REPUBLIC OF KENYA

KWALE COUNTY HIV AIDS STRATEGIC PLAN (KCASP) 2016/2020

"Destination Kwale"

Republic of Kenya

KWALE COUNTY

HIV AND AIDS

STRATEGIC PLAN

2016/2019

'Destination Kwale'

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Acronyms and Abbreviations

AIDS	Acquired Immune-Deficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
CACC	County AIDS Coordinating Committee
CASCO	County AIDS and STI Coordinator
CBO	Community-Based Organizations
CD4	Cluster of Differentiation 4
CDCDCTM	County Department of Community Development, Culture and Talent Management
CECM	County Executive Committee Member
CHMT	County Health Management Team
CHMIS	County Health Management Information Systems
CHRIS	County Health and Records Information System
CHWs	County Health Workers
CIDP	County Integrated Development Plan
COBPAR	Community-Based Programme Activity Report
CSO	Civil Society Organization
CUs	Community Units
DHIS	District Health Information System
eMTCT	Elimination of Mother-to-Child Transmission of HIV
FBO	Faith-Based Organizations
FHOK	Family Health Options Kenya
FSW	Female Sex Workers
HCBC	Home and Community-Based Care
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information Systems
HTC	HIV Testing and Counselling
HRBAP	Human Rights-Based Approach to Programming
KAIS	Kenya AIDS Indicator Survey
KASF	Kenya AIDS Strategic Framework
KCASP	Kwale County (HIV and) AIDS Strategic Plan
KNASP	Kenya National AIDS Strategic Plan
KNBS	Kenya National Bureau of Statistics
KSPA	Kenya Service Provision Assessment
M&E	Monitoring and Evaluation
MAT	Medically-Assisted Therapy
MCAs	Members of County Assembly
MNCH	Maternal, Neonatal and Child Health
MoH	Ministry of Health
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission
NACC	National AIDS Control Council
NSP	Needle and Syringe Programme

NTSA	National Transport and Safety Agency	OST	Opiate Substitution Therapy
NLTP	National TB and Leprosy Programme	RCT	Reach out Centre Trust
NPT	New Prevention Technologies	SCAC	Sub-County Aids Community
PEP	Post-Exposure Prophylaxis	SD	Strategic Directions
PWIDs	Persons Who inject Drugs	SRH	Sexual and Reproductive Health
PrEP	Pre-Exposure Prophylaxis	TBP	To Be Provided
PLHIV	People Living with HIV	TSU	Technical Support Unit
PMTCT	Prevention of Mother-to-Child Transmission of HIV	UNODC	United Nations Office on Drugs and Crime
PPP	Public Private Partnership	WOFAK	Women Fighting AIDS in Kenya

Foreward

HIV and AIDS remain a major challenge in Kenya as well as in Kwale County. The epidemic continues to adversely impact on all spheres of the County; economic, social and health sectors. With an estimated HIV prevalence of 5.7% (National HIV Estimates 2014) Kwale County is ranked as a medium-epidemic county. With 21,159 People Living with HIV (PLHIV) in the county, it is of concern that two thirds of this population are women and over 2,600 of them are children. These facts prompt us to audit our efforts towards elimination of mother-to-child HIV transmission (eMTCT) and other related programmes.

In our quest to deliver quality health services, my Government has in the last three years initiated many health infrastructural projects, equipped health facilities and employed more healthcare workers. These are gains that can quickly be eroded without a proper focus in communicable diseases such as HIV and AIDS.

To guide the County HIV response, the County Government of Kwale has developed a four-year HIV and AIDS Strategic Plan (KCASP 2016-2019) that will be integrated into other policies and strategies; including County performance contracting to realize a county-owned and led evidence informed HIV response. The KCASP 2016-2019 is anchored on the Kenya AIDS Strategic Framework (KASF 2016 - 2019) and also aligned to the County Integrated and Development Plan (CIDP), Health Strategic and Investment Plan, the Constitution of Kenya 2010 and the Kenya Vision 2030.

My Government is fully committed to the implementation of this plan through provision of leadership and oversight towards achievement of the results. In doing so, we will build on the progress made so far through decades of hard work ,unity of purpose, courage and commitment to step up the momentum towards ending the HIV and AIDS epidemic.

H.E Salim Mvurya
Governor, Kwale County

Preface

The County Government of Kwale has further demonstrated its resolve towards the HIV response by developing the Kwale County HIV and AIDS Strategic Plan (KCASP) 2016-2019. In the wake of the new constitutional dispensation seeking local solutions to local issues, the KCASP 2016-2019 epitomizes devolution by providing a Kwale County-specific HIV and AIDS response. True to its focus of providing quality health services, the County Government of Kwale has invested tremendous resources (though not sufficient due to budgetary allocation constraints) in scaling up the HIV and AIDS related programmes. We appreciate that HIV and AIDS is not only a health issue and hence the KCASP 2016-2019 will accelerate behavioural and structural interventions to complement the existing biomedical interventions in the County.

According to the National HIV Estimates 2014, Kwale County has a 5.7% HIV prevalence with over 600 people infected with HIV annually. Over 40% of new HIV infections occurred among Key Populations (KPs) while over 20% occurred among priority populations including adolescents, young people and women. This has seen the number of PLHIV grow to 18,500 adults and 2,659 children. Illicit drugs, especially in areas along the coastal strip continue to fuel new infections among Persons Who Inject Drugs (PWIDs) through sharing of needles, whereas poverty has seen many young girls and women who venture into sex work getting exposed to high-risk behaviours such as multiple sexual partners and unsafe sexual practices. HIV and AIDS-related stigma remains a key barrier to addressing HIV and AIDS in Kwale County.

HIV and AIDS is not only a health issue and hence the KCASP 2016-2019 will accelerate behavioural and structural interventions to complement the existing biomedical interventions in the County

KCASP 2016-2019 commits to provision of a comprehensive HIV prevention, treatment, care services and mitigation of negative social and economic impacts of the HIV epidemic through a human rights-based approach. It further binds all players to the clearly-defined KCASP objectives and results to ensure pooling and prudent utilization of resources towards the County HIV response.

To achieve this and more, KCASP 2016-2019 has set four broad objectives that are aligned to the Kenya AIDS Strategic Framework (KASF as follows:

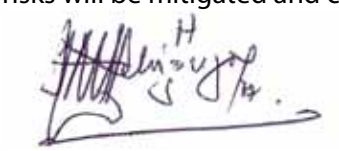
(i) Reduction of new infection by 75%.

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

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

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

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



Dr. Athman Chiguzo

CEC Member, Medical Services and Public Health

Acknowledgements

The Kwale County HIV and AIDS Strategic Plan 2016-2019 is a product of efforts of many individuals and organizations in and out of Kwale County. The process started in 2014 when Kwale County participated in the End Term Review of the Kenya National AIDS Strategic Plan (KNASP III) and later the development and dissemination of Kenya AIDS Strategic Framework (KASF), which factors in the devolved system of governance. As such, a lot of effort has been directed to this process in terms of time, resources and technology. It is difficult to put value to all this support or mention each and everyone who has contributed to the success of KCASP 2016/2019.

The Office of the Governor, H.E. Salim Mvurya, of Kwale County provided the much-needed strategic leadership to the entire process. We also thank the County First Lady, Mrs Christine Mwaka Mvurya for her passionate participation in the development and review of this document. Thanks to the entire Department of Medical Services and Public Health where the entire process was domiciled for the technical guidance, review and support. In addition, we thank the Members of County Assembly (MCAs) and many other local leaders who contributed immensely to this process.

Special thanks to National AIDS Control Council (NACC) national and regional offices for providing technical and financial support during the entire process. To the members of various working committees who laboured tirelessly through drafting, review and validation processes, we say thank you.

Though a number of county, regional and national partners participated in the success of the process, I particularly wish to extend our appreciation to Family Health Options Kenya (FHOK), Pathfinder International and Women Fighting AIDS in Kenya (WOFAK) for their financial and technical support during the process.

We further acknowledge the participation of networks of PLHIV, community and religious leaders, Persons living With Disability (PWDs), representatives of priority populations including women, adolescents and young people whose gainful insights enriched the process of developing the KCASP 2016-2019.

The Department of Health is committed towards implementation of this Strategic Plan in order to fulfill the wishes and aspirations of all Kwale residents and the entire country.

Dr. Kishindo Mwaleso
Chief Officer of Health

Comments from NACC Director

National AIDS Control Council congratulates the Government of Kwale County, implementing partners and stakeholders for successfully developing and rolling out the Kwale County HIV and AIDS Strategic Plan (KCASP 2016-2019). The Plan has been developed through a rigorous process involving a review and analysis of gaps within current County HIV response and also identifying programmes and interventions that will guarantee maximum impact as set in the M&E Result Framework.

Though the Kwale County HIV prevalence (5.7%) is almost at par with the national HIV prevalence (5.6%), it is classified as a medium-prevalence county (with regards to the HIV burden) and efforts towards managing the HIV response in the County are facing a number of challenges. This has seen 623 new HIV infections annually and the number of PLHIV rise to 21,159 (18,500 adults and 2,659 children). ART coverage in the County is 31% among adults and 16% among children, way below the national average of 79% among adults and 42% among children. In addition, Kwale County has substantial numbers of key and priority populations which are vulnerable to HIV transmission and acquisition. Notably, the County is well known for its tourism and mining activities, a factor that can likely create 'HIV epidemiological sinks,' if proper programmes are not put in place.

KCASP 2016-2019 is designed to ensure that the County HIV and AIDS response remains a multi-sectoral function in Kwale. The plan further seeks to strengthen coordination structures and define the expected deliverables after the three-year implementation period.

Dr. Nduku Kilonzo

Director - National Aids Control Council

Executive Summary

Health remains a key deliverable of the County Government of Kwale. HIV and AIDS are among the largest public health concerns in Kwale County. The HIV epidemic continues to take a toll across the population with its impact experienced in health, economic and social sectors. With an estimated prevalence rate of 5.7% (National HIV Estimates 2014) Kwale is ranked as a medium-epidemic county. The Kwale HIV and AIDS epidemic has both characteristics of general and concentrated population trends with the HIV incidence being high among KPs along the coastal strip. There are 21, 000 persons currently living with HIV, with 2,659 of these being children. The County annual HIV incidence remains significant. In 2013, 623 people got infected with HIV, with injecting drug use and other high-risk behaviours contributing to the highest incidence. Similarly, in the same year, 774 people died due to AIDS-related complications, among them 136 children. Disease burden among KPs continues to be significantly high with the prevalence among sex workers, people who inject drugs, men who have sex with men and prison populations ranging from 15% to 20%. Other populations of concern include women, adolescents and young people, fishing communities and persons with disabilities. Among the general population, the sexual and social determinants of health continue to play a key role not only in HIV transmission, but also access to services.

Kwale County is committed towards achieving international and national targets with regards to HIV response. Kwale County HIV and AIDS Strategic Plan has been developed through a rigorous highly consultative process driven by data and other evidences.

HIV and AIDS is among the largest public health concern in Kwale County.

The Plan envisages a County free of new HIV infections, AIDS-related deaths, stigma and discrimination. The goal of KCASP is "Commitment to HIV universal access through a comprehensive HIV prevention, treatment, care and mitigation of negative social and economic impact of the epidemic."

VISION

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

GOAL

Commitment to provision of comprehensive HIV prevention, treatment, care services and mitigation of negative social and economic impacts of the HIV epidemic.

KCASP OBJECTIVES

1. Reduce new HIV infections by 75%
2. Reduce AIDS related deaths by 25%
3. Reduce HIV & AIDS related stigma by 50%
4. Increase County HIV response financing by 50%

KCASP has spelt out four major objectives as follows:.

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

The interventions are clearly defined in a Results Framework that spells out the activities, indicators, and baseline and end-term deliverables after four years. Programmatic costing of KCASP has ben done using the standard health costing manual.

Chapter 1

Background Information on Kwale County

The County is located in the South Coast of Kenya, bordering the Republic of Tanzania to the South West, the Indian Ocean to the East and the following counties; Taita Taveta to the West, Kilifi to the North and Mombasa to the North East. The County has a total surface area of 8,270.2 square kilometres which accounts for 1.42 per cent of Kenya's total surface area. The county has a population of 739, 435 persons (2013, KNBS Projections). The population of Kwale County is largely classified as a young population with largest proportion averaging 15 to 35 years (Kenya Open Data Source, 2003). Similarly, the county boast of a higher rural population.

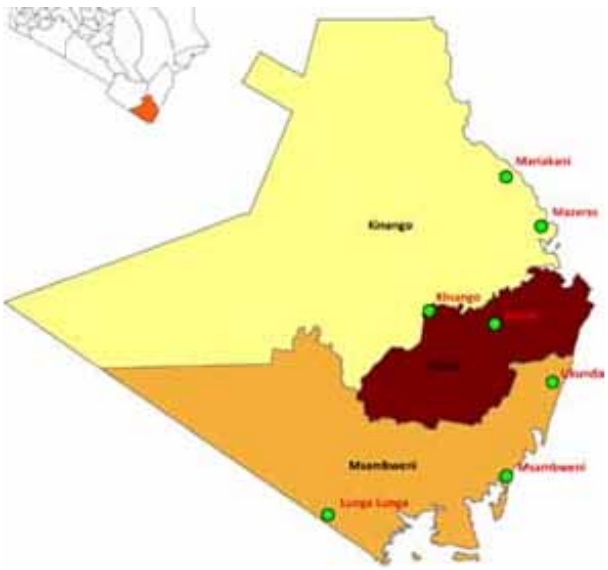


Figure 1.1: Map of Kwale County

Kwale is mainly an inland County but it has a coastline south of Mombasa. Kwale County forms a part of the larger Kenyan South Coast well known for its rich tourist attraction sites such as, Diani Beach, globally renowned beach hotels, Shimba Hills National Reserve (the home of Sable antelope), Mwaluganje Sanctuary, marine reserves and parks, indigenous coastal forests and mangroves, coral and swathes of sandy beaches.

Furthermore, due its rich mineral deposits, Kwale has often been referred to as the 'mineral' county of Kenya. On-going mining projects in the County include; exploitation of limestone at Waa and mining of Titanium at Nguluku and Mrima areas. In spite of the above, poverty levels remain comparatively high in the County, with majority of the residents depending on small-scale farming, fishing and keeping of livestock to earn their livelihood.

Administratively, Kwale County is divided into 4 sub-counties:

- Msambweni Sub-County
- Matuga Sub-County
- Kinango Sub-County
- Lunga Lunga Sub-County

Health remains a key deliverable of the County Government of Kwale. To this effect, the County Government created a County Health Department that combines medical services, public health and sanitation. Inadequate health services in Kwale County are attributed to shortage of health workers and high incidences of preventable diseases such as malaria, diarrhoea and HIV and AIDS. Relatively high levels of illicit drugs and substance abuse continue to compound health challenges in Kwale.

Accessibility of hard drugs and substances, especially along the coastal strip has resulted into an increase in the number of persons who use and inject drugs. Whereas that County Government has partnered with the national Ministry of Health (MoH), UNODC and a number of CSOs to address the drugs menace through harm reduction programmes such as Medically Assisted Therapy (MAT), there is still a lot of ground to cover in this area.

Drugs and substance abuse continues to compound health challenges in Kwale County.

