MAKUENI COUNTY

HIV, AIDS & TB STRATEGIC PLAN

2015/16 – 2018/19

Published by the County Government of Makueni

"For posterity of generations,
the future of Makueni
is in our hands"

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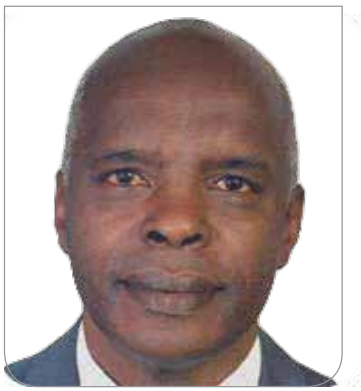
Abbreviations and Acronymns

ACUs	AIDS Control Units
AFB	Acid Fast Bacilli
AHF	AIDS Health Foundation
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Clinic
APOC	Adolescent Package of Care
ART	Anti-Retroviral Treatment/Therapy
ARV	Anti-Retroviral Drugs
BCC	Behaviour Change Communication
cART	Combined ART
CASCO	County AIDS and STI Coordinator
CSOs	Civil Society Organisations
CBHTS	Community-Based HTS
CBO	Community-Based Organization
CBTBC	Community-Based TB Care
CCC	Comprehensive Care Centre
CEC	County Executive Committee
CHEW	Community Health Extension Worker
CHTC	County HIV and TB Committee
CHVs	Community Health Volunteers
COBPAR	Community Based Programme Activity Reporting
CPT	Cotrimaxazole Preventive Therapy
CSO	Civil Society Organization
CTLC	County TB and Leprosy Coordinator
DHIS	District Health Information System
DOT	Direct Observed Treatment
DRTB	Drug-Resistant TB
DSTB	Drug-Susceptible TB
DWA	Dominion of World Agriculture
EBI	Evidence-Based Intervention
EMTCT	Elimination of Mother-to-Child Transmission
ETR	End Term Review
FBO	Faith-Based Organization
FM	Fluorescent Microscopy
FSW	Female Sex Worker
HBC	Home-Based Care

HBTC	Home-Based Testing and Counseling
HCBC	Home and Community-Based Care
HCW	Health Care Worker
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HR	Human Resources
HTS	HIV Testing Services
ICAP	International Centre for HIV and AIDS Programme
ICF	Intensify Case Finding
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
INH	Isoniazid
IPC	Infection Prevention and Control
IPT	Isoniazid Preventive Therapy
IPV	Intimate Partner Violence
KAIS	Kenya AIDS Indicator Survey
KASF	Kenya AIDS Strategic Framework
KDHS	Kenya Demographic and Health Survey
KP	Key Populations
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MCHTSP	Makueni County HIV, AIDS and TB Strategic Plan
MDAs	Ministries, Departments and Agencies
MIPA	Meaningful Involvement of PLHIV
MoH	Ministry of Health
MOT	Modes of Transmission
MSM	Men who have Sex with Men
MSW	Male Sex Worker
MTR	Mid-Term Review
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
NBTS	National Blood Transfusion Service
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organizations
NTLD Program	National Leprosy, Tuberculosis and Lung Disease Program
OIs	Opportunistic Infections
OJT	On-the-Job Training
OPD	Out Patient Department
OVC	Orphans and Vulnerable Children
PAL	Pulmonary Approach to Lung Health
PEP	Post-Exposure Prophylaxis
PHDP	Positive Health, Dignity and Prevention
PITC	Provider Initiated Testing and Counseling
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PPM	Private Practice Mix
PrEP	Pre-Exposure Prophylaxis
PwD	People/Persons with Disabilities
PWID	People Who Inject Drugs
SCACCs	Sub-County AIDS Control Committees
SD	Strategic Direction
SGBV	Sexual and Gender-based Violence
SGR	Standard Gauge Railway
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Workers
SWOT	Strength, Weakness, Opportunities and Threats
TAT	Turn-Around Time
TB	Tuberculosis
TBA	Traditional Birth Attendants
TIBU	Treatment Information for Basic Programme
TOWA	Total War against AIDS
TSC	Teachers Service Commission
TSR	Treatment Success Rate
TST	Tubercullin Skin Test
TTIs	Technical Training Institutes
TWG	Technical Working Group
VL	Viral Load

Foreword



HIV, AIDS AND TUBERCULOSIS continue to be epidemics that do not only claim many lives, but also put a significant amount of strain on financial resources in treatment and management. Efforts to combat these challenges have borne fruit as Makueni County continues to realize a steady drop in new infections and deaths. Cognizant of the enormous challenge that lies ahead, the County Government has developed a proactive intervention strategy to creatively respond to these challenges. This four-year Makueni County HIV, AIDS and TB Strategic Plan (MCHTSP) provides a holistic County approach to the HIV, AIDS and Tuberculosis response. The Strategic Plan has been developed through the collaborative efforts of the County Government of Makueni, the civil society, the faith sector, the private sector, the networks of PLHIV, the networks of PLWDs, Youth representatives, and the implementing partners.

The County has so far established 57 new care and treatment centers, 72 new PMTCT sites, revamped the School Health program, strengthened the partner-supported drop-in centers along the Nairobi-Mombasa highway addressing issues of the Key Populations and strengthened the HIV-in-workplace interventions among others. With this Strategic Plan, we are confidently assured of contributing to the global vision of zero new infections, zero HIV related-stigma and discrimination, and zero AIDS-related deaths through combined prevention approaches, population-driven strategies, geographical prioritization for specific interventions and using a shared responsibility approach.

The County leadership, in partnership with the national government and other stakeholders, continues to address using a Human Rights approach the many socio-economic challenges resulting from HIV, AIDS and TB. Notably, the County will strive to mobilize domestic financing for HIV, AIDS and TB programming, taking into account the limited County fiscal space, other competing priorities and the dwindling donor support.

We deeply believe that this Strategic Plan will guide the implementation of the HIV, AIDS and TB response to achieve the highest attainable healthcare for all the people of Makueni as enshrined in the Constitution of Kenya 2010.

PROF. KIVUTHA KIBWANA

GOVERNOR

Preface

THE MAKUENI COUNTY HIV, AIDS AND TB STRATEGIC PLAN (MCHTSP) 2015/16-2018/19 constitutes an integrated and multi-sectoral response to HIV, AIDS and TB. The Plan is designed to provide adequate space and opportunities for Communities, Civil Society Organizations, Faith Sector, Private Sector, Schools and Academic Institutions, Health Care Facilities, Implementing Partners and County Government Departments to actively participate in the implementation based on the individual stakeholder's mandate and comparative advantage.

The MCHTSP has been developed through a very participatory and consultative process that reflects the aspirations of the people of Makueni in their efforts to fight the scourge of HIV, AIDS and TB. This Plan will support implementation with meaningful involvement of communities, PLHIV and civil society organizations.

I therefore urge all the stakeholders to formulate and implement innovative intervention plans that are aligned to the MCHTSP. It is my sincere hope that all stakeholders shall join the fight against the HIV, AIDS and TB epidemic, through concrete MCHTSP guided interventions to achieve the objectives of the various strategic directions.

DR. ANDREW MULWA,
ECM – HEALTH SERVICES

Acknowledgement

THE MAKUENI COUNTY HIV, AIDS AND TB STRATEGIC PLAN (MCHTSP) - 2015/16 - 2018/19 is the first combined strategic plan developed to tackle HIV, AIDS and TB epidemic in the County. It is aimed at synergizing the response in a way that will significantly maximize on the scarcely available resources and provide the guidance for addressing HIV, AIDS and TB epidemic in the County by all stake holders.

The plan was developed through a thorough multi-sectoral consultative process that involved many sectors of society and various partners. We wish to thank all those who found time and offered resources towards the process of developing this strategic plan. In particular, we thank the Directors of The Department of Health Services and the County Health Management Unit Heads for the enormous efforts put towards realizing this ground breaking strategic document.

We appreciate the support from the National AIDS Control Council (NACC) through the regional office for the technical and financial support during the drafting, review and validation of this important document. We also thank the Drafting Team for their selfless efforts and zealous dedication to come up with the excellent document. We also thank in a special way the Technical Support Team for reviewing and finalizing the document in the stipulated time frame. We as well recognize the immense contribution of the Sub-County Health Management Teams, the various supporting and Implementing Partners especially ICAP-K for the technical and professional input as well as all the stakeholders from all spheres of Society who tirelessly participated in the development of this Strategic Plan.

Special tribute goes to the team of representatives from The Association of People Living With Disabilities of Kenya (APDK), The Networks of People Living with AIDS in Kenya (NEPHAK), the Faith Sector, The Civil Society Organizations (CSOs) and the Youth representative. It is from these engagements that we developed a four-year working plan to achieve the County HIV, AIDS and TB strategic objectives.

This Strategic Plan would not have been complete without the inputs from the Various County Government Departments in particular Agriculture, Social Services, Information and Technology, and Education who provided vital statistics, data and information.

Finally, we acknowledge in a very special way the great People of the County of Makueni for the opportunity to serve them and to whom this document is dedicated.

DR. PATRICK KIBWANA

CHIEF OFFICER, HEALTH

Executive Summary

MAKUENI IS CLUSTERED AS A medium-burden, medium-incidence County, with a HIV prevalence rate of 5.6%. The prevalence among women is higher (7.6%) compared to that of men (3.3%) (NACC 2014 estimates). HIV and TB co-morbidity poses a serious health challenge, impacting negatively on labour and productivity.

