integrated HIV services HIV policies formed and implemented	Community and stakeholders advocacy	No. of stakeholders/partners reached: Police Gate keepers Health care workers CHVs Judiciary MCAs
		No. of schools with stigma free messages
	Policy	No. of HIV and AIDS workplace policies developed No. of guidelines and policies to stop GBV formulated
	Training	No. of staff trained on Kenya sign language and Braille
	Empowerment	Amount of cash transfers for youth given
	Campaigns	No. of campaign forums to reduce GBV conducted
	Male involvement	No. of men involved in HIV and SRH programmes
	Infrastructure	No. of youth friendly centres established No. of GBV recovery centres established

STRATEGIC DIRECTION 4: STRENGTHENING INTEGRATION OF HEALTH AND COMMUNITY SYSTEMS		
KCASP Results	**Service Delivery Area**	**Indicators**
Motivated and competent workforce Strengthen Health service delivery systems and linkages Strengthen Community service delivery system Community Resource accountability	Continuous professional development	No. of motivational speeches made to HCW No. of staff deployed for balancing No. of staff promoted and their salaries harmonized with counterparts in other fields
	Linkages and integration created or expanded	No. of health facilities where mentor mothers strategy was incorporated No. health facilities offering KEPH services No. of periodic review conducted
	Financial support	Amount of money allocated to support community volunteers
	New technologies and issues	No. of periodic updates given to CHEWs, CHC and CHVs on emerging issues on HIV

Baseline	Data source	Midterm Target	End Term Target
25 400 591	HIS HIS	25 450 591	25 600 600
6%	MOE	20%	40%
1 1	HIS HIS	1 1	1 2
0	HR	1	2
0	COUNTY	0	0
1	HIS	2	2
200	HR	300	400
2 1	HIS HIS	3 1	4 2

Baseline	**Data source**	**Midterm Target**	**End Term Target**
1 TBD 800	HIS HIS HRM	2 TBD TBD	2 TBD TBD
9 201 3	PMTCT PROGRAM HIS HIS	12 201 2	24 201 3
TBD	4/100 of Department of Health Budget.	TBD	TBD
12	HIS	6	12

STRATEGIC DIRECTION 5: STRENGTHENING RESEARCH, INNOVATION AND INFORMATION MANAGEMENT TO MEET KCASP GOALS

KCASP Results	Service Delivery Area	Indicators	
Increased evidence-based planning and programming	Research coordination	No. of research institutions reporting their research finding to the County	
Increased capacity to conduct HIV research at County level	Research activities conducted No. of surveys conducted	No. of research proposals developed and conducted	
		No. of surveys conducted	
Increased funding for HIV Research	Research financing	Amount of money allocated for research	
	Ethical committees	No. of research proposals approved and reported to the County	

STRATEGIC DIRECTION 6: PROMOTE UTILIZATION OF STRATEGIC INFORMATION FOR RESEARCH MONITORING AND

KCASP Results	Service Delivery Area	Indicators	
Increased availability of strategic information to inform HIV programming at the County level Planned evaluation reviews and surveys implemented and results disseminated	M& E infrastructure	No. of County HIV hubs established	
	Training	No. of health managers using situation room No. of HIV reports produced from situation room for programming % of managers and frontline HCW trained on M&E % of staff trained on online data transmission % of managers trained on DHIS 2	
	Supervision	No. of quarterly M&E support supervision conducted No. of data quality assessments conducted	
	Data tools	No. of data tools printed and distributed No. of routers installed	
	Meetings	No. of M&E meetings held	

Baseline	Data source	Midterm Target	End Term Target
2	HIS	2	2
0	CDH	5	10
0	CDH	1	2
0	CDH	2,500,000	5,000,000
0	CDH	5	10

EVALUATION TO ENHANCE PROGRAMMING

Baseline	Data source	Midterm Target	End Term Target
0	HIS	1	1
0 0 24% 15% 20%	HIS HIS HIS HIS CDH	5 0 26% 30% 50%	10 0 42% 40% 100%
56 6 HTS VMMC ART	HIS COUNTY TWG M$E	TBD 8	TBH 12
1000 0	HIS	600 0	2000 0
1	HIS	2	3