According to the County Website, Kwale County has a total of three (3) government hospitals, eight health centres and 64 dispensaries located in Msambweni, Kwale and Kinango constituencies. The doctor and nurse population ratio stands at 1:76,741 and 1:3,133 respectively. In addition the county has 2 level three private hospitals.

The average distance to the nearest health facility within the County is seven kilometres as opposed to the required maximum of three kilometres. The County delivery of health services remains inadequate. As a result, child mortality rate is high at 149 compared to the national figure of 116 deaths for 1000 live births. Unskilled and home delivery stands at close to 50%, a factor that fuels mother-to-child HIV transmission. HIV and AIDS is among the largest public health concern in Kwale. HIV continues to take a toll across the populations with its impact experienced in health, economy, social and education sectors.

About 50% of pregnant women do not deliver under the care of qualified healthcare providers in Kwale County, a factor that fuels mother-to-child HIV transmission.

Chapter 2

Situation Analysis

2.1 HIV Trends in Kwale County

With an estimated prevalence of 5.7% (National HIV Estimates 2014), Kwale County is considered as having a medium-HIV burden and ranked is 24th highest HIV prevalent county nationally. The Kwale HIV and AIDS epidemic exhibits both characteristics of generalized and concentrated epidemic trend with Key Populations (KPs) leading in acquisition and transmission of HIV along the coastal strip. There are 21,000 persons currently living with HIV, with 2,659 being children. In 2013, an estimated 623 adults and children were infected with HIV, with injection drug use and other high-risk sex behaviours contributing to the highest percentage. Similarly, in the same year, 774 persons died due to AIDS related complications, of whom 136 were children. Disease burden among KPs continues to be significantly high with prevalence among Female Sex Workers (FSW), Men who have Sex with Men (MSM) and Persons Injecting Drugs (PIDs) ranging from 15% to 20%. Other populations of concern include women, adolescents, young people, fishing communities and People With Disabilities (PWDs).

HIV/ AIDS epidemiology in Kwale exhibits marked geographical and population diversity. All sub-counties along the coastal strip; Lunga Lunga, Msambweni and Matuga carry a higher burden and this has been attributed to increased youth activities due to tourists' presence and easy access of drugs and other substances of abuse. KCASP further seeks to address social-cultural determinants of health such early children marriages, gender-based violence, family sexual violence and high school drop-out rates, especially among girls.

Among the general population, the sexual and social determinants of health continue to play a key role not only in HIV transmissibility, but also in access to services. Whereas the county's ANC uptake has improved in recent years to 92%, most mothers still do not deliver in hospitals. The County PMTCT coverage is 56% - a factor that contributes not only to HIV transmission to infants but also heightens maternal and infant mortality. HIV and AIDS-related service uptake remains low in Kwale. Only slightly above 30% of the county population

knew of their HIV status in 2012 (KAIS, 2012). In 2013, 58% of HIV-positive pregnant women did not deliver in health facilities. Other social determinants that continue to affect HIV programming include gender-based violence, high illiteracy levels, especially among women and girls, and cultural practices that deter health and HIV service uptake among the general population. Youth and adolescents continue to suffer disproportionate effects of HIV and AIDS in Kwale. Nationally, in 2014, 21% of new infections occurred among adolescent a factor that was replicated in most counties-including Kwale.

Table 2.1: Key HIV and AIDS indicators for Kwale County

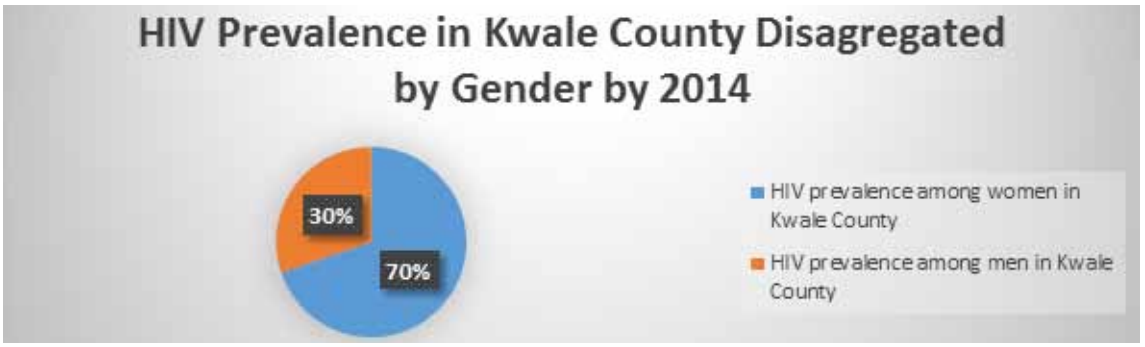
INDICATOR		KWALE
Total population (2013)		739,435
HIV adult prevalence (overall)		5.7%
HIV prevalence among women		8.1%
HIV prevalence among men		3.5%
Number of adults living with HIV		18,500
Number of children living with HIV		2,659
Total number of people living with HIV		21,159
% of people never tested for HIV by 2009		73%
ANC HIV testing for pregnant women		92%
% of HIV positive pregnant women who do not deliver in a health facility		58%
MTCT rate (2014 estimates)		10.6%
PMTCT coverage		56%
New adult HIV infections annually	County	623
	National estimate	88,620

(Source National HIV Estimates 2014)

2.1.1 HIV Prevalence by Gender

There are more women living with HIV than men in Kwale. Data shows that 70% of those infected with HIV are women as compared to 30% men. According to County health data, women also bear the largest proportion of other major diseases in Kwale.

Figure 2.1: Kwale County HIV prevalence by gender



Other populations that are largely affected by HIV in the County include adolescents and young people and identified Key Populations.

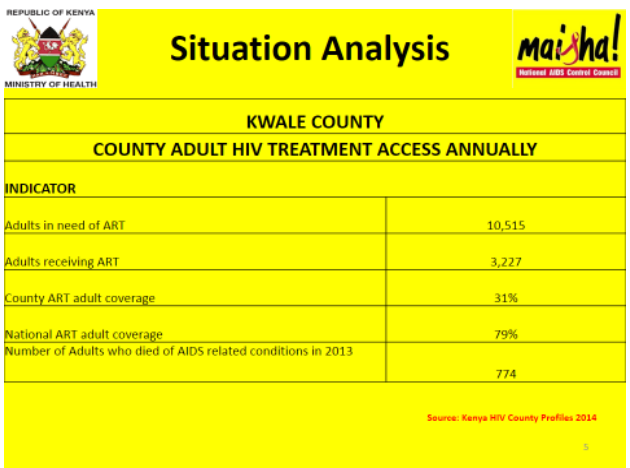
2.1.2 HIV Treatment Uptake

HIV treatment uptake for both adults and children remains unnaceptably low in Kwale. According to the National HIV and AIDS Estimate report(2014), Among 10,515 PLHIV in 2013, only 3,227 adults were initiated on ART, representing 31% treament coverage. The figure was even worse for children whose treament coverage was 16% as compared to the national coverage of 42% (Kenya is still performing poorly in paedtriac HIV treatment coverage). Poor HIV treatment coverage is associated with relatively high HIV-related mortality. In 2013, about 774 adults were estimated to have died of AIDS-related causes while the number of deaths among children was 136.

2.1.3 The Key Population Factor

According to the Kenya Modes of Transmission Study (KMOT, 2009) the largest percentage of new HIV infections (44%) in Kwale County and Coast Region occur among three sub-groups of Key Populations; Men who have Sex with Men (MSMs), and prison populations the Female Sex Workers (FSWs) and their clients and Persons Who Injects Drugs (PWIDs). Though the estimated number of people who inject drugs is reportedly low in Kwale, (<0.1% of Kwale County Population), evidence shows that injection drug use is the most efficient mode for HIV transmission. According to the Reachout Hotspots Mapping report 2015, there are about 720 PWIDs in Kwale, mainly along the coastal strip. Similarly, the report indicates a conservative figure of 2500 persons who use addictive drugs in ways other than injecting (PWUDs). A survey by International Centre for Reproductive Health (ICRH 2009) put the figure of FSWs in Kwale at about 4,645.

Table 2.2: Kwale County HIV treatment access indicators



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Situation Analysis

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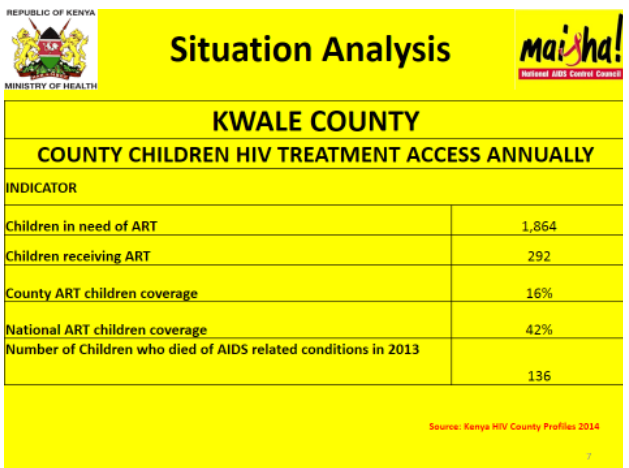
KWALE COUNTY COUNTY ADULT HIV TREATMENT ACCESS ANNUALLY	
INDICATOR	
Adults in need of ART	10,515
Adults receiving ART	3,227
County ART adult coverage	31%
National ART adult coverage	79%
Number of Adults who died of AIDS related conditions in 2013	774

Source: Kenya HIV County Profiles 2014



REPUBLIC OF KENYA
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Situation Analysis

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KWALE COUNTY COUNTY CHILDREN HIV TREATMENT ACCESS ANNUALLY	
INDICATOR	
Children in need of ART	1,864
Children receiving ART	292
County ART children coverage	16%
National ART children coverage	42%
Number of Children who died of AIDS related conditions in 2013	136

Source: Kenya HIV County Profiles 2014

Table 2.3: National and regional HIV prevalence by mode of transmission (KMOT, 2009)

GROUPS	NATIONAL	COAST
Heterosexual sex with union/regular partnership	44.1%	37.9%
Casual heterosexual sex	20.3%	14.9%
Sex workers and clients	14.1%	18.2%
MSM and prison populations	15.2%	20.5%

PWIDs	3.8%	6.1%
Health facility-related	2.5%	2.3%
Number of new infections	76,315	6,656

Even with Kwale-specific data on Key Populations being scanty, the available figures point to a worrying trend noting that nationally, these groups are estimated to have a HIV prevalence of 15% to 25% (which is four to five times higher than the Kwale County HIV prevalence).

Facts about Key Populations:

- **HIV Prevalence among KPs is 4 or 5 times higher than the national prevalence (15 to 20%).**
- One of every two females who inject drugs is HIV positive (50% prevalence).
- The three main sub-groups of KPs (MSMs, FSWs, PWIDS) contribute 44% of new infection annually in Coast (KMOT study 2009).

2.1.4 Vulnerable Populations

These are populations whose social contexts increase their vulnerability to HIV risk. In Kwale County, vulnerable populations include:-

- Adolescents and young people (girls)
- Women in general
- Fishing communities
- Truck drivers
- Persons With Disabilities
- Persons working in mining, plantation or factory set-up
- PLHIVs
- Boda boda and taxi drivers
- Communities living along Lunga Lunga border point

KCASP recommends targeted interventions for the Key and Vulnerable Populations.

2.2 The HIV and AIDS-Related Stigma and Discrimination Factor

The UNAIDS (2007) defines HIV-related stigma as a process of devaluation of people living with or associated with HIV and AIDS: A person who is stigmatized is seen as having less value or worth to other people (International Planned Parenthood Federation (IPPF, 2008). Jones *et al.* (1984) also defines stigma as an attribute that links a person to undesirable characteristics. Although different scholars have defined stigma differently, one idea is common in all the definitions that the individual who is stigmatized is considered different, discounted as not being okay or of equal

Discrimination involves treating someone in a different, unjust, unfair or prejudicial way, often on the basis of their actual or perceived belonging to a particular group. It consists of actions or omissions that are a result of stigma and are directed towards those individuals who are stigmatized.

status as the "other people". This happens when the individual has attributes that are associated with what society considers improper.

Addressing stigma and discrimination (S&D) of PLHIV, Key and other Priority Populations remains keyto ensuring a successful HIV response in Kenya. According to the National HIV Stigma Index Report, 2014 (NACC), stigma impact on treatment, care and support of PLHIV and other priory populations. It alienates the PLHIV and denies them opportunities to get involved fully in societal issues like the "other people". The deprivation is not only a human rights violation but has profound consequences on the physical and psychological wellbeing of the PLHIV and other priority populations, their families, care givers and society as a whole. Stigma manifests in many forms at all levels.

Stigma alienates the PLHIV and other priority populations and denies them opportunities to get involved fully in societal issues like the "other people". S&D affects not only service uptake among beneficiaries, but also service delivery, and especially the health care-givers-related stigma and discrimination.

HIV-related stigma and discrimination is highly prevalent in Kwale County - and indeed the entire coastal region. The Stigma Index Report, 2014 (NACC) indicated a 50% stigma index in Coast compared to the national stigma index of less than 40%. S&D affects not only service uptake among beneficiaries, but also service delivery, and especially the health care-givers-related stigma and discrimination. KCASP 2016-2019 has set an ambitious target of reducing the HIV-related S&D by 50%. The Plan proposes the use of various strategies.

Cross-Border HIV-Related Programmes in Kwale

KCASP 2016-2019 highlights the need of both national and County Government to ensure cross-border intervention and programmes within Lunga Lunga border point. LungaLunga border point is located in Kwale County (LungaLunga Sub- County). It's the extreme south-eastern point of Kenya and the international border with the Republic of Tanzania. The coordinates of Lunga Lunga are 4°33'18.0"S, 39°07'23.0"E (Latitude: 4.5550; 39.1231). In keeping with East African Community recommendations and guidelines, the Lunga Lunga border crossing is one of those selected for a one-stop crossing. The area has relatively good Infrastructure, linking Kenya, and for both humans and cargo transport.

Clients can easily access a HIV treatment in the neighbouring counties, a factor that makes it difficult to institute defaulter tracing programmes along Lunga Lunga border Point.