The MCHTSP is informed by national strategies including the Kenya AIDS Strategic Framework (KASF 2014/15-2018/19) and the National Strategic Plan for TB, Leprosy and Lung Health(2015-2018). The purpose of this plan is to inform policy formulation on HIV and TB response, implementation of HIV and TB interventions and serves as an advocacy tool for resource mobilization and allocation.

Guided by the principles of equity, people-centredness, inclusivity; multi-sectoral approach; efficiency; social accountability; integration (HIV and general health) and evidence-based programming, the MCHTSP has the following eight Strategic Directions:

1. Reduce new HIV and TB infections.
2. Improve health outcomes and wellness of TB patients and people living with HIV .
3. Use a human rights-based approach to facilitate access to HIV and TB services.
4. Strengthen integration of health and community systems.
5. Strengthen research and innovation to inform the MCHTSP objectives.
6. Promote utilization of strategic information for HIV and TB programming.
7. Increase domestic financing for a sustainable HIV and TB response.
8. Promote accountable leadership for delivery of the MCHTSP results by all sectors and actors.

The MCHTSP is a four-year guide with clear deliverables, performance indicators and targets. Implementation of this Strategy will go a long way in contributing to the health of Makueni residents, raising their economic productivity as well as contributing to the wider realization of the Vision 2030.

Chapter 1

Background

Makueni County is located in the eastern part of Kenya with its headquarters at Wote town. The County is endowed with:

1. Natural resources such as forests, wildlife, minerals, building sand, water (rivers), pasture and farming land.
2. Tourist attractions such as Kyulu Hills and National Park, part of Tsavo East National park and historical sites.
3. Main economic activities include subsistence agriculture, beekeeping, small-scale trade, dairy farming and limited coffee growing and commercial businesses.

The County is faced by a growing population, water scarcity and falling food production among others.

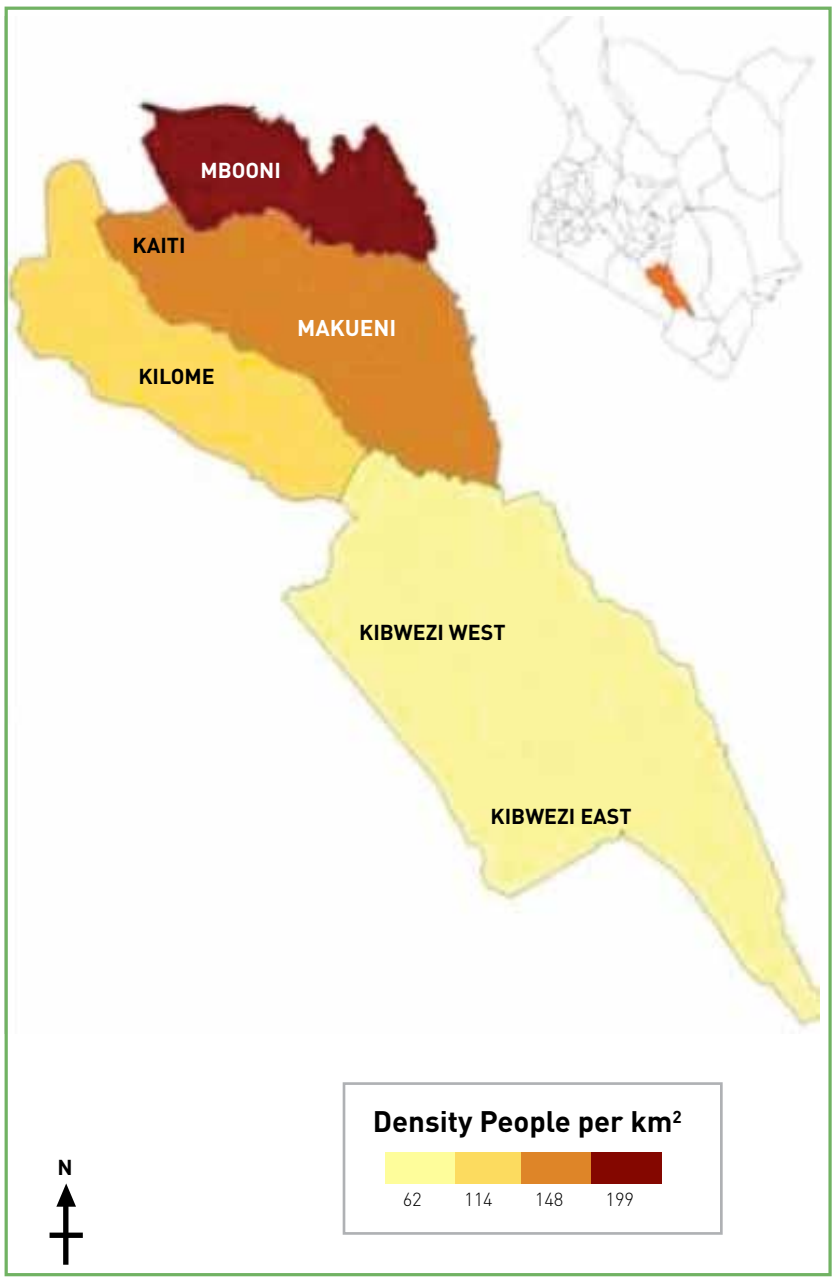


Fig 1.1: Makueni County Map

Table 1.1: Key County parameters

Category	Description
Location and size	8,034.7km^2; borders several counties; Kajiado to the West, Taita Taveta to the South, Kitui to the East and Machakos to the North. It lies between Latitude 1º 35´ and 30º 00' South and Longitude 37º10´ and 38º 30´ East
Administrative units	Constituencies: Mbooni, Makueni, Kaiti, Kibwezi East, Kibwezi West and Kilome
Population (2015 projected)	Male – 468,297; Female – 493,442. Total 961,740
Educational institutions	ECDE centers – 1,510 Primary schools - 982 Secondary schools - 339 Tertiary institutions -12 Primary school net enrollment rates - 58.6%; Drop-out rate - 3% Secondary school net enrollment - 50 %; Drop-out rates 5%
Health facilities	223 (Source RHIS)
Immunization coverage	62.26%
Contraceptives acceptance	30.75%
Morbidity rate	33.6%
Mortality rates	Infant Mortality 53/1000 live births (National - 54) Under five mortality - 61/1000 live births (National - 79) Maternal mortality - 400/100,000 live births (National - 495) Crude death rate - 11.9/1000 (National - 10.4)
Doctor-patient ratio	1: 22, 217 against WHO recommendation of 1:10,000
Nurse-patient Ratio	1:2,197 against WHO recommendation of 1: 1, 000
Poverty indicators	Absolute poverty - 64.3% Food poverty - 57.2% Poverty is prevalent in the County and manifests itself in other socio-economic outcomes such as poor nutrition, health, and education, as well as a lack of access to basic services
Human Development Index (HDI	The County scores a 0.56 on the HDI — a composite measure of development that combines indicators of life expectancy, educational attainment and income. This is at par with the national average.
Socio-economic	Agriculture is the main source of income in the Makueni County and accounts for 78% of the total household income. Populations living in the lowlands of the County engage more in fruit farming while those in the highlands grow maize, millet, tubers and rear dairy cows. Communities bordering the coastal region mainly rear traditional cows and goats. Since Makueni County is classified in the Arid-and-Semi-Arid region category, farm productivity is very low.

Source: Makueni CIDP 2013

1.1. HIV, AIDS and TB Planning and Implementation

Prior to Devolution, HIV and TB planning were coordinated centrally through national strategic plans. The implementation has been through several structures including facility based structures (dispensaries, health centres, sub-county and county hospitals, private and faith based facilities); community based interventions through the CSOs and community units and work place interventions through AIDS Control Units (ACUS). The National AIDS Control Council established multi-sectoral District Technical Committees (DTCs) and Constituency AIDS Control Committees as coordinating structures. However the DTCs were disbanded and 6 CACCS (referred to as Sub County AIDS Coordinating Committee (SCACCS) have been established and are functional. In facility based HIV and TB response, the County has the County AIDS and STI coordinator (CASCO), County TB and Leprosy Coordinator (CTLC) and 6 Sub CASCOs and 6 Sub CTLC respectively.

1.2: HIV and TB Financing

Over the years, implementation of the HIV and TB programmes has heavily relied on donor support. Donor funding to health and HIV and TB has been channeled through either the government budgetary system commonly referred to as on-budget or through the extra-budgetary – off-budget, mainly directly from donors through donor administered project/ programmes or through NGOs without going through the Government budget process. The extra-budgetary allocation by donors is by far larger than the on-budget support and has been growing over the years. The donor categories comprise both multi-lateral and bilateral agencies, and include funds made available through the World Bank Multi-Country HIV/AIDS Programme (MAP), and its project KHADREP (2000-2007) and TOWA (2008-2014), which supported community based HIV interventions and HIV and TB commodities in the county through the national government .The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is another funding mechanism that is supporting HIV and TB programmes in Kenya and in the county, and complements the ongoing efforts by multi- and bi-lateral agencies, and by the government[1].

The national donor dependency scenario is reflected at the county level with Partner contributing a higher proportion. Currently most of the ongoing facility based HIV programs in the County are financed by International Centre for HIV and AIDS Programme (ICAP). For instance, ICAP supports 176 HIV HCWS and 32 peer educators, AHF supports facility and community based HIV interventions in four sub counties namely Kilome, Kaiti, Kibwezi East and Kibwezi West. Key Population programming is supported by UoN MARPS Project and World Provision Centre along the Nairobi – Mombasa Highway, Nutritional supplements for TB patients are supported by AMREF while Community based interventions are supported by CSOs out of pocket financing. The County has a health budget with no specific budget line for HIV and TB.