STRATEGIC DIRECTION 7: INCREASE DOMESTIC FINANCING FOR SUSTAINABLE HIV RESPONSE			
KCASP Results	**Service Delivery Area**	**Indicators**	
Increased Domestic Financing for sustainable HIV and AIDS response	Training	No. of On Job Training models utilized	
	Coordination	No. of HIV partners mapped	
	Financing	No. of clients with NHIF insurance % of County health budget allocated for HIV specific interventions No. of private partners involved in HIV activities No. of charity events conducted No. of philanthropists supporting HIV interventions	

STRATEGIC DIRECTION 8: PROMOTING ACCOUNTABLE LEADERSHIP FOR DELIVERY OF THE KCASP RESULTS BY ALL SECTORS			
KCASP Results	**Service Delivery Area**	**Indicators**	
Good Governance Practice and Accountable leadership entrenched for the multi-sectoral HIV and AIDS response for the County	HIV CONTROL	No. of County address on HIV by the governor	
		No. of active HIV stakeholders identified	
		No. of County HIV coordination units established	
		No. of PLHIV networks strengthened	
		% of staff trained on HIV	
		No. of HIV programs benchmarked	
		Amount of HIV money lobbied by MCAs	

Note: TBD- To Be Determined

Baseline	Data source	Midterm Target	End Term Target
1	HIS	2	3
22	PARTNER INVENTORY	25	25
-	County HRM	TDB (To be Determined)	TBD
TBD	6/100	TBD	3%
1	HIS	5	5
-	TBD	TBD	TBD
-	TBD	TBD	TBD

Baseline	Data source	Midterm Target	End Term Target
2	HIS	2	5
25	HIS	25	25
1	HIV PROGRAM	1	1
5	HIS	5	5
50%	HIS	70%	90%
5	HIS	7	10
N/A	N/A	N/A	N/A

Annex 4: Leverage on Sectors for HIV prevention

OTHER SECTOR	JUSTIFICATION	
Education	It provides an opportunity where we can tap on a captive audience comprising of a school going population.	
Matatu SACCOs and NTSA	Offers employment to touts, drivers and conductors in the public transport sector. They have been identified as a vulnerable population. Through NTSA they have formed SACCOs and this can be an entry point to highlight their vulnerability and target them for services	
Private sector institutions: commercial, manufacturing	They employ staff PLHIV who require HIV services and provide a captive audience for implementation of work place HIV programs	
Institutions of higher learning (universities/polytechnics)	This is where older adolescents and young adults (both men and women) age 15 – 24years can be found.	
Faith based organizations, CBOs, donors and NGOs	Resource and community mobilization	
Clubs, youth groups, women groups, interest groups	As an organized community groups they provide a captive audience that can be used in HIV social mobilization activities in the community.	
Media	Community mobilization and messaging	

	RECOMMENDED ACTIONS	RESPONSIBILITY
	Increase knowledge on HIV and HIV status, STI and HPV among teachers and students	County Department of Health, Partners
	Target them for HTS; use them to convey HIV prevention and treatment messages; Peer education and role model	County Department of Health, Partners
	Advocate for the provision of HIV services and establish work place HIV programs, Resource mobilization.	County Department of Health, Partners, Private sector
	Integrate HIV services, STI and HPV screening among them.	County Department of Health, Partners, Institutions of higher learning.
	Provide psychosocial support for stigma reduction. They also have a large audience and thus mobilizing the community and resource mobilization capacity is substantial.	County Department of Health, Partners
	Engage them in HIV communication activities.	County Department of Health, Partners
	Engage the community in levels of knowledge, testing, stigma and service provision.	County Department of Health, Partners

Annex 5: References

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[TEST OFTEN] + [TREAT EARLY] + [STAY SAFE] = ENDING HIV 2020