The interaction between the communities in the two countries is real and encouraged as they share the same ethnicity. Hence health service points, schools and other institutions in Kenya are easily accessed by the Tanzania residents and vice versa. Clients can easily access a HIV treatment in the neighbouring counties, a factor that makes it difficult to institute defaulter tracing programmes. There is an increased social interactions and inter-marriages across and within the border, hence the need for cross-border HIV programmes as recommended by KCASP 2016-2019

Chapter

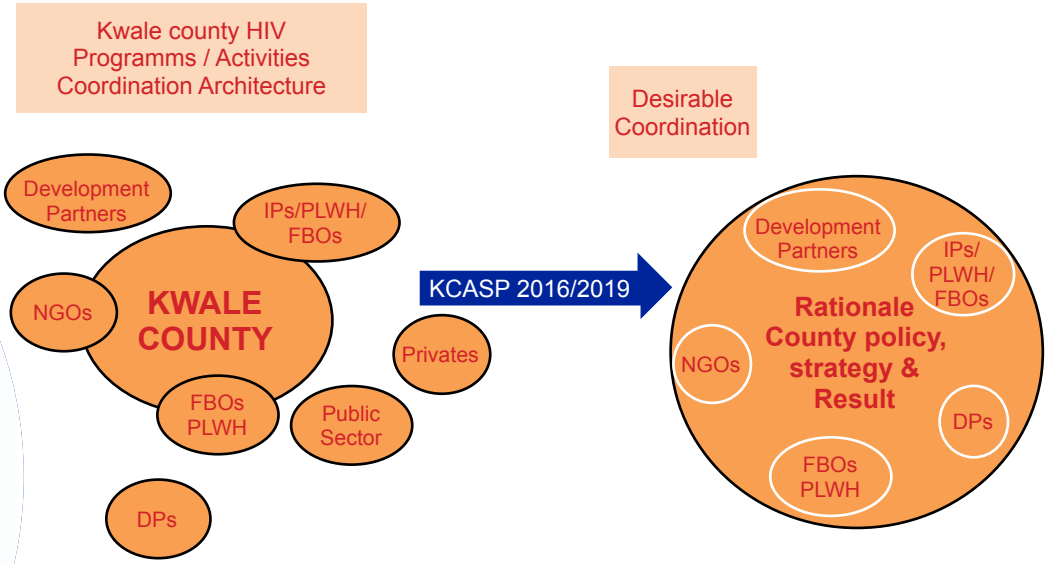
3

Rationale, Strategic Plan Development Process, Guiding Principles and Public Participation

3.1 Rationale

The Constitution of Kenya 2010, Bill of Rights Article 43 established a right "*to the highest attainable standard of health*" and the resulting devolution of the responsibility for the implementation of most health services including the HIV response lies at county level. The KCASP 2016-19 provides guidance for coordination and implementation of the HIV response; resource mobilization, allocation and accountability in the County.

Figure 3.1: Kwale County HIV programmes/activities coordination architecture



The KCASP 2016-19 provides guidance for coordination and implementation of the HIV response; resource mobilization, allocation and accountability in the County.

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

3.2 Process of Developing the KCASP 2016-2019

This plan was developed through in-depth analysis of available data and information in a highly participatory and consultative environment. The process was prompted by an end term review of the third Kenya National AIDS Strategic Plan III (KNASPIII) and the consequent development of Kenya AIDS Strategic Framework (KASF) that took into consideration the county-based governance structure. Through technical assistance from the NACC and partners, the County Department of Health initiated the process of development the strategic plan, based on identified intervention priorities and gaps.

Figure 3.2: Strategic directions and interventions

The Department took leadership of the process through formation of KCASP working committees. Development of KCASP 2016-2019 was a systematic elaborate process that was informed by available evidences, extensive data and information and expert reviews and stakeholder participation. The process entailed the following key steps:

3.2.1: County HIV intervention gaps and priority identification

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

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

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

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

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

3.2.4: Constitution of working groups and technical committees

Three committees were identified and constituted to draft and manage the KCASP 2016-2019 process. The Management Committee was domiciled with the Office of the County Health Executive. This was an oversight committee that also provided linkage

of the process to higher levels of the government. The Drafting or the Technical Committee undertook actual drafting together with organizing peer and technical review sessions. This committee was supervised by the Office of the County Health Director.

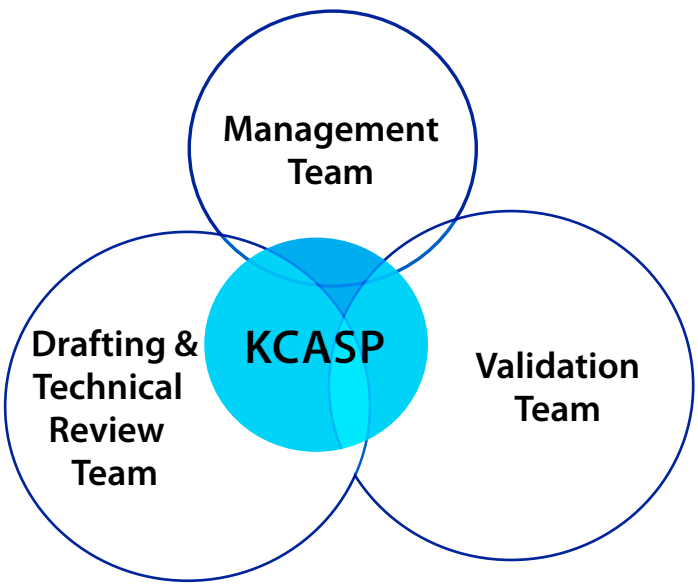
3.2.5: Drafting process

The Drafting process involved review of the County priorities and gaps, consultations with health care workers, PLHIVs, implementing agencies and other stakeholders and consolidation and prioritization of the information collected. Drafters were selected in line with their expertise on various strategic directions.

3.2.6: Expert/peer review of the KCASP Draft

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

Figure 3.3: KCASP development working teams



3.2.7: Validation process

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

3.3 Guiding Principles of KCASP 2016-2019

1. Prioritization of evidence-based and result-oriented interventions with clearly defined targets.
2. Efficiency, effectiveness and innovation: The KCASP promotes the design and implementation of innovative HIV programmes that are efficient and effective.
3. Integration of service: The KCASP promotes integration of services for efficient use of resources and maximum results.
4. County ownership and partnership: All key stakeholders including the County, development partners, private sector, faith-based organizations and communities of PLHIV were involved. All players are expected to align their efforts and resources to the envisioned KCASP 2016 -19 targets.
5. Rights-based and gender transformative approaches: The KCASP promotes HIV programmes that support the respect for human rights, advocates eradication of sexual and gender- based violence, stigma and discrimination.
6. Multi-sectoral approach: KCASP 2016/19 strategic plan promotes County HIV response as everyone's business and calls upon different

sectors to use their comparative advantages to combat HIV and AIDS in the County.

KCASP 2016/19 strategic plan promotes HIV response as everyone's business and calls upon different sectors to use their comparative advantages to combat HIV and AIDS in the County.

3.4 Public Participation

The Kenya Constitution 2010 stipulates that one of the functions of counties is "to encourage the involvement of communities and community organizations in the matters of the county government". Article 105(1) subsection (d) and Article 106 section (4) of the County Government Act 2012 provides for public participation in county planning processes. The preparation of this plan involved pre-drafting consultation with communities. The consultation strategy included public information and workshops and focused group discussions to encourage as much public engagement as possible. KCASP 2016-2019 draft was widely circulated both in hard and soft copies to various stakeholders and players within and out of the county for their inputs. These included PLHIV, Persons With Disability, public and private sector players, youth groups, women groups, and religious leaders among others.

Chapter 4

Vision, Mission, Objectives and County Strategic Directions

VISION

A County free from new HIV infection, AIDS-related deaths and stigma.

GOAL

Commitment to provision of comprehensive HIV prevention, treatment, care services and mitigation of negative social and economic impacts of the HIV epidemic.

KCASP 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 Kwale County financing for the HIV response by 50%

The Constitution of Kenya 2010, Bill of Rights Article 43 established a right "*to the highest attainable standard of health*" and the resulting devolution of the responsibility for the implementation of most health services including the HIV response lies at county level. The KCASP provides guidance for coordination and implementation of the HIV response; resource mobilization, allocation and accountability in the county. It ensures that the HIV response remains multi-sectoral and key institutions both at County and sub-county levels are synergized in response to achieve common results aimed at reducing new HIV infections, putting more people on treatment and mitigating the social economic impact to the most vulnerable members of the community.

4.4 Strategic Directions

1 Reduce new HIV infections	2 Increase health outcomes and wellness of all people living with HIV	3 Using a human rights-based approach to facilitate access to services for PLHIV, KPs and other priority populations in all sectors
4 Strengthening integration of health and community systems	5 Strengthening research, innovation and information management to inform the KCASP goal	6 Utilization of strategic information for research and monitoring and evaluation (M&E) to enhance programming
7 Increasing domestic financing for a sustainable HIV response	8 Promoting accountable leadership for the delivery of the KCASP results by all sectors and actors	

Strategic Directions, Interventions and Recommended Actions

4.1 Strategic Direction 1: Reducing New HIV Infections

4.1.1 Context

With an estimated prevalence of 5.7 % (National HIV Estimates 2014), Kwale is ranked as a medium HIV-prevalent County. The Kwale HIV and AIDS situation exhibits both characteristics of general and concentrated epidemic with KPs leading in HIV acquisition and transmission, especially along the coastal strip. KPs contribute up to 44% of new infections in Coast. Annual HIV incidence in Kwale is 661 persons, 66 of who are children. This underscores the need for targeted interventions. Among the general population, the social determinants of health, such as early marriages, high school dropouts, poverty, and gender-based violence continue to increase vulnerability towards acquisition and transmission of HIV.

Program Gaps:

- Low uptake of HIV testing services.
- Low knowledge of HIV status for children and infants.
- Low uptake of PMTCT services among HIV-positive pregnant women.
- Minimal sexual behaviour change among KPs, general populations and priority groups.

Table 4.1 Interventions for reducing new HIV infections

KASF Objective: Reduce new HIV infections by 75%				
Biomedical Interventions				
KCASP Result	**Key Action**	**Target Population**	**Geographical areas by sub-county**	**Responsibility**
Increase uptake of HIV Testing Services (HTS) to 90%	Develop and deliver innovative targeted and integrated HTS approaches and models	General population Key Populations Priority populations	Lunga Lunga Msambweni Matuga Kinango	County Health Department MoH NACC NASCOP Implementing partners
Improved diagnosis and treatment of STI	Increased access to quality and affordable STI diagnosis and treatment services	General Population, Key Populations Priority populations	Lunga Lunga Msambweni Matuga Kinango	County Health Department MoH NACC NASCOP Implementing partners
Increased access to PMTCT	Offer comprehensive eMTCT interventions integrated with MNCH services	Pregnant women and partners	Lunga Lunga Msambweni Matuga Kinango	County Health Department MoH NACC NASCOP Implementing partners
Increased availability and access to harm-reduction commodities and programmes	Scale up harm reduction interventions including, NSP, MAT, condoms, lubricants provision of PrEP, PEP etc.	General population Key Populations Priority populations	Lunga Lunga Msambweni Matuga Kinango	County Health Department MoH NACC NASCOP Implementing partners UNODC

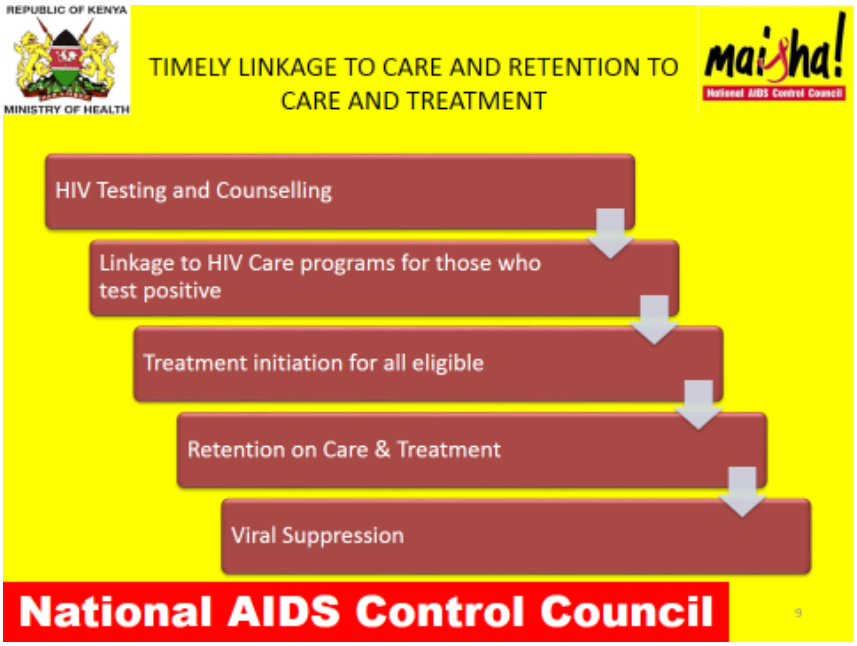
Behavioural Interventions				
Reduced risky behaviours and factors	Scale up access to comprehensive sexuality education including sexual health (HIV prevention education)	General population Key Populations Priority Populations	Lunga Lunga Msambweni Matuga Kinango	County Health Department (CHD) County Department of Community Development, Culture and Talent Management (CDCDCTM) MoH NACC NASCOP Implementing partners
	Design and implement peer education and outreach programmes			
	Implement Behaviour Change Communication (BCC) programmes			
	Improve media Communication to improve behaviour change			
Reduced risky behaviours and factors	Offer harm reductions services including risk reduction counselling & skill building and psychosocial support services	Key Populations Priority populations	Lunga Lunga Msambweni Matuga Kinango	CHD, CDCDCTM MoH, NACC NASCOP Implementing partners
Structural Interventions				
Increased access to PMTCT	Engage men in eMTCT programmes	General population	Lunga Lunga Msambweni Matuga Kinango	CHD CDCDCTM MoH NACC NASCOP Implementing partners
Increased uptake of HIV Testing Services to 90%	Establish and strengthen integrated youth-friendly services	Adolescents and young people	Lunga Lunga Msambweni Matuga Kinango	CHD, CDCDCTM MoH, NACC NASCOP Implementing partners UNICEF
Consistent supply and availability of male and female condoms	100% condom programming	General population Key Populations Priority populations	Lunga Lunga Msambweni Matuga Kinango	CHD, CDCDCTM MoH, NACC NASCOP Implementing partners
Reduced vulnerability for HIV infection	Establish income generating supplementation programmes	Sex workers, youth and women	Lunga Lunga, Msambweni, Matuga, Kinango	CHD, NACC NASCOP Implementing partners

4.2: Strategic Direction 2: Improving Health Outcomes and Wellness of all PLHIV

4.2.1: Context

Kwale is the 7th poorest performing county with respect to ART coverage. Only 32% of adults and 16% of children living with HIV have access to life-saving treatment. The factors impinging access and uptake of treatment include stigma and discrimination, especially among KPs, shortage of health facilities and poor health-seeking behaviour among the community. KCASP puts in place robust interventions geared towards scaling up access and uptake of treatment through mobilization to HIV testing, enrolment to care and treatment and defaulter tracing mechanisms. The Plan further singles out and responds to the needs of various sub-populations such as children, adolescents, youth, PWDs, rural residents and KPs among others. For maximum impacts and efficacy, KCASP 2016-2019 identifies and recommends for targeted interventions to the identified sub-groups.

Figure 4.1: Timely linkage to care and retention to care, and treatment chart



Program Gaps:

- Inadequate referral and tracking mechanisms.
- Low uptake of ART among the PLHIV.
- Human resources shortage.
- Low retention rate of patients on ART.
- Inadequate monitoring of patients in care.

4.2.3 SD 2 implementation matrix

Table 4.2: Interventions for reducing AIDS mortality

KASF Objective: Reduce AIDS mortality by 25%				
Biomedical Interventions				
KCASP Result	**Key Action**	**Target Population**	**Geographical areas by sub-county**	**Responsibility**
Increased linkage to care within 3 months of HIV diagnosis to 90%	Improve timely linkage to care for persons diagnosed with HIV	PLHIV	Lunga Lunga, Msambweni, Matuga, Kinango	County Health Department MoH, NACC NASCOP Implementing partners
Increased sustained ART coverage to 90%	Increase coverage of care and treatment ,and reduced loss in the cascade of care	PLHIV	Lunga Lunga, Msambweni, Matuga, Kinango	CHD, MoH NACC, NASCOP Implementing partners
Behavioural Interventions				
Increased sustained ART coverage to 90%	Scale up education on ART, treatment literacy, adherence and retention	PLHIV	Lunga Lunga, Msambweni, Matuga, Kinango	CHD, CDCDCTM MoH NACC NASCOP Implementing partners
Structural Interventions				
Increased sustained ART coverage to 90%	Integrating community strategy to HIV treatment, care and support	Community health workers and Community members	Lunga Lunga Msambweni Matuga Kinango	CHD, CDCDCTM MoH NACC NASCOP Implementing Partners
Improved quality of care and health outcomes	Scale up interventions to improve quality of care including consistent capacity building of County health workers	County health workers CHMT	Lunga Lunga Msambweni Matuga Kinango	CHD, CDCDCTM MoH NACC NASCOP Implementing partners

4.3: Strategic Direction 3: Using a Human Rights-based Approach to Facilitate Access to Services for PLHIVs, Key Populations and other Priority Populations in all Sectors

4.3.1 Context

The Kenya HIV Prevention Revolution Roadmap estimates that 21,159 people are living with HIV in Kwale County. The evidence suggests that PLHIV and other priority populations are consistently under-served. Low service coverage remains an important driver for HIV transmission. At the core of these inequities are the social and structural barriers of stigma and social discrimination, including discrimination in healthcare settings, and the criminalization of substance use, sex work and same sex relations. These social and structural realities can generate risk environments which undermine public health goals, violate human rights, and limit safe and effective provision of services. In contrast, even in settings where laws are unlikely to be changed and social stigma likely to remain, pragmatic human rights based approaches can help to develop enabling environments where inclusion in HIV services can be progressively realized. To achieve its goal, the KCASP 2016-2019 underpins the rights-based HIV programming for all interventions. This will enhance adherence to the provision of the Article 27 of the Constitution of Kenya 2010 that outlaws discrimination on the basis of one's health status. The County shall work with NACC, the Judiciary, Office of the Prosecutor, Kenya Police and Prison Service, Kenya National Human Rights Commission, HIV and AIDS Tribunal and other human rights institutions to educate the public on human rights approach to HIV programming. In Kwale County, there are reported cases of stigma and discrimination towards PLHIV and Key Populations in families, communities and in institutions. KCASP 2016-2019 seeks to reduce such cases.

Figure 4.2: Advocating for human rights programming for all populations including KPs

Program Gaps:

- HIV-related stigma and discrimination against PLHIV and violence against Key Populations.
- Negative provider attitudes that reduces access to care and affect disclosure and adherence.
- Legal barriers related to drug use, same sex relations and sex work.

Table 4.3: Interventions towards reducing HIV and AIDS- related stigma and discrimination

KASF Objective: Reduce HIV & AID-related stigma and discrimination by 50%				
Structural Interventions				
KCASP Result	**Key Action**	**Target Population**	**Geographical areas by sub-county**	**Responsibility**
Reduced HIV and AIDS- related stigma and discrimination by 50%	Implement PHDP programmes	PLHIV	Lunga Lunga Msambweni Matuga Kinango	MoH County Health Department CDCDCTM NACC NASCOP Implementing partners
	Sensitize county health workers on provision of population-friendly services	County health workers	Lunga Lunga Msambweni Matuga Kinango	CHD CDCDCTM MoH NACC NASCOP Implementing Partners
	Design and implement stigma reduction programs	General population Key Populations Priority populations	Lunga Lunga Msambweni Matuga Kinango	CHD CDCDCTM MoH NACC NASCOP Implementing partners
Reduced levels of gender-based violence and police harassment	Design and Implement GBV education programmes	General Population, Key populations Priority populations	Lunga Lunga Msambweni Matuga Kinango	CHD CDCDCTM MoH NACC NASCOP Implementing partners
	Integration and mainstreaming of gender-responsive programmes	General population Key Populations Priority populations	Lunga Lunga Msambweni Matuga Kinango	CHD CDCDCTM MoH NACC NASCOP Implementing partners
	Strengthen referral and access to legal and health services for survivors of GBV	General population, Key Populations Priority populations	Lunga Lunga Msambweni Matuga Kinango	CHD CDCDCTM MoH NACC NASCOP Implementing partners

Structural Interventions				
Reduced levels of gender-based violence, police harassment	Establish and strengthen GBV survivor sub-county centres Educate law enforcement agencies on HIV and human rights	General Population Key Populations Priority populations County Health Department Ppolice and prisons	Lunga Lunga Msambweni Matuga Kinango	CHD, CDCDCTM MoH NACC NASCOP Implementing partners
Increased Involvement and participation of KPs in decision making	Design and implement leadership development programmes for KPs	Key Populations Priority populations	LungaLunga Msambweni Matuga Kinango	CHD, CDCDCTM MoH NACC NASCOP Implementing partners
Strengthened engagement of PWDs in HIV programmes	Develop and implement population-specific programmes leveraging on PWD networks	PWDs	LungaLunga Msambweni Matuga Kinango	CHD, CDCDCTM MoH NACC NASCOP Implementing partners

4.4 Strategic Direction 4: Strengthening Integration of Community and Health Systems

4.4.1 Context

A strong, well-functioning and sustainable health system capable of efficiently delivering and managing healthcare services is vital to improving the health status of Kwale residents. Health systems in the County are constrained by insufficient financial resources, a shortage and un-even distribution of healthcare workers and weak health information management systems. There is a need to strengthen linkages and referrals and integrate HIV services in primary health care. Kwale County has 68 Community Units (CUs) that serve a third of her population. The KCASP 2016-2019 lays out concrete strategies for formation of additional CUs, strengthening the existing ones and forging an integrated links between the community and health systems.

Program Gaps:

- **Inadequate workforce, equipment, commodities and supplies.**
- **Few functional Community Units (CUs).**
- **Weak coordination mechanism between different community actors and other community structures such as CUs.**
- **Weakened community mobilization processes, which limit utilization of key HIV services, especially enrolment in care and treatment.**
- **Few programmes and interventions to reduce SGBV, stigma, discrimination and harmful cultural practices.**

4.4.2 SD 4 implementation matrix

Table 5.4: Interventions towards building a strong and sustainable system for HIV deliveryKASF Objective: To build a strong and sustainable system for HIV service delivery				
Structural Interventions				
KCASP Result	**Key Action**	**Target Population**	**Geographical areas by sub-county**	**Responsibility**
Strengthened health service delivery and community systems	Streamline commodity management through effective and efficient management of medical supplies and consumables	County Health Management Teams Community units	Lunga Lunga Msambweni Matuga Kinango	MoH County Health Department KEMSA NACC NASCOP Implementing partners
	Establish and strengthen effective community-to-facility referral and tracking of referral mechanisms	Community Units Primary health facility heads	Lunga Lunga Msambweni Matuga Kinango	MoH County Health Department KEMSA NACC NASCOP Implementing partners
Increased number of health facilities providing KEPH integrated HIV services	Strengthen health service delivery systems for integration of HIV services in the essential health package	Primary health facility heads, CHD	Lunga Lunga Msambweni Matuga Kinango	MoH County Health Department KEMSA NACC NASCOP Implementing partners
Improved community health workforce for the County HIV response	Formalize engagement of community health workers including recruitment, orientation, training, supervision and reporting	County Health Management Teams	Lunga Lunga Msambweni Matuga Kinango	MoH County Health Department KEMSA NACC NASCOP Implementing partners

4.5 Strategic Direction 5: Strengthening Research, Innovation and Information Management

4.5.1 Context

There is increased need for new evidences and information to guide programming in both national and county levels. However, efficient translation of strong health research findings into policies and practices remains a challenge in Kenya. Gaps in understanding drivers of the epidemic by population and geography still exit. Data and research on social determinants of health and their impacts on incidence and mortality are scanty. Timely generation and translation of data and evidence is important in informing decision making and programming. Absence of a research agenda, lack of qualified research personnel with the requisite epidemiological and statistical skills and equipment for development of quality research proposals and protocols, field data and specimen collection and processing continue to be key impediments in HIV response in Kwale County.

Program Gaps:

- Inadequate data on barriers to access services for KPs.
- Inadequate information on the progress of OST and NSP interventions for PWIDs.
- Inadequate data on determinants of linkage to care by populations and geography.
- Inadequate information on barriers to access to ART by paediatrics and adolescents.
- Limited data on effective models for increasing adherence to treatment in Kwale County.

4.5.2: SD 5 implementation matrix

Table 4.5: Interventions for providing a mechanism for effective knowledge generation, information sharing and management that will inform the County HIV response

KASF Objective: To provide a mechanism for effective knowledge generation, information sharing and management that will inform the County HIV response				
KCASP Result	**Key Action**	**Target Population**	**Geographical areas by sub-county**	**Responsibility**
Increase capacity for conducting quality HIV-related research	Research capacity building through training and recruitment	County government Iinternal implementers and partners	Lunga Lunga Msambweni Matuga Kinango	County Health Department Universities and colleges Private institutions NACC NASCOP Implementing partners

Promote/ Conduct targeted implementation research in priority areas	Identify and prioritize research themes and areas	County Government Iinternal implementers and partners	Lunga Lunga Msambweni Matuga Kinango	County Government NCPWD NACC NASCOP, MoH
Increase funding and resources for HIV-relevant research and evidence generation	Develop the County HIV research financing strategy	County Government Internal implementers and partners	Lunga Lunga, Msambweni, Matuga, Kinango	County Health Department Networks and support groups NACC NASCOP Implementing partners
Increase capacity to monitor and regulate research in the county	Establish research approval procedures and structures in the county	County Government	Lunga Lunga Msambweni Matuga Kinango	County Health Departmment, Universities and colleges, Youth Dept., NACC NACADA NASCOP Implementing partners
Strengthen usage of research findings and evidence in service delivery	Increase evidence-based programming/ interventions	County Government Internal implementers and partners	Lunga Lunga Msambweni Matuga Kinango	County Health Department Networks and support groups NACC NASCOP Partners
Increase capacity for data demand and information use in HIV-related programming	Strengthen County health data analysis and management capacity	County Government Internal implementers and partners	Lunga Lunga Msambweni Matuga Kinango	County Health Department Universities and colleges Youth Dept. UNODC NACC NACADA NASCOP Internal implementers Implementing partners

Increase production of knowledge products and information	Establish a multi-sectoral and interactive web based County HIV research hub / platforms	County Government Iinternal implementers and partners	Lunga Lunga Msambweni Matuga Kinango	County Health Department Networks and support groups , NACC NASCOP Implementing partners
	Develop and disseminate regular review of papers on key research findings and local innovations	County Government Iinternal implementers and partners	Lunga Lunga Msambweni Matuga Kinango	County Health Department Networks and support groups, NACC NASCOP Implementing partners

4.6 Strategic Direction 6: Promote Utilisation of Strategic Information for Research and Monitoring & Evaluation to Enhance Programming

4.6.1Context

A functional, integrated monitoring and evaluation system for HIV is vital for effective evidence-informed decision making at national and county levels. The Constitution demands for transparency, accountability, participation of people in order to assure good governance and stewardship of the HIV response. Over the past decade, the country has relied on quality national surveys (KAIS and KDHS); facility based HIV sero-prevalence surveys as well as bio-behavioral surveys to provide trends in HIV prevalence and incidence as well as HIV-related risk behaviors. Majority of these data sources are supported and maintained by various stakeholders. Both routine and non-routine M&E subsystems are in place with reasonable infrastructure and personnel. The Kenya AIDS Strategic Framework has a detailed M&E framework in place to guide and inform M&E activities. KCASP 2016-20219 seeks to strengthen all data and M&E systems in the County.

Program Gaps:

- Lack of County HIV information hub.
- Inadequate data use for decision making in the County.
- Parallel data collection and reporting systems are not interoperable.
- Inadequate data quality in terms of timeliness and completeness.
- Overdependence on external funding for M&E activities at county level.

4.6.3: SD 6 implementation matrix

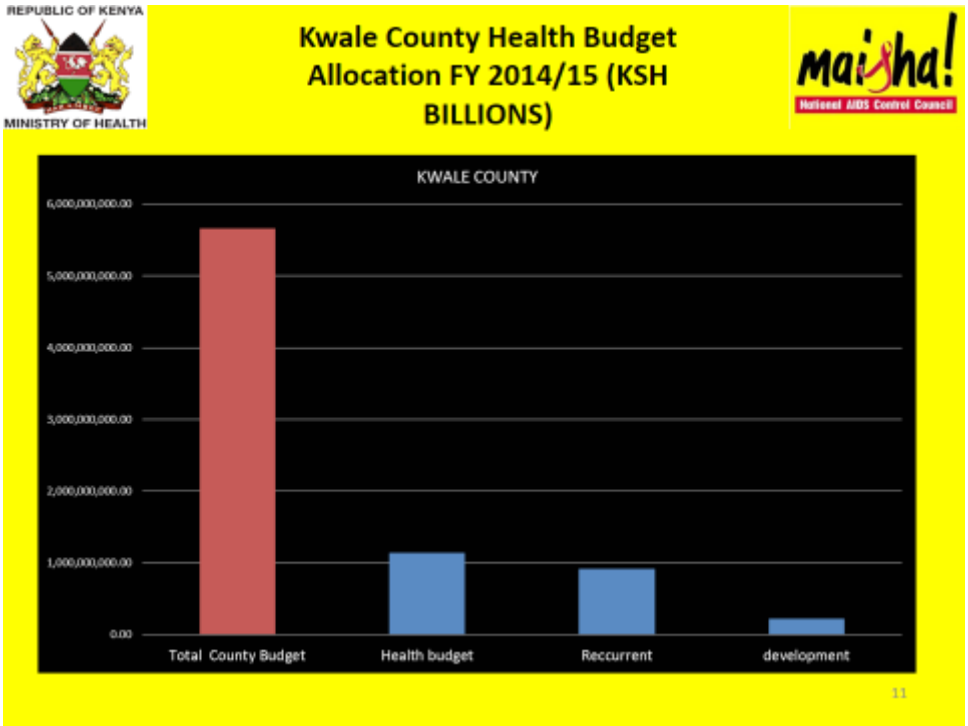
Table 5.6: Interventions to facilitate the tracking of progress towards the KASF results and generation of strategic information to inform decision makingKASF Objective: To facilitate the tracking of progress towards the KASF results and generation of strategic information to inform decision making				
KCASP Result	**Key Action**	**Target Population**	**Geographical areas by sub-county**	**Responsibility**
Established HIV information hub at the county level	Establish an integrated real time HIV platform to provide update data on HIV epidemic in the County.	County Health Department	Lunga Lunga Msambweni Matuga Kinango	County Health Department NACC NASCOP Implementing partners
Improved data use for decision making	Strengthening M& E capacity to effectively monitor the KASF/KCASP performance and HIV epidemic at all levels	County Health Department Implementers	Lunga Lunga Msambweni Matuga Kinango	County Health Department NACC NASCOP Implementing partners
Increased availability of quality and timely strategic information to inform HIV response at county level	Ensure harmonized, timely and comprehensive routine monitoring systems to provide quality HIV data as per national, county and sector priority information needs	CHWs County Health Management	Lunga Lunga Msambweni Matuga Kinango	County Health Department NACC NASCOP Implementing partners
Planned evaluations, reviews, surveys and implementation science on HIV response for general and KPs implemented and results disseminated in a timely manner	Strengthen county M&E capacity to effectively track KCASP performance and HIV dynamics at county and decentralized levels	HCWs County Health Management Teams	Lunga Lunga Msambweni Matuga Kinango	County Health Department NACC NASCOP Implemneting partners

4.7Strategic Direction 7: Increasing Domestic Financing for a Sustainable HIV Response

4.7.1 Context

The Health Sector is disproportionately underfunded across all counties in Kenya. HIV and AIDS, being a sub-sector in health, is highly affected. In 2015, Kwale County allocated approximately KES1.6 billion to the health sector - an allocation considerably low owing to the massive needs of the sector. HIV and AIDS is a health function and therefore the allocation catered for the biomedical aspect of the epidemic. Allocation to structural and behavioural interventions such as stigma reduction was minimal or lacking. We need to get approximates to use in this section on how much was used on HIV and AIDS activities by county.

Table 4.7: Kwale County health budget allocation



4.7.2: SD 7 implementation matrix

Table 4.8: Interventions for increasing domestic financing for a sustainable HIV response

KASF Objective: To increase domestic financing for sustainable HIV response				
Structural Interventions				
KCASP Result	**Key Action**	**Target Population**	**Geographic areas by sub- county**	**Responsibility**
15% of the County health budget allocated to the HIV programmes annually	Develop and implement a county HIV response funding advocacy strategy	County Government	Lunga Lunga Msambweni Matuga Kinango	County Health Department NACC NASCOP Implementing partners
Involvement and inclusion of private sector in the HIV response	Establish and operationalize a county HIV response Public-Private Partnerships	County Government	Lunga Lunga Msambweni Matuga Kinango	County Health Department NACC NASCOP Implementing partners
	County private partners to formulate and implement workplace HIV policies and programmes	County Government Workplaces and professional associations	Lunga Lunga Msambweni Matuga Kinango	County Health Department NACC NASCOP Partners FKE KEPSA
Efficient utilization of HIV programme resources	Develop systems to track the HIV County investment	County Government	Lunga Lunga Msambweni Matuga Kinango	County Health Department NACC NASCOP Partners
	Integrate HIV programmes into other health programmes including TB, malaria, non-communicable diseases	County Government	Lunga Lunga Msambweni Matuga Kinango	County Health Department NACC NASCOP Partners

4.8 Strategic Direction 8: Promoting Accountable Leadership for Delivery of the Kwale County Strategic Plan Results by all Sectors and Actors

4.8.1 Context

The Constitution of Kenya 2010 guarantees every Kenyan the right to highest attainable standard of health. Health is a devolved function and therefore all counties are obligated to ensure all residents access quality health care services. The Constitution has provided for new legal and policy environment upon which all functions shall be implemented. Articles 10(2) and 73 outline key defining elements of good governance and leadership while Article 21 (3) bestows on all State organs and all public officers the duty to address the needs of vulnerable groups within society. Kwale County Government continues to put into place responsive regulatory and service delivery policies and guidelines for ensuring efficient and effective delivery of quality health care. This applies to the HIV and AIDs sub-sector. Delivery of quality HIV and AIDS care, prevention and mitigation of social economic impacts of the epidemic is provided for in Kwale County development policies including in the **KCASP and** Kwale County Health Investment Plan. Responding to HIV and AIDS will continue being a part of the county planning and budgeting process. The County Government will continue promoting responsive leadership, ensure mainstreaming of HIV and AIDS across all sectors through a multi- sectoral approach, involvement of PLHIV, civil society and other key stakeholders. The existing community, religious, social and cultural structures will provide leverage in the leadership on HIV programmes. In the context of shrinking the HIV and AIDS resource basket, Kwale County Government will strength accountability within all systems and units responding to HIV and AIDs and also encourage Public Private Partnerships (PPP) investments on the entire health sector.

Program Gaps:

- Leadership gaps in ensuring effective delivery and quality of care.
- Gaps in implementation and adherence to County HIV coordination structures.
- Weak mechanisms to leverage on existing County strengths, especially in public and private sectors.
- Weak coordination and supervision of partners, implementers and other stakeholders.
- Inadequate political will to drive the HIV agenda in the County Assembly.
- Inadequate will to allocate adequate resources for HIV programmes.

Table 4.9: Interventions to promote accountable leadership for the delivery of the KCASP Results

KASF Objective: Promoting accountable leadership for the delivery of the Kwale County Strategic Plan results by all sectors and actors				
Structural Interventions				
KCASP Result	**Key Action**	**Target Population**	**Geographical areas by sub-county**	**Responsibility**
Effective leadership mechanisms that ensure quality service delivery	Institute and adhere to responsive results measurement mechanisms, supervision and controls to ensure efficient and effective quality service delivery	County Assembly, County Health Executive	Lunga Lunga Msambweni Matuga Kinango	County Health Department NASCOP NACC
County HIV multi-sectoral coordination structure established	Establish and strengthen functional and competent HIV coordination mechanism	County Assembly, County Health Executive	Lunga Lunga Msambweni Matuga Kinango	County Health Department NASCOP NACC

4.8.4 Leveraging other sectors for a sustainable HIV response in Kwale County

Kwale County boasts many sectoral advantages that could aid HIV response. These include tourism, mining, transport, hotel and cultural sectors. The County leadership is committed to tapping on these and other sectoral advantages in addressing the HIV and AIDS epidemic. Under the principle of multi-sectorality, the KCASP will create mechanisms of leveraging on these sectors, especially in bridging the resource gap. All formal and informal workplaces will be encouraged to develop and implement workplace HIV and AIDS policies and programmes to prevent the spread of HIV and mitigate its impact on the world of work as per ILO/ FKE/COTU and Ministry of Labour code of practice.

4.8.4.1 Leveraging key sectors

Table 4.10: Recommended sectoral functions for each County entity/sector for the delivery of KCASP results

County entity/ sector	Recommended sectoral function	Responsibility
County executives	Establishment of a robust Kwale County HIV and AIDS workplace policy. County sectoral and Departmental HIV advocacy by including targeted HIV messages in all the County employee payslips.	County Secretary

Members of County Assembly	Resource allocation across HIV intervention spectrum. Provision of a conducive legislative environment for HIV programming for all populations Provision of oversight role for executive on progress and status of HIV and health interventions	Chair of Health Committee TCounty Assembly
Transport (public and private)	Develop and implement workplace HIV and AIDS policies and programmes.	County transport Department National Transport and Safety Agency (NTSA)
Tourism and hotels	Develop and implement workplace HIV and AIDS policies and programmes.	CEC - Tourism
Private sector associations	Develop and implement workplace HIV and AIDS policies and programmes.	CEC - Trade, FKE, KEPSA
Education	Impact knowledge on HIV , STIs and reproductive health among teachers and students. Address stigma reduction in schools. Improve access to accurate information on sexuality through introduction of age appropriate comprehensive sexuality education in the school curriculum.	CEC - Education, MoEST, TSC, Teachers Unions
Religious organisations and the faith sector	Leveraging on strong religious and community leadership structures by recommending appropriate messages on HIV prevention, care and treatment	Inte-faith TWG
Civil Society Organizations and other Implementing Partners	Scaling up HIV combination prevention, care and treatment for general, vulnerable and key populations.	Implementing partners

Chapter 5

Implementation Arrangements

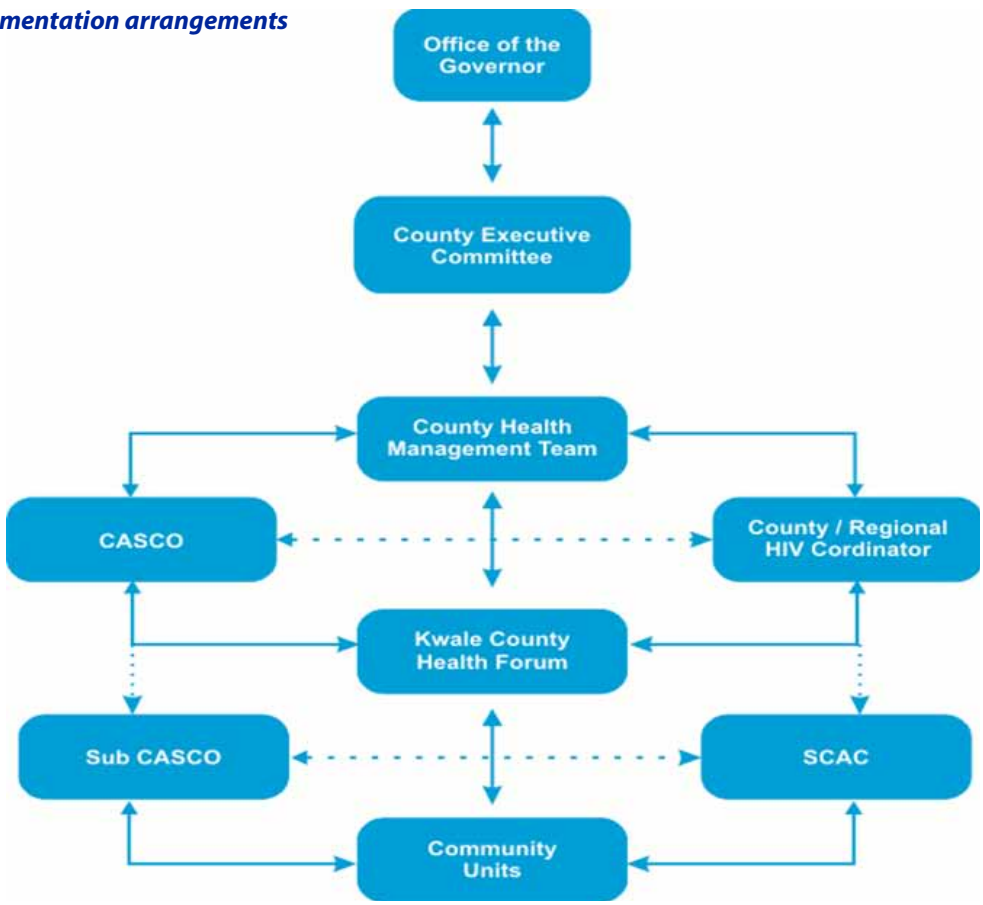
The achievement of set targets under KCASP requires a committed leadership at all levels. The Office of the Governor and the County Executive will provide overall political and administrative leadership to provide a conducive environment for HIV programming. Technical leadership and management will be provided by the Health Department Office. The national Government will be incorporated in and aligned to the Kwale County HIV response through offices of County and Sub-County AIDs and STI Coordinators (CASCOs) while HIV Community, sectoral and mainstreaming functions shall be vested to the NACC County focal persons at county and sub-county levels. County and sub-county health teams will be required to oversee and report on the implementation of all health strategies including KCASP in their respective areas. The established County HIV and AIDS Committee (CHC) will advise CHMT on progress of KCASP implementation and also act as technical arm of CHMT.

In order to attain the set objectives and targets, responsive coordination mechanisms and structures are necessary. KCASP has clearly defined the county and sub-county structures that will work together, in a system model, to deliver on the Plan. They are as follows:

1. **Office of the Governor:** This is the supreme office in the County. Headed by the Kwale County Governor, this office will be responsible for provision of high level leadership, promotion of engagement with National Government, inter-county or bilateral or even multi-lateral negotiations and relationship in HIV matters. The Office will be responsible for the overall KCASP results.
2. **County Executive Committee**: Made up of the entire County Executive Officers and other Senior County officers. The office will provide a crucial link for HIV programmes with the Executive arm of the Government and the Governor's office. The County Executive Officer in charge of HIV or Health matters will be focal person. Further, this Office will be a liaison point between HIV programmes with other arms of the County Government such as the County Assembly, County Service Board and linkages with private and public entities, among others.

3. **County Health Management Team (CHMT**): Oversee direct implementation of HIV and Health programmes. This Office consists of among other health Officials, the Health CEC, Chief Officer of Health and County Health Director. The team backstops all HIV activities in the County.
4. **County HIV and AIDS Committee (CHC):** Advises, CHMT and County Executive on HIV matters. The unit advocates for HIV and AIDS issues and has strong representation of persons living with HIV. The CHC reflects a multi-sectoral coordination in Kwale County.
5. **County AIDS/STI Coordinating Office (CASCO-NASCOP):** In charge of HIV health/ facility-based interventions.
6. **County/regional HIV Coordinating Office-C/RHC (NACC):** Coordinate Community and sectoral-based intervention (structural and behavioural interventions) mainstreaming and foster demand creation for the health services.
7. **Sub-county AIDS/STI Coordinating Unit (SUB-CASCO**) - In charge of HIV health/facility-based interventions at sub-county level.
8. **Sub-County AIDS Community (SCAC):, sectorial and mainstreaming coordinating unit** Coordinate Community and sectorial-based intervention (structural and behavioural interventions) mainstreaming and foster demand creation for the health services at sub-county level.
9. **Community Units:** This ensures smooth coordination of activities and results delivery at community level. Headed by a CHEW in line with the County Community Strategy.

Figure 5.1: Implementation arrangements



Chapter 6

Research, Monitoring and Evaluation/Reporting Framework

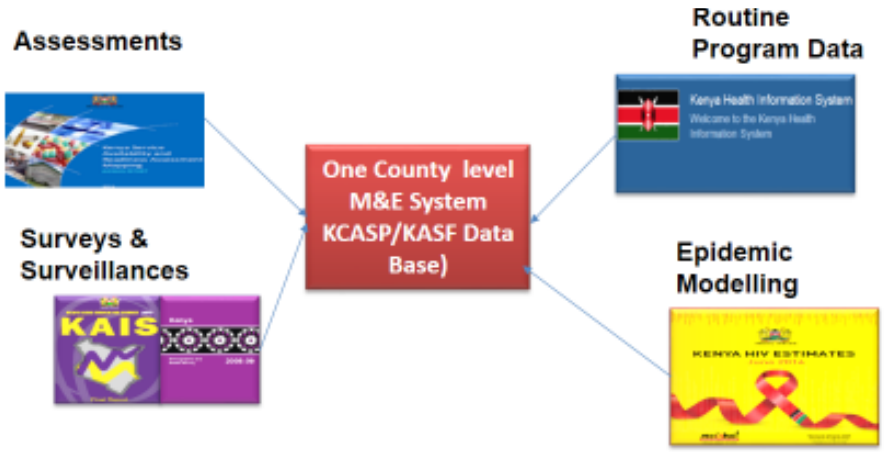
Kwale County Government will strive to establish and strengthen one County health data architecture to manage health/HIV-related information as stipulated by KCASP 2016/2019 and also KASF. One County HIV database will ensure that information is generated, managed and shared in a coordinated manner. The database will capture data on the core indicators outline in the KCASP and KASF M&E framework; from routine programmatic data generated from all sectors - health, community, private and public. The database will also be made interoperable with the relevant national M&E data sub-systems to enable it to gather and filter non-routine data from evaluations, surveys and surveillances (KDHS, KAIS and KSPA among others). The Department of Health will backstop the entire County HIV and Health data systems - through the County Health and Record and Information system (CHRIS). Kwale County will invest in resources and technology to bridge the existing gaps in terms of personnel, equipment, technology and finances as far as Health and HIV M&E and data system and sub-systems are concerned.

The following are some of the identified data sub-systems that will be unified and made interoperable to serve as the Kwale County M&E System:-

County Health Management Information System (HMIS) Managed by Department Health and MoH

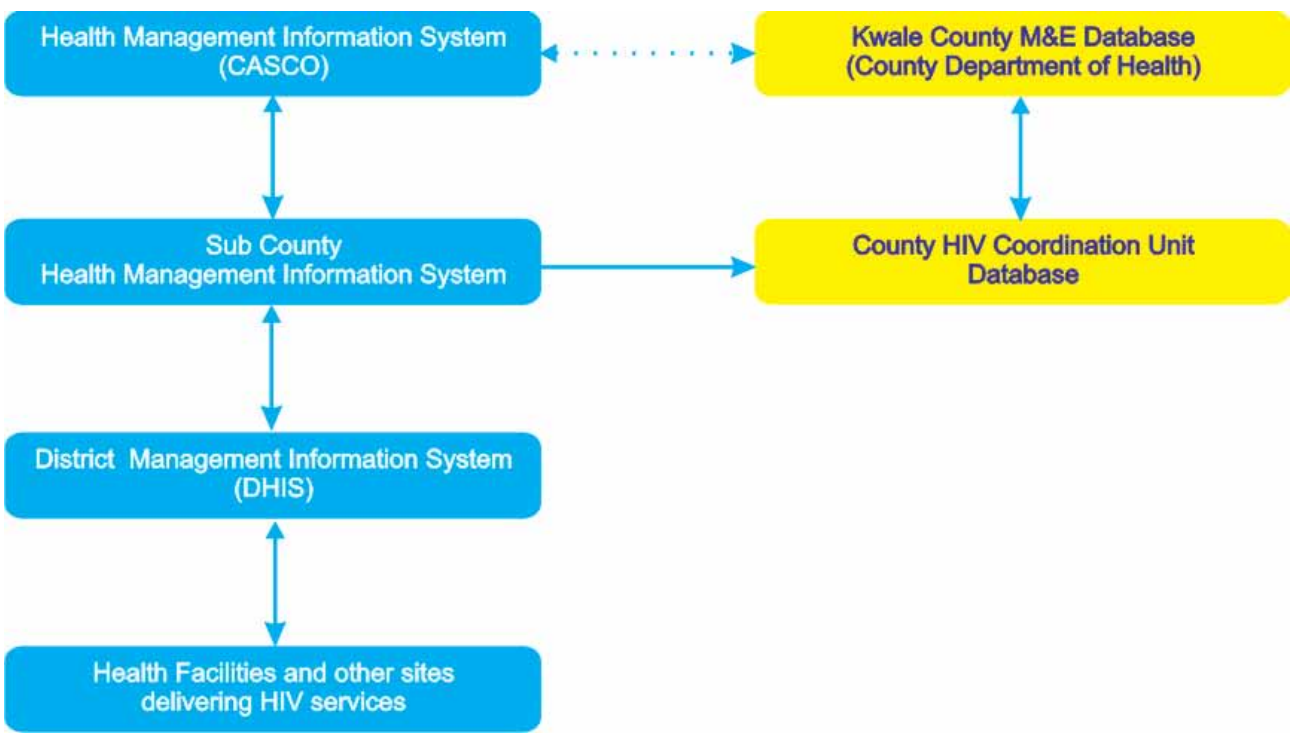
All health facilities will be strengthened and supported to ensure regular quality data submission to the DHIS. The Sub-County Health Data will be aggregated into County Data - CHMIS, which will then be reported to the national HMIS managed by MoH. All KCASP/KASF health facility based and biomedical indicators from facility and community level will be tracked through this system.

Figure 6.1: Kwale County HIV M&E structure



County Logistics Management and Information System (LMIS) - Managed by CDH and KEMSA LMIS tracks supply of pharmaceuticals and other health commodities to the health facilities. The system is managed by KEMSA. Kwale County will work closely with KEMSA to ensure that the data from LMIS is filtered and used at county level. This will strengthen commodity and resource accountability, forecasting and mitigating on stock-outs as stipulated in the KCASP 2016/19.

Figure 6.2: Data and information flow under HMIS

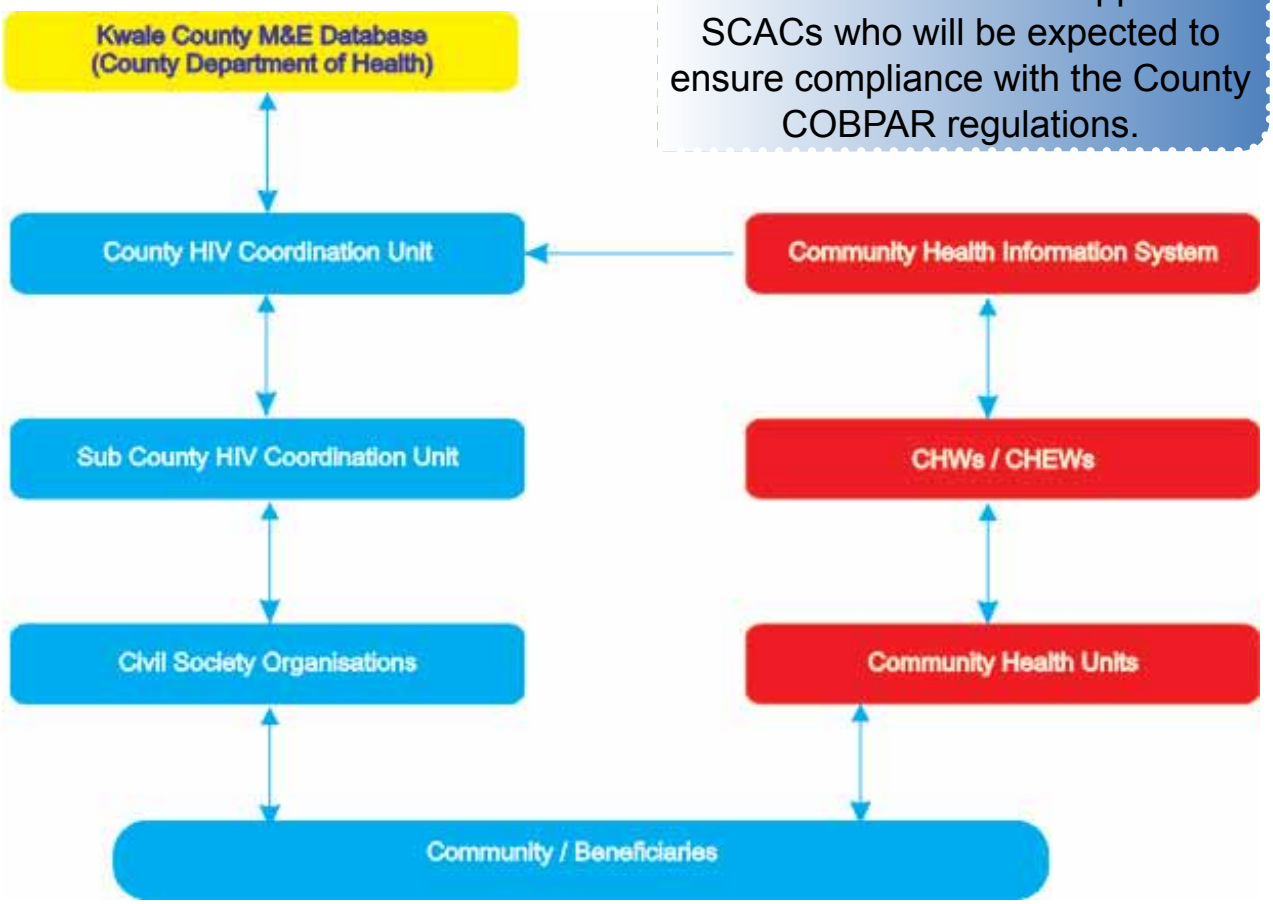


County Community-Based Activity Reporting system (COBPAR) - currently managed by NACC at national level.

COBPAR system will be strengthened and converted into a county system to track, especially the important, non-health facility data indicators generated by CSOs, CBOs, FBOs, and private and public sectors implementers at community and grassroots level. The COBPAR tool will be revised to ensure that there will be no duplication between the indicators tracked in other sub-systems. Kwale County Government will liaise with NACC to ensure a continued support for SCACs. SCACs are expected to continue taking responsibility and ensuring compliance with set COBPAR reporting regulation maintenance of inventory community implementers, among other roles.

COBPAR will be co nverted into a county system. Kwale County Government will liaise with NACC to ensure a continued support for SCACs who will be expected to ensure compliance with the County COBPAR regulations.

Figure 6.3: Data and information flow for community-based HIV response



Public Sector HIV Response (online) Reporting system - to be managed by CDH and NACC (Regional/County Office)

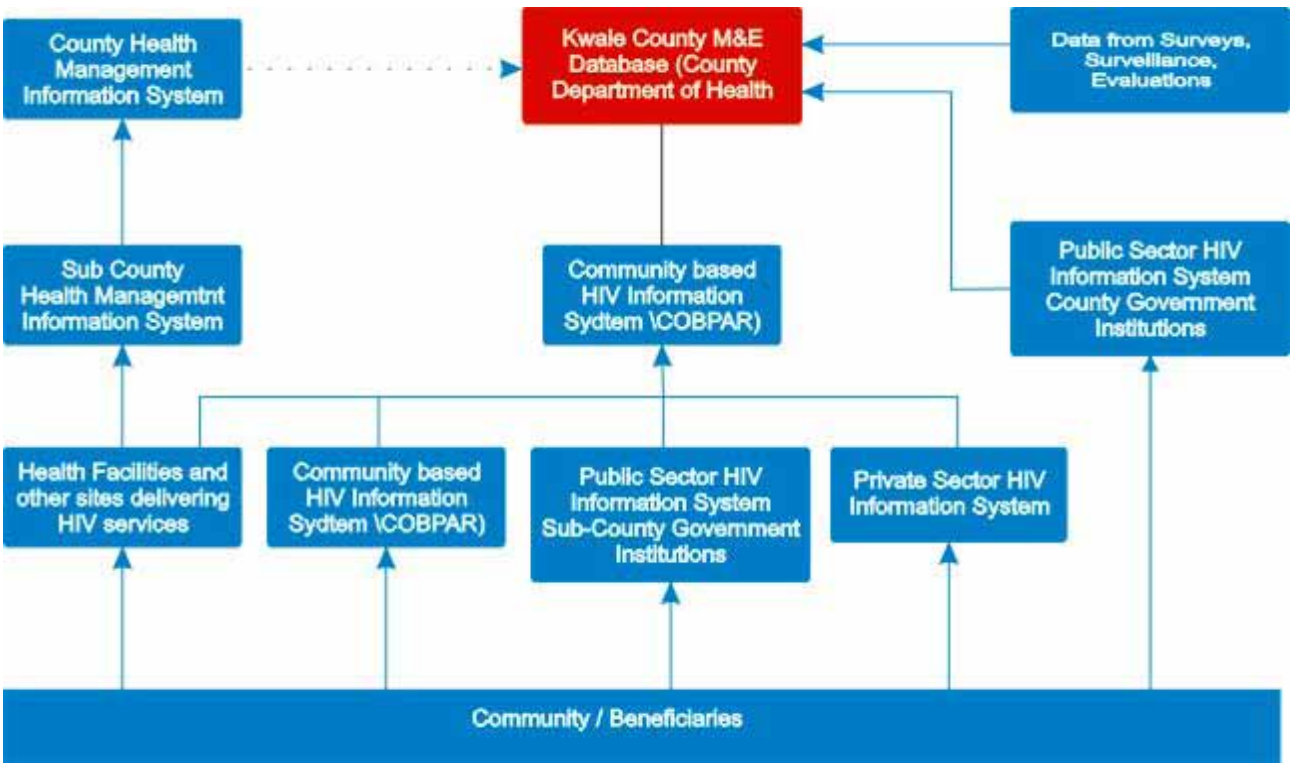
The entire public sector in Kwale County (both county and national government-based)- government ministries, departments and agencies, will be required to report or give information and data through the Public Sector Reporting System Departments within County Government will be expected to comply

with the County Performance Contracting System that will incorporate HIV delivery - an indicator of performance.

Private Sector HIV Response system - to be managed by CDH and NACC (Regional/County Office)

All private sector implementers, both formal and informal will report on HIV and AIDS-specific indicators through the Private Sector Reporting System. This will include small-scale and micro enterprises undertaking HIV and AIDS activities and also medium and large-scale and manufacturing firms. The latter (medium and large scale firms) will be expected to have HIV and AIDS workplace policies and programmes which will effectively mainstream HIV in their daily operations.

Figure 6.4: Kwale County unified HIV response management system



Chapter 7

Risk Assessment and Mitigation Plan

An assumption has been made that implementation of KCASP 2016-2019 will proceed without hitches. However, anticipated risks will be assessed and mitigated in a systematic continuous manner as proposed in the risk matrix below. The County HIV Committee (CHC) will be will be expected to report to the County Department of Health, NACC, NASCOP and the other partners on the status of the identified risks, effects and the necessary mitigation.

Table 7.1: Risks and mitigation

Risk Category	Risks	Status	Mitigation	Responsibility	When
Social-cultural	Impinging programming HIV environment for PLHIV, KPs and other vulnerable groups due to high society/ culture/religious stigma and intolerance	High	Enhanced community education and continuous engagement of community and religious leaders using the NACC nterfaith Comittee and other committees	County Government NACC National Government Partners	Continuous
Systems	Weak systems to address commodity stock-out and guarantee inter- and intra-county redistribution.	Medium	Work with KEMSA, NASCOP, NACC and County Health to strengthen HIV/ Health commodity forecasting, supply and distribution to avert stock-outs.	KEMSA County Government, MoH NASCOP NACC	Y1
	Weak service delivery supervision systems to guarantee quality, efficiency and effectiveness.	Medium	Strengthened routine, non-routine and ad hoc supervision to all service delivery facilities.	County Health Department NASCOP MoH	Continuous

	Weak, uncoordinated and irregularly updated M&E and data systems that lead to poor quality or lack of data/strategic information.	High	Strengthen data andM&E systems.	County Health Department MoH, NACC NASCOP	Continuous
Human resource and staffing	Inadequate staffing at all cadres of HIV/Health service delivery	Medium	Undertake staffing assessment and initiate the process of ensuring minimum staffing at all cadres of health and HIV service delivery.	County Health MoH NASCOP NACC Partners	Y1

Financial	Technical capacity to implement programmes such as New Prevention Technologies (NPT) MAT and NSP among others.	High	Initiate systematic capacity building programmes to CDH staff to implement and oversee technical programmes such as NPT, MAT, NSP among others	County Government MoH UNODC NACC NASCOP	Continuous
	Inadequate prudent utilization of available resources.	Medium	Initiate resource utilization transparency, accountability mechanisms and enforce corruption eradication processes	County Government National Government	Y1
	Low resources allocation to the HIV sub-sector, especially for key structural and behavioural interventions such as stigma reduction.	High	Lobby for increased resource allocation to support implementation of targets set under KCASP 2016-2019	County Government CCounty Assembly NACC, NASCOP CSOs	Y1
			Initiate local resource mobilization strategies through an elaborate PPP strategy, among others.	County Government, County Assembly NACC NASCOP Private sector CSOs	Y1

ANNEX 1

Results Framework

Strategic Direction 1 Implementation Matrix: Reducing New HIV Infections

KASF Objective: Reduce New HIV infections by 75%

Biomedical Interventions						
KCASP Result	**Key Action**	**Indicators**	**Baseline**	**MTT**	**ETT**	**Responsibility**
Increased uptake of HIV Testing Services to 90%	Develop and deliver innovative targeted and integrated HTS approaches.	Percentage of people accessing HIV testing services	40%	75%	90%	County Health Department MoH NACC NASCOP Implementing partners
Improved diagnosis and treatment of STIs	Increased access to quality and affordable STI diagnosis and treatment services.	Percentage of PLHIV with access to affordable STI services	TBP	TBP	TBP	County Health Department MoH NACC NASCOP Implementing partners
Increased access to PMTCT	Offer comprehensive eMTCT interventions integrated with MNCH services.	Percentage of policies and guidelines developed/ improved institutionalizing eMTCT in MNCH	30%	50%	70%	County Health Department MoH NACC NASCOP Implementing partners

Increased availability and access to harm reduction commodities and programmes	Scale up harm reduction interventions including NSP, MAT, consistent and correct condom use, lubricants provision of PrEP, PEP etc.	Percentage of KPs accessing harm reduction services	30%	60%	90%	County Health Department MoH NACC NASCOP Implementing partners UNODC

Behavioural Interventions						
KCASP Result	**Key Action**	**Indicators**	**Baseline**	**MTT**	**ETT**	**Responsibility**
Reduced risky behaviours and factors	Scale up access to comprehensive sexuality education including sexual health (HIV prevention education)	Percentage of adolescents and young people accessing SRH-HIV services and information	TBP	50%	70%	CHD CDCDCTM MoH NACC NASCOP Implementing Partners
	Design and implement peer education and outreach programmes					
	Implement Behaviour change communication programmes					
	Improve media communication to improve behaviour changed					
	Offer harm reductions services including risk reduction counselling, skill building and psychosocial support services	Percentage of KPs accessing harm reduction services and information	30%	60%	90%	CHD CDCDCTM MoH NACC NASCOP Implementing Partners

Structural Interventions						
KCASP Result	**Key Action**	**Indicators**	**Baseline**	**MTT**	**ETT**	**Responsibility**
Increased access to PMTCT	Engage men in eMTCT programmes.	Percentage of men accessing HIV testing services in ANC, Maternity & PN department	10%	70%	90%	CHD CDCDCTM MoH NACC NASCOP Implementing partners
Increased uptake of HIV Testing Services to 90%	Establish and strengthen Integrated youth-friendly services.	Percentage of health facilities offering comprehensive YFS	TBP	40%	60%	CHD CDCDCTM MoH NACC NASCOP Implementing partners, UNICEF
Consistent supply and availability of male and female condoms	100% condom programming	Number of condoms distributed	250000	400,000	600000	CHD CDCDCTM MoH NACC NASCOP Implementing Partners
Reduced vulnerability for HIV infection	Establish income generating supplementation programmes					CHD NACC NASCOP Implementing partners

Strategic Direction 2 Implementation Matrix: Improving Health Outcomes and Wellness for all PLHIV

KASF Objective: Reduce AIDS mortality by 25%

Biomedical Interventions						
KCASP Result	**Key Action**	**Indicators**	**Baseline**	**MTT**	**ETT**	**Responsibility**
Increased linkage to care within 3 months of HIV diagnosis to 90%	Improve timely linkage to care for persons diagnosed with HIV.	Percentage of people diagnosed as HIV positive linked to care within 3 months	30%	70%	90%	CHD MoH NACC NASCOP Implementing partners
Increased sustained ART coverage to 90%	Increase coverage of care and treatment and reduce loss in the cascade of care.	Percentage of PLHIV initiated on ART	50%	70%	90%	CHD MoH NACC NASCOP Implementing partners
Behavioural Interventions						
Increased sustained ART coverage to 90%	Scale up education on ART, treatment literacy, adherence and retention.	Percentage of PLHIV initiated on ART and retained in care	50%	70%	90%	CHD CDCDCTM MoH NACC NASCOP Implementing partners
Structural Interventions						
Increased sustained ART coverage to 90%	Integrating community strategy to HIV treatment, care and support.	Percentage of PLHIV initiated on ART and retained in care	55%	70%	90%	CHD CDCDCTM MoH NACC NASCOP Implementing partners
Improved quality of care and health outcomes	Scale up interventions to improve quality of care including consistent capacity building of county health workers.	Percentage of PLHIV initiated on ART and retained in care	55%	70%	90%	CHD CDCDCTM MoH NACC NASCOP Implementing partners

Strategic Direction 3 Implementation Matrix: Using a Human Rights-based Approach to Facilitate Access to Services for PLHIV, KPs and other Priority Groups in all Sectors

KASF Objective: Reduce HIV and AIDS-related stigma and discrimination by 50%

Structural Interventions						
KCASP Result	**Key Action**	**Indicators**	**Baseline**	**MTT**	**ETT**	**Responsibility**
Reduced HIV and AIDS related stigma and discrimination by 50%	Implement PHDP programmes.	Percentage of PLHIV reached with PHDP programmes	20%	50%	70%	MoH CHD CDCDCTM MoH NACC NASCOP Implementing partners
	Sensitize County health workers on provision of population-friendly services.	Percentage of county health workers sensitized on population-friendly services	10%	40%	70%	CHD CDCDCTM MoH NACC NASCOP Implementing partners
	Design and implement stigma reduction programmEs.	Percentage of programmes addressing stigma and discrimination developed and institutionalised under the Ministry of Education	20%	40%	60%	CHD CDCDCTM MoH NACC NASCOP Implementing partners
Reduced levels of gender based violence, police harassment	Design and implement GBV education programmes.	Number of GBV population specific programmes developed and disseminated	1	4	10	CHD CDCDCTM MoH NACC NASCOP Implementing partners

	Integration and mainstreaming of gender responsive programmes.	Percentage of implementers integrating gender-responsive programmes	10%	40%	90%	CHD CDCDCTM MoH NACC NASCOP Implementing partners
	Strengthen referral and access to legal and health services for survivors of GBV.	Percentage of GBV survivors linked to care and legal aid	20%	60%	90%	CHD CDCDCTM MoH NACC NASCOP Implementing partners

Structural Interventions						
KCASP Result	**Key Action**	**Indicators**	**Baseline**	**MTT**	**ETT**	**Responsibility**
Reduced levels of gender-based violence, police harassment	Establish and strengthen GBV survivor sub-county centres	Number of established GBV survivor centres	1	3	5	CHD CDCDCTM MoH NACC NASCOP Implementing partners
	Educate law enforcement agencies on HIV and human rghts	Percentage of law enforcement agents sensitized on HIV interventions and HRBAP	TBP	TBP	TBP	CHD Kenya Police Service NACC NASCOP
Increased involvement and participation of KPs in decision making	Design and implement leadership development programs for KPs.	Percentage of KPs-led and driven programmes	25%	50%	70%	CHD CDCDCTM MoH NACC NASCOP Implementing partners
Strengthened engagement of PWDs in HIV programmes	Develop and implement population specific programmes leveraging on PWD networks.	Percentage of programmes that are PWD-friendly	35%	60%	80%	CHD CDCDCTM MoH NACC NASCOP Implementing partners

Strategic Direction 4 Implementation Matrix: Strengthening Integration of Community and Health Systems

KASF Objective: To build a strong and sustainable system for HIV service delivery

Structural Interventions						
KCASP Result	**Key Action**	**Indicators**	**Baseline**	**MTT**	**ETT**	**Responsibility**
Strengthened health service delivery and community systems	Streamline commodity management through effective and efficient management of medical supplies and consumables.	Percentage of health facilities experiencing commodity stock-out	40%	30%	5%	MoH CHD KEMSA NACC NASCOP Implementing partners
	Establish and strengthen community to facility referral and tracking of referral mechanisms.	Percentage of health facilities with appropriate community referral systems	45%	60%	90%	MoH County Health Department NACC NASCOP Implementing partners
Increased number of health facilities providing KEPH integrated HIV services	Strengthen health service delivery systems for the elivery of HIV services integrated in the essential health package.	Percentage of health care facilities with integrated healthcare services	60%	75%	90%	MoH County Health Department NACC NASCOP Implementing partners
Improved community health workforce for the county HIV response	Formalize engagement of community health workers including recruitment, orientation, training, supervision and reporting	Percentage of healthcare facilities with appropriate number of healthcare workers at all cadres	55%	65%	80%	MoH County Health Department NACC NASCOP Implementing partners

Strategic Direction 5 Implementation Matrix: Strengthening Research, Innovation and Information Management to Meet KASF Goals

KASF Objective: To provide a mechanism for effective knowledge generation, information sharing and management that will inform the County HIV response

KCASP Result	Key Action	Indicators	Baseline	MTT	ETT	Responsibility
Increase capacity for conducting quality HIV-related research	Research capacity building through training and recruitment	Number or percentage of county personnel including health workers trained on research methods	15%	45%	60%	County Health Dpartment Universities and colleges Private institutions NACC NASCOP Implementing partners
Promote/ Conduct targeted implementation research in priority areas	Identify and prioritize research themes and areas	Number or percentage of research themes based on KCASP conducted annually	TBP	45%	60%	County Government NCPWD NACC NASCOP MoH
Increase funding and resources for HIV-relevant research and evidence generation	Develop the County HIV research financing strategy	Proportion of HIV funds utilized on County research.	5%	10%	20%	County Health Department Networks and support groups NACC NASCOP Implementing partners
Increase capacity to monitor and regulate research in the County	Establish research approval procedures and structures in the County	Percentage of research topics/ themes approved by County Approval Authority	TBP	5	10	County Health Department Universities Colleges Youth Dept. NACC NACADA NASCOP Implementing partners

Strengthen usage of research findings and evidence in service delivery	Increase evidence-based programming/ interventions	Number or percentage of programmes/ interventions informed by the County's own research	-	30%	60%	County Health Networks and support groups NACC NASCOP Implementing partners
Increase capacity for data demand and information use in HIV-related programming	Strengthen data analysis and management capacity.	Number or percentage of programmes informed by the County-specific data	-	30%	60%	County Health Department Universities and colleges Youth Department UNODC NACC NACADA NASCOP Implementers Partners
Increase production of knowledge products and information	Establish a multi-sectoral and interactive web-based County HIV research hub /platform.	Number or percentage of researches available on the County research hub	-	5	10	County Health Networks and support groups NACC NASCOP Implementing partners
	Develop and disseminate regular review of papers on key research findings and local innovations	Number or percentage of county-based research papers/products disseminated in various forums		10	20	County Health Networks and support groups, NACC NASCOP Implementing partners

Strategic Direction 6 Implementation Matrix: Promote Utilization of Strategic Information for Research and Monitoring & Evaluation to Enhance Programming

KASF Objective: To facilitate the tracking of progress towards the KASF results and generation of strategic information to inform decision making

KCASP Result	Key Action	Indicators	Baseline	MTT	ETT	Responsibility
Established HIV information hub at the county level	Establish a multi-sectoral and integrated real time HIV platform to provide update on HIV epidemic response accountability.	Percentage of planned M&E products generated at county/sub-county levels	TBP	50%	100%	CHD NACC NASCOP Partners
Improved data use for decision making	Strengthening M&E capacity to effectively monitor the KASF/ KCASP performance and HIV epidemic at all levels.	Percentage of M&E performance reports generated by the system	TBP	5	>10	CHD NACC NASCOP Partners
Increased availability of quality and timely strategic information to inform HIV response at county level	Ensure harmonized, timely and comprehensive routine monitoring systems to provide quality HIV data as per national, county and sector priority information needs.	Percentage of planned M&E products generated and disseminated at county/sub-county levels	1	5	>10	CHD NACC NASCOP Partners
Planned evaluations, reviews, surveys and implementation science on HIV response for general and key populations implemented and results disseminated in a timely manner	Strengthen County M&E capacity to effectively track KCASP performance and HIV dynamics at county and decentralized levels.	Percentage or number of evaluations undertaken based on KCASP	TBP	1	2	CHD NACC NASCOP Partners

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

KASF Objective: To increase domestic financing by 50%

Structural Interventions						
KCASP Result	**Key Action**	**Indicators**	**Baseline**	**MTT**	**ETT**	**Responsibility**
15% of the County health budget allocated to the HIV programmes annually	Develop and implement a county HIV response funding advocacy strategy.	Proportion of county health budget allocated to HIV sub-sector including structural and behavioural interventions	5%	30%	50%	County Health Department NACC NASCOP Partners
Involvement and inclusion of the private sector in the HIV response	Establish and operationalize county HIV response Public Private Partnerships	Proportion of HIV funding coming from the public and private sectors	30%	45%	60%	County Health Department NACC NASCOP Partners
	County private partners to formulate and implement workplace HIV policies and programmes.	Proportion of county sectors that have developed and implemented HIV work place policies	10%	40%	70%	CHD NACC NASCOP Partners FKE KEPSA
Efficient utilization of HIV program resources	Develop systems to track the HIV county investmen.t	Total county funds invested on HIV from various sources	TBP	20%	40%	CHD NACC NASCOP Partners
	Integrate HIV programs into other health programs including TB, malaria, non-communicable diseases.	Percentage of health and non-heath programs integrating HIV and AIDS in the county	60%	75%	100%	CHD, NACC NASCOP Partners NTLP

Strategic Direction 8 Implementation Matrix: Promote Accountable Leadership for Service Delivery of KCASP Results by all Sectors and Actors

KASF Objective: Promoting accountable leadership for delivery of the Kwale County Strategic Plan results by all sectors and actors

Structural Interventions						
KCASP Result	**Key Action**	**Indicators**	**Baseline**	**MTT**	**ETT**	**Responsibility**
Effective leadership mechanisms that ensure quality service delivery	Institute and adhere to responsive results measurement mechanisms, supervision and controls to ensure efficient and effective quality service delivery.	Proportion of HIV-related indicators included and rated within the county performance contracting system.	TBP	TBP	TBP	CHD NASCOP NACC
County HIV multi-sectoral coordination structure established	Establish and strengthen functional and competent HIV coordination mechanism.	Number of HIV coordination meetings held and documented at county/sub-county and community levels annually	TBP	TBP	TBP	CHD NASCOP NACC

ANNEX 2

KCASP 2016-2019 Costing Framework

STRATEGIC DIRECTION 1- REDUCTION OF NEW INFECTIONS							
Recommended Actions	**Target Population**	**Targets Numbers**	**Cost per Person**	**Year (2)**	**Total cost**	**By when**	**Responsibility**
Innovative HIV testing and counselling (HTC) models	All populations	300,000	1,200	3	1,080,000,000	2019	County Health Department NASCOP NACC Partners
Establish youth-friendly HTC services	Youth/ adolescents	120,000	1,500	3	540,000,000	2019	County Health Department MoE NACC NASCOP Partners
Initiate community stigma reduction strategies in order to create service demand for HTC	All populations	300,000	50	3	45,000,000	2019	County Health Department NASCOP NACC Partners
Offer HTC to partners and families of all HIV-positive clients	PLHIVs	20,000	1,500	3	90,000,000	2019	County Health Department NASCOP NACC Partners
Regular outreach and contact with KPs through peer based education, treatment and support	KPs	5,000	2,000	3	30,000,000	2019	County Health Department NASCOP NACC Partners

Offer harm reduction interventions to PWIDS and PWUDs	KPs	1,000	10,000	3	30,000,000	2019	County Health Department NASCOP NACC Partners
100% proper condom promotion among sexual active groups	KPs	5,000	1,000	3	15,000,000	2019	County Health Department NASCOP NACC Partners
Sub total					**1,830,000,000**		

STRATEGIC DIRECTION 2: IMPROVING HEALTH OUTCOMES OF PEOPLE LIVING WITH HIV AND AIDS							
Recommended Actions	**Target Population**	**Targets Numbers**	**Cost per unit**	**Year (2)**	**Total Cost**	**By when**	**Responsibility**
Improve timely linkage to care for persons diagnosed with HIV	PLHIVs	600	10,000	3	18,000,000	2019	CHD NASCOP MoH
Strengthen facility and community linkages with inter- and intra- facility referral protocols and linkage strategies	HCW	500	20,000	3	30,000,000	2019	CHD NASCOP MoH
Integrate HIV testing, care and treatment services into maternal, neonatal and child health settings and services	Health facilities	10,000	2,500	3	75,000,000	2019	CHD NASCOP MoH Partners
Utilize peer support and networks of all and adolescents living with HIV	Youth/adolescents	60,000	2,500	3	450,000,000	2019	CHD NACC NASCOP MOH, Partners Youth support groups

Integrate alcohol and drug dependence reduction strategies in care services	PWUDS and health facilities	5,000	10,000	3	150,000,000	2018	CHD NASCOP MOH Partners
Scale up KP-friendly HIV care and treatment services with peer mobilization and support	KPs and health facilities	5,000	10,000	3	150,000,000	2019	CHD NACC NASCOP MoH Partners KP support groups
Purchase and installation of CD4 machine - Pima machine and of viral load machine	Health facilities	3	1,000,000	1	3,000,000	2019	CHD NASCOP MOH Partners
Sub total					**876,000,000**		

STRATEGIC DIRECTION 3: USING HUMAN RIGHTS BASED APPROACH TO FACILITATE ACCESS TO SERVICES							
Recommended Actions	**Target Population**	**Targets (Numbers)**	**Cost per unit**	**Year (s)**	**Total Cost**	**By when**	**Responsibility**
Remove barriers to access of HIV, SRH and rights information and services to all populations	General population, KPsA-dolescents, Children	300,000	50	3	45,000,000	2019	County Health NASCOP NACC Social Services
Reduce levels of sexual and gender-based violence for PLWH, KPs, women, men, boys and girls	Indicated populations	5000	50	3	750,000	2019	Law enforcement NACC NASCOP-TSU Human Rights Organizations
Promote uptake of HIV pre and post-exposure prophylaxis among survivors of sexual violence and priority population	Indicated populations	5000	10,000	3	150,000,000	2019	CHD, NASCOP MOH Partners

Leverage on religious and cultural institutions to address HIV-related stigma among PLHIV and violence among KPs	Religious and faith communities	5000	1,000	3	15,000,000	2019	CHD SUPKEM CIPK KENERELA NCCK NACC NASCOP Partners
Develop and disseminate population specific and user-friendly information including Braille	PWDs, PLHIVs	4000	2,000	3	24,000,000	2019	SUPKEM CIPK KENERELA NCCK NACC NASCOP Partners
Develop policies to protect priority populations when accessing HIV and health services	PWDs, vulnerable and marginalized populations	5000	2,500	3	37,500,000	2019	CHD NACC NASCOP MOH Partners NCPWD
Monitoring stigma and discrimination among health workers	Health facilities	1,000	100,000	3	300,000,000	2019	CHD NASCOP NACC Social Services
Initiating health setting stigma reduction campaigns	Health facilities	20	100,000	3	6,000,000	2019	Law enforcement NACC NASCOP-TSU Human Rights Organizations
Increased protection of human rights and access to justice for PLHIV, KPs, women, boys and girls	Indicated populations	5000	2,000	3	30,000,000	2019	Law enforcement County Government, TSU, SUPKEM CIPK, KENERELA NCCK NACC NASCOP Implementing partners Human Rights Organizations

Improving access to legal and social justice and protection from stigma and discrimination in the public and private sectors	All populations	300,000	100	3	90,000,000	2019	Law enforce-mentagencies County Government TSU SUPKEM CIPK KENERELA NCCK NACC NASCOP Partners Human Rights Organizations
Sub Total					**698,250,000**		

STRATEGIC DIRECTION 4: STRENGTHENING INTEGRATION OF COMMUNITY AND HEALTH SYSTEMS							
Recommended Actions	**Target Population**	**Targets (Numbers)**	**Cost per unit**	**Year (s)**	**Total Cost**	**By when**	**Responsibility**
Increased number of functional Community Units in the County Improve community and facility referral system	Communities	40	1,000,000	3	120,000,000	2019	CHD Partners
Improve community and facility referral system	Communities	1	500,000	3	1,500,000	2019	CHD
Scale up Community Health High Impact Interventions through integration, use of peer support networks and technology including socialmedia	Communities youth adolescents	60,000	100	3	18,000,000	2019	CHD NACC Partners
Improve procurement and management of medical products and technologies, with emphasis being placed on ensuring the commodities are available throughout	HCW	1,000	400,000	3	1,200,000,000	2019	CHD KEMSA NASCOP

Provide adequate and competent work force to deliver integrated HIV services in the County	County health workers	10	2,000,000	3	60,000,000	2019	County Government
Revitalize the Community Health Strategy (CHS), on how to realize its implementation with regard to establishment of CUs and the remuneration of CHWs	CUs	40	400,000	3	48,000,000	2019	County Health Partners
Ensure firm leadership by the County Department of Health to guide the delivery of the health sector priorities	Faclities	40	400,000	3	48,000,000	2019	County Government
Improve community and facility referral system	facilities	40	400,000	3	48,000,000	2019	County Government MoH, Beyond Zero mobile services Partners
Establish minimal package/standards for guiding community and workplace health implementation and practice	Communities and facilities	40	400,000	3	48,000,000	2019	County Department ofHealth
Sub total					**1,591,500,000**		

STRATEGIC DIRECTION 5: STRENGTHENING RESEARCH, INNOVATION AND INFORMATION MANAGEMENT							
Recommended Actions	**Target Population**	**Targets (Numbers)**	**Cost per unit**	**Year (s)**	**Total Cost**	**By when**	**Responsibility**
Identify barriers to testing and access to interventions services by populations in the County	All populations	300,000	100	3	90,000,000	2019	County HealthPartners NASCOP MoH
	PWID Other priority populations	1,000	2,000	3	6,000,000	2019	County Health Partners NASCOP MoH, NACC UNODC
Determine impact of alcohol and drug use on HIV prevention by populations (young adolescent and KPs) and geography	General and specific populations PLHIV	60,000	2,000	3	360,000,000	2019	County Health Partners NASCOP, MoH NACC, UNODC NACADA
Evaluate Opiate Substitution Therapy/ Medically Assisted Therapy programme and Needle and Syringe Exchange Programme	PWIDs	1,000	5,000	3	15,000,000	2019	County Health Partners NASCOP MoH, NACC UNODC, NACADA
Identify and test interventions that address determinants and barriers to linkage into care for PLHIV Determine outcomes and causes of loss to follow up among PLHIV on care and treatment	PLHIV PLHIV	20,000	2,500	3	150,000,000	2019	CHD Partners NASCOP MoH NACC
Single out, amend or repeal all health access disenabling laws at national and county assemblies	General populations	6,000	2,000	3	36,000,000	2019	CHD County Assembly NACC, NASCOP
Identify and test interventions that address determinants and barriers to linkage into care for PLHIV	PLHIV	1	1,500,000	3	4,500,000	2019	CHD County Assembly NACC, NASCOP
Sub total					**661,500,000**		

STRATEGIC DIRECTION 6: PROMOTE UTILIZATION OF STRATEGIC INFORMATION FOR RESEARCH, MONITORING AND EVALUATION TO ENHANCE PROGRAMMING							
Recommended Actions	**Target Population**	**Targets (Numbers)**	**Cost per unit**	**Year (s)**	**Total Cost**	**By when**	**Responsibility**
Establish a multi-sectoral HIV programming web-based data	County health system	1	1,000,000	1	1,000,000	2019	County Health Department NACC, NASCOP, Partners
Establish and strengthen functional multi-sectoral HIV M&E coordination structure and partnership at county level	Health facilities, CUs	1	3,000,000	3	9,000,000	2019	County Health Department NACC, NASCOP, Partners
Put in place ustainable financing for HIV and M&E activities	County	1	1,000,000	3	3,000,000	2019	County Health Department NACC, NASCOP, Partners
Strengthen routine HIV information management at county level	CHIMS HMIS Situation Room HIPSOR	1	2,000,000	1	2,000,000	2019	County Health Department NACC, NASCOP, Partners
Conduct regular M&E supervision, data quality audits and verification	CHD	1	1,500,000	3	4,500,000	2019	County Health Department NACC, NASCOP, Partners
Sub total					**19,500,000**		

STRATEGIC DIRECTION 7: INCREASING DOMESTIC FINANCING FOR SUSTAINABLE HIV RESPONSE							
Recommended Actions	**Target Population**	**Targets (Numbers)**	**Cost per unit**	**Year (s)**	**Total Cost**	**By when**	**Responsibility**
Developing and implementing a county HIV financing lobbying strategy	County Health Department	1	1,000,000	3	3,000,000	2019	County Health County Assembly Partners NACC NASCOP MoH

Ensure participation PLHIV and other interested stakeholders in budget forums (citizen participation)	PLHIV Stakeholders Wananchi	1	1,000,000	3	3,000,000	2019	County Health Partners CSOs NACC
Establish a framework for HIV Combination Prevention Strategy	County Health Department	1	1,000,000	3	3,000,000	2019	County Health Partners NASCOP MoH
Institute corruption eradication strategy for health/HIV programmes at all levels	County Government	1	1,000,000	3	3,000,000	2019	County Government County Assembly
Establish, operationalize a County HIV funding PPP	Private partners	1	500,000	3	1,500,000	2019	County Health Department KEPSA FKE Partners Private institutions,
Sub Total					**13,500,000**		

STRATEGIC DIRECTION 8: PROMOTING ACCOUNTABLE LEADERSHIP FOR THE DELIVERY OF THE KCASP RESULTS BY ALL SECTOR AND ACTORS							
Recommended Actions	**Target Population**	**Targets (Numbers)**	**Cost per unit**	**Year (s)**	**Total Cost**	**By when**	**Responsibility**
Regular support supervision for healthcare givers	County Health Department	500	5,000	3	7,500,000	2019	County Health MoH
Establish and strengthen functional and competent HIV coordination mechanism at the county and sub-county level	County Health Department	1	1,000,000	3	3,000,000	2017	County Government MoH NACC NASCOP
Establish and operationalize a HIV multi-sectoral committee to oversee the HIV mainstreaming at the county level	County Government	1	2,000,000	3	6,000,000	2016	County Government MoH NACC NASCOP
Roll out partner-coordination online reporting platform	County	1	3,000,000	1	3,000,000	2016	County Government MoH NACC NASCOP
Sub total					**19,500,000**		

ANNEX 3

KCASP References and Operational Documents

1. The Kenya AIDS Strategic Framework (KASF) 2014/2015- 2018/2019 - that seeks to reduce new HIV infections by 75% come 2019.
2. The Kenya HIV Prevention Revolution Road Map: Count Down to 2030 – that set out to reduce HIV incidence by 50% in 2015, by 75% by 2020 and zero new HIV infections by 2030.
3. The Kenya HIV County Profiles 2014 – that analyzed each county profile, established baseline programme data and made county-specific priority programme interventions.
4. The Monitoring and Evaluating Framework for KASF 2014/2015-2018/2019 – providing indicators for KASF strategic directions.
5. The Annual Kenya HIV Estimates – that provides an annual progress in HIV programming.
6. The Strategic Framework towards Elimination of Mother-toChild Transmission of HIV and keeping Mothers Alive 2012-2015 – that aims to reduce MTCT rate to less than 5% and HIV-related maternal mortality by 50%.
7. A Strategic Framework for Engagement of the First Lady in HIV Control and Promotion of Maternal, Newborn and Child Health in Kenya 2013-2017 - which seeks to provide guidance for the engagement of the Country's First Lady on political championship towards elimination of new HIV infections among children and promoting maternal health.
8. The National Guidelines for HIV Testing and Counselling, Couples and Prevention with Positives (Positive Health, Dignity and Prevention - PHDP).
9. Policy Analysis and Advocacy Decision Model for services for populations in Kenya.

10. Kenya's Fast-track Plan to End HIV and AIDS among Adolescent and Young People 2015-2017 – which seeks to reduce among adolescents and young people HIV incidence, AIDS-related mortality and stigma and discrimination by 40%, 15% and 25% respectively by 2017.
11. The Constitution of Kenya (2010).
12. The Kenya Vision 2030.
13. The Adolescents and Youth Sexual Reproductive Health and Development Policy (2003) and its Plan for Action (2007).
14. Education Sector Workplan Policy on HIV and AIDS Second Edition (2013).
15. Eastern and Southern Africa Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People.
16. The Kenya Guidelines for conducting HIV and Sexual Reproductive Health Research with adolescents.
17. The Kenya National Reproductive Health Policy (2007) and Strategy (1997 – 2010).
18. The Kenya National Maternal and Newborn Health (MNH) Road Map (2010).
19. Kwale County Integrated and Development Plan.

ANNEX 4

List of KCASP Development Working Teams

Drafting Team

Dr. AThman Chiguzo - CEC Health

Dr. Kishindo Mwaleso - Chief Officer of Health

Christine Mwaka - Kwale County First Lady

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Rhoda Pola - County Health Department

Julius Koome - NACC

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Hanifa Mwarora	- CHD Kwale
Suleiman Matsudzo	- Religious Leader
Stanley Chepkirwok	- SCASCO
Ezekiel Kodonde	- WOFAK
Pastor Mgala	- Religious Leader
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Dr. Saade Abdallah - UNODC

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Elizabeth Simba - SCAC Chair Kinango

Eliza N Chakayo - SCAC Matuga

Florence Mutemi - SCAC Member Lunga Lunga

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Ali Lutseso - SCAC Kinango

Cleotilda M Kadilo - SCAC Lunga Lunga

Athman Nyaa - SCAC Msambweni

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Lewa Njemo - Kwale County

Secretariat

Julius Koome - NACC

Dr Ben Makenzie - CASCO

Martha Wandera - NACC

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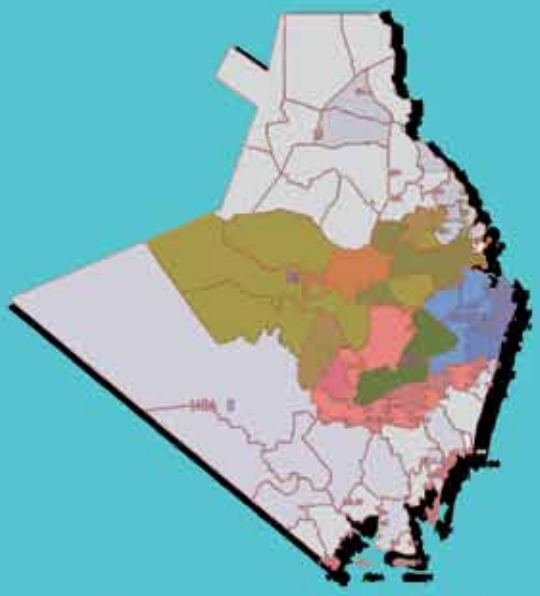
Arnold Mwaklindo - FHOK



KWALE HIV & AIDS STRATEGIC PLAN