1.3: HIV policy environment

The constitution and legal framework form the base around which all actions are defined. Though health is a devolved function, the national government formulates policies, guidelines and legislative frameworks through which all health programmes are to be implemented in the country. HIV and TB response in the County is therefore guided by these national policies, guidelines and legislations.

[1] Kenya National AIDS spending assessment report for the financial year 2009/10-2011/12

HIV, AIDS and TB Situation Analysis

Chapter 2

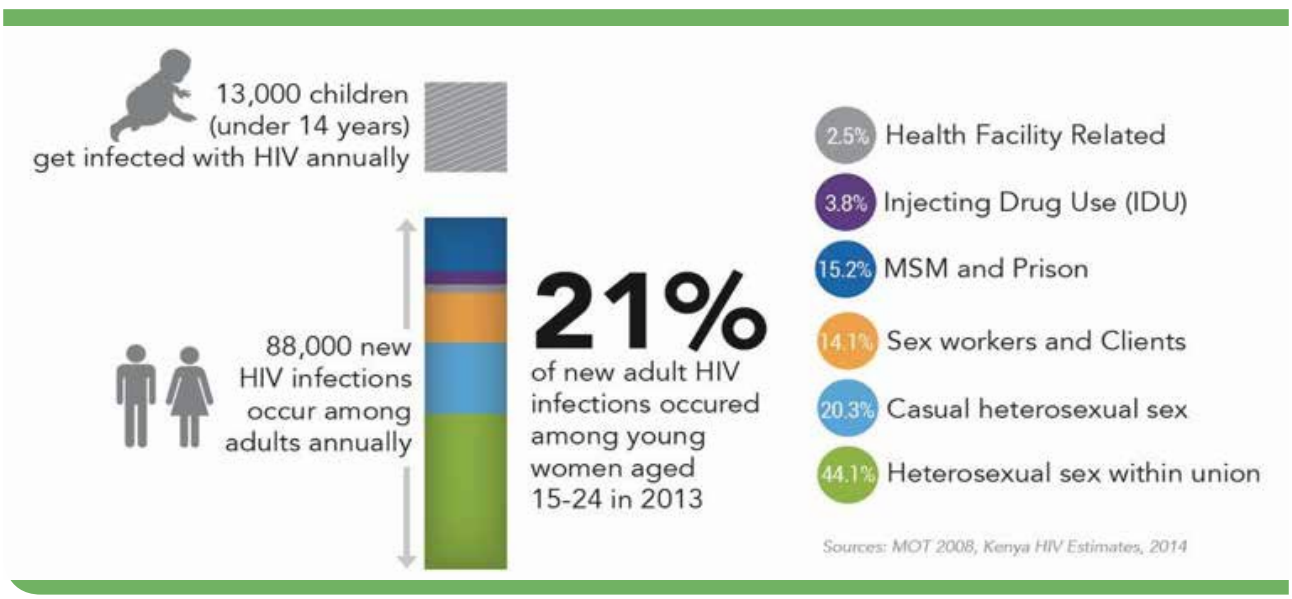
HIV, the virus that causes AIDS is one of the world's most serious health and development challenges. About 36.9 million people worldwide are currently living with HIV. The vast majority of these people are in low income countries, particularly in Africa. HIV and tuberculosis (TB) are so closely connected that their relationship is often described as a co-epidemic. In the last 15 years the number of new TB cases has more than doubled in countries where the number of HIV infections is also high. TB case detection remains low in many countries compromising the efficacy of TB Control efforts[2].

2.1 National HIV and TB Overview

2.1.1 HIV and AIDS in Kenya

The HIV epidemic in Kenya is both generalized and concentrated in some populations. The national Prevalence stands at 6.0%[3]. The MoT survey of 2008 outlines the sources of new infection as per the figure below.

Figure 2.1: New HIV Infections



[2] Public Health Report Journal 2005 May-June Edition

[3] KASF 2014/15 – 2018/19

2.1.2 Tuberculosis in Kenya

Within Africa, Kenya was the first country to achieve WHO targets for case detection and treatment success. This was made possible by sustained government commitment, evidence based innovations, adoption and roll out of new diagnostic technologies and strong partnership. However, challenges exists in TB response include; limited capacity for commodity management, financial gap for TB control, limited prioritization of TB control and prevention in counties and the shifting epidemiology of TB[4].

2.2 County HIV and TB profile

2.2.1 HIV Profile

HIV and AIDS remain a big challenge due to its devastating effects. In Agriculture, where 78 per cent of the rural population derives their livelihood, the pandemic has reduced productivity through loss of manpower and productive time. Generally HIV and AIDS has affected all sectors of the economy in the county as a result of absenteeism, sick offs and deaths. The caring for the sick leaves less time for work while high costs of treatment means resources are diverted from productive use.

Makueni is clustered as a medium burden, medium incidence county with prevalence of 5.6%. The HIV prevalence among women is higher (7.6%) than that of men (3.3%) (NACC 2013)

Table 2.1: County HIV profile[5]

Indicator	
Total population (2013)	930,530
HIV adult prevalence (overall)	5.6%
HIV prevalence among women	7.5%
HIV prevalence among men	3.3%
Number of adults living with HIV	22,100
Number of children living with HIV	3,372
Total No. of people living with HIV	25,472
New adult HIV infections annually	1,193
New child HIV infection annually	65

[4] National Strategic Plan for Tuberculosis, Leprosy and Lung Disease (2015-2018)

[5] Kenya HIV County Profiles, NACC 2014

2.2.2 Key Drivers of HIV in the county

The following were identified as the key drivers of the epidemic:

- Poverty:-manifests itself in other socio economic outcomes such as poor nutrition and lack of access to basic services.
- Economic activities (Truckers, migrant workers in the Standard Gauge Railway (SGR) and proposed Konza Technocity, DWA Sisal Estate; Mobile populations trading on fruits and vegetables and sand harvesting; Rural urban migration in search of jobs, Boda Boda riders
- Key population – MSM, sex workers and PWID along the Mombasa–Nairobi highway and urban centres
- Stigma and Discrimination negatively influences access to services
- Intergenerational sex
- Alcohol and substance Abuse – Alcohol abuse is an important co-factor in the sexual transmission of HIV and risk of TB disease. Cigarette smoking is linked to increased TB disease. Drug possession, use, selling and trafficking is illegal, causing drug users to remain a hidden population.
- Sexual and Gender Based Violence (SGBV)
- Ignorance and lack of information

2.2.3 Tuberculosis profile

County TB key indicators[6]

The County has:

- Mid Case Notification Rate (CNR) (175-250/ 100,000)
- High poverty prevalence (> 45%)
- >40% of TB patients with Body Mass Index (BMI) < 18
- High HIV prevalence in general population (>5%)
- Low community case notification (< 9% of total)
- Low pediatric case notification (<8% of total)

Table 2.2: Trend of County TB Outcomes

	TSR	Cure rate	Lost To Follow-up	Failure	Deaths	Transfer Out
2012	90%	85%	2%	1%	4%	2%
2013	91%	87%	3%	1%	4%	2%
2014	92%	90%	2%	1%	5%	1%

Source: TIBU 2015

County TB case finding

County TB case detection is at 82%. There's need for concerted efforts to improve case finding in all sub-counties.

Table 2.3 TB Outcomes Case Findings

SUB COUNTY	NEW						PREVIOUSLY TREATED					
	Bacteriologically confirmed			Clinically Diagnosed			Bacteriologically confirmed			Clinically Diagnosed		
	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015
Kilome	93	84	78	95	61	54	12	16	15	13	16	15
Makueni	159	124	205	211	144	192	24	15	24	38	27	18
Kibwezi West	126	116	141	222	159	103	15	20	9	19	9	3
Kibwezi East	160	187	175	174	115	100	20	20	27	13	14	19
Kaiti	66	65	82	95	79	74	9	2	4	14	14	8
Mbooni	161	162	149	173	138	121	21	30	11	14	12	10

Source: TIBU 2014

[6] National Strategic Plan for Tuberculosis, Leprosy and Lung Disease (2015-2018)

County TB Outcomes

2.2.4 Social determinants of TB

The role of poverty as a determinant of TB cannot be overlooked. According to the Makueni CIDP the County poverty rate stands at 64.3 per cent. In the Kenyan Demographic and Health Survey of 2009, financial barriers were a primary cause of delay in seeking of health care. The review team identified financial barriers stemming from the following areas: transportation costs, fee-based diagnostic tests, and lack of nutritional and financial support during the intensive phase of TB treatment. Malnutrition is known to negatively affect treatment outcomes. The NTLD programme estimated that 17% of notified TB cases were severely malnourished and a further 21% moderately malnourished.

2.4: HIV and TB programmatic gaps and challenges

Table 2.4: Programmatic gaps and challenges

Programmatic areas of intervention	Major Challenge/ Gap
eMTCT	-Home deliveries (use of TBA) - Lack of Disclosure to spouses -Non adherence to PMTCT prevention measures -ART defaulter -Low male involvement in eMTCT -Delay in receiving DBS results -Stigma and discrimination Low partner testing -Lack of knowledge
ANC	-Low uptake of ANC services(64% coverage) DHIS 2015
HTS	Low uptake of HTS services (21%- DHIS, 2015) - Low partner testing -Donor dependency -Repeat testers -Inadequate supply of RTKs - Frequent changes in the HTS algorithm -Missed opportunities -Stigma and denial -Attitude of Health care workers
Adolescents and young people	- No tools to capture adolescent data - Non-adherence to support in schools - Limited youth-friendly centres or resource centres in health facilities - School drop out - Family-based stigma and discrimination in OVCs - No youth-friendly centre/ resource centres - Knowledge gap in adolescent and young people programming

Programmatic areas of intervention	Major Challenge/ Gap
Key populations, MSM, Sex Workers and PWID)	- Mainly donor supported - No drop-in and rehabilitation centres - Stigma and discrimination inhibiting Health seeking behaviours - Lack of key population-sensitive health service points in health facilities - Lack of size-estimate data - Data tools do not disaggregate data to capture the Key Populations - Inadequate psychosocial support groups - Inadequate supply and accessibility to condoms and lubricants - Inadequate sensitization of law enforcers on KPs and HIV programming - Knowledge gap in KPs programming
Gender Based Violence	- Tools to capture data on GBV rarely utilized (Post-Rape Care (PRC) form tool) - PRC tool not harmonized with DHIS - Lack of coordination between healthcare facilities and legal system - Knowledge in GBV programming - Lack of GBV reduction focal office
ART	- Non-adherence - Long Turn-around Time (TAT) for viral load results - Pill Burden to HIV co-infections - HIV testing entry points and enrollment into the Care and Treatment programme gaps - Low pediatric ART coverage gap (45-%), adults coverage gap 37% - Missed opportunities - Inadequate linkage/ referral structures - ART defaulters - Self transfers - Stigma and discrimination - Multi-drug resistance (patients on second and third line treatment) - Management of drug side effects (Pharma-covigilance utilization) - Inadequate /stockouts of OIs
Psychosocial support groups	- Inadequate support during literacy classes (snacks and transport) - Non-involvement in programming - Stigma and discrimination - Poor linkage to community support systems
Nutritional Support	- Conditionality of donor supplies on nutritional feeds - Erratic supply of government supplementary feeds (food by prescription)
Faith healing and Herbalists	- Treatment interruptions with herbal prescriptions and religious beliefs
Behavior change and communication	- Inadequate targeted IEC and BCC messages - Access to IEC materials - Low level of sensitization at grassroots

Programmatic areas of intervention	Major Challenge/ Gap
School Health programs	Non-integration of HIV and TB in school health programmes - Drug holiday in school setups - Stigma and discrimination in school settings - Overcrowded boarding schools
Work place interventions	- Inactive/non-existing workplace policies and implementation in County Departments and other government agencies -Non-existing workplace policies and interventions in private sector (both formal and informal) - Weak enforcement of occupational / Public health policies
Human resources	- Donor dependency in HR (E.g. ICAP supports 176 HIV HWS and 32 peer educators) - High clinician-patient ratio - Staff burn-outs - Lack of skills and competence inventory
HIV financing	- Donor fatigue (Donors shifting priority areas) - Lack of a HIV budget line in the health budget - Non-disclosure of donor resource envelope
Leadership and Governance	Lack of political will and buy-in on some of the HIV activities, e.g. the KP interventions - Poor parenting to the adolescents on sexual reproductive health - Inadequate budgetary/ funding allocation towards TB, HIV/AIDS activities - Poor accountability structures on HIV received funds at the periphery - Weak structures to oversee the HIV/AIDS activities on the ground
TB	- Few diagnostic sites (76 sites) - Faulty microscopy equipment - Stockouts of commodities, i.e. Falcon tubes, sputum mugs, Xpertcartridges - Knowledge gap in AFB/FM, GeneXpert - Inadequate support supervision for sub county Medical laboratory Technologists - Few geneXpert machines (the county has 3 GeneXpert TB machines in 3 subcounties) - Inadequate nutritional support - Poor health seeking behaviours (non-adherence, stigma and discrimination) - Low screening of TB contacts - Donor dependency
GK Prison and Remand	- Inmates sharing of ART and TB drugs - Inmates not aware of their drug regimens - Non-disclosure of inmates - Inmates buying sputum from TB patients for exemption from prison duties and to get special diet (dispensing TB drugs to non TB patients) - Denial of detainees' conjugal rights leading to homosexuality
Condoms	- Lack of demand for female condoms - Inadequate supply of condoms - Inadequate promotion of condom use - Lack of condom dispensers in strategic points

Programmatic areas of intervention	Major Challenge/ Gap
Human rights and legal access	- Inadequate information on legal rights of PLHIV - Low level of awareness among the community on enforcement and protection of rights of PLHIV, OVC, PWD and Key Populations - Limited access to HIV and AIDS tribunal by PLHIV and general population - Few trained paralegals on HIV and AIDS issues - Inadequate coverage of cash transfer to OVC households (34% coverage) -Non-utilization of cash transfer funds to support OVCs by guardians
M & E	- Inadequate data capturing - Poor feedback mechanisms - Lack of aggregated tools for sub-populations such as adolescents, Isoniazide Preventive Therapy (IPT) - Data quality issues in DHIS and COBPAR - Inadequate M & E and support supervision to facilities and community-based implementers - Non-harmonized reporting tools - one service reported in different registers - Distortion of data

2.4 SWOT Analysis

Table 2.5: SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
• Presence of strong HIV response programmes and structures in the County such as, CACCs; CSOs Health facilities and trained staff • Partner support • Integration of HIV and TB lessons in schools • Integration of HIV and TB services	• High levels of stigma • Illiteracy • Irregular and inadequate funding of HIV and TB activities • Lack of resources to conduct regular mobile HTS to hinterland areas • Few sub-ACUs implementing workplace policy on HIV and TB • Inadequate statistical data on the impact of HIV and TB on the Human Resource in the County • High rate of drug and substance abuse • HIV and AIDS hot spots along Mombasa road • Stigma and discrimination • Donor Dependency of TB and HIV programming • Poor health-seeking behaviours • Alcohol and substance abuse (increased use of miraa) • Inadequate support of CSOs in HIV and TB response	• Mobile HTS and PMTCT services • BCC campaigns to promote couple counseling • HIV and TB prevention and anti-stigma campaigns • Existence of the KASF 2014/15-2018/19 • Training and capacity building programmes; • Cash Transfer Support Programme for OVCs • Home and community care-based programmes • Establish youth-friendly testing centres • Establish a data bank for PLWHIV and OVCs • Scale up TB and HIV integration	• Stigma towards usage of condoms due to cultural and religious barriers • Food shortage • Droughts • Epidemics • Rising poverty levels • Increase number of OVCs

Chapter 3

Rationale, Strategic Plan Development Process

3.1 Rationale

The Kenya Constitution 2010 introduced two tiers of governance i.e. the National Government and the County Government. Health was amongst the devolved functions. Makueni County, being one of the devolved governments, has therefore developed a strategic plan to cater for the needs of her people. The National Government is mandated with policy and guideline function to guide the counties in HIV and other health functions. The National AIDS Control Council (NACC), a national agency mandated to coordinate HIV response developed the Kenya AIDS Strategic Framework (KASF) 2014/15-2018/19; the National TB, Leprosy and Lung Disease Programme developed the national strategic plan for TB, Leprosy and Lung Health (2015-2018), which guides counties to develop their specific HIV and TB strategic plans respectively.

In response to the dual epidemics of HIV and TB, this strategic plan combines HIV and TB strategies.

HIV is the strongest risk factor for developing tuberculosis (TB) disease in those with latent or new Mycobacterium tuberculosis infection. The risk of developing TB is between 20 and 37 times greater in people living with HIV than among those who do not have HIV infection[7]. TB is responsible for more than a quarter of deaths among people living with HIV[8]. The combined strategy for HIV and TB is a cost-effective measure since HIV and TB are correlated in programming and response strategies.

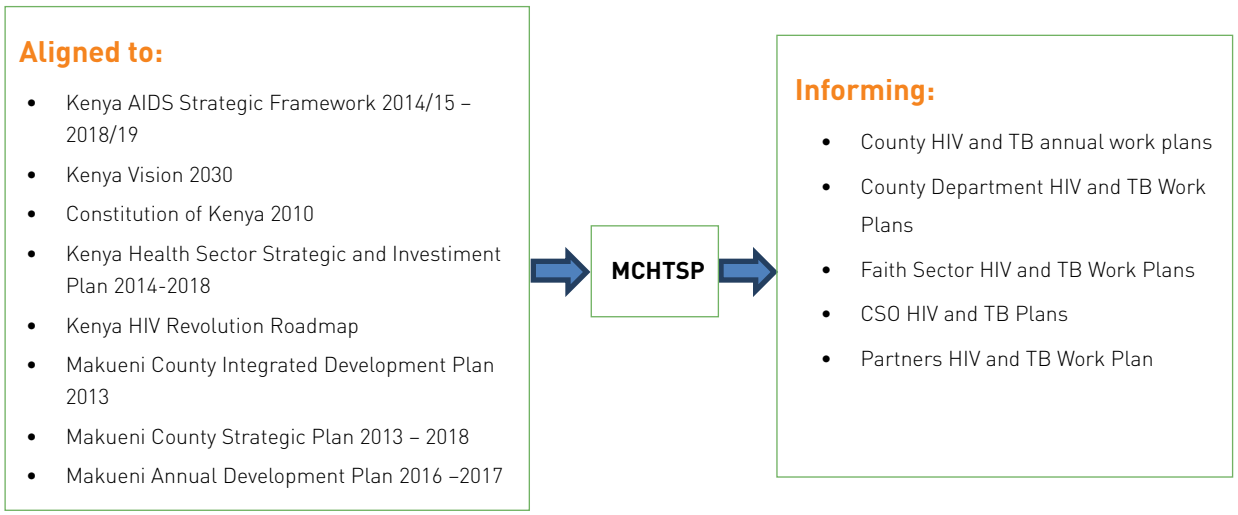
Purpose of the plan

- To guide policy formulation on HIV and TB County response.
- To inform HIV, AIDS and TB interventions in the County.
- To serve as the framework for resource mobilization and allocation.
- To guide the implementation of the County multi-sectoral HIV, AIDS and TB response

[7] WHO. Global Tuberculosis Control: A Short Update to the 2010 Report. December 2009. Geneva, Switzerland, World Health Organization, 2010

[8] Getahun H et al. HIV Infection Associated Tuberculosis: The Epidemiology and the Response. Clinical Infectious Diseases, 2010

Figure 3.1: MCHTSP alignment and linkages



3.2 Guiding Principles

- **Equity**: This is to ensure all services provided avoid exclusion and social disparities. Investments are defined to ensure access to services is equitable, irrespective of persons' gender, age, colour, geographical location and social class.
- **People-centredness**: To ensure that HIV and TB interventions are organized around people's legitimate needs and expectations. Interventions involving community participation are prioritized.
- **Participation**: Involvement of different actors to attain the objectives of the plan.
- **Multi-sectoral approach**: This is based on the recognition that health cannot be improved by interventions relating to health services alone, with a focus of 'Health in all Sectors' required.
- **Efficiency**: To maximize the use of existing resources.
- **Social accountability**: To improve on the public perception of HIV and TB services, interventions that involve performance reporting, public awareness, transparency and public participation in decision making on HIV and TB-related matters are prioritized.
- **Integration of HIV and TB into general health programme**: Integrated approach helps to avoid the creation of vertical implementation of care and treatment of HIV and TB. Integrated delivery reduces the unit cost of services. This strategy emphasizes on integration of HIV and TB into existing general health programme.
- **Evidence-based programming**: Informed Result-based management on what works in HIV and TB prevention, care and treatment for effective and sustainable interventions.

3.3 Strategic Plan Development Process

The process of developing the Makueni County Strategic Plan began after dissemination of the Kenya AIDS Strategic Framework (KASF) 2014/15-2018/19 on November 28, 2014 at the national level and cascaded on December 1, 2014 into Makueni County.

The development of the MCHTSP started during the KASF dissemination and roll out for the County that was held on 14th – 15th October, 2015 at Lau Guest House, Machakos town. The stakeholders present at the meeting consisted of County Government representatives (CASCO, Sub-CASCOs, CACCs), Faith Sector, Key Population representatives, Youth, PLHIV,

NEPHAK and Community-Based Organizations. The participants were made aware of the KASF, its proposed strategies and outcomes. The County level dissemination further focused on enhanced commitment, sustainability and ownership of the County-specific HIV and TB response.

During the meeting, participants reviewed and approved the Terms of Reference for the Committee that was to oversee the development of the County Aids Strategic Plan. The participants also approved the Committee members.

During the two-day workshop, participants were taken through the County HIV situation analysis and deliberated on the strategic directions for the County HIV strategic plan. The team also agreed on County HIV Committee TORs and membership.

The participants further agreed on a drafting team for a strategic plan that would address the HIV and TB response in the County. The team met for five days in November 2015 and came up with a zero draft. The Zero Draft was subjected to the national review team for further analysis and input. A follow-up meeting by the County Drafting Team was held in March, 2016 to incorporate the inputs. A subsequent meeting for both the County Drafting Team and the Technical Review Team culminated the process in April 2016.

The final copy of the MCHTSP was validated during a stakeholders meeting held on 21st – 22nd April, 2016 at Kusyombunguo Hotel, Wote Town. A Communiqué on amendments agreed upon was endorsed by the CEC Health for adoption and circulation of the official MCHTSP.

Vision, Mission, Objectives & Strategic Directions

Chapter 4

Vision

A county free of new HIV and TB infections, stigma and related deaths

Mission

Provision of high quality HIV and TB prevention, care and related support services for all.

Objectives

THE MCHTSP HAS FOUR STRATEGIC OBJECTIVES:

1. **Reduce new HIV infections by 80% and reduce TB incidence by 5%:** The primary aim is to use a combination of biomedical, behavioural, social and structural interventions to prevent new HIV and TB infections.
2. **Reduce AIDS-related mortality by 30% and reduce mortality due to TB by 3%:** The primary aim is to ensure access to quality treatment, care and support services for those infected with HIV and/or TB and to develop and implement interventions that focus on sustaining health and wellness.
3. **Reduce HIV and TB-related stigma and discrimination by 50%:** The aim is to protect the human rights of people living with HIV and TB, end stigma, discrimination, other human rights violations and gender inequality.
4. **Increase domestic financing of the HIV and TB response to 50%:** The aim is to reduce dependency on external HIV and TB funding and seek local alternatives.

4.4 County Strategic Directions

The County adopted eight Strategic Directions in HIV and TB response as follows:

1. Reduce new HIV and TB infections.
2. Improve health outcomes and wellness of TB patients and people living with HIV.
3. Use a human rights-based approach to facilitate access to HIV and TB services.
4. Strengthen integration of health and community systems.
5. Strengthen research and innovation to inform the MCHTSP objectives
6. Promote utilization of strategic information for HIV and TB programming
7. Increase domestic financing for a sustainable HIV and TB response.
8. Promote accountable leadership for delivery of the MCHTSP results by all sectors and actors.

4.4.1 Strategic Direction 1: Reduce new HIV and TB infections

One of the County health strategic interventions is to invest in preventive health care. The County had an estimated 1,193 new adult and 65 children infections in 2013. This strategic direction seeks to reduce new HIV infections by 80% thus reducing 1,258 new HIV infections to 252 by 2019. To reduce new HIV infections, the County will utilize the following key interventions:

- Combination prevention approach.
- Targeted HIV prevention to priority populations.
- Maximize efficiency in service delivery through integration.
- Leverage opportunities through creation of synergies with other sectors for HIV and TB prevention.

(a) Combination prevention approach

Evidence-informed and human rights-based combination prevention recognizes the importance of biomedical, behavioural and structural interventions working together to achieve prevention and care outcomes[9]. A mixed approach addressing both immediate risks and underlying causes of vulnerability of priority populations (key and vulnerable populations) is both possible and necessary.

[9] Catherine A. Hankins and Barbara O. de Zalduondo AIDS 2010, Core biomedical prevention interventions include condoms, VMMC, PMTCT/ART

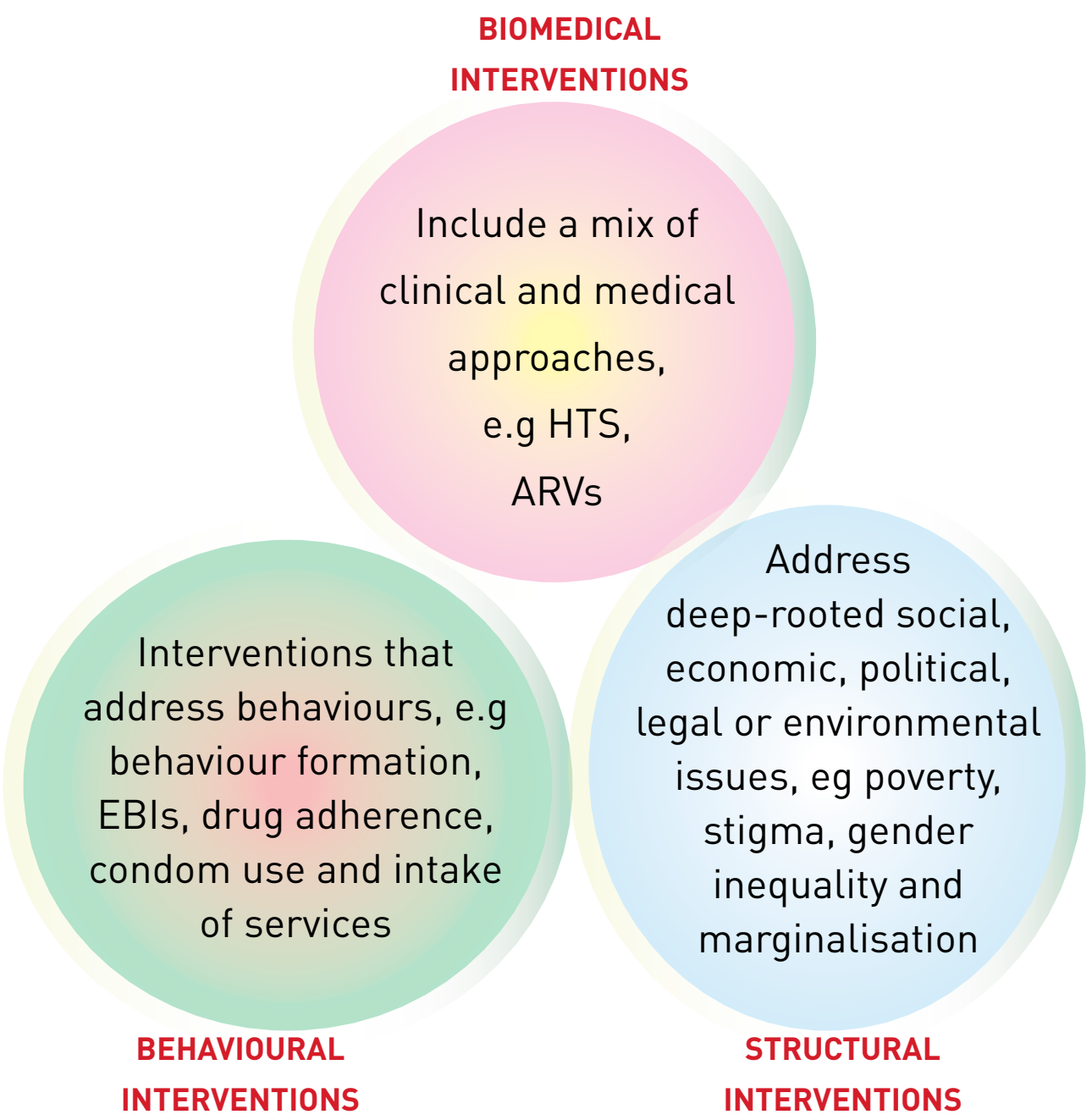


Figure 4.1: Combined approach interventions

Tuberculosis is known to have a strong association with poverty[10]. Patients and households affected by TB are likely to be caught in a 'medical poverty trap' – a situation where treatment expenditures increase as income levels decrease.

There are many complex factors which influence the twin HIV and TB epidemics and their prevalence among populations. An effective response requires knowledge of the disease burden and main drivers of the HIV and TB epidemics in an area in order to tailor appropriate interventions. There is a correlation between HIV and TB as compromised immunity in people living with HIV increases the risk of developing active TB, and TB can accelerate the course of HIV. The incidence of TB has increased parallel to the increase in the estimated prevalence of HIV in the adult population. TB case-fatality rates are between 16% and 35% among people living with HIV who are not on ART compared to between 4% and 9% among people who are HIV-negative[11]. There is overwhelming evidence that early ART reduces TB risk by 51%, AIDS-defining clinical events by 51%, and primarily clinical events by 27%[12].

The National Strategic Plan for Tuberculosis, Leprosy and Lung Disease (2015 - 2018) recognizes the following high-risk groups as hosting disproportionately high rates of TB and/or being under-served by health services: The MCHTSP targets the following high-risk groups:

- **Urban slums**: While the incidence of TB in slum areas throughout Kenya is not known, slums are considered a high-risk setting given the ease of transmission due to overcrowding and financial, geographical and social barriers to care.
- **Health care workers**: In Kenyatta National Hospital, a study showed that the rate of TB among health care workers was three times higher than in the surrounding community.
- **Mobile/migrant populations**: Labour-related movement to plantations, road/railway construction across County is common. Social determinants arising from migration, such as living in cramped settlements, and income and food instability, increase the risk of TB. Access to continuous care is constrained by many of the social dimensions of migration[13].
- **Prisoners**: TB case notification rates in two large prisons in Kenya - Meru and Embu - were 941 and 4,714/100,000 respectively in 2012. These rates are 4-10 times higher than in the surrounding population. It is estimated that similarly disproportionately high rates occur in other prison settings.
- **Boarding schools**: The County has had case notifications from overcrowded boarding schools.
- **People Living with HIV**: The incidence of TB is eight times higher among PLHIV than in the rest of the population in Kenya.[14]
- **Contacts of TB patients**: WHO Global recommendation in favour of screening of close contacts of active TB patients is based on five cross-sectional studies showing that contact tracing contributed 2% – 19% of all cases.
- **Chronic immuno-suppressive non-communicable diseases**: These include diabetes and cancers.

Pregnant women living with HIV are at risk for TB, which can impact on maternal and perinatal outcomes. These could range from death of the mother and the newborn, to prematurity and low birth weight of the newborn[15].

The County will utilize a combination prevention approach for an effective response to TB. The following interventions combine behavioural, social, structural and biomedical approaches.

[10] WHO. Addressing Poverty in TB Control Guidelines (2005)
[11] Mukadi YD, Maher D, Harries A (2001) Tuberculosis case fatality rates in high HIV prevalence populations in sub-Saharan Africa. AIDS
[12] Cohen MS, Chen YQ, McCauley M, et al. Prevention of HIV-1 infection with early antiretroviral therapy. N Engl J Med 2012
[13] International Organization for Migration, 2011: An Analysis of Migration Health in Kenya
[14] Comparison of Trends in TB Incidence in Kenya, 1998 - 2012
[15] Gupta A. et al. Postpartum tuberculosis incidence and mortality among HIV-infected women and their infants in Pune, India, 2002–2005. Clinical Infectious Diseases, 2007,

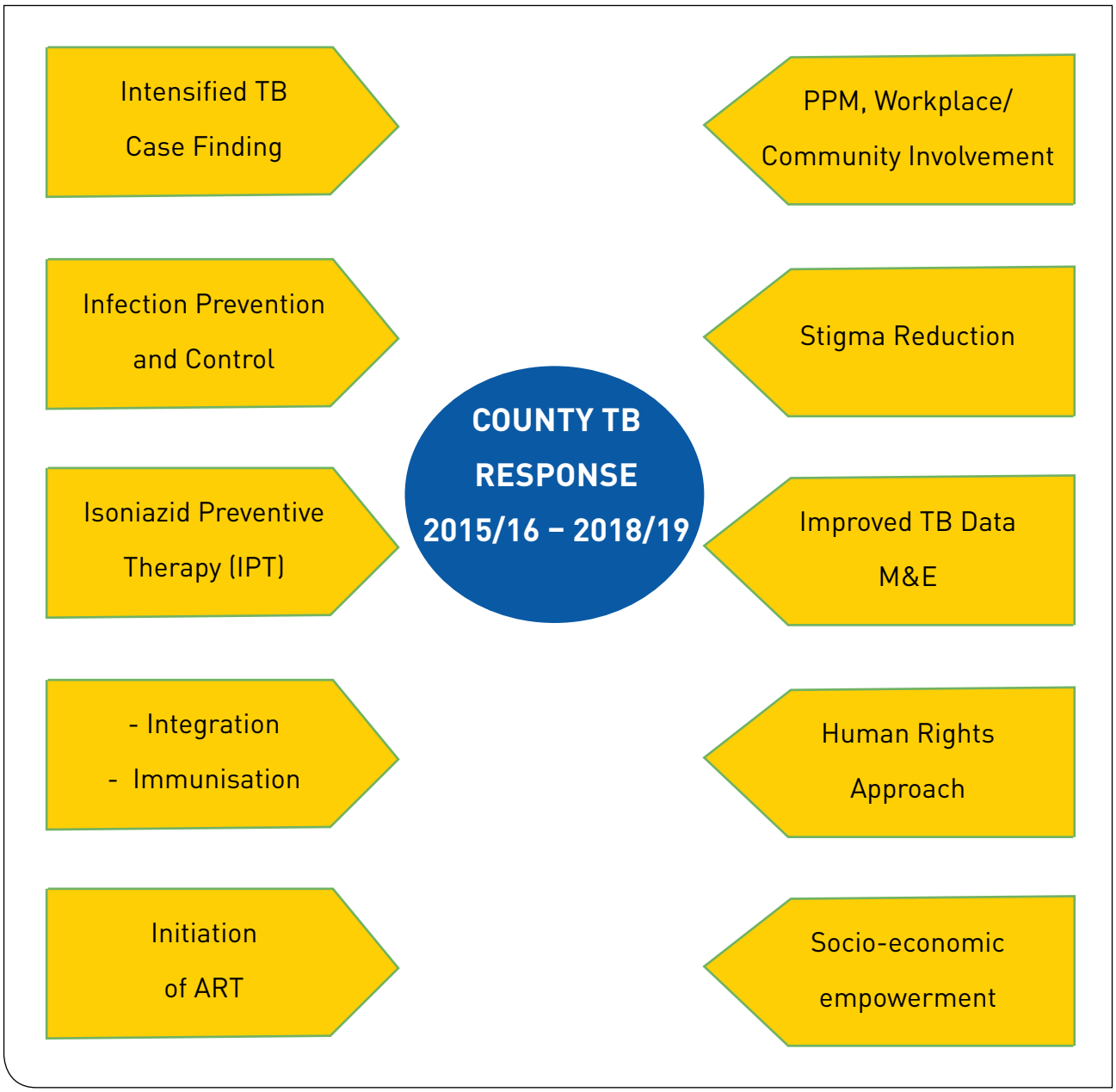


Figure 4.2: County TB response

(b) Targeted HIV prevention to priority populations

The County has had HTS campaigns which significantly increased the total number of annual tests conducted; however, such campaigns are conducted at significantly higher programmatic cost when compared with facility-based testing and with only a fraction of the yield. In addition, there is no evidence to show that the high-risk populations who are less likely to access HTS services at facilities were accessing the community-based HTS campaigns.

With this in mind, the County is shifting the community-based testing model which focuses on general population access, to a more focused, targeted approach on priority populations (Key and vulnerable populations), and in which the highest incidence and prevalence of HIV are documented. In line with KASF 2014/15-2018/19, the County will focus on the following priority populations:

(i) Key Populations (KP)

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

They include:

- Men who have Sex with Men (MSM),
- People who Inject drugs (PWID) and
- Sex Workers (SWs), both male and female.

(ii) Vulnerable population

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

- Adolescents and young people
- Truckers and migrant populations (SGR workers, workers in DWA Rea Vipingo Plantation)
- Men, children and pregnant women living with HIV
- People Living with HIV and discordant couples
- People in prisons and remand settings
- OVC, PWD, widows and widowers
- Drug dependants and alcoholics
- Religious sects (E.g. Kavonokya sect)

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

(c) Maximize efficiency in service delivery through integration

The MCHTSP identifies the following integrations as key in maximizing efficiency in service delivery.

- **TB and HIV:** This plan prioritizes high impact interventions for TB and HIV integration with an emphasis on gaining efficiency from aligning programme management and consistent collaboration and coordination of TB and HIV services through joint planning, budgeting, implementation, supervision, monitoring and feedback.
- **Family Planning and HIV:** Rapid population growth is a threat to all health and development goals in the County. Family Planning (FP) is the second prong of PMTCT; widely accessible and consistently available FP services through multiple points of contact with patients and clients are critical components to controlling the HIV epidemic.
- **Integration of HIV and TB diagnosis and care in all service points**: To minimize on missed opportunities, this plan seeks to integrate HIV testing and TB screening care and treatment to all the facility entry points.

(c) Leverage opportunities through creation of synergies with other sectors for HIV and TB prevention

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

- GK prisons and remand centres
- Road, transport and infrastructure
- Education sector
- Faith sector
- Media
- Workplace settings
- Trade industry, tourism and cooperatives

Table 4. 1: Interventions utilizing combination approach in targeted populations

MCHTSP Result	Key Activity/ Intervention on area	Sub Activity/Intervention			Target Population	Geographic areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
New HIV infections reduced by 80%	HIV prevention targeting adolescent and young people	-Offer age appropriate contraceptives, condoms, microbicides -Establish youth-friendly clinic services -Home-based HTS during school holidays - Parents follow up as index clients for testing adolescents -Implement APOC	-Increase access to sexual and reproductive health services - Offer peer-to-peer outreaches in school and out of school. - Implement Evidence-based Interventions(EBIs) - Conduct life skill trainings - Send messages intended to reduce intergenerational sex - Mass campaigns to motivate those testing HIV-negative to adopt risk reduction behaviour and stay negative. - Enhance abstinence and behaviour-change messages	- Implement cash transfer programmes to keep girls and boys in school and social protection for vulnerable families - Stigma reduction campaigns - Economic empowerment through micro-financing for youth out of school - Review requirement of parental consent for HIV testing - GBV reduction programme - Develop data collection tools to capture adolescents and young people	Adolescents and young people	All sub-counties	All health facilities CSOs Partners CASCOs Social development Children department

Interventions utilizing combination approach in targeted populations

MCHTSP Result	Key Activity/ Intervention on area	Sub Activity/Intervention			Target Population	Geographic areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
New HIV infections reduced by 80%	HIV prevention targeting general population	- Carry targeted community outreaches - Scale up PITC services to periphery health facilities	- Mass campaigns to increase uptake of HTS - Promote post-test HIV clubs - Promote safe sex practices - Promote proper and consistent condom use	- Stigma reduction campaigns - Implement GBV elimination programmes	General population	All sub-counties	All health facilities CSOs Partners
	HIV prevention targeting truckers and construction workers	- Carry out mobile outreaches - Moonlight HTS - Establish wellness centres along the transport corridor - Offer HTS in all SGR camps	- Promote condom use campaigns - Install condom dispensers in strategic points	- Stigma reduction campaigns - Implement GBV elimination programmes	Truckers - (SGR construction workers)	Along the transport corridor SGR camps	CEC Health CSOs Partners CHMT
	PLHIV and discordant couples	PLHIV and discordant couples - Implement prevention with positives (PWP) package - Offer family planning services - Offer HTS to partners and families of all HI-positive clients through intensive contact tracing and Community-Based HTS (CBHTS) - Offer HTS to partners and families of all HIV-positive clients	- Assist in partner disclosure for PLHIV - Motivate HIV-negative partner to stay negative - Engage peer educators to scale up family testing for PLHIV - Promote proper and consistent use of condoms - Establish and strengthen psychosocial support groups for discordant couples	- Initiate linkages between human rights abuses identified in health facilities with the legal system - Create awareness on the HIV tribunal services - Decentralize the HIV tribunal -Implement GBV reduction strategies	PLHIV and discordant couples	All sub-counties	CHMT CSOs Networks of PLHIV Partners

Interventions utilizing combination approach in targeted populations

MCHTSP Result	Key Activity/ Intervention on area	Sub Activity/Intervention			Target Population	Geographic areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
New HIV infections reduced by 80%	Prevention targeting People With Disability (PWD)	- Scale up HTS among PLWD by disability category - Increase access to ART and other HIV services -Train HCWs on sign language to enhance service provision - Integrate HIV sensitization during medical assessments	- Develop appropriate IEC materials customized to each specific category - Sensitization campaigns intended to reduce stigma and discrimination in the community	Raise awareness of people with disabilities to enable them to claim for their rights - Implement disability-conducive infrastructures in health facilities -Advocate for condom packaging and ART labels with Braille	- HCWs PWD	All sub-counties	All health facilities Partners CSOs Community gate-keepers Faith Sector Media, County Social Services
	Prevention targeting Key Populations (MSM, sex workers and PWID)	- Offer targeted HTS - Scale up STI management in all health facilities - Offer PEP and PrEP as the national guidelines - Carry out moonlight HTS at hot spots - Train HCWs and law enforcers on HIV-sensitive programming	- Establish support groups - Mass campaigns to increase service uptake - Targeted messaging - Implement alcohol and substance abuse reduction programmes - Targeted distribution of condoms and lubricants	- Lobby for 100% condom use policy in the County	Key Populations (MSM, sex workers and PWID)	All sub-counties	All health facilities CSOs Partners, CEC - Health Chair - Health Committee

Interventions utilizing combination approach in targeted populations

MCHTSP Result	Key Activity/ Intervention on area	Sub Activity/Intervention			Target Population	Geographic areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
New HIV infections reduced by 80% New TB infections reduced by 5%	PMTCT	- Scale up family planning to prevent unwanted pregnancies - Provide care, treatment and support for mothers with HIV and their children - Ensure all children, pregnant and lactating women are initiated on ART as per national guidelines - Support partner disclosure - Implement regular community outreaches in far-to-reach areas - Strengthening Clinical Mentoring to improve provider skills for managing pediatric patients at all health facilities. - Screen all pregnant mothers for TB - Offer IPT to all eligible pregnant mothers infected with HIV found not to have active TB - Integration of HIV services for the whole family in the MCH and PMTCT clinic - Implement PMTCT national guidelines	Establish and strengthen support groups for pregnant women -Advocate for pregnant mother to attend ANC clinics and deliver in health facilities. -Utilize mentor mothers to support HIV-positive pregnant women and pregnant adolescents - Promote and scale up exclusive breastfeeding - Promote male engagement in child HIV testing and prevention - Promote ART adherence by use HTS adherence counselors and mentor mothers. - Step up community awareness campaigns to improve awareness, linkage to and retention in care through community structures	- Involve communities to challenge gender norms that affect the health of women and children - Address home-births through engagement and education of Traditional Birth Attendants (TBAs). - Encourage TBAs to escort mother to health facilities for deliveries - Promote child rights and protection - Lobby for incentives for mentor mothers -Renaming of MCH to Family Centres	Pregnant women Children	All sub-counties	All health facilities CSOs Partners

Interventions utilizing combination approach in targeted populations

MCHTSP Result	Key Activity/ Intervention on area	Sub Activity/Intervention			Target Population	Geographic areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
New HIV infections reduced by 80%	Scale up use of male and female condoms	- Distribution of condoms as lubricants to targeted populations - Increase access to both male and female condoms	Promote consistent and proper condom use and disposal - Male and female condom demonstrations - Create awareness on the importance of condom use among religious leaders, herbalists and community gate keepers	Strengthen the supply management chain - Purchase penile and vaginal models - Provide condom dispensers in strategic positions	General population KPs Adolescents and young people	All sub counties	KEMSA, County procurement unit Health facilities CSOs Partners
	Early infant diagnosis (EID)	- Conduct PCR DBS at six weeks for all exposed infants - Integrate EID in immunization centres	- Community sensitization for uptake of service	- Enhance DBS transportation to national reference laboratory and feedback of results to facilities - Procure PCR machine - Decentralize KEMRI service to the County	Infants	All sub counties	KEMRI Health facilities CSOs

Table 4.2: Interventions to maximize efficiency in service delivery through integration

MCHTSP Result	Key Activity/ Intervention on area	Sub Activity/Intervention			Target Population	Geographic areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
New HIV infections reduced by 80% New TB infections reduced by 5%	TB/HIV integration	- Implement TB/ HIV collaborative activities - Integrate TB services in the already existing HIV services for mobile and migrant population - Integrate TB in already existing HIV service points and improve uptake of interventions for the co- infected	- Sensitize the community of availability of TB/ HIV integrated services	- Strengthen critical enablers i.e. nutritional support and other social protection	General population	All sub–counties	All health facilities CASCO CTLC Partners, CSOs
	TB/HIV in other service delivery points	- Offer screening for TB among all patients with chronic immuno-suppressive NCDs - Screen TB patients for diabetes - Integrate TB and HIV screening and treatment in all service delivery points -Scale up IMCI in all facilities	- Strengthen referral networks to bring care closer to patients - Community engagement in defaulter tracing		Diabetic clients General population	All sub-counties	All health facilities CASCO CTLC Partners, CSOs

Table 4.3: Interventions to leverage on other sectors to reduce new HIV and TB infections

MCHTSP Result	Key Activity/ Intervention on area	Sub Activity/Intervention			Target Population	Geographic areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
Reduced new HIV infection by 80%	GK Prison - Makueni and Remand set up	- Offer frequent and regular HTS and TB screening - Establish prison dispensaries - Train Prison warders on ART/ TB management - HIV/TB education for inmates and staff - Provide IPT to all prisoners - Increased access to appropriate HIV prevention, treatment, care and support services in prison settings including condom and lubricant distribution - Offer STI screening and treatment - Offer TB screening and appropriate treatment	Risk reduction counseling for HIV negative testers - Establish psychosocial support mechanisms - ART adherence session in prisons and remand	- Review of prison policy on HIV prevention to include condom use, PrEP, safe injecting needles and conjugal visits	Inmates Prison staff	Makueni GK prison, and remands	Prison admini-stration, Police admini-stration CEC - Health CASCO, CTLC
	Workplace	- Offer HTS at workplaces - Offer self-testing as per the national guidelines	- Promotion and social marketing of condoms in hotspots (hotels, lodges and bars) - Implementation of a minimum package of HIV services in the workplace (sensitization, BCC, HTS, referral to clinical services, reduction of stigma and discrimination)	- Enforce HIV/ TB stigma and discrimination policy. Establish peer educators for HIV and TB at the workplace - Mainstream HIV prevention activities in workplaces in all the sectors - Support HIV prevention as a Cooperate Social Responsibility (CSR)	Workplace settings County Department	All sub-counties	Employers County Public Service Boards

Interventions to leverage on other sectors to reduce new HIV and TB infections

MCHTSP Result	Key Activity/ Intervention on area	Sub Activity/Intervention			Target Population	Geographic areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
New HIV infections reduced by 80% New TB infections reduced by 5%	Education Sector	- Targeted HTS outreaches in schools, Technical training institutes (TTIs) and universities - Screening of TB in boarding schools and tertiary institutions - Provide IPT to contacts of smear-positive TB cases	- Improve access to accurate information on sexuality through introduction of age-appropriate comprehensive sexuality education in school curriculum - Sensitization on TB IPC activities in schools	- Ensure girls and boys stay in schools through social security programmes, conditional cash transfers and sanitary towels for girls - Address stigma reduction in schools - Implement education policy, guidelines and teacher training that includes age-appropriate lessons on HIV, sexual reproductive health and rights - Enforce public health regulations in schools and tertiary institutions	Students Teachers and support staff	All schools and colleges	MoEsT CEC - Education CEC - Health Partners, CSOs CPHO
	Road, transport and infrastructure	-Targeted HTS and STI screening to Standard Gauge Railway (SGR) construction workers, bodaboda riders, matatu drivers and turn boys - Establish wellness centres along the SGR and transport corridors	- Promotion of consistent and proper condom use. - Establish psychosocial support groups for HIV-positive workers - Train peer educators to offer peer-to-peer sessions. - Distribute targeted IEC messages - Use public transport systems for prevention messages, condom and lubricants distribution targeting the general and Key Populations	- Develop capacity through cross-county collaboration and coordination of HIV along transport corridor	Matatu drivers Turnboys Bodaboda riders SGR construction workers	Transport corridor Matatu terminals SGR camps	CEC - Transport, CEC - Health Partners CSOs

Interventions to leverage on other sectors to reduce new HIV and TB infections

MCHTSP Result	Key Activity/ Intervention on area	Sub Activity/Intervention			Target Population	Geographic areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
New HIV infections reduced by 80% New TB infections reduced by 5%	Trade Tourism and Cooperatives industries	- Offer moonlight HTS services	- Require HIV prevention messages and services in hotels, bars and lodgings - Condom and lubricants distribution in lodges and bars - Targeted IEC materials	- Install condom dispensers in Bars and lodges	General population, KP	All hotels, lodges and bars in all sub counties	CEC Health Partners Hotel owners
	Faith Sector	Offer HIV and TB prevention services in Faith based hospitals -Hold workshops with religious leaders to address the notion of faith healing as a barrier to HIV treatment and adherence	- Conduct and adapt stigma-free HIV prevention campaigns - Establish networks for religious leaders living with HIV networkers - Utilize youth groups for HIV and TB prevention - Faith sector-led/ initiated HTS campaigns	- Develop curriculum for training religious leaders on HIV and TB	Religious leaders	All sub-counties Religious centres	Faith sector represen-tatives
	Media		- Hold joint media sharing forums on HIV, TB, GBV and stigma reduction - Develop and initiate consistent broadcast programmes on HIV and AIDS through the local FM/TV stations - Develop age-appropriate messages as pamphlets in newspapers - Create new and strengthen existing coalitions of media organizations on specific themes of HIV prevention - Promote health service utilization including comprehensive HIV services - Documentaries on success stories, best practices and prevention messages	- Strengthening and provision of specific support to media associations of PLHIV, adolescents and young people for Meaningful Involvement of PLHIV (MIPA)	General Population, KP, men, pregnant mothers, adolescents and young people	All sub-counties	County Public Service Board Department of Labour and ICT Local media houses

Table 4.4: Intervention to reduce new TB infections

MCHTSP Result	Key Activity/ Intervention on area	Sub Activity/Intervention			Target Population	Geographic areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
New TB infections reduced by 5%	Infection Prevention and Control (IPC) in health facility settings	- Implement IPC in all County Government and privates facilities - Conduct annual screening of HCWs - Accelerate the operationa-lization of infection control plans, starting with high-volume facilities - Integrate TB Infection, Prevention and Control (IPC) into the general IPC committees at facilities - Enhance TB IPC in diagnostic facilities (Provide bio-safety hoods, ventilators and N95 masks) - Intensify sputum transport to Central Reference laboratories and regional DR-TB gene-expert centres - Periodic screening for TB and HIV tests for HCWs - Carry out baseline risk/ need assessment in health facilities for IPC - Immunize all children as per national guidelines	- Carry out TB awareness and screening campaigns in school, colleges and prisons to intensify detection of new cases - Capacity build HCWS on personal preventive measures - Implement the components of IPC (Administrative, personal and environmental measures)	- Address social economic barriers to prevention, treatment initiation and treatment completion	HCWS, TB index clients	All sub-counties	CTLC, CHMT CSOs Partners CASCO County laboratory office

Intervention to reduce new TB infections

MCHTSP Result	Key Activity/ Intervention on area	Sub Activity/Intervention			Target Population	Geographic areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
New TB infections reduced by 5%	IPC in work places	Carry out screening of households contacts of children index TB cases	-Develop and implement TB and TB/HIV work place policies to promote infection control -Intensify early case finding through structured contact tracing in facility and community settings. - Community sensitization on IPC in public transport vehicles	-Leverage on other ministries e.g. housing, to embed IPC in planning policies - Enforce occupational and public health policies in workplace settings	Work place settings	All sub counties	County PHIO CTLC Partners Employers
	IPC in urban slums	Intensify community engagement and outreach	-Expand the availability of diagnostic sites and referral networks, including sputum collection points to bring services closer to patients	- Expand eligibility of social protect programs to include TB patients -Increase the engagement of non-government providers already present in the slums or reaching slum dwellers	- Urban slums and townships	All urban slums	CTLC Partners Community pharmacies CSOs
	IPT children and PLHIV	- Offer IPT as per national guidelines -Trace and screen TB contacts -Offer IPT to all child exposed to smear positive -Scale up IPT with focus to reach all eligible PLHIV and children exposed to PTB+ - Harmonize clinic appointments for INH Review and routine HIV Care - Provide reporting tools - Ensure availability of Isoniazid	-Strengthen adherence of TB patients to treatment - Offer supportive adherence to INH Prophylaxis		- Children and PLHIV	All sub counties	CTLC Partners Community Pharmacies CSOs

4.4.2 Strategic Direction 2: Improve Health Outcomes and Wellness of TB patients and People Living with HIV

The County has an estimated 22, 100 adults and 3, 372 Children Living with HIV[16]. There were 644 clinically-diagnosed and 830 bacteriologically-confirmed new TB cases in 2015. The TB/HIV co-infection was 28% as at end of 2015, with a higher rate of mortality among HIV-positive clients (17% among the co-infected and 6% in HIV negative)[17].

This strategic direction aims to:

- Reduce morbidity and mortality resulting from HIV and TB.
- Ensure that people living with HIV and TB remain within the health care system and adhere to their treatment through universal access to affordable and good quality diagnosis, treatment and care.
- Ensure that all services are responsive to the needs of people living with HIV and TB patients by integrating TB and HIV services within the chronic-care system (to deliver longterm care), expanding clinic operating hours and decentralizing HIV and TB care to community and dispensary levels.

The focus of this Strategic Direction is to put the County on the path to achieving, by 2019, the TB and HIV treatment targets of:

- Ensuring that 90% of all people living with HIV are diagnosed and linked to care.
- Ensuring that 90% of all people diagnosed with HIV infection are initiated on anti-retroviral therapy and retained in care.
- Ensuring that 90% of all people receiving anti-retroviral therapy achieve viral suppression.
- Increasing case notification of new TB infections to 85%.
- Ensuring treatment success of at least 95% among all Drug Susceptible (DS) forms of TB.

a) Ensuring that 90% of all people living with HIV are diagnosed and linked to care

HIV testing is the gateway to accessing HIV treatment and care and a successful public health response to HIV requires robust HTS services. The County will re-focus its HTS programme to meet the goal of having 90% of PLHIV know their status by 2019. With increasing HTS and ART coverage, finding the remaining undiagnosed PLHIV becomes increasingly challenging. Following the law of diminishing returns, the HTS programme projections in this plan are based on the assumption that the number of tests required will need to increase dramatically towards the end of the 4-year period in order to identify sufficient numbers of previously undiagnosed PLHIV to sustain the targeted ART scale-up. HTS will be delivered through a strategic mix of facility and outreach-based models to cover the County gap of 7,730 PLHIV (34% gap) [18]who do not know their Status as at December, 2015, including linking them to care and treatment.

b) Ensuring that 90% of all people diagnosed with HIV are started and retained on anti-retroviral therapy

Patients may be lost at various stages in the continuum of care. Early identification of PLHIV and their prompt enrollment in care would support the 90-90-90 UNAIDS goal and maximize the effectiveness of the existing programme strategies to virtually eliminate progression to AIDS, premature

[16] Kenya HIV County Profile 2014

[17] TIBU 2015

[18] NASCOP ACT Dash Board 2015

death and HIV transmission. Early ART has by far the most substantial effect on HIV incidence among all scientifically-tested interventions[19]. The County strives to meet the pediatric and adult ART gap of 31 per cent translating to 6,359 PLHIV[20].

c) Ensuring that 90% of all people receiving anti-retