KITUI COUNTY HIV & AIDS STRATEGIC PLAN

2015/16 - 2018/19

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National AIDS Control Council

Table of Contents

Acronyms and abbreviations

ACU	AIDS Control Units
ACT	Acceleration of Care and Treatment
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Clinic
APOC	Adolescent package of Care
ART	Anti-Retroviral Therapy
ARVS	Anti-Retroviral Medicines
BCC	Behaviour Change Communication
CEC	County Executive Committee
CHC	County HIV Committee
CHEWs	Community Health Extension workers
CHVs	Community Health Volunteers
CIDP	County Integrated Development Plan
CITC	Client Initiated Testing and Counselling
COBPAR	Community Based Program Activity Reporting
CPAD	CCC Patient Application Database
CSOs	Civil Society Organizations
CBOs	Community Based Organizations
OVC	Orphans and Vulnerable Children
DBS	Dried Blood Sample
DHIS	District Health Information System
DICEs	Drop In Centres
DRT	Drug Resistance Testing
EID	Early Infant Diagnosis
EIT	Early Infant Treatment
EMR	Electronic Medical Records
eMTCT	Elimination of Mother To Child transmission
FBO	Faith Based Organization
FSWs	Female Sex Workers
GBV	Gender Based Violence
HCWs	Health Care Workers
HPV	Human Papilloma Virus
HTS	HIV Testing Services
IEC	Information, Education and Communication
IGA	Income Generating Activities
IYCF	Infant and Young Child Feeding
KASF	Kenya AIDS Strategic Framework
KCHSP	Kitui County HIV and AIDS Strategic Plan
KDHS	Kenya Demographic Health Survey
KEPH	Kenya Essential Package for Health
KMMP	Kenya Mentor Mothers Program
KP	Key Population
LMIS	Logistic Management Information System
M&E	Monitoring & Evaluation
MCH	Maternal Child Health
MIPA	Meaningful Involvement of People with HIV
MoEST	Ministry of Education Science and Technology
MoT	Modes of Transmission
MSM	Men who Have Sex with Men
NGO	Non-Governmental Organization
NSP	Needle and Syringe Program
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PHDP	Positive Health Dignity & Prevention
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PLWD	People Living with Disability
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre Exposure Prophylaxis
PWID	People Who Inject Drugs
RTKs	Rapid Test Kits

SD	Strategic Direction
SP	Strategic Plan
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SWs	Sex Workers
TB	Tuberculosis
NACC	National AIDS Control Council
TBA	Traditional Birth Attendants
VL	Viral Load
AYP	Adolescents and Young People
HIV	Human Immunodeficiency Virus
FP	Family Planning
KEMSA	Kenya Medical Supplies Authority
MDAs	Ministries, Departments and Agencies
TAT	Turn Around Time
SCACC	Sub County AIDS Control Coordinator
OPD	Out Patient Department
IQ Care	International Quality Care
CASCO	County AIDS and STI Coordinator
CSR	Corporate Social responsibility
CLHIV	Children Living With HIV

Foreword

The importance of having an HIV and AIDS free society cannot be overemphasized. As a result, the Kitui County HIV Strategic Plan (KCHSP) will be critical in laying a firm foundation for combating HIV and AIDS in our County. Effective implementation of the plan will be pivotal in nurturing an inclusive and enabling HIV free environment in Kitui County that will in turn deliver prosperity and a high quality of life for our people.

The KCHSP will guide our HIV intervention over the next four years and form the basis for HIV programme planning, policy and budgeting. The plan is aligned to the 2010 Constitution of Kenya, Kenya Vision 2030, and the Sustainable Development Goals (SDGs). It is also informed by the experiences on the implementation of past global and national policies such as the Millennium Development Goals (MDGs). KCHSP therefore, aims to build on these experiences to establish a strong base and framework for sustainable socio-economic and health development for our county. In addition, the KCHSP seeks to address related challenges such as reluctance for HIV testing, stigma and discrimination associated with HIV and AIDS.

The KCHSP is organized into seven strategic pillars that are designed to assist the county realize 'Universal Access to Comprehensive HIV Care,Treatment and Preventive Services, the 90,90,90 approach and provides the situational analysis for the identified County Health challenges as provided for in Kenya Vision 2030.

Whereas it is the primary duty of the County Government of Kitui to coordinate the implementation of this KCHSP, participation and cooperation from all stakeholders will be key in its realization. I therefore, call upon all stakeholders to join hands and work as a team in laying the requisite solid foundation for combating the spread of HIV and improvement of the livelihoods of all Kitui people.

Finally, I would like to thank the drafting team for spear heading this process and reiterate the commitment and support of my Government in ensuring successful implementation of the HIV Strategic Plan.

H.E DR. JULIUS M. MALOMBE

Governor, Kitui County

Acknowledgements

The Kitui County Department of Health Services wishes to acknowledge with gratitude the valuable contribution of individuals and organisations who contributed to the development of this Kitui County HIV and AIDS Strategic Plan (KCHSP).The department wishes to express special thanks and appreciation to county drafting team members for their invaluable contribution in providing technical guidance and administrative oversight during the process.

The department further wishes to thank the CHMT, CASCO, SCASCO, CACCS county departments and various stakeholders, civil society organisations, NEPHAK, ICAP, APHIA Plus Kamili, Catholic Diocese of Kitui, University of Nairobi MARPS project and MoEST for their meaningful participation. Their participation has helped to improve the quality and comprehensiveness of this document.

We thank His Excellency Dr Julius M. Malombe the Governor of Kitui County, Her Excellency Mrs. Peninah Malonza, the Deputy Governor of Kitui County and all Members of the County Executive Committee for their invaluable ideas and inputs during the entire process of preparing this framework.

Further, we wish to acknowledge the contributions The country declared HIV and AIDS as a national disaster in 1999, and has been committed to a comprehensive, and expanded multi-sectoral response to fight the epidemic, as well as to curb its impact on society. With devolvement of Health, the Government of Kitui County galvanises the active involvement and participation of communities, local, national sectors with clearly defined roles and responsibilities assigned to each entity.

Exective Summary

Kitui County is categorised as a medium burden county with HIV Prevalence of 4.2%, with prevalence among female higher (5.7%) than male (2.5%).[1] HIV and AIDS morbidity and mortality poses a serious challenge thus impacting negatively on labour force productivity. In this strategic plan , the county will adopt a more strategic approach to managing all the elements of the County Response, together with a management approach that is robust, but equally adaptable to critical emerging issues in a rapidly changing environment.

The purpose of the Plan is to provide clear guidance for the County, the sub counties, CSOs, Networks of PLHIV, Faith sector, partners, Public and the Private sector, to enable them to work in a collaborative manner in achieving the ultimate goal of eliminating new HIV infections. Going forward, the Plan sets strategic objectives for its timeframe of execution:

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

The KCHSP has eight strategic directions:-

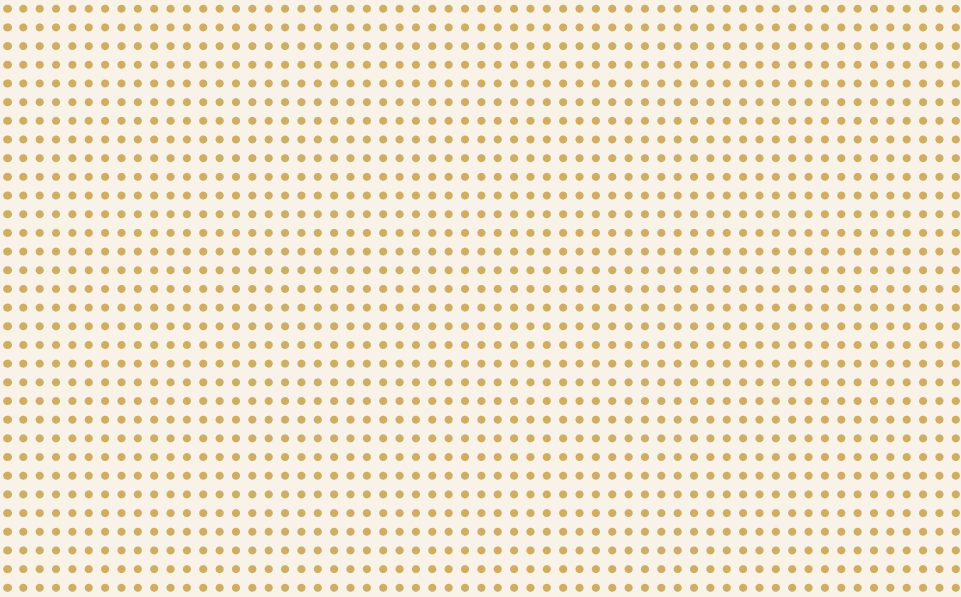
1. Reduce New HIV Infections
2. Improve Health Outcomes of People Living with HIV (PLHIV)
3. Promote Human Rights approach to facilitate access to HIV services
4. Strengthen community integration of health and community systems
5. Strengthen Research and Innovation to inform KCHSP results
6. Promote utilisation of strategic Information to Enhance HIV Programming
7. Increase Domestic Financing for a Sustainable HIV response
8. Promote Accountable Leadership for delivery of the KCHSP results by all sectors and actors

The KCHSP has a four year implementation and coordination arrangement outlining the roles and responsibilities of the various players and a results framework with key indicators with mid and end term targets to be achieved. Implementation of this strategic Plan will go a long way in contributing to the health of Kitui residents, raising their economic productivity as well as contributing to the wider realisation of Vision 2030 objectives.

1 Kenya HIV County Profiles, NACC 2014

01.

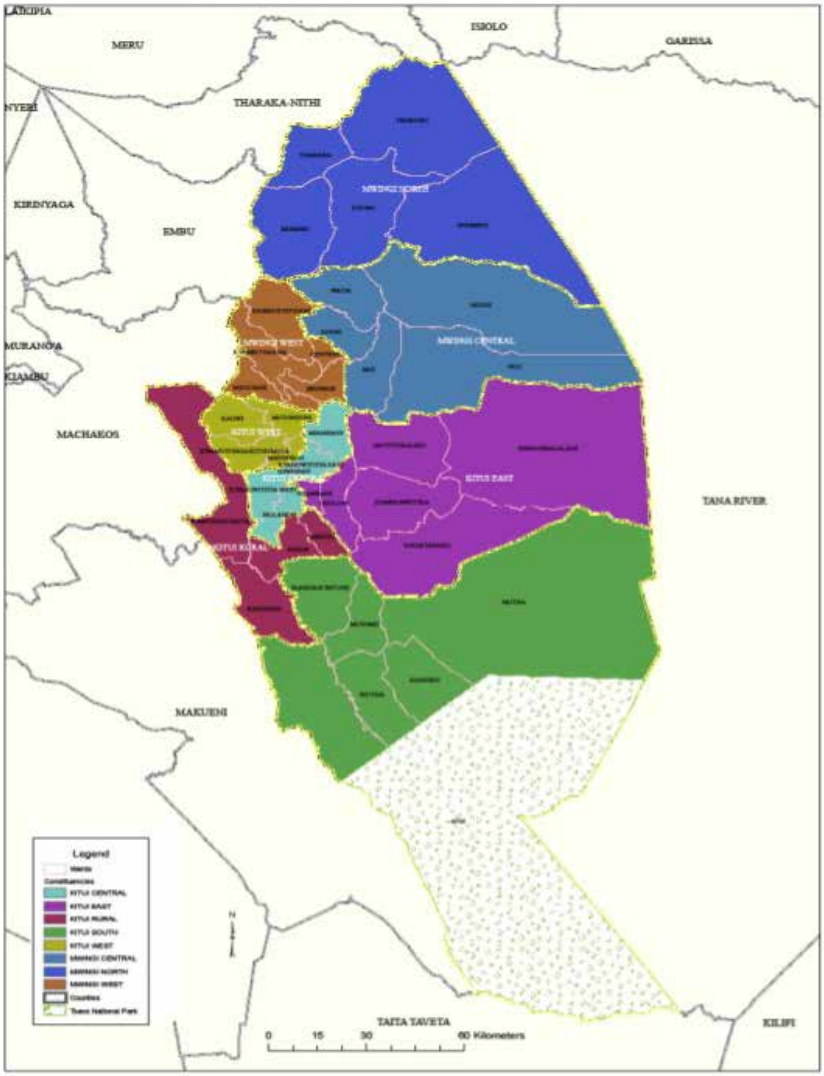
BACKGROUND



Overview of Kitui County

Kitui County is located in the former Eastern province of the country about 160 km East of Nairobi. It is one of the largest counties in the country covering an area of 30,496.5 square kilometres. Kitui shares its borders with seven counties. These are; Tharaka and Meru to the north, Embu to the northwest, Machakos and Makueni to the west, Tana River to the east and southeast and Taita Taveta to the south. The name Kitui means 'a place where iron goods are made'. The Kamba iron-smiths who settled in the county many years before the colonial period are the ones who named the area Kitui. Kitui County constitutes eight constituencies. They are: Mwingi North, Mwingi West, Mwingi Central, Kitui West, Kitui Rural, Kitui Central, Kitui East and Kitui South.

Figure 1: Kitui County Map



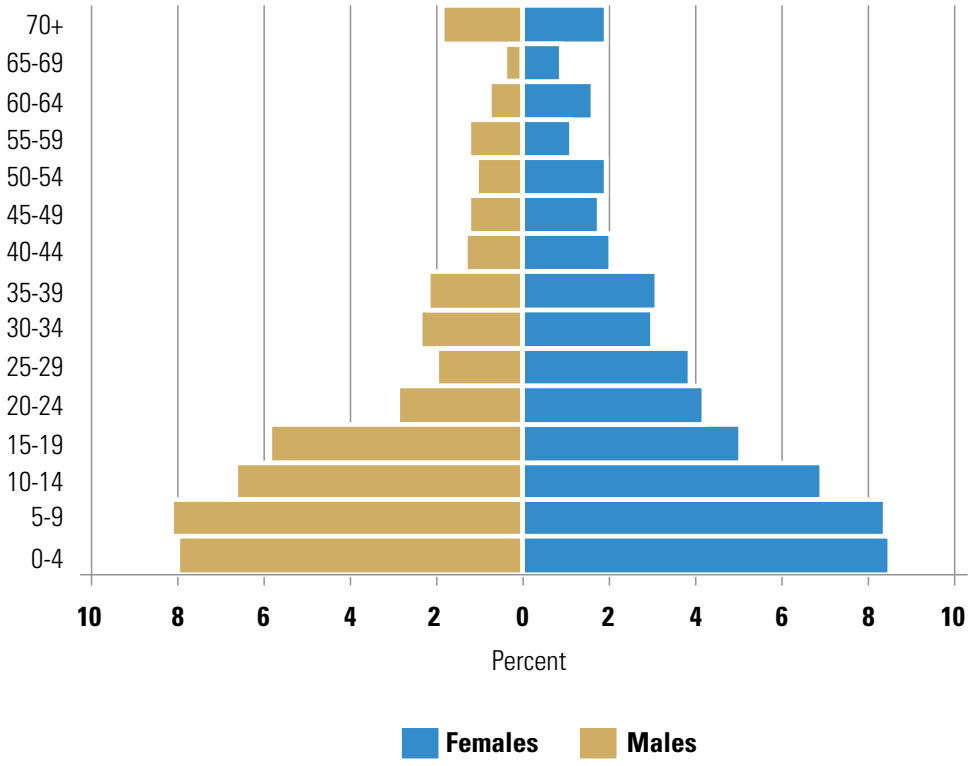
Population

Kitui County has an estimated total population of 1,112,228 representing a population density of 70 people per square km. The population structure of the county reflects an almost sex-balanced ratio of female: male (52:48). The crude birth rate for the county is 47/1000 while the crude death rate is 57/1000. The county has high fertility rate (total fertility rate) of 4.6 (census 2009).

About the People

The main residents are Kambas - the fifth largest tribe in Kenya - making about 11% of the country's population. Kambas are famous for their wood/soapstone carving and basket weaving skills. They are also involved in livestock rearing, subsistence farming and hunting. Other communities who live in the county in small numbers include Ameru, Tharaka, Aembu, Kikuyu and Somali, who primarily do business or are in the formal employment.

Figure 2: Age and sex distribution of household population,



Source: KNBS 2009

Religion and Traditional Culture

Majority of the residents are Christians. Kitui also has a significant number of Muslims and other faiths as well. Traditional Kamba religion resembles that of many Bantu-speaking peoples, in that there is one supreme god, usually conceived of as male and who can be prayed or sacrificed to, and the existence of spirits.

As in many sedentary pastoralist societies, Kamba marriage practices include the exchange of cattle as a form of bride wealth payment. In addition, Kaweto is a traditional form of marriage where a woman who is not able to bear children 'marries' a young woman of childbearing age to bear children for the purpose of continuity of the family lineage. This should not be mistaken for homosexuality for the woman bears children with any man from the clan.

Climate and Weather

Kitui County is mostly dry and hot with temperatures ranging between 14°C during the coldest months (July-August) and 34°C during the hottest months (January-March). The county receives between 500mm and 1050mm of rainfall annually, with average rainfall of 900mm a year. It has two rainy seasons; May-June (long rains) and September-October (short rains).

Economic Activities

Agriculture is the backbone of Kitui County. In the highlands of Kitui, farmers are involved in subsistence agriculture - mainly growing cotton, tobacco, sisal, mangoes, maize, beans, cassava, sorghum, millet and pigeon peas. These crops are well adapted to the climatic conditions of Kitui. Crops produced are consumed locally with the surplus being sold to traders from Nairobi and neighbouring towns.

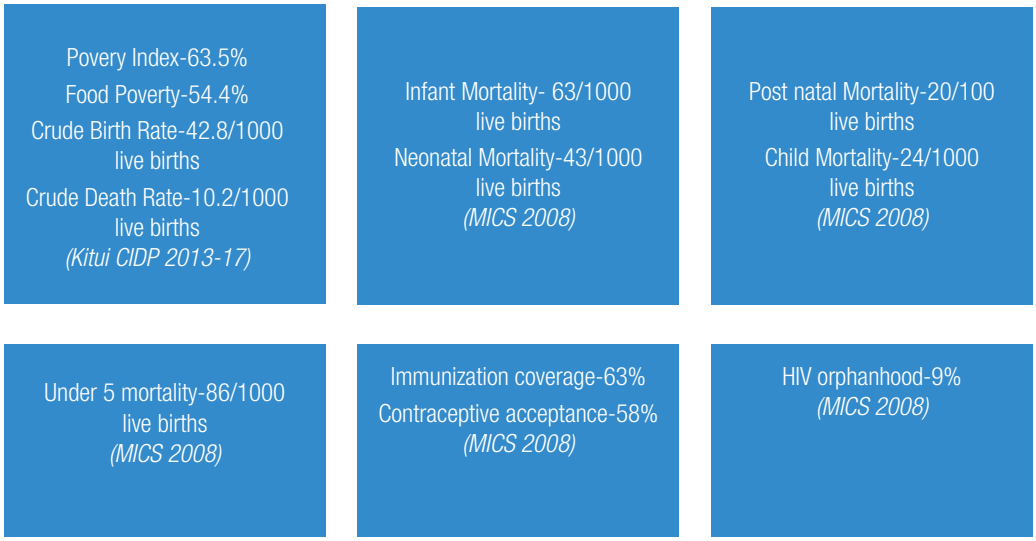
In the lowlands, farmers keep livestock - mainly cattle, sheep, goats and chicken - as a means to supplement crop farming as their source of income. Tourism is a low-key economic activity with some of the residents building hotels and lodges that serve visitors coming to the main towns for business and leisure. Mwingi National Reserve, South Kitui National Reserve as well as the Tsavo East National Park are the tourist attractions which also offer a thriving market for local artefacts such as baskets and soapstone/woodcarvings - another major source of revenue to the people of Kitui. The county is also endowed with minerals and other natural resources that are exploited for commercial purposes.

Education

There are 1,359 primary schools and 330 secondary schools in Kitui County, serving 348,887pupils and 69,531 students respectively. Secondary school completion rate is estimated to be 93.4% while the retention and dropout rates are estimated to be 87.7% and 20% respectively[2]. Institutions of higher education in the county include South Eastern University (SEKU) Kenyatta University (Kitui Campus), Kenya Medical Training College (KMTC-Kitui) and other tertiary institutions.

2 Kitui County Integrated Development Plan 2013-2017

Figure 3: Key County indicators



HIV and AIDS Policy and Planning Environment

The KCHSP shall be implemented within the existing planning, policy and legal framework in the country. The Constitution of Kenya 2010 provides a broader framework for delivering HIV and AIDS services in the county and inspires county action at policy formulation, planning, programming and service delivery levels. It also promotes a Human Rights-based; gender-sensitive legal and policy environment to address HIV and AIDS. The HIV Act 2006 is currently under review and its enactment will form a basis for implementation at the county.

The county adopts the National HIV policies for the HIV implementation and delivery of services. Health implementation in Kitui County is in all the 8 sub-counties. Integrated HIV services are offered in all tiers of facilities. There are approximately 230 operational public health facilities in the county. Out of these facilities, 205 offer PMTCT, 87 offer ART and 211 offer HTS.

Partnerships

The County Health Management Team has endeavoured to work in collaboration with partners by providing a platform of stakeholders' forum where the partners share their objectives and line support areas. This has ensured quality of service delivery. In delivery of HIV services, the county has also worked closely with the line ministries and in collaboration with the partners. The county has the following partners supporting HIV programming;

a. ICAP Kenya: The organisation is the main partner in the county. Its areas of intervention include care and treatment for PLHIV, Elimination of Mother to Child Transmission of HIV and HTS Services.

b. Aphia Plus Kamili: This partner works with the Faith Based Organisations supporting care and treatment, eMTCT and HTS Services.

c. University of Nairobi MARPS Project: The Project supports Key Populations and has two DICES (Kitui County Referral Hospital and in Mwingi Level 4 Hospital).

d. Christian Health Association of Kenya (CHAK)- a faith based organisation supporting health care services

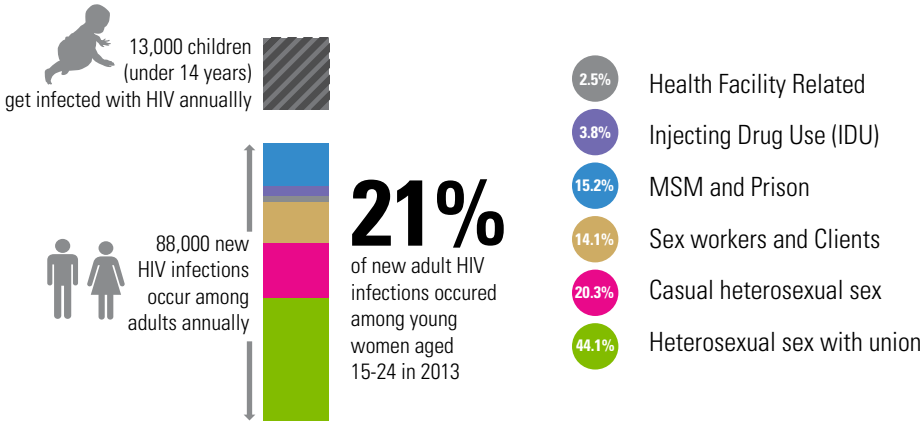
02.

SITUATION ANALYSIS

2.1. HIV and AIDS in Kenya

The HIV epidemic in Kenya is both generalised and concentrated in some populations. The national Prevalence stands at 6%[3]. The Mode of Transmission survey of 2008 outlines the sources of new infections.

Figure 4: New HIV infections

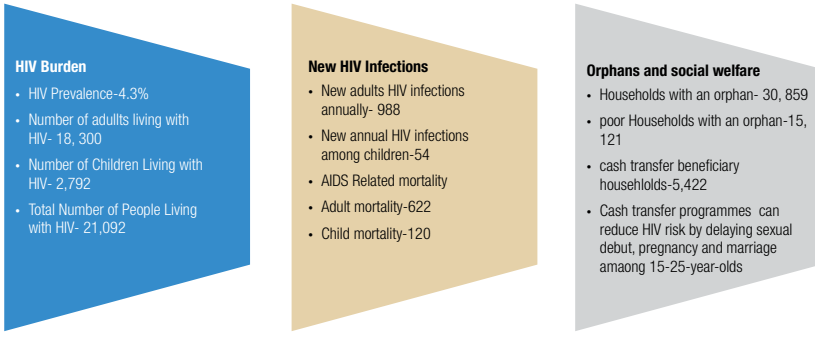


Source: KMOT 2008, Kenya HIV Estimates, 2014

2.2 Kitui County HIV profile

The HIV prevalence among women in Kitui is higher (5.8%) that that of men (2.5%). There were about 1,603 HIV pregnant women in the county in 2013. The county is committed to eliminating Mother to Child HIV Transmission. About 83% of HIV positive pregnant women in the county do not deliver in health facilities and only 41% of pregnant women attend the recommended four antenatal visits. Statistics show that 55% of individuals had their first sexual intercourse before the age of 15, an indication of early sexual debut (County HIV profile 2014).

Figure 5: County HIV profile



Source: Kenya County HIV profile 2014

3 KASF 2014/15 – 2018/19

Table1: Trends of HIV positivity (graphical representation)

Sub county	2012	2013	2014	2015
Kitui Central	4.58%	3.79%	3.02%	9.21%
Kitui Rural	10.31%	3.68%	2.27%	1.43%
Kitui East	13.57%	6.89%	2.11%	1.43%
Kitui West	6.9%	2.29%	2.24%	1.49%
Kitui South	15.43%	4.31%	2.7%	1.07%
Mwingi North	5.7%	2.98%	2.6%	1.42%
Mwingi Central	8.41%	5.81%	2.69%	1.8%
Mwingi West	8.93%	5.86%	4.06%	1.42%

Source: DHIS 2015

HIV TB Co-infection

The risk of developing TB is between 20 and 37 times greater in people living with HIV than among those who do not have HIV infection[4]. TB is responsible for more than a quarter of deaths among people living with HIV[5].

Table2: County HIVTB Co-infection trend

Sub county	2012	2013	2014	2015
Kitui Central	53.4%	30%	32.2%	29.6%
Kitui East	62%	28.8%	36.3%	37.4%
Kitui rural	66%	34.7%	32.6%	40.3%
Kitui West	67%	46.8%	34.1%	28%
Kitui south	66.3%	37%	39%	39.8%
Mwingi North	72.2%	31.3%	32%	39.4%
Mwingi Central	71%	36.8%	30.7%	23.7%
Mwingi west	51%	32.5%	26.7%	30.4%

Source: Tibu

4 WHO. Global tuberculosis control: a short update to the 2010 Report. December 2009. Geneva, Switzerland, World Health Organization, 2010.

5 Getahun H et al. HIV infection associated tuberculosis: the epidemiology and the response. Clinical Infectious Diseases, 2010,

Key drivers

HIV transmission remains predominantly sexually driven. The drivers of the HIV epidemic in the county include behavioural, socio-economic and structural factors like gender norms and constructs of masculinity, gender relations, gender-based violence and stigma and discrimination. The key drivers of HIV transmission in the county revolve around:

1. **High risk sexual behaviour** characterised by a) high incidences of current sexual relations linked to mobility, intergenerational sex, transactional sex, denial and marginalisation of MSM and SW groups, b) limited and inconsistent condom use c) limited awareness about personal and/or partner HIV status.
2. **Sub-optimal scale-up of ART;** low utilisation of antenatal care (ANC) and skilled delivery services.
3. **Mother to Child Transmission;** Mother to child transmission of HIV accounts for 90% HIV infection in children aged 0-14 years. The county had 54 new HIV infections among children in 2013.[6]
4. **Early sexual debut-** Early marriage is common in the county. Studies show 28 per cent of women aged 20-49 years got married before reaching age 18 and that 11 per cent of women between 15-19 years age category are either married or in some union[7].
5. **Social-Cultural factors including:**
   i. Stigma and discrimination.
   ii. Poor attitude to regular use of condoms.
   iii. Religious beliefs against use of condoms.
   iv. Gender based violence and vulnerability of young girls.
   v. High poverty levels and food insecurity in the county.

6 Kenya HIV County Profile 2014

7 Multi Cluster Indicator Survey (2008)

vi. Alcohol and substance abuse in the community.

vii. Illiteracy

6. Economic factors which include:

i. Labour migration, mobile population earning on sand harvesting, Boda Boda riders, charcoal burning and trade, mango farming among others.

ii. Poverty and inequalities.

iii. Vulnerability of adolescents, women and children.

7. Legal and Political factors which include:

i. Poor enforcement of anti-discrimination laws.

ii. Weak social and legal protection of vulnerable populations

iii. Lack of political HIV ambassadors.

8. Structural factors related to issues such as inequitable access to health services, governance, accountability, human rights, coordination, stigma and discrimination and gender inequalities including Gender Based Violence (GBV) exacerbated by alcohol drinking. Gender inequality refers to the norms and roles, cultural practices, policies and laws, economic factors, and institutional practices that collectively contribute to and perpetuate unequal power relations between women and men, boys and girls.

Table 3: Gaps and Challenges

Adolescent and Young people Programs

Low uptake of HTS

- Alcohol and drug abuse.
- Inadequate youth friendly services.
- Lack of education forums to address the youths and adolescents.
- Inadequate information to guardians and teachers leading to stigma & discrimination.
- Lack of guided adolescent transition process
- Cultural beliefs that portrays it as a taboo for parents talking to their children about sex
- Conservatism with regards to sexuality and contraceptives
- Unregulated access to social media

HIV Testing Services (HTS)

Low uptake of HIV testing among couples

- Inconsistency in dissemination of educational messages on the importance of knowing one's status
- Low disclosure of HIV positive status to partner(s)
- Stock outs of RTKs
- National policies and guidelines that prohibits HTS among minors without consent

eMTCT

Home deliveries (use of TBA)

- Lack of disclosure to spouses
- Non adherence to PMTCT prevention measures
- ART default
- Low male involvement in eMTCT
- Delay in receiving DBS results
- Stigma and discrimination
- Low coverage of ANC services (actual verses the expected population based expected pregnancies)

Key Populations

- Stigma and discrimination from the community
- Self stigma among the Key Population
- Discriminatory laws
- Inadequate supply of condoms and lubricants
- Low coverage of Key Population programme

OVCs

- Low coverage of cash conditional transfer programme. Only 36% of poor households with orphans are beneficiaries of cash transfer program1
- Diversion of funds meant for OVCs by guardians to other projects

ANC

- Late ANC Attendance leading to few ANC visits (less than recommended 4 ANC visits)
- Clients travelling long distances to access services
- Inadequate partner support

Labour and Delivery

- Home deliveries
- No or delayed postpartum attendance
- 52 per cent of births in the county are assisted by traditional birth attendants (MICS 2008).

Human Resources

- Inadequate healthcare workers
- Knowledge gaps within health workers in regards to new updates on HIV
- Poor remunerations of healthcare providers
- Lack of county health workers skills inventory

HIV Financing

- Limited resources allocated to HIV by the national & county governments
- Misappropriation of available resources by sectors and CSOs
- Poor prioritisation
- Inadequate alignment of HIV and health resources by county partners due to poor coordination
- Inadequate county mechanisms to tap resources from private and other key sectors

ART

- Lack of mechanism to track the clients who receive treatment at another facility leading into Loss to Follow-up (LTFU).
- Lack of population based IEC materials on adherence
- Non adherence to treatment
- Stigma, discrimination and denial
- Food insecurity and poor livelihoods

HIV Commodities

- Stock outs of OI drugs, DBS commodities, condoms, lubricants and test kits
- Long procurement processes (consumable and general supplies)
- Inadequate functional HIV diagnostic equipment
- Inadequate effective laboratory equipment and systems for diagnostic and monitoring of ART(viral loads)
- Inadequate HIV commodity management and supply chains monitoring at facility levels
- Budgeting and non-execution of budgeted activities

Work Place interventions

- Weak governance and leadership for community and workplace health actions
- Inadequate human resource capacity for development and implementation
- weak institutional capacity for implementing actions and service
- inadequate resources (working tools, supplies and equipment)

Behaviour formation and Behaviour Change Communication

- Interventions are fragmented, generic in nature, inadequate coverage and intensity
- Inadequate targeted interventions for sexually active children and young people
- No targeted interventions for KP and vulnerable Groups

Herbal medicine

- Clients taking alternative medicine and there is no evidence to show that herbal medicine can cure or suppress HIV leading to non-adherence /drug resistance
- Weak regulation and adherence to existing legislations and guidelines

Monitoring & Evaluation

- Weak M&E capacity especially at provincial and district levels and among civil society
- Inadequate use of M&E information in decision making, planning and resource allocation
- Poor alignment and harmonisation of M&E systems and tools
- Inadequate focus on evaluation compared to monitoring

Knowledge Management

- Poor documentation of existing knowledge and best practices has compromised the use of such experiences in improving service delivery

Faith healing

- Delayed health seeking behaviour related to religious and cultural practices.
- Beliefs in divine healing (Non adherence to treatment after being prayed for)

Table 4: County HIV and AIDS SWOT Analysis

STRENGTHS	WEAKNESSES
• Existing national policies, standard operating procedures and guidelines • 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. • Partner support (ICAP, Aphia Plus Kamili, CHAK, UoN MARPS Project, NEPHAK	• Donor dependency in HIV programming • Erratic supply of HIV commodities attributable to unreliable supply chain • Lack of prioritisation of HIV services in the county budget making process. • Weak work place HIV interventions and policies. • Uncoordinated reporting structures for HIV services • Inadequate HIV services and commodities. • Inability to authoritatively state the resource requirements in HIV programming. • Inadequate supply of data tools, data quality issues and low demand and use of data. • Inadequate capacity in HIV management among health care workers • Under reporting of GBV and unawareness of channels of redress • Poor documentation
OPPORTUNITIES	**THREATS**
• High level of HIV awareness • Devolution policy – local priorities will be considered in funding HIV and AIDS activities • Political will at the county level • Multi-sectoral approach • High interest by stakeholders • School Health Programs • Fast track plan to end HIV and AIDS among adolescents and young people	• Low individual HIV status awareness (correct/accurate information) • Lack of established legal structures to address HIV issues e.g. HIV tribunal to address matters discrimination at the county level. • Poor health seeking behaviour among pregnant and breastfeeding mothers • Existing Traditional Birth Attendants (TBA) leading to low health facility deliveries. • Institutionalised stigma in health care settings limiting access to services by Key Populations and PLHIV. • Lack of awareness on availability and use of PEP services. • Increasing number of priority (KP and vulnerable) population e.g. MSMs, sex workers, migrant populations due to urban growth

03

RATIONALE AND STRATEGIC PLAN DEVELOPMENT PROCESS

The Constitution of Kenya 2010 ushered a fundamental paradigm shift in Kenya. It introduced devolution which saw the creation of a National government and 47 County Governments and also vested substantial power and authority on governance to the county governments. This placed governance and public affairs management in the hands of the people at the local level. In order to create a mechanism of identifying the priority for development, it was a requirement of the County Government Act 2012 that each county prepares a County Integrated Development Plan (CIDP) to have comprehensive baseline information on infrastructure and social economic development for equal resource mobilisation and application thereof. The Kitui CIDP identifies HIV and AIDS as a cross cutting issue in all the sectors including social economic development.

National and county governments are distinct but interdependent as provided for in the constitution of Kenya 2010. The county government is composed of the Governor, County Executive Committee and County Assembly. The County Executive Committee is expected to supervise the administration and delivery of services to citizens as well as conceptualise and implement policies and county legislation. The County Assembly is a legislative organ and will play an oversight role on all county public institutions. Though Health is a devolved function, health guidelines and policies remain a function of the national government. In this regard, the National AIDS Control Council, a national agency mandated with the coordination of HIV response developed the Kenya AIDS Strategic Framework (KASF) 2015/16-2018/19 to guide counties in developing and implementing County HIV and AIDS Strategic Plans.

Looking ahead, there is an urgent need to invest in impactful combination interventions to drastically reduce the number of new infections, stigma and AIDS related deaths. This will require county government commitment and tough decisions being made at multiple levels - political, technical and operational. This includes funding the county response which is currently underfunded and heavily donor dependent.

Strategic Plan Development process

The process of developing the Kitui County HIV Strategic Plan (KCHSP) started with the dissemination of the KASF in October, 2015. It has been participatory involving a wide range of stakeholders from public sector institutions, private sector and civil society organisations (NGOs, FBOs, and CBOs) to networks of PLHIV and communities.

Desk review: A desk review of secondary data focused on key documents related to the national and county HIV and AIDS response. Some of the key documents consulted included Modes of Transmission Survey 2008, KDHS 2009, Kenya HIV Prevention Revolution Roadmap, Kenya HIV County Profiles, Kitui County Integrated development Plan, DHIS and TIBU databases.

A taskforce which comprised of members of CHMT, social services and other key partners drawn from University of Nairobi-MARPS Project, NEPHAK, ICAP, NACC was formed to spearhead the process of development of KCHSP. The team met in November 2015 and came up with a zero draft.

The zero draft was then circulated to all stakeholders and the national review team for their inputs. A taskforce to incorporate all inputs sat in June 2016 and came up with a final draft, which was subjected to a validation process by county stakeholder team and adopted.

Purpose of the KCHSP

- Guide and inform the planning, coordination, implementation, monitoring and evaluation of the county multi-sectoral HIV and AIDS response.
- Articulate county priorities, results and targets that all stakeholders and partners will contribute to.
- Provide the basis for consolidating strategic partnerships and alliances especially with civil society organisations, public and private sector and partners.
- Establish the basis for the county to consolidate its efforts in developing

sustainable financing mechanisms for HIV and AIDS response.

Alignment with Existing Documents

The HIV and AIDS epidemic has many complex social and economic consequences that include declining life expectancy, reduced human productivity, reductions in household investment in education, overburdened health systems, reduced agricultural output and limited sustainable human capital development. At the household level, the epidemic is competing for resources, reducing the ability of households to save and invest in addition to increasing household food insecurity. The epidemic threatens to destroy traditional community coping mechanisms and safety nets, making communities even more vulnerable. Addressing these consequences requires a comprehensive response anchored in broad national and county social and economic development frameworks.

The KCHSP is premised on and complementary to the following:

- Kenya AIDS Strategic Framework 2015/16-2018/19
- Kenya Vision 2030
- UNAIDS 90-90-90 Strategy
- The Constitution of Kenya 2010
- Kenya's Fast track Plan to End HIV and AIDS among Adolescents and young people 2015
- Kenya Health Sector Strategic and Investment Plan 2014-2018
- Kitui County Integrated Development Plan 2013-2017
- Kenya HIV Prevention Revolution Roadmap

04

VISION, MISSION, OBJECTIVES, PRIORITISED INTERVENTIONS AND STRATEGIC DIRECTIONS

4.1 Vision

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

4.2 Mission

To provide effective health services and an enabling environment for all inclusive and sustainable socio- economic development and improved livelihoods for all.

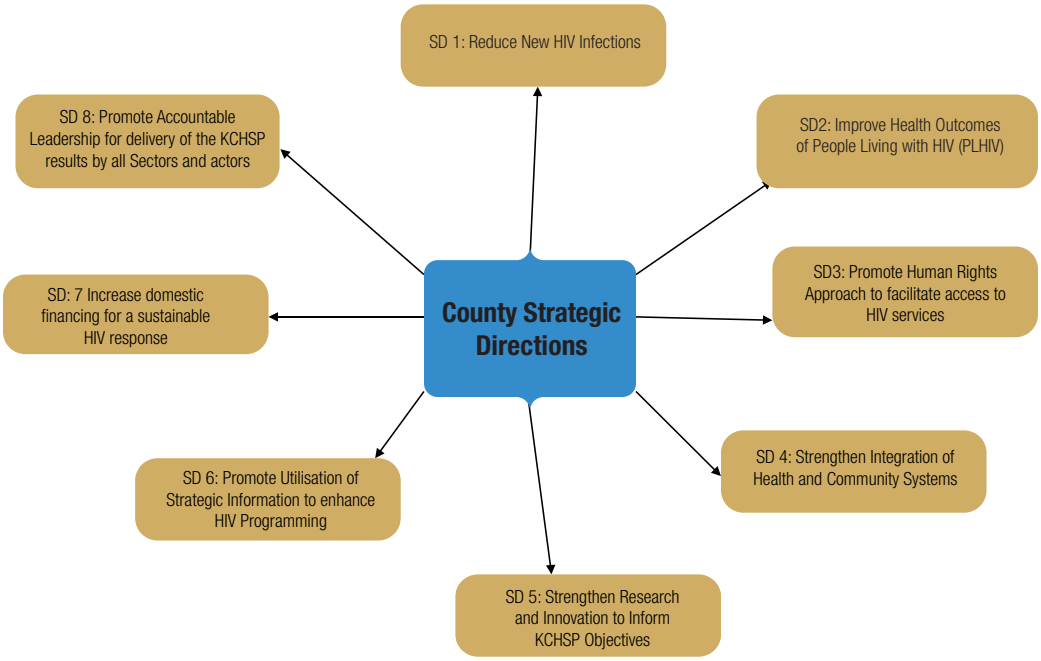
4.3 County Strategic Objectives

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

Table 5: Prioritised interventions

PREVENTION	ACCELERATING CARE AND TREATMENT (ACT)	SYSTEMS STRENGTHENING, COORDINATION AND MANAGEMENT
Biomedical Intervention • Scale up high yield HIV Testing Service (HTS), Post Exposure Prophylaxis (PEP), Pre Exposure Prophylaxis (PrEP), Screening and treatment of STIs, Prevention of Mother To Child Transmission (PMTCT) using national guidelines • Roll out Early Infant Male Circumcision (EIMC) as per national guidelines • Blood safety Behavioural Interventions • Behaviour formation targeting adolescents and young people • Social and behaviour change communication • Condoms – promotion and distribution • Use of mentor mothers in eMTCT. • Lobby for 100% condom use enactment targeting Key population Structural Interventions • Address gender norms and socio cultural barriers that increase risk of HIV infection • Implement cash transfer programmes to keep girls and boys in school • Implement stigma reduction campaigns • Address factors inhibiting male engagement in Health	Biomedical Intervention • Diagnose and Link 90% of all PLHIV • Start and retain 90% of those diagnosed on ART • Achieve viral suppression for 90% of patients on ART Behavioural Interventions • Adherence counselling • Promote self-disclosure • Establish and strengthen existing psychosocial support groups. • Scale up public education and treatment literacy • Partner tracing and notification Structural Interventions • Enhance food security for PLHIV • Implement stigma reduction campaigns	• Enabling Policy and Legal Environment • Human rights protection and stigma reduction for Key Population and PLHIV • Integration of HIV within SRH, maternal and Child health services • Coordination and management of the County response • Mainstreaming / Integration of HIV and AIDS • Health and community Systems Strengthening • Research and Strategic information Management • Sustainable financing and resource mobilisation

Figure 6: County Strategic Directions



4.6: Strategic Direction 1: Reduce New HIV infection

The priority for the county is to reduce new HIV infections by 50% by 2019. This will be achieved through the implementation of a series of interventions using the "combination prevention strategy" and focusing on prioritised epidemic drivers. HIV prevention programmes are interventions that aim to halt the transmission of HIV. This plan seeks to reduce new HIV infections from 1042[8] to 521 by:

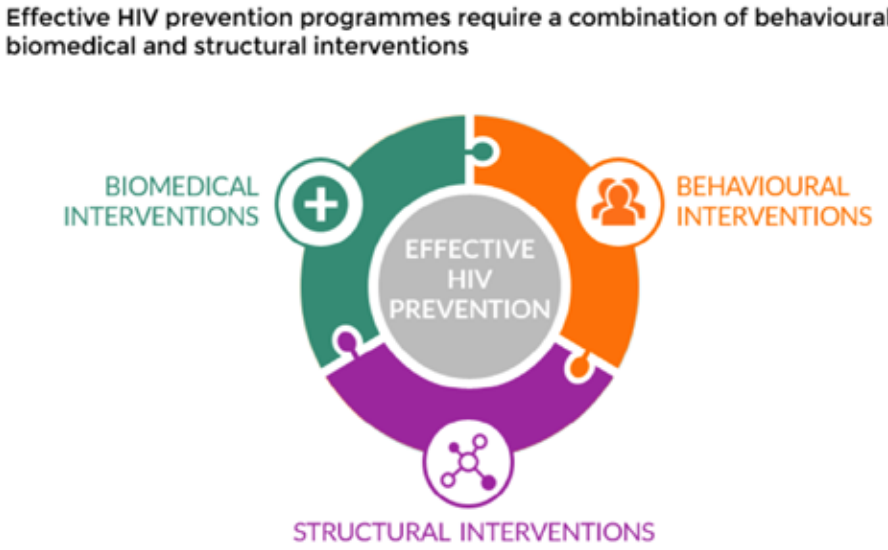
4.6.1 Increasing coverage of combination prevention approach

Combination prevention advocates for a holistic approach whereby HIV prevention is not a single intervention (such as condom distribution) but the simultaneous use of complementary behavioural, biomedical and structural prevention strategies. UNAIDS defines combination prevention as "rights-based, evidence-informed, and community-owned programmes that use a mix of biomedical, behavioural and structural interventions, prioritised to meet the current HIV prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections."[9]

8 Kenya HIV County Profiles 2014

9 UNAIDS 2010, Combination HIV prevention: Tailoring and coordinating Biomedical, Behavioral and Structural strategies to Reduce New HIV Infections

Figure 7: Combination Prevention Approach



Biomedical interventions uses a mix of clinical and medical approaches to reduce HIV transmission. Examples of biomedical interventions include: Male and female condoms, sexual and reproductive health services, voluntary medical male circumcision, antiretroviral drugs for the prevention of mother-to-child transmission, pre-exposure prophylaxis, post-exposure prophylaxis and treatment as prevention, HIV testing, management of STIs, needle and syringe programmes, opioid substitution therapy and blood screening[10].

Behavioural interventions seek to reduce the risk of HIV transmission by addressing risky behaviours. A behavioural intervention may aim to reduce the number of sexual partners individuals have; improve treatment adherence among people living with HIV or increase the consistent and correct use of condoms. To date, these types of interventions have proved to be the most successful.[11] Examples of behavioural interventions include: Information provision (such as sex education), counselling and other forms of psycho-social support, safe infant feeding guidelines, stigma and discrimination reduction programmes and cash transfer programmes.[12]

Structural interventions seek to address underlying factors that make individuals or groups vulnerable to HIV infection. These can be social, economic, political or environmental. For many people, the simple fact that 90% of the world's HIV infections occur in developing countries is evidence that social, economic and political structures drive risk behaviours and shape vulnerability.[13] Structural interventions are much more difficult to implement because they attempt to deal with deep-rooted socio-economic issues such as poverty, gender inequality and social marginalisation. They can also be reliant on the cooperation of governments to achieve law or policy reforms. For example, laws that criminalise same-sex relationships often hinder MSM from accessing condoms. A woman's subordinate status can affect her ability to negotiate condom use while a lack of infrastructure such as transport, prevents many people from accessing health clinics. Examples of structural interventions include: Interventions addressing gender, economic and social inequality, decriminalising sex work,

10 UK Consortium on AIDS and International development 2013 Working group Briefing paper Combination prevention

11 Coates, T.J et al (2008). Behavioural strategies to reduce HIV transmission

12 UK Consortium on AIDS and International development 2013 Working group Briefing paper Combination prevention

13 Rao, G. et al (2008). Structural approaches to HIV prevention

MSM, drug use and the use of harm reduction services, interventions to protect individuals from police harassment and violence and laws protecting the rights of people living with HIV.[14]

4.6.2 Targeted HIV prevention to priority populations

During the next 4 years, there is need for intensified implementation of combination HIV prevention interventions that are targeted to the local HIV epidemiology. County challenges to prevention still exist including inadequate funding, fragmented programming, and lack of programming standards for interventions targeting behavioural and structural drivers of the epidemic, low coverage of biomedical prevention services and inadequate coordination of actors.

The county will focus on the following priority populations:

1. Key Population (KP)

   The KP are populations with higher risk behaviours and are at increased risk of HIV.

   They include:

   - Men who have sex with Men (MSM)
   - People who inject drugs (PWID) and
   - Sex Workers (SWs) both Male and Female.

2. Vulnerable population

   These are populations whose social contexts increase their vulnerability to HIV. They include:

   - Adolescents and young people.
   - Migrant populations.
   - Men, children and pregnant women living with HIV.
   - People Living with HIV and discordant couples.
   - People in prisons and remand settings.
   - OVCs, PWD, widows and widowers.
   - People with disabilities tend to be socially marginalised and economically disadvantaged, and exposed to stigma and discrimination because of their physical or mental condition. Often they are among the extremely poor because of lack of education and skills training, and are unable to afford regular health care because of inability to afford the fees or because the cost of getting to a facility is beyond their financial means.
   - Drug dependants and alcoholics.

Key and vulnerable populations face barriers to HIV testing and access to HIV care services due to age, gender, marginalisation and stigma. Community settings provide an important entry point for case finding of HIV positive at risk individuals within high prevalence areas or groups.

4.6.3 Maximise Efficiency in service delivery through integration

The integration of HIV services is achieved at various levels:

- **Complementarity of HIV services. The HIV** response employs combinations of strategies and achieves synergy between different HIV strategies and services in order to offer a comprehensive package of services adapted to different target groups. This includes linkages between preventive and curative services and between community-based and facility-based interventions.

- **Integration of HIV services within broader health programs.** As HIV progressively becomes a chronic disease, it needs to be better integrated into the general system of healthcare provision, particularly health programs with strong linkages to HIV interventions, including sexual and reproductive health, nutrition and mental healthcare. Integration of HIV services into the health system has always been a strong characteristic of the HIV response, and this has benefited both the HIV program and the health system in general. In this KCHSP, a large component of the overall planning of resources is linked to health infrastructures and equipment and to human resources for health, which cannot be managed separately for the HIV program. On the contrary, it can be analysed through a systemic approach, where HIV is contributing to and benefiting from the general health system's resources.

14 UK Consortium on AIDS and International development 2013 Working group Briefing paper Combination prevention

- **HIV mainstreaming.** The multi-sector integration of HIV in the wider county development agenda is ensured by the identification of HIV as a cross-cutting issue.

4.6.4 Leverage opportunities through creation of synergies with other sectors

The county will leverage on the following key sectors to reduce new HIV infection;

- Road, Transport and infrastructure
- Education sector
- Faith sector
- Media
- Workplace settings
- Trade industry, Tourism and cooperatives

Table 6: Interventions to reduce new HIV infections utilising combination approach in targeted priority populations

KCHSP RESULTS	KEY ACTIVITY	TARGET POPULATION	SUB-ACTIVITY/INTERVENTION	
			BIOMEDICAL	
75% Reduction in new HIV Infections	HTS	General population	• Scale up HTS with emphasis on high yield CITC and PITC approaches • Linkage of those testing HIV positive to care and early ART initiation • Provision of key commodities including lubricants and condoms • Scale up and sustain needle and syringe programme • Alcohol screening and addiction support • Scale up STI management in all health facilities • Establish youth friendly clinical services • Offer HPV screening and education • Increase access to sexual and reproductive health services • Offer HTS to partners and families of all HIV positive clients • Offer pre-exposure prophylaxis as per national guidelines	
	eMTCT	Pregnant women and their partners	Implement all 4 prongs of eMTCT Prevention of HIV among women of child bearing age • Prevent unintended pregnancies among women living with HIV • Prevent transmission from a woman living with HIV to her infant • Provide care and treatment to women living with HIV and their children	
	Early infant diagnosis (EID)	Infants	• Conduct PCR DBS at six weeks for all exposed infants as per national guidelines • Integrate EID in immunisation centres	

	BEHAVIOURAL	STRUCTURAL	GEOGRAPHIC AREAS	RESPONSIBILITY
	• Use of advocacy by societal leaders to enhance testing among general and key populations and their partners • Create awareness on the availability of HTS • Introduction of varied activities that can reduce stigmatisation among the general population • Enhance distribution and skilled demonstration on use of male and female condoms • Increase campaigns on behavioural change among general population • Conduct testing outreaches targeting general populations • Engagement of young people as testing stewards during school outreaches • Implement wholesome age-specific PHDP services • Initiate behavioural change support groups to offer support and disclosure services to HIV and sero discordant couple	• Train and involve community health workers to link communities and health facilities • Involve religious leaders and elders in HIV and AIDS awareness campaigns • Introduction of workplace policies that protect PLHIV	All sub counties	All health facilities, partners, CSOs, CEC Health
	• Promote ANC attendance and skilled deliveries • Promote KMMP by use of mentor mothers • Scale up male engagement in PMTCT • Offer psychosocial support to HIV positive children, pregnant women, and lactating mothers • Encourage TBAs to escort mother to health facilities for deliveries.	• Demystify and actively work to change gender norms that negatively affect the health of women, children and men • Implement innovative strategies that will encourage men to accompany their partners to ANC and reproductive health services • Improve access to eMTCT in all health facilities offering ANC • Lobby for incentives for mentor mothers • Rename MCH to Family Centres	All sub counties	HCWs, CASCO Community gatekeepers, CSOs, faith sector, partners
	• Community sensitisation for uptake of service	• Enhance DBS transportation to national reference laboratory and feedback of results to facilities- • Procure PCR machine • Decentralise KEMRI service to the county	All sub counties	KEMRI, HCWs, CSOs, partners

KCHSP RESULTS	KEY ACTIVITY	TARGET POPULATION	SUB-ACTIVITY/INTERVENTION	
			BIOMEDICAL	
75% Reduction in new HIV Infections	HIV Prevention	Adolescents and young people	• Offer PITC,HTS,PEP as per national HTS guidelines • Offer age appropriate contraceptives, condoms and microbicides • Establish youth friendly clinic services • Offer Home based HTS during school holidays • Increase access to adolescent SRH services through HCWs training and availability of services at all health facilities • Parents follow up as index clients for testing adolescents • Implement APOC	
		General population	• Carry targeted community outreaches • Scale up PITC services to periphery health facilities	
		PLHIV and Discordant Couples	• Offer PHDP services/initiatives at all health facilities • Offer HTS to partners and families of all HIV positive clients through intensive contact tracing and Community Based HTS (CBHTS)	

	BEHAVIOURAL	STRUCTURAL	GEOGRAPHIC AREAS	RESPONSIBILITY
	• Strengthen caregivers support and mentorship on early initiation of disclosure in children • Implement peer led condom use campaigns • Conduct peer led campaigns on risk reduction for HIV negative testers • Offer peer to peer outreaches in school and out of school • Implement Evidence Based Interventions(EBIs) eg sister to sister and health choices • Conduct life skill trainings • Messaging to reduce intergenerational sex • Mass campaigns to motivate those testing HIV negative to adopt risk reduction and stay negative. • Introduction of HIV and STI prevention peer counsellors in schools Enhance abstinence and safe sex	• Implement cash transfer programmes to keep girls and boys in school to delay sexual debut, and social protection of vulnerable families • Establish youth friendly HIV service centres/ sites • Strengthen school health programmes • Address barriers that limit health seeking behaviours amongst adolescents, young people and men • Stigma reduction campaigns in and out of school • Economic empowerment through micro financing for youth out of school • Review requirement of parental consent for HIV testing. • implement GBV reduction programme and increase accessibility of services for GBV survivors • Develop data collection tools to capture adolescent and young people	All sub counties	HCWs, CSOs, partners, CASCOs, County Social development, Children Department
	• Mass campaigns to increase uptake of HTS • Strengthen post-test HIV clubs • Promote safe sex practices • Promote proper and consistent condom use	• Stigma reduction campaigns • Implement GBV elimination programmes	All sub counties	HCWs, CASCO CSOs, partners
	• Assist in partner disclosure for PLHIV • Peer led campaigns to motivate HIV negative partner to stay negative • Engage peer educators to scale up family testing for PLHIV • Establish and strengthen facility and community based population Psychosocial support groups	• Strengthen the PHDP package in the community strategy to allow access to the services at community level • Establish a referral system between community and facility support groups for seamless continuum of services • Employ a multi-sectoral approach to implementing PHDP initiatives at both facility and community level • Involve community leaders in stigma reduction campaigns • Lobby for zero stigma and anti-discriminatory county by- laws • Initiate linkages between human rights abuse identified in health facilities with the legal system • Create awareness on the HIV tribunal services • Decentralise the HIV tribunal • Implement GBV reduction strategies	All sub counties	HCWs ,CHMT, CSOs, Networks of PLHIV, partners

KCHSP RESULTS	KEY ACTIVITY	TARGET POPULATION	SUB-ACTIVITY/INTERVENTION	
			BIOMEDICAL	
75% Reduction in new HIV Infections	HIV Prevention	Key Population (MSM, sex workers and PWID)	• Enhance HCWs skills in provision of facility-based package of services including systematic initiation of treatment as prevention, regular screening and testing for STIs and HIV, condom provision, provision of family planning services • Provision of key commodities including lubricants and condoms • Screening for substance abuse and addiction • Provide Pre-exposure prophylaxis and post exposure services as per the national ART guidelines	
		Kitui and Waita GK prisons and remand settings	• Offer frequent and regular HTS • Train prison warders on ART management • Increased access to appropriate HIV prevention, treatment, care and support services in prison settings including condom and lubricant distribution • Offer STI screening and treatment	
		GBV Survivors	• Offer PEP as per the national guidelines	
		People Living with Disability(PLWD)	• Scale up HTS among PLWD by disability category • Increase access to ART and other HIV services • Train on sign language to enhance service provision • Integrate HIV sensitisation during medical assessments	
	Scale up use of male and female condoms	General population, KP, adolescents and young people, PLHIV and discordant couple	Distribution of condoms as lubricants to targeted populations • Increase access to both male and female condoms	

	BEHAVIOURAL	STRUCTURAL	GEOGRAPHIC AREAS	RESPONSIBILITY
	• Increase public awareness to promote service utilisation for key populations through targeted mass campaigns • Public campaigns with targeted messaging for key populations such as reduction of number of partners, correct and consistent use of condoms and lubricants • Establish support groups for different categories of key populations using the peer approach • Establish support groups for people with substance addictions • Sensitise HCW on package of care for Key Populations • Develop targeted intervention towards harm reduction. • Develop innovative and sustainable models to improve health seeking behaviours such as flexible clinic hours • Utilise community strategy to promote referral of KP to health facility level interventions to ensure continuum of care • Empower KP to negotiate for safer sex (safer sex negotiation skills)	• Provision of services such as HTS, STI screening, FP and condom distribution at the community level through outreach strategies • Lobby for 100% condom use policy in the county • Strengthen the participation of key populations in development of KP policies and their implementation • Improve protection of FSW and MSM through advocacy with law enforcement and local authorities to avert human rights' violation that can lead to unsafe sexual practices • Address violence against KPs through Human Right approach	All sub counties	HCWs, CSOs, partners, CEC Health, Chair Health Committee
	• Risk reduction counselling for HIV negative testers • Establish psychosocial support mechanisms • HIV/TB education for inmates and staff • ART adherence session in prisons and remand	• Review of prison policy on HIV prevention to include condom use, PrEP, safe injecting needles and conjugal visits • Establish prison dispensaries	Waita GK prison, remand cells	Prison administration, police administration, CEC Health
	• Offer psychosocial support • Carry out community mobilization for uptake of PEP services • Build capacity of CSOs and community units to monitor and prevent GBV	• Address gender norms which predispose women/ adolescents and young people to violence • Establish a gender desk in police stations/ posts • Sensitise law enforcers on HIV prevention for GBV survivors • Lobby county legislation on GBV	All sub counties	HCWs, CSOS, Partners, Chair Health Committee
	-Develop appropriate IEC materials customised to each specific category -Sensitisation campaigns intended to reduce stigma and discrimination in the community	• Raise awareness of people with disabilities to enable them to claim for their rights. • Implement disability conducive infrastructures in Health facilities • advocate for condom packaging and ART labels with Braille	All sub counties	HCWs, Faith sector, Partners, CSOs, Community gate Keepers, media, county social services
	• Promote consistent and proper condom use and disposal • Male and female condom demonstrations	• Strengthen the supply management chain • Purchase penile and vaginal models • Avail condom dispensers in strategic positions	All sub counties	KEMSA, county procurement unit, HCWs, CSOs, partners

KCHSP RESULTS	KEY ACTIVITY	TARGET POPULATION	SUB-ACTIVITY/INTERVENTION	
			BIOMEDICAL	
75% Reduction in new HIV Infections	Male engagement	Men	• Capacity building of health-care staff on HIV counselling and testing for couples • Scale up HTS targeting men and couples • Extended working hours to include evening and weekends	
	Treatment as prevention	General population, KP, adolescents and young people, PLHIV and discordant couple	• Increase linkage of clients testing positive to high impact services • Initiate HIV positive persons on ART as per the national guidelines • Pre-exposure Prophylaxis (PreP) as per the national guidelines • Post exposure Prophylaxis (PEP) to rape and GBV survivors and other priority populations	

	BEHAVIOURAL	STRUCTURAL	GEOGRAPHIC AREAS	RESPONSIBILITY
	• Create a male conducive environment in ANC, MCH and maternity • Offer incentives for male partners accompanying women e.g. fast tracking of services • Implement innovative strategies that will encourage men to accompany their partners for RH services • Address the attitude of HCWs that discourage male engagement in ANC and MCH	• Promote peer led BCC on social and cultural norms and values that encourage multiple concurrent sexual partnerships • Restructuring and renaming of Maternal Child Health Clinic (MCH) to Family Health Clinic both by name and service provision. • Involve religious leaders, community gatekeepers to actively work to change gender norms that negatively affect the health of women and children.	All sub counties	HCWs Partners, CSOs, Community gate Keepers, faith Sector, media
	• Reinforce adherence ART to reduce viral load • Promote proper consistent condom use	• Empowering communities to guard against human rights violation (including those of minorities); • Strengthen linkage to care and treatment • Prompt structures for viral load testing and accessing results.	All sub counties	HCWs, Partners, CSOs, Networks of PLHIV

Table7: Interventions to reduce new HIV infections through leveraging on different sectors

KCHSP RESULTS	SECTOR	SUB-ACTIVITY/INTERVENTION	RESPONSIBILITY
75% Reduction in new HIV Infections	Media	• Strengthen peer led HIV prevention campaigns through various media platforms • Hold joint media sharing forums on HIV, GBV and stigma reduction • Develop and initiate consistent broadcast programs on HIV and AIDS through local FM/TV stations • Develop age appropriate messages as pamphlets in newspapers • Create new and strengthen existing coalitions of media organisations on specific themes of HIV prevention • Broadcast and promote health service utilisation including comprehensive HIV services • Documentaries on success stories, best practices in HIV prevention and messaging • Report and highlight county government HIV best practices	Local media houses, social media platform, CEC health
	Education	• Facilitate targeted HTS outreaches in schools, technical training institutes (TTIs),colleges and universities • Improve access to accurate information on sexuality through introduction of age appropriate comprehensive sexuality education in school curriculum • Ensure girls and boys stay in schools through social security programmes, conditional cash transfers and sanitary towels for girls • Address stigma reduction in schools • Implement education policy guidelines and teacher training that includes age appropriate HIV, sexual reproductive health and rights. • Offer supportive adherence to students on ART	MoEST, CEC Education CEC Health, partners, CSOs
	Road, Transport and infrastructure	• Provide condoms and prevention IEC materials at all public transport hubs • Support innovations that provide access to HTS at all transport hubs and corridors • Mount HIV prevention messages in public transport vehicles and hubs • Train and involve peers from the transport sector to pass on BCC key messages • Establish DICES and scale up number of facilities offering prevention and PEP services along all transport corridors and hubs • Develop capacity through cross county collaboration and coordination of HIV along transport corridors	CEC transport, CEC Health, partners, CSOs, SACCOs, Matatu Owners Associations. Touts' and, 'Boda boda' associations

KCHSP RESULTS	SECTOR	SUB-ACTIVITY/INTERVENTION	RESPONSIBILITY
75% Reduction in new HIV Infections	Faith sector	• Offer HTS and other HIV prevention services in faith based health facilities and institutions • Increase access of their congregation to HTC, prevention care and treatment • Train and involve religious sector in passing key messages to the public • Lobby for inclusion of HIV key messages into religious curriculums such as Madrasah • Use evidence based messaging to challenge faith healing among unscrupulous religious leaders • Scale up evidence based HIV prevention in faith based schools, tertiary institutions and health facilities • Involve religious gatekeepers to enhance positive entry into communities	HCWs in Faith based facilities, religious institutions
	Work place	• Offer HTS at work places • Offer self-testing as per the national guidelines • Implement a minimum package of HIV services in the workplace (sensitisation, BCC, HTS, referral to clinical services, reduction of stigma and discrimination). • Enforce HIV stigma and discrimination policy • Establish peer educators for HIV at the workplace • Mainstreaming HIV prevention activities in workplaces in all the sectors. • Support HIV prevention as a Cooperate Social Responsibility (CSR)	CEC Health, County Public Service Board Private sector (formal and Informal)
	Tourism and hotel industry	• Provide free condoms in all hotel facilities (receptions, bars, toilets, rooms) • Avail a system of referrals for PEP. • Provide Prevention IEC materials • Initiate and sustain condom use campaign • Innovative peer-led BCC campaigns especially among sex workers and their clients • Establish forums in which key messages can be passed to the industry's employees and consumers • Lobby for a law to enforce 100% condom use for Key Population • Champion for legal protection for sex workers and protection against abuse • Enforce laws inhibiting access to alcohol to minors	CEC Health, CEC trade, partners, hotel owners, CSOs

4.7 Strategic Direction 2: Improve health outcomes of People Living with HIV (PLHIV)

The county intends to reduce morbidity and mortality rates resulting from HIV through accelerated care and treatment by identifying and linking at least 90% of PLHIV into ART and retain them in care to achieve maximum viral suppression. The KCHSP in the next 4 years will target to increased enrolment, early initiation, and better retention in chronic HIV care. The County HIV services have been aligned to the paradigm shift in HIV programming towards achieving the 90-90-90 targets. This is aimed to decrease HIV associated morbidity and mortality by 25% from 742 to 557 by:

- Diagnosing and linking 90% of all PLHIV
- Starting and retaining 90% of those diagnosed on ART
- Achieving viral suppression for 90% of patients on ART

a) Diagnose and link 90% of all PLHIV

HIV testing is the gateway to accessing HIV treatment and care. A successful public health response to HIV requires robust HTS. The county has strategic placement of HIV testing counsellors to increase identification of new positives. Linkage to care is at 88% for children and 97% for adults.

Table 8: Towards the first 90

Indicators	Jul 2013-Jun 2014	Jul 2014-Jun 2015	Jul 2015-Sep 2015
Total Children Tested	20,892	30,427	9,611
Total Children HIV +ve	367	393	70
Total children Enrolled (n,%)	294(80%)	342(87%)	62(88%)
Total Children Currently in Care	1,800	1,948	1,993
Total Adult Tested	136,107	153,713	43,720
Total Adult HIV +Ve	3,755	3,524	1,096
Total Adult Enrolled (n, %)	2629(70%)	2,502(71%)	1.063(97%)
Total Adult Currently in care	11,113	13,096	13,760

b) Start and Retain 90% of those Diagnosed on ART

Early ART has by far the most substantial effect on HIV incidence among all scientifically tested interventions.The county has notable improvement in enrolment of both children and adults.

Table 9: Towards the second 90

Indicators	Jul 2013-Jun 2014	Jul 2014-June 2015	Jul 2015-Sept 2015
Infants HIV +Ve	71	56	14
Infants started on ART (n, %)	49(69%)	41(73%)	13(93%)
Total Children started on ART	288	489	68
Total Children Currently on ART	1482	1880	1897
Pregnant mothers HIV +Ve	1417(82%)	825(97%)	203(95%)
Pregnant mothers on ART (n, %)	695(49%)	781(94%)	191(94%)
Total TB.HIV patients	569	548	121
TB.HIV patients on ART (n, %)	532(93%)	528(96%)	121(100%)
Total Adult started on ART	1697	2935	493
Total adults currently on ART	9148(82%)		12888(94%)

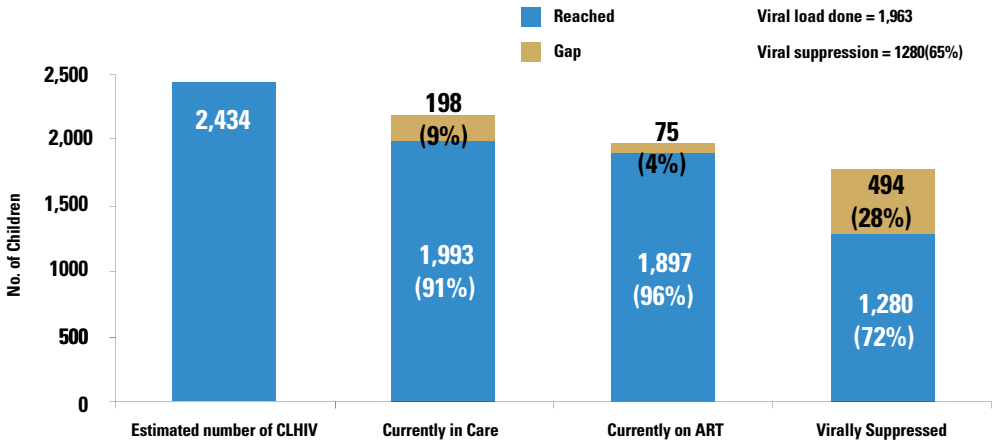
c) Achieve viral suppression for 90% of patients on ART

Viral load measurement is gold standard for monitoring ART treatment response. The Ministry of Health now recommends routine viral load testing for all patients on ART. There is significant increase in viral load suppression in both children and adults as noted in Table 10 below.

Table 10: Towards the third 90

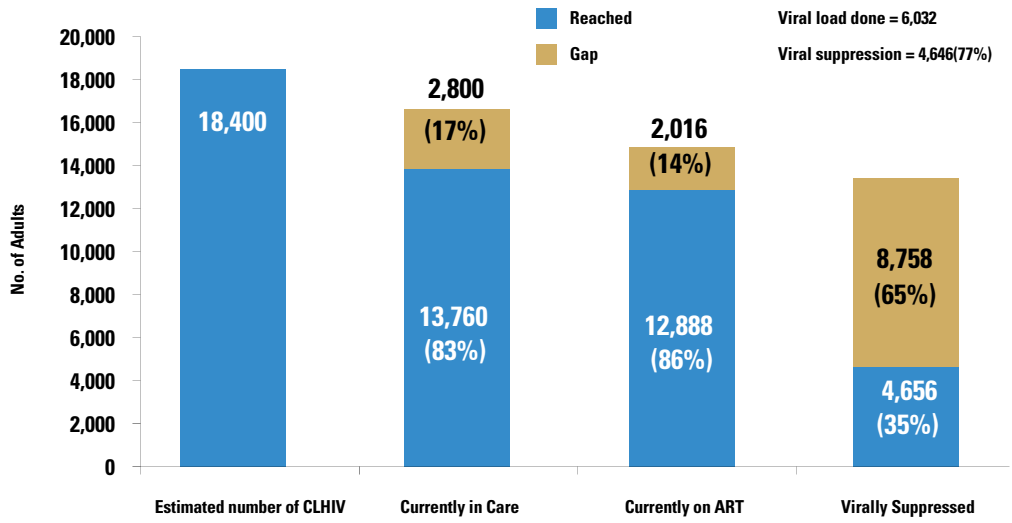
Indicators	Jul 2013-Jun 2014	Jul 2014-Jun 2015	Jul 2015-Sept 2015
Net Overall Cohort	4,983	1,963	1,426
Alive and on ART	4,983	1,737	1,222
Percentage Retained on ART	100%	88%	86%
Total children currently on ART	1,482	1,880	1,897
Total Viral loads done and result received for children	213	1,326	424
Total viral suppressed (n, %)	98(46%)	896(68%)	286(67%)
Total Adult current on ART	9,148	12,549	12,888
Total Viral loads done for Adult	836	4,270	926
Total Viral load suppressed among Adults (n, %)	467(56%)	3,443(81%)	746(81%)

Figure 8: Children Cascade



Source NASCOP ACT Dashboard, 2015

Figure 9: Adult Cascade



Source NASCOP ACT Dashboard, 2015

Table 11: Interventions to improve health outcomes of People Living with HIV (PLHIV)

KCHSP RESULTS	KEY ACTIVITY/ INTERVENTION AREA	TARGET POPULATION	SUB-ACTIVITY/INTERVENTION	
			Biomedical	
Improved health outcomes of PLHIV	Diagnose and Link 90% of PLHIV	General population	• Conduct targeted HTS at high yield areas • Scale up targeted HTS in all inpatient wards • Identify high positivity areas (hotspots) to conduct outreach testing services (Moonlight HTS) • Promote self-testing and expansion of eligible groups per the national guidelines. • Provide supervision and mentorship for HTS counsellors • Increase access to SRH services	
		Adolescents and young people	• Conduct home based testing during school holidays • Carry out testing of index clients' contacts targeting adolescents and young people	

			GEOGRAPHICAL AREA BY COUNTY/ SUBCOUNTY	RESPONSIBILITY
	Behavioural	**Structural**		
	• Sensitise communities on the availability of HTS • Conduct targeted HTS and stigma reduction campaigns • Demonstration and distribution of male and female condoms • Conduct Peer outreach and support services to create treatment and awareness on HIV testing. • Conduct health education campaigns on male involvement in health services	• Improve accessibility of the test in the community and facilities • Conduct Stigma reduction campaigns within the communities • Sensitise and engage communities and leaders such as religious leaders and elders on key populations and HIV to reduce stigma and increase service uptake. • Strengthen workplace protection policies	all sub counties	HCWS, CMLT, CASCO, partners, CSOs
	• Implement integrated HIV services in youth friendly sexual and reproductive health service clinics • Behaviour formation interventions through public education	• Provide education subsidy programs to keep adolescents in school • Establish/strengthen adolescents and youth friendly centres		HCWs, CMLT, CASCO, CSOs, partners, KEMSA.

KCHSP RESULTS	KEY ACTIVITY/ INTERVENTION AREA	TARGET POPULATION	SUB-ACTIVITY/INTERVENTION	
			Biomedical	
Improved health outcomes of PLHIV	Diagnose and Link 90% of PLHIV	Children, pregnant women and their partners	Implement eMTCT interventions within MCH/ANC settings • Conduct targeted testing in all entry points (ANC, Maternity and Postnatal clinics) • Implement EID services for exposed infants in eMTCT • Conduct PITC for children at points of care i.e. MCH, OPD and paediatric wards MCH • Family and partner testing (index clients) • Integrate eMTCT interventions in the beyond zero campaigns	
		Key Populations	• Conduct targeted HTS to key populations • Scale up STI screening and management using current syndromic management algorithm •	
	100% linkages	Linkages of General population, KP, AYP Pregnant mothers	• Implement same day enrolment strategy for HIV infected persons • Implement follow up strategies for identified clients	
	Start and retain 90% of those diagnosed on ART	children, pregnant/lactating mothers and their partners	Initiate ART as per national guidelines	
		Adolescent and young people	• Implement the APOC in all facilities • Capacity build HCWs to offer adolescent and young people friendly services • Establish and/or strengthen youth friendly centres • utilisation of Fixed Dose Combination therapy (FDCs) • Increase ART central sites • -Introduce electronic appointment cards (in selected facilities	
		Key population Key population	• Integrate ART services in drop in centres • Offer PrEP and PEP as per national guidelines • Conduct alcohol screening and addiction support among the KPs	

			GEOGRAPHICAL AREA BY COUNTY/ SUBCOUNTY	RESPONSIBILITY
	Behavioural	**Structural**		
	Strengthen the community strategy in referral and follow up of ANC/ PMTCT and postnatal mothers and their children by use of CHVs and peer educators/mentor mothers • Sensitise communities for update of HTS	• Provide integrated PMTCT services in all health facilities • Implement male friendly services to support eMTCT interventions	All Sub-Counties	HCWs, CMLT, CASCO, Partners, CSOs
	• Implement snowballing to reach KP • Engage and train peer educators and CHVs in conducting referrals to healthcare facilities	• Conduct stigma reduction campaigns • Increase number of DICEs		HCWs, CMLT, CASCO, Partners, CSOs
	• Build capacity of HTS providers to be able to counsel and enrol clients to care • Utilise community strategy to follow up and link clients to care (community testing) • Strengthen follow up of newly diagnosed clients	• Ensure services availability in same room/ department (One stop-shop) • Develop county referral directory for HIV services delivery points		HCWs, CMLT, CASCO, Partners, CSOs
	• Implement family centred clinics in selected MCHs • Establish/strengthen family psychosocial support, • Support disclosure process for PLHIV • Strengthen ART adherence counselling Offer nutritional assessment and/or support	• Empower families to initiate and sustain livelihoods		HCWs, CMLT CASCO partners, CSOs
	• Provide caregivers with HIV information, treatment literacy and empowerment • Establish/strengthen adolescent support groups linked up with community groups • Utilise teacher/school nurse/matrons to provide support for adherence • Facilitate supported disclosure	• Empower families to initiate and sustain livelihoods • Offer regular HIV care and treatment updates to teachers • Enhance peer mobilisation strategies for recruitment, enrolment and retention in the care. • Strengthen community and facility linkages with inter and intra facility referral protocols and linkage strategies.		MoEST & TSC, CEC Health, Partners CSOs, Faith sector, County Director of Education
	• Implement stigma reduction campaigns to increase access to care and treatment services • Address stigma and discrimination by HCWs	Engage community gatekeepers to address socio-cultural barriers to ART access and adherence to drugs Empower families to initiate and sustain livelihoods Build capacity of the HCWs to be able to offer services to KP	All Sub-Counties	HCWS, CMLT, CASCO CASCOs Partners CSOs

KCHSP RESULTS	KEY ACTIVITY/ INTERVENTION AREA	TARGET POPULATION	SUB-ACTIVITY/INTERVENTION	
			Biomedical	
Improved health outcomes of PLHIV	Start and retain 90% of those diagnosed on ART	General Population	• Offer ART as per national guidelines • Manage HIV/TB Co infections • Implement strategies to increase adherence and/or retention e.g. use of Fixed Dose Combination • Decentralisation of ART services and increase ART central sites • Utilise technology including social media for education, recruitment and retention in care • Offer preventive and managerial services of co-infection and co- morbidities.	
	Viral suppression for 90% of patients on ART	Children Living with HIV, PLHIV	- Perform viral load monitoring for all eligible clients -Improve Turn Around Time(TAT) of viral load results from KEMRI -Capacity builds HCWs on interpretation of viral load results -Strengthen multi-disciplinary teams to be able to discuss management of clients with high viral load (as per the national guidelines) - Expand and implement surveillance plans, protocols and periodic surveys and cohort analysis.	

4.8: Strategic Direction3: Promote human rights approach to facilitate access to HIV services

Human rights, HIV and AIDS are inextricably linked. Lack of respect for human rights fuels the spread of HIV and exacerbates the impact of the epidemic on children and families. At the same time, HIV undermines progress in the realisation of human rights. Stigma and discrimination are particularly pronounced for socially excluded populations (e.g. Sex Workers, transgender people, Men who have Sex with Men or People Who Inject Drugs) and their families as well as adolescents at higher risk of HIV exposure.

Strategies to address the HIV epidemic in the county are hampered by an environment where human rights are not respected. For example, stigmatisation and discrimination against marginalised groups such as sex workers and MSM drive these populations underground. This impedes efforts to reach them with prevention initiatives, thereby increasing their vulnerability to HIV. Similarly, failure to provide access to appropriate information about HIV, or treatment, and care and support services further fuels the AIDS epidemic.[15]

The county will uphold Article 27 of the Constitution of Kenya 2010 which outlaws discrimination on the basis of one's health status, provides for equality between men and women and allows the use of affirmative action to redress past discrimination. Kenya's HIV and AIDS Prevention and Control Act, 2006, provides the legal framework to address HIV. It encourages the protection and promotion of public health, the appropriate

15 UNAIDS 2014

			GEOGRAPHICAL AREA BY COUNTY/ SUBCOUNTY	RESPONSIBILITY
	Behavioural	**Structural**		
	• Implement strategies to improve drug adherence e.g. Peer Education program • Support literacy classes and/or Psychosocial support groups, Treatment partners (Buddy system) • Utilise technology/mass media campaigns to increase uptake of ART services through social media	Address stigma and discrimination through anti stigma campaigns, sensitisation of community/ religious leaders/ HCWs • Empower families to initiate and sustain livelihoods	All 8 Sub-Counties	HCWs CMLT CASCO, partners CSOs
	• Offer pre ART adherence counselling and booster adherence counselling for all clients on ART	• Ensure stable commodity management for the DBS consumables to ensure consistent and sustainable supply. • Use of innovative mobile and web based technology to increase adherence and follow up options. • Reduce TAT for results and feedback. • Strengthen Laboratory networks.		HCWs, CASCOs CSOs Partners KEMSA KEMRI

treatment, counselling, support and care of persons infected or at risk of HIV infection.

The core interventions underpinning this SD relate to:

- Remove barriers to access of HIV, SRH and rights information and services
- Improve county legal and policy environment for protection and promotion of the rights of Key Populations and PLHIV
- Improve access to legal and social justice and protection from stigma and discrimination
- Monitor and document human rights abuses that include stigma and discrimination, social exclusion , child labour and gender-based violence

Table12: Interventions to promote human rights approach to facilitate access to HIV services

KCHSP RESULTS	KEY ACTIVITY/ INTERVENTION AREA	SUB-ACTIVITY/INTERVENTION	RESPONSIBILITY
50% reduction in stigma and discrimination	Remove barriers to access of HIV, SRH and rights information and services	• Promote use of KPs peer groups • Sensitise HCWs to reduce stigmatising attitudes in health care settings • Develop and disseminate population specific and user friendly information • Promote uptake of HIV PrEP and PEP among survivors of sexual violence and priority populations • Integrate HIV information and encourage service uptake in religious teachings • Engage men in HIV/sexual and reproductive health programs and interventions • Ensure implementation of MIPA • Support media campaigns to reduce stigma and discrimination • Provide education subsidy programs to keep adolescents in schools • Adapt legal framework to de-criminalise key population(s) activities and increase their demand for and access to HIV services.	CEC- Health, Partners Community gate keepers Religious leaders CSOs
	Provide an enabling legal and policy environment	• Disseminate and enforce policies to protect the patient's rights. • Sensitise the communities on gender inequalities, cultural practices and discriminatory health practices • Enrol adolescents, youths and other priority groups into social protection programmes. • Establish community and youth groups and utilise champions living positively to campaign against cultural and gender based discrimination.(Implement MIPA) • Address structural barriers that limit knowledge of patient's rights. • Address policy and cultural gaps that form barriers to access of information and services. • Hold the county government accountable to its constitutional obligations • Sensitise law and policy makers on the need to enact laws regulations and policies that prohibit discrimination and support access to HIV prevention, treatment care and support • Ensure people with disabilities access equal rights as their peers in protection against HIV	CEC health County legislative arm Media CSOs County department of Culture, Youth & social services
	Reduce and monitor human rights violations	Develop tools to monitor incidents of rights violation, including discrimination, GBV, child labour and denial of health care services for KP and PLHIV • Sensitise communities/ populations on their rights • Invest in community programmes to change harmful gender norms and stereo types • Introduce SGBV desks in health facilities and train health personnel on SGBV • Lobby for a County legislation on SGBV • Establish SGBV rescue centres	Human rights institutions employers CEC - Health HIV tribunal Partners CSOs

4.9 Strategic Direction 4: Strengthen Integration of Community and Health Systems

The implementation of the KCHSP depends on the availability of adequate human, financial and technical resources at all levels. Although some capacity does exist, it is not sufficient to meet the need for the county multi-sectoral response. The KCHSP suggests the development of a county capacity development programme within the context of health systems strengthening, community systems strengthening and developing the capacity of civil society organisations. With regard to human resources, the focus will be improving existing skills and competences, ensuring the adequacy of human resources and developing a retention strategy to avoid loss of skilled and experienced personnel. In the context of organisation development, capacity development will focus on operational service delivery systems, financial management systems, governance and leadership. The use of appropriate technology will be strengthened.

Community systems strengthening

HIV prevention, care and support requires a process that strengthens community systems. Community systems promote the development of informed supportive communities for PLHIV and key populations and community-based structures that enable them to contribute to the longer-term sustainability of health and other interventions. Community systems strengthening (CSS) permits the development of an enabling and responsive environment in which these contributions can be effective to deal with the HIV epidemic. Key actors in community systems include community opinion leaders, community units, CSOs and NGOs.

Health system strengthening

A strengthened health system is a prerequisite for improved health outcomes. Health systems strengthening refers to an array of initiatives or strategies that improve the functions of a health system and lead to better health outcomes.

Table 13: Strengthening integration of communities and health systems

KCHSP RESULTS	KEY ACTIVITY/ INTERVENTION AREA	SUB-ACTIVITY/INTERVENTION	RESPONSIBILITY
Strengthened health and community systems	Build Capacity of Community systems (CSOs, Community units and communities	• Build strong linkages between institutionalised facilities and community systems and ensure an effective referral system, greater adherence to treatment and improved monitoring of service delivery • Build capacity of CSOs and communities for increased advocacy and mobilisation for demand and uptake of services, social participation, self-regulation and accountability in the multi-sectoral response. • Establish and strengthen community units as per the national guidelines • Build capacities of CSOs to report through COBPAR • Establish Community units as per the national guidelines • Support and motivate CHVs	County Department of Culture, sports, Gender and Social services CEC health Partners SCACCs
	Health facility strengthening	• -Expand availability and capacity of laboratories at different levels for delivery of HIV and AIDS services • - Increase the accreditation of dispensaries and health centres to provide comprehensive HIV and AIDS and TB services	CEC Health
	Human resource	• Redistribute staff to ensure availability of appropriate competent and skilled clinical personnel. • Recruit staff to improve the overall staff: population ratio in line with the Kenya staffing norms • Improve human resource management system to ensure efficient and effective use of available resources • Establish mentorship platform for skills transfer, task sharing to ensure delivery of the essential health package including HIV prevention, treatment and care services. • Integrate and improve capacity building of staff in HIV management and leadership. • Train health personnel • Develop staff motivation and retention strategies including recognition, appreciation among others. • Develop and implement a system for caring for caregivers especially in areas with high burden of HIV	County public services board CEC Health Partners
	Service delivery	• Upgrading of health facility infrastructure to be able to meet the basic standards for HIV services provision. Adaption and implementation of Kenya quality improvement framework (KHQIF) • Integration of HIV referral and linkage services into mainstream health services referral and linkage services including community linkage.	CEC Health Partners
Improve supply chain management for HIV commodities	Supply chain management	• Strengthen capacity of the county, sub county and facilities to appropriately plan for, procure, store, distribute and manage inventories of commodities • Strengthen and link DHIS, TIBU and LMIS systems for better management of supplies • Timely distribution of HIV commodities from county to sub county level • Proper quantification and timely procurement of HIV commodities from KEMSA by county • Timely distribution of HIV commodities (Ols drugs, Condoms, test kits, TB drugs) from KEMSA to facilities • Establish commodity security committees at the county and sub county levels • Build capacity of HIV commodities management into exiting LMIS commodity management packages	KEMSA, CEC Health, CHMT, CHC. NASCOP,

4.10: Strategic Direction 5: Strengthen Research Innovation and Information Management to meet KCHSP Objectives

The increasing complexity of HIV and AIDS demands the use of strategic information and empirical evidence to make informed choices and decisions on the nature and kind of interventions and strategies to adopt. A national research agenda has been developed and research priority areas identified. The KCHSP focuses on the implementation of the gaps and challenges identified in the Research Agenda Strategy and facilitating the research on county prioritised areas. The county is focusing on increasing capacity to conduct operational research on HIV; increase evidence based planning, programming and policy change.

County Research Priority areas

- Understanding drivers of epidemic by population and geography
- Map HIV sub types and sexual networks
- Identify barriers to testing and access to intervention services by populations
- Barriers to linkage, initiation and adherence into care for PLHIV
- Determine effective models for increasing adherence in different populations

In order to strengthen the county research, innovation and information agenda, this plan proposes to:

- Resource and implement county HIV research priorities
- Build capacity of HCWs on research
- Increase evidence planning and programming

Table14: Interventions to strengthen Research, innovation and information Management

KCHSP RESULT	KEY ACTIVITY/ INTERVENTION ON AREA	SUB ACTIVITY/INTERVENTION	RESPONSIBILITY
Strengthened county research, innovation and information management	Resource for Research	• Partner with universities and colleges to prioritise HIV research. • Lobby for HIV research budget line in the HIV budget.	CHMT.,CEC Health, Partners, Academic institutions
	Build Capacity of HCWs on research	• Train HCWs on HIV research • Enhance collaboration with local training institutions • Establish a HIV research coordinating unit • Conduct operational research to generate data needed for evidence based decision making, KCHSP evaluation and planning • Develop a county research agenda on the basis of detailed knowledge of the burden of disease	CEC Health, CHMT, partners, Local training institutions
	Application of research in decision making	• Disseminate research finding to county stakeholders and policy makers • Establish a resource centre • Publication of research findings in pamphlets and postings in the county web page for wider dissemination	-CHMT, Partners, CEC Health

4.11 Strategic Direction 6: Promote Utilisation of Strategic Information to Enhance Programming

An effective strategic information management approach is necessary to ensure consistent review of the programs and to ensure constant progress towards the KCHSP objectives. Data collection, analysis and reporting constitute the basis for Strategic Information Management. Strategic information is necessary for decision-making, planning and resource mobilisation and allocation. The Health Information System (DHIS) is challenged by the following: Lack of adequate ICT infrastructure, lack of maintenance for ICT equipment in health facilities, presence of multiple systems with minimal standards for integration and interoperability and major gaps in data collection.

Table 15: Interventions to promote utilisation of strategic information to enhance programming

KCHSP RESULTS	KEY ACTIVITY/ INTERVENTION AREA	SUB-ACTIVITY/INTERVENTION	RESPONSIBILITY
Increased availability of strategic information to inform HIV response	Knowledge management	• Document and disseminate best practices • Establish and strengthen the capacity of resource centre to provide easy access to HIV and AIDS information • Establish HIV web page, improve access, scope and access to county web site	CHRIO, CASCO, Partners, NASCOP, NACC
	M& E	• Promote data demand and use of HIV strategic information to inform planning and programming • Promote/Strengthen reporting through DHIS • Harmonisation of data collection tools to capture all the required variables and data elements especially adolescent and young people age groups • Conduct quarterly county data review meetings to discuss data issues and/or elements • Conduct continuous quality improvement initiatives through health worker trainings and use of electronic records management systems • Develop quality audit tool and conduct periodic data quality audits/ verification to ensure availability of quality data • Ensure accurate and timely reporting in both facility and community based interventions, county and national level reporting • Harmonise and create linkages between data collection tools and databases • Harmonise the county and implementing partners reporting tools • Strengthen county M&E systems through quarterly supportive supervision, OJT and mentorship	CHRIO, CASCO, Partners, NASCOP, NACC
		• Strengthen the capacity of M&E personnel – Training, recruitment of personnel, and develop a retention strategy • Advocate for use of evidence based information in decision making and planning. • Strengthening the culture and capacity for reporting	

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

At the core of any county response is the mobilisation of financial resources. A twin pronged approach will be administered to mobilise resources. The first being advocacy work to increase the level of domestic funding and second to encourage partners to at least maintain their current funding levels or increase their contributions so as to facilitate the scale up of HIV and AIDS activities.

Table 16: Kitui County HIV Budgetary Allocation Trend

2014/2015	2015/2016	2016/2017	2017/2018
Recurrent_Budget 2014(A)	**Recurrent_Budget 2015(A)**	**Recurrent_ Budget 2015(A)**	**Recurrent_Budget 2015(A)**
4,000,000	4,000,000	4,384,963	4,806,976

Source: County Health Accounts (CHA) reports

The county has a goodwill in HIV intervention. However there is need to increase the HIV allocation.

Table 17: Interventions to increase domestic financing for a sustainable HIV response

KCHSP RESULTS	KEY ACTIVITY/ INTERVENTION AREA	SUB-ACTIVITY/INTERVENTION	RESPONSIBILITY
Increased domestic funding	Establish sustainable local financing options	• Advocate for increased HIV budgetary allocation during annual financial planning by County Assembly • Develop and present HIV funding proposals to local investors, corporate, and other funding agencies • Organise local drives to allow informal sector contributions towards HIV response with incentives such as recognition awards	CEC Health, Chair Health Committee CSOS
	Align County HIV resources to the identified priorities	• Ensure all HIV funding is subjected to a transparent accountability framework to ensure alignment to the county priorities • Annual joint work planning of county government and partners	CEC Health, Chair Health Committee

4.13 Strategic Direction 8: Promote Accountable Leadership for Delivery of KCHSP by all Sectors

Governance and leadership are critical in guiding the county's response. Thus, under governance and leadership component, the county will support greater involvement of leaders as champions and role models in the multi-sectoral HIV and AIDS response. Deliberate efforts to remove structural barriers will be made so that a conducive environment is provided in this strategic direction. The county will:

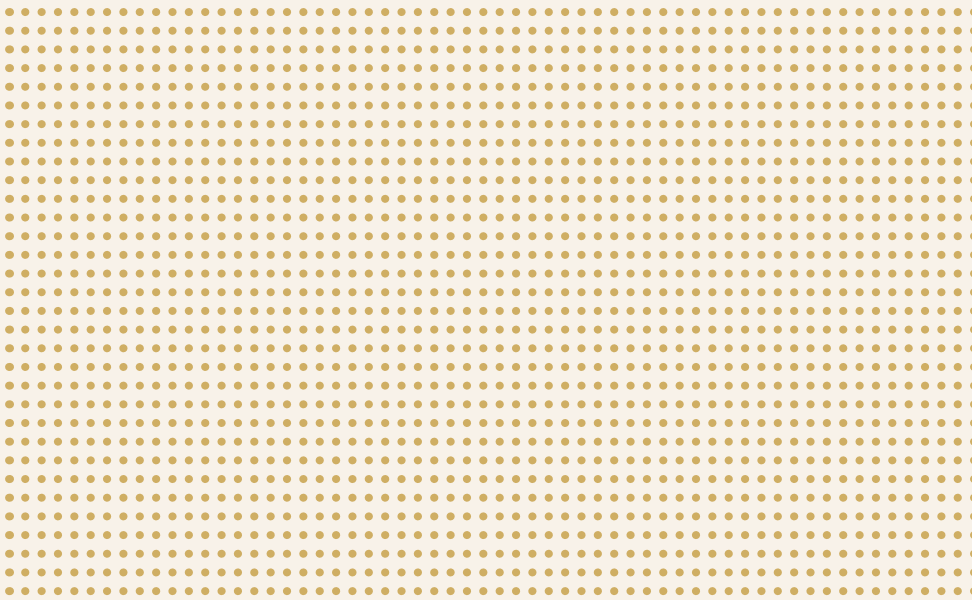
- Build and sustain high level political and technical commitment for strengthening county HIV ownership.
- Formulate enabling county HIV policy, legal and regulatory framework.
- Establish and strengthen a functional HIV coordinating mechanism at the county level.

Table18: Interventions to promote accountable leadership for delivery of KCHSP by all sectors

KCHSP RESULT	KEY ACTIVITY	SUB-ACTIVITY	RESPONSIBILITY
Accountable leadership for delivery of KCHSP objectives	Build and sustain high level political and technical commitment for strengthening county HIV ownership	• Prioritisation of HIV response in county fiscal budget • Resource mobilisation • Enhance good governance to strengthen multi partner and multi sectorial accountability for strategic plan implementation • Establish centres of excellence for training of HIV specialists among the health workforce • Strengthen the existing Kitui County workplace interventions in line with KCHSP and performance contracting requirements	Governor's Office, CEC Health, Chair Health Committee, Communities, CEC Finance
	County coordination framework	• Establish and strengthen of a county HIV coordinating committee • Operationalization of a well, effective and efficient stakeholders' coordination and accountability framework • Clearly define mandates, roles and responsibilities among institutions, stakeholders and sectors • Carry out multi-sectoral and evidence-informed reviews of the county HIV response to incorporate changing priorities and results from operational research	CEC Heath , CHMT, Partners
	County HIV policy, legal and regulatory framework	• Conduct an inventory of all policies and statutory instruments likely to impact on the HIV and AIDS response. • Work with the county legislative arm to ensure that HIV and AIDS are embedded into policies at the county level • Establish a legal framework for multi-sectorial HIV and AIDS response through a county legislation	CEC Health, CHMT, Chair County Assembly Health Committee, Partners, Communities

05

COORDINATION AND IMPLEMENTATION PLAN



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

Table 19: Role and Responsibilities of Key Stakeholders

COMMITTEES	ROLES AND RESPONSIBILITIES
County HIV Committee	• Provide leadership and oversight, • Mobilise resources • Set the county HIV agenda, • Approve county HIV targets, • Approve county HIV Plans/Strategy, • Present county HIV budgets to Health Sector Working Group and County Assembly, • Receive and approve reports on KCHSP performance • Monitoring the progress of KCHSP implementation
Technical Working Groups (TWGs)	• Provide oversight to the various program areas
National agencies	**Roles and Responsibilities**
National AIDS Control Council	• Coordinate the multi-sectoral HIV response in the country • Provide policy and guidelines for HIV response • Offer technical support to the county • Monitoring and evaluation of the country HIV response • Secretariat functions to the County HIV Committee (CHC) • Coordinate HIV advocacy in the county
NBTS	Supply safe blood products • Set up a satellite in the county
NASCOP	• Review and disseminate HIV related guidelines • Review, print and distribute data collection registers to capture emerging issues e.g. adolescent disaggregated data • Support utilisation of the DHIS systems. • Provide Support and technical assistance in implementing facility based EMR system • Ensure commodity availability
KEMSA	Timely distribution of HIV commodities to the county as per county needs. • Strengthen and improve LMIS
KEMRI and National Laboratories	Support the county in VL testing and Drug Resistant Testing (DRT), DBS-PCR and sputum for culture • Expeditious relay of results
Prisons	• Enhance infection control programs • Uphold human rights of detainees

COMMITTEES	ROLES AND RESPONSIBILITIES
Ministry of Labour and Social Security	• Incorporate HIV into existing social protection schemes, including nutritional support platforms
County Department/ sectors	
County Department of Health	• Champion county HIV legislations to ensure that HIV line budget is not diverted to other activities • Scale up HIV interventions targeting priority populations • Offer non-discriminatory HIV services in health facilities • Use strategic information to inform programming • Resource mobilisation for scale up of interventions • Procure HIV commodities and infrastructures
County of Department Finance	• Allocate appropriate resources per the work plans of line ministries and departments for HIV interventions • Allocate a budget line for HIV in the county health budget • Establish a County HIV Fund • Streamline audit mechanisms to ensure efficiency and effectiveness of allocated funds
County Department of Agriculture	• To provide leadership in integration of HIV in livelihood programmes
County department of Education	• Ensure that the rights of infected and affected children are protected • Strengthen school health programs to include life skills, drug adherence and abstinence • Put in place policies to keep boys and girls in school • Address stigma and discrimination in school/ college settings • Implement infection control in school/college settings • Initiate and sustain school feeding programmes • Implement the HIV curriculum in schools
County legislative arm	• Legislate appropriate policies and laws • Advocate for community to participate in HIV response
County Department of Culture, youth, Sports and Social Services	• Integrate HIV prevention care and treatment into sporting activities and other youth forums • Establish youth resource centres • Initiate sustainable IGAS for youths out of school • Implement OVC social protection programs • Implement structural interventions that empower vulnerable populations especially OVCs, PWD, Youth and women eg IGAs
County Department of Tourism	• Incorporate HIV in internal and external training programme including tourists training institution • Promote HIV prevention in bars, hotel and lodges
County Department of Coordination and Administration	• Encourage free condom outlets in hotels, bars and lodgings through use of IEC materials • Enforce laws that protect the minors in lodges and bars
County department of Transport	Use public transport systems for HIV prevention and health promotion messaging
County Public Service Board	• Ensure that all county departments have HIV related work-place programmes • Ensure non-discriminatory recruitment of PLHIV in county departments

Key Partnerships

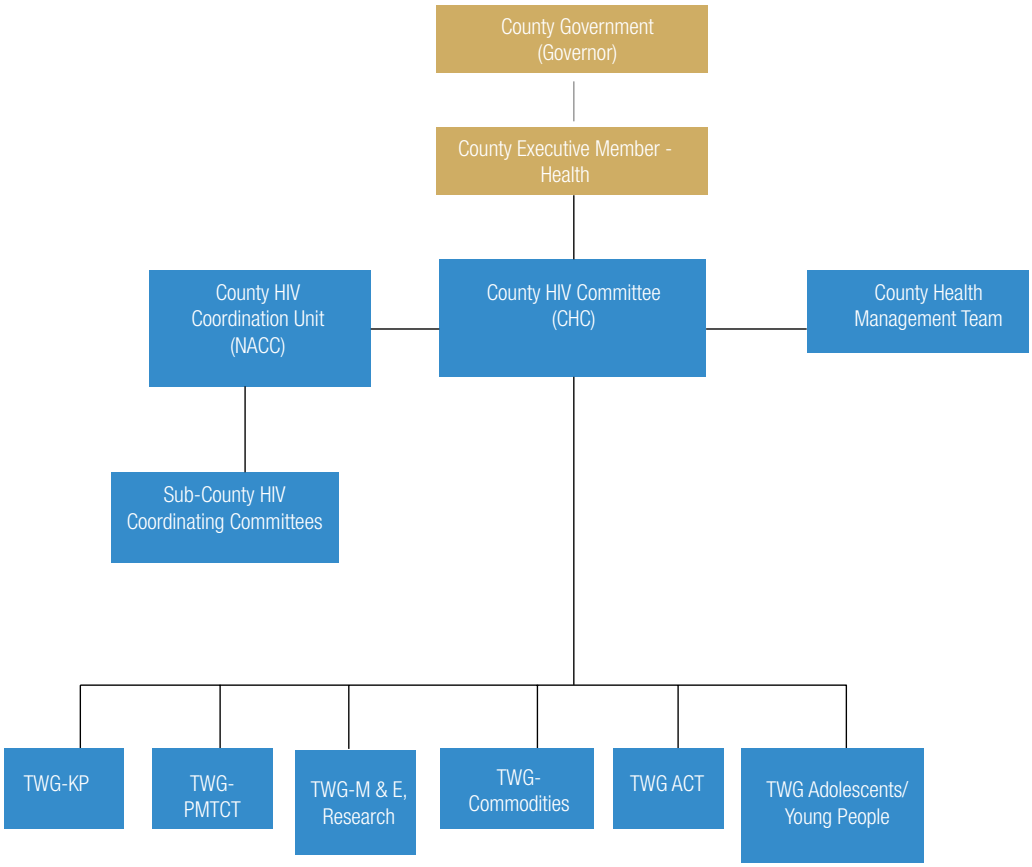
CSOs	• Actively engage in demand creation for HIV services • Support adherence and defaulter tracing • Work as "watch dog" of the county government to ensure accountability of results • Participate in the county budgeting process (MTEF) and resource mobilisation • Educate communities on legal issues,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

Critical assumptions

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

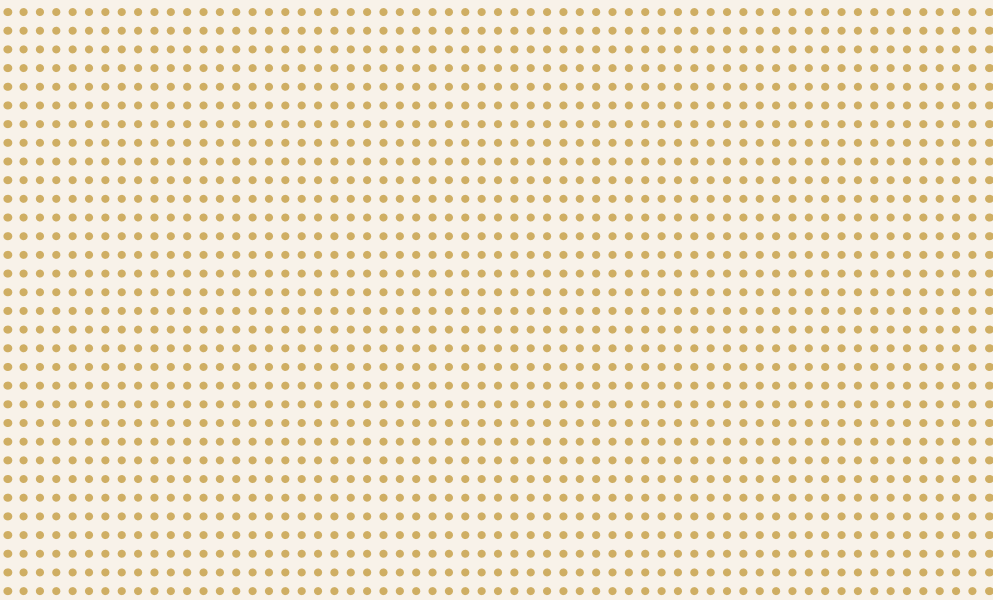
- The community will be willing to support the initiatives.
- Adequate funds will be made available in time.
- Political stability and security will prevail.
- All stakeholders including partners and non-state actors will be supportive.
- Political will and support will be sustained.
- National agencies,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

Figure 10: County Coordination infrastructure for HIV Plan Delivery



06

MONITORING AND EVALUATION PLAN



Monitoring and evaluation of the county multi-sectoral response to HIV and AIDS relies on a variety of systems and data sources which are routine and periodic, supported and maintained by many stakeholders. During the course of implementing the KCHSP, these M&E systems will require improvement, strengthening and integration for improved inter-operability and fostering linkages between interventions. All M&E systems will need to produce reliable data that are widely shared among stakeholders and which translate into improved decision-making.

6.1 Health sector information systems

District Health Information System (DHIS) has been developed and maintained by Ministry of Health. The system utilises paper based registers and EMR (CPAD and IQCARE) at facility level which is keyed in at sub county level by HRIOS. The challenge is that different registers have similar indicators, inadequate data quality audits and data validation, management of EMR including personnel and infrastructure.

6.2 Logistic management Information systems (LMIS)

The LMIS is used for reporting use of drugs and related medical supplies as well as for requesting, re-supply and replacing the vertical supply systems that previously existed. In order for the KCHSP to ensure no stock-outs and expiries and ensuring patients' access to HIV medicines and commodities, health facilities will be encouraged to adopt and use the LMIS. LMIS utilises both EMR and manual systems.

6.3 Non Health Sector Systems

6.3.1 COBPAR

The COBPAR is maintained by the NACC. It collects and collates data from community based interventions carried out by CSOs. The challenges here include non-reporting of CSOs and double reporting hence data quality issues. The COBPAR will be integrated into the DHIS to ensure accessibility of community data at the DHIS platform.

6.3.2 School health programme reports

Interventions in schools use paper based reports. The challenge with school programmes is limited to de- worming and immunisation. There is need to enforce school health policies. These reports are not captured in the county M &E system.

6.3.3 Work place reporting

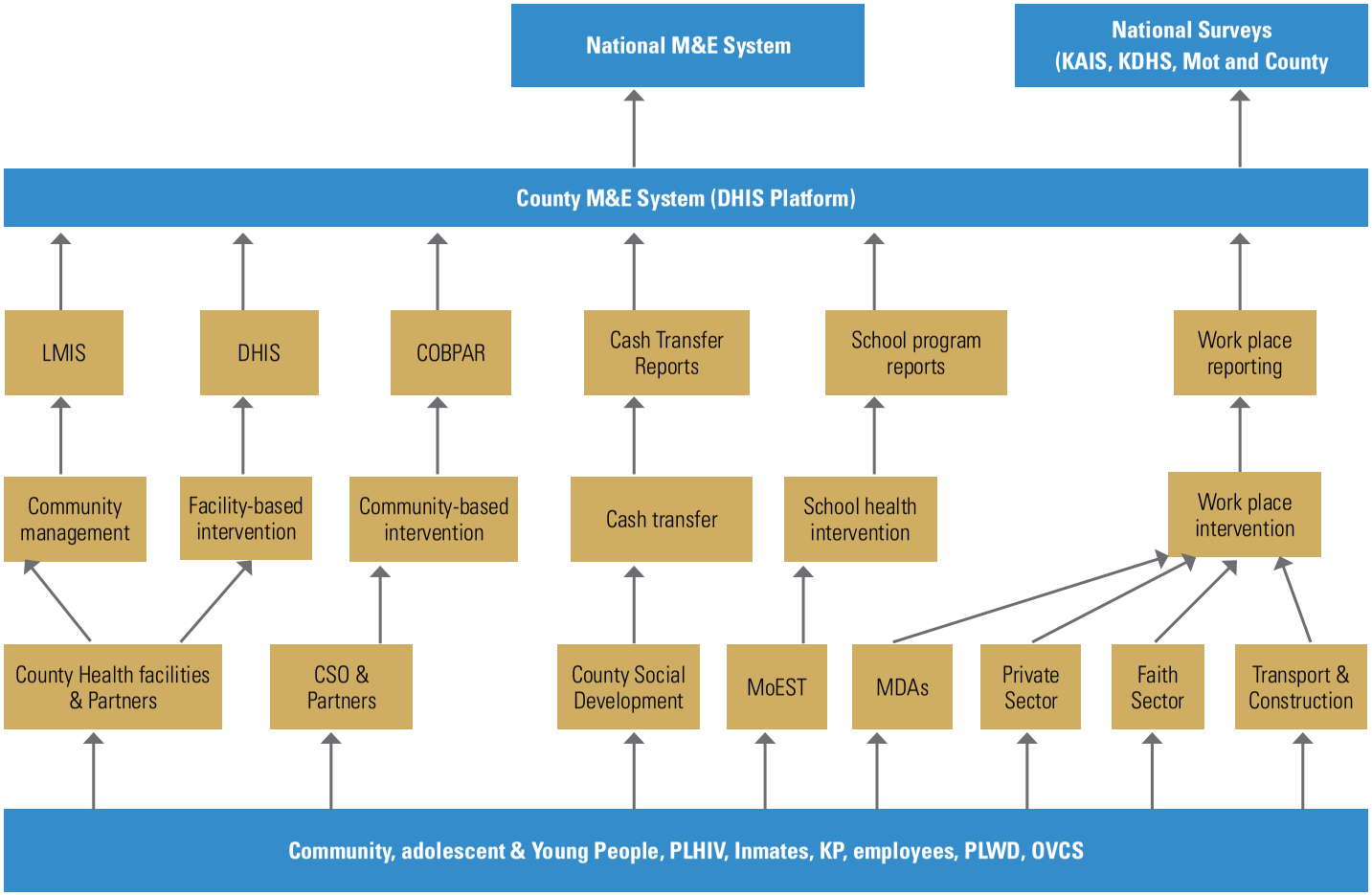
The work place reporting provides a platform for reporting of HIV interventions at the work place. HIV is an indicator in the performance contracting cycle and counties, departments and agencies report using the work place reporting tool.

6.3.4: OVC Cash Transfer programme

Conditional cash transfer program is coordinated by the Department of Culture, Youth, Sports and Social Services. The reports should be channelled to the County M & E system.

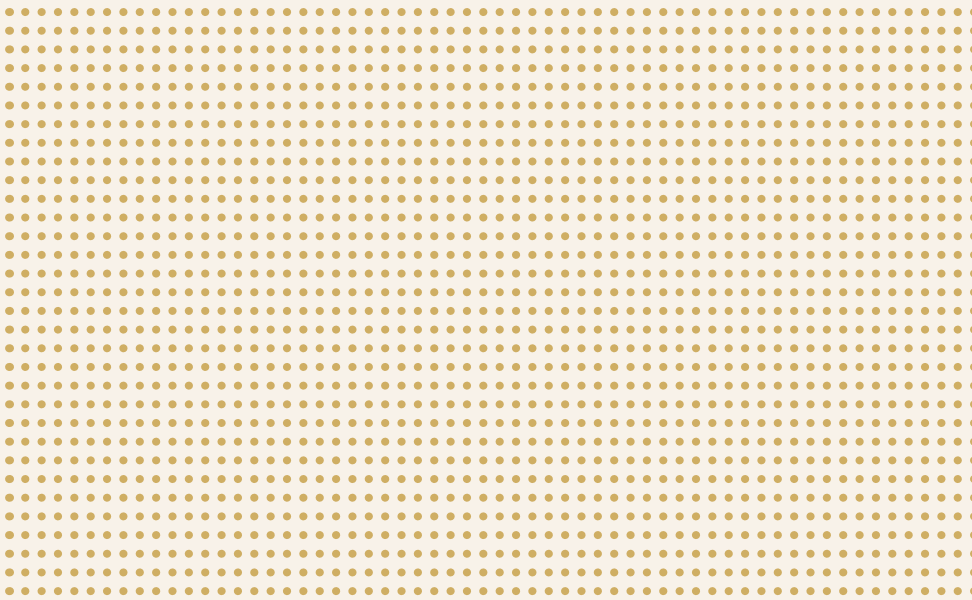
6.4 Data Flow

Figure 2: Data Flow



07

RISK AND MITIGATION PLAN



The actualisation of KCHSP will depend on many factors. Several 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 21: Risk and Mitigation Plan

RISK CATEGORY	RISK NAME	STATUS	PROBABILITY (1-5)	IMPACT (1-5)	RISK AVERAGE SCORE	RESPONSE	RESPONSIBILITY
Technological	Loss of data	medium	2	3	2.5	Back up data -Improved documentation -Regular DQA	CEC Health CHRIO
	Staff limitations in ICT	Medium	2	2	2	-Staff training -Regular OJT and mentorship -External quality assessment	CEC Health CHRIO
Political	Non prioritisation of HIV programmes	High	4	4	4	County ownership of HIV programmes	CEC health
	Displacement of populations	Low	2	5	3.5	-Disaster management fund in place	CEC Health
Operational	Partner dependency	High	4	4	4	Establish HIV budget line in the county budget	CEC Health
	Herbalists and faith healing	Medium	3	3	3	-County legislation on herbal medicine to include vetting and licensing. -Empower community in health decisions Enhance CAP 242 laws of Kenya	CEC health Chair, Health Committee
	Sustainability and predictability of funding for the KCHSP	High	4	4	4	-Advocacy to increase domestic funding for HIV response -Negotiations to have partners aligning implementation with KCHSP.	CEC Health Chair Health Committee
Legislative	Non enforcement of the school health policy	Medium	2	2	2	-Collaborative planning between TSC and MoEST	County director education-national -County director TSC -School BOMs
	Lack of county legislations on HIV, Gender, Stigma and Discrimination	Medium	2	2	2	-Sensitisation of county assembly on HIV gender stigma and discrimination issues. -County executive to draft HIV bills and present to the County Assembly	CEC Health CHMT

08

COSTING AND RESOURCE MOBILISATION STRATEGIES

8.1 Costing and resource needs per strategic Direction

Successful implementation of the county response depends a lot on the availability of adequate financial resources. The organisation of funding the county response is the responsibility of the county government. The KCHSP costing was estimated using the templates utilised in costing the resources required in implementing KASF (in USD Millions). The total 4-year cost for implementation of the KCHSP is estimated at USD 65.5 Million. The majority of the resources are estimated to be directed for Treatment and Care, followed by Prevention.

Figure 12: Total 4- Year KCHSP Cost Estimate Distribution by programmatic area (%)[16]

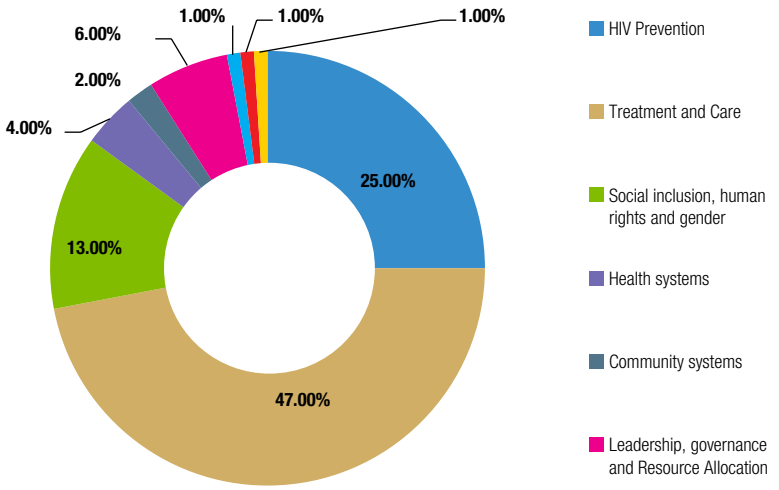


Table 22: Estimated KCHSP Cost Summary by Strategic Direction over the Four-Year Period (in USD millions)

Strategic Directions	Specific KCHSP Intervention areas	% of Resource dedicated for the strategy	2015/2016	2016/2017	2017/2018	2018/2019	Total
SD1	HIV Prevention	25.00%	3.13	3.53	3.95	4.28	17.65
SD2	Treatment and Care	47.00%	5.65	5.91	6.01	5.94	28.68
SD3	Social inclusion, Human Rights and Gender	13.00%	1.86	2.31	2.80	3.33	11.73
SD4	Health Systems	4.00%	0.40	0.33	0.29	0.15	1.61
	Community Systems	2.00%	0.20	0.16	0.15	0.08	0.80
SD5	Research	1.00%	0.11	0.11	0.10	0.09	0.52
	Supply Chain Management	1.00%	0.12	0.14	0.15	0.15	0.67
SD6	Monitoring & Evaluation	1.00%	0.12	0.14	0.15	0.15	0.67
SD7 & SD8	Leadership & Governance	6.00%	0.67	0.65	0.61	0.55	3.15
	Grand Total	100.00%	12.27	13.27	14.22	14.74	65.50

16 NACC and USAID health policy project 2014

8.2 Programme Based Costing and Resource Needs

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

Table 23: Programme Based Costing and Resource Needs

EPI and Program Data	Revised value	Default value
HIV prevalence among 15-49 year old adults	4.3%	4.3%
Adults receiving ART	9,273	9,273
Children receiving ART	1,269	1,269
Number receiving PMTCT	698	698
Number receiving HTC	179,132	179,132

Interventions	Current	Unit costs of services		
	Coverage	Revised value	Default value	Units
ART	87.8%	KSh51,612	KSh51,612	per patient
PMTCT	53.8%	KSh1,748	KSh1,748	per mother/ baby
HTC	31.4%	KSh513	KSh513	per person tested
Key populations		KSh6,440	KSh6,440	per person reached
Behaviour change		KSh138	KSh138	per person reached
Program support		15.5%	15.5%	% of other services

Where the Default values are national level costs and Program costs are calculated as a percentage of other costs

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

Table 24: KCHSP Programme resource needs

Resource Needs (Millions of Kenyan Shillings)					
	2015	2016	2017	2018	2019
ART	KSh504	KSh518	KSh531	KSh544	KSh558
PMTCT	KSh1	KSh1	KSh2	KSh2	KSh2
HTS	KSh47	KSh55	KSh64	KSh73	KSh82
Condoms	KSh21	KSh28	KSh31	KSh35	KSh39
Key populations	KSh4	KSh6	KSh8	KSh10	KSh12
Behaviour change	KSh95	KSh117	KSh139	KSh164	KSh191
Medical services	KSh0	KSh0	KSh0	KSh0	KSh0
OVC	KSh81	KSh92	KSh92	KSh93	KSh94
Program support	KSh116	KSh129	KSh137	KSh146	KSh154
Total	KSh870	KSh947	KSh1,004	KSh1,067	KSh1,133

ANNEXES

Annex 1: Results Framework

Strategic Direction 1: Reduce new HIV and TB infections

KCHSP Results	Service Delivery Area	Indicators	
75 % Reduction in new HIV infection in adults and children	County to input	Annual Number of new adult HIV infections	
		Annual Number of new child HIV infections	
	Key population	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	
		Percentage of FSW reporting the use of condom during penetrative sex with their most recent client	
		Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	
	Adolescent programme	Percentage of young women and men aged 15-2 4who have had sexual intercourse before age 15	
		Percentage of schools that provide life skills based HIV education	
	HTS	Number of the population Counselled and tested	
	PEP	Number of Health facilities providing PEP services	
	General Population	Percentage of people aged 15-49 who had sexual intercourse with more than one partner in the last 12 months	
		Percentage of people aged 15-49 who had sexual intercourse with more than one partner in the last 12 months and reported condom use during the last sexual intercourse	
	PMTCT	Percentage of pregnant women attending ANC whose male partner was tested for HIV	
		Number and Percentage of infants born to HIV infected women starting on cotrimoxazole prophylaxis within 2 months of birth	
		Number and Percentage of infants born to HIV infected women who receive DNA-PCR test for HIV within 2 months of birth.	
		Number and Percentage of pregnant women who know their HIV status (1ST ANC Visit).	
		Number of HIV positive women who receive anti-retroviral to reduce risk of mother to child transmission (ANC- PMTCT).	
		Percentage of health facilities providing EID.	
		Percentage of clients who finished four ANC visits.	

	Baseline	Data Source	Mid Term Target	End Term Target
	988	County Estimates 2014	494	247
	54	County Estimates 2014	27%	13%
	35%*	MoT study (2008)	20%	15%
	0	Partner data		
	88%*	PBS	90%	95%
	77%*	IBBF	80%	85%
	12.7 %*	KAIS 2012	8.0%	5.0%
	No data			
	208 190	DHIS 2015	60%	70%
	205	CIDP-KITUI 2014	230	230
	8.4%*	KAIS 2012	6%	4%
	37.7%*	KAIS 2012	50%	75%
	2.2%	DHIS 2015	5%	10%
	50.3%	DHIS 2015	605	80%
	62.7%	DHIS 2015	70%	80%
	27304	DHIS 2015	95%	98%
	763	DHIS 2015	98%	99%
	87%	DHIS 2015	95%	995
	43.6%	DHIS 2015	55%	60%

Strategic Direction 2: Improve health outcomes of People Living with HIV

KCHSP Results	Service Delivery Area	Indicators	
25% Reduction in AIDS related mortality	County to input	Annual number of HIV related deaths (Adults)	
	County to input	Annual number of HIV related deaths (children)	
	ART Program	Percentage of people diagnosed HIV positive linked with care within 3 months.	
		Percentage of PLHIV receiving HIV care services.	
		Number and percentage HIV positive adults and children currently on cotrimoxazole prophylaxis	
	PMTCT 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.	
	Viral Load	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	Number of health facilities providing HIV care and treatment services	
		Number of health facilities implementing continuous quality improvement activities according to MoH standardised protocols	
		Number of health facilities providing care and treatment according to MoH standardized protocols	

Strategic Direction 3: Promote human rights approach to facilitate access to HIV services

KCHSP Results	Service Delivery Area	Indicators	
50 % Reduction in Stigma and discrimination	Stigma and discrimination	Percentage of PLHIV who self-reported that they experienced discrimination and/or stigma due to their HIV status	
		Percentage of women and men ages 15–49 expressing accepting attitudes towards people living with HIV	
	General population	Percentage of ever married or partnered women and men ages 15–49 who experienced sexual and/or gender based violence	
	KP	Percentage of MSM who experienced sexual and/or gender-based violence	
		Percentage of sex workers who experienced sexual and/or gender-based violence	
	OVCs	Percentage of OVCs reached with social protection programs	

	Baseline	Data Source	Mid Term Target	End Term Target
	622	Kenya County HIV profile 2014	560	466
	120	Kenya County HIV profile 2014	108	90
	636	DHIS 2016 1st quarter	90%	100%
	12843 88.5%	DHIS 2015	90%	100%
	1966	DHIS 2015	70%	80%
	1423	DHIS 2015	85%	90%
	4610	DHIS 2015	40%	50%
	12 months-72%	DHIS2015	80%	85%
	24 months- 55%	DHIS 2015	60%	70%
	36 months		County to input	County to input
	60 months		County to input	County to input
	95%	DHIS 2015	98%	100%
	9005	DHIS 2015	95%	98%
		DHIS 2015		
	30%	DHIS 2015	60%	90%
	205	DHIS 2015	215	230
		DHIS 2015		
	205	DHIS 2015	215	230

	Baseline	Data Source	Mid Term Target	End Term Target
	49.2%	Stigma index survey 2013	35%	25%
	Men: 32.6%* Women: 46.9%*	KDHS 2009	75%	80%
	6.6%*	KDHS 2009	3%	0%
	24%*	IBBS	15%	10%
	44%*	IBBS	25%	10%
	36%	County estimates	50%	65%

Strategic direction 4: Strengthen integration of health and community systems.

KCHSP Results	Service Delivery Area	Indicators	
Adequately staffed workforce	Health Care Workforce	Ratio of cadres of health care staff to population in line with staffing norms	
Improved access to HIV commodities and services	Health Facilities	Percentage of health facilities providing KEPH defined HIV&AIDS services	
	Commodity Management	Percentage of health facilities dispensing ART that experienced a stock-out of ARVs at least once in the last 12 months	
Strengthened community service delivery of HIV prevention, treatment, care and support	Community Units	Number of community units implementing AIDS competency guidelines	
	Community Based Organizations	Number of Community Health Units given training on HIV module	
		Number of Community Health volunteers reporting on HIV programmes	
		Number and percentage of community-based organizations that submit timely, complete, and accurate reports according to guidelines	
Health Systems Strengthening	Health Systems Strengthening	Number of health facilities providing integrated HIV services	
		Number of health facilities implementing universal precautions to prevent HIV infection	

Strategic Direction 5: Strengthen research and innovation to inform KCHSP objectives

KCHSP Results	Service Delivery Area	Indicators	
Increased evidence based planning and programming	Application of research finding in decision making	Number of research products disseminated to inform policy, planning, and programming	

Strategic Direction 6: Promote utilization of strategic information for HIV programming

KCHSP Results	Service Delivery Area	Indicators	
Increase availability of strategic information to inform HIV response	Increase access and strengthen to Strategic information	Number of planned M & E reports generated	
		Number and percentage of planned M & E reports disseminated	
		Established and functional M & E TWG	
		Number of sub counties submitting timely, complete and accurate reports	
		Percentage and number of implementing partners reporting through DHIS	

	Baseline	Data Source	Mid Term Target	End Term Target
	1.69/1000*	County to input	2.0/1000	2.4/1000
	No data	RHIS	County to input	County to input
	0%	DHIS 2015	0	0
	82	County community health focal person	82	84
	82	RHIS	82	84
	82	RHIS	82	84
	47%*	COBPAR	75%	80%
	205	DHIS 2015	230	230
	230	DHIS 2015	230	230

	Baseline	Data Source	Mid Term Target	End Term Target
	n/a	County to input	1	1

	Baseline Data	Data Source	Mid Term Target	End Term Target
	n/a	County to input	1	1
	n/a	County to input	1	1
	0	County to input	1	1
	8	DHIS	8	8
	4	DHIS	4	4

Strategic Direction 7: Increase Domestic Financing for Sustainable HIV Response

KCHSP Results	Service Delivery Area	Indicators	
Increase domestic financing to 50%	Government funding	Establishment of specific budget lines and funding for HIV	
		Total amount of government funding for the HIV response	

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

KCHSP Results	Service Delivery Area	Indicators	
Functional Coordination framework	Establishment of coordination framework	County HIV coordinating committees in place	
		Percentage of County MDAS with result based HIV plans aligned to KCHSP	

	Baseline Data	Data Source	Mid Term Target	End Term Target
	0	County to input	County to input	County to input
	4 Million		6 million	8 Million

	Baseline Data	Data Source	Mid Term Target	End Term Target
	SCACCs-8	RHIS	SCACCs-8	SCACCs-8
	County HIV Committee-0		County HIV Committee-1	County HIV Committee-1
	0	Public sector reporting tool	80%	90%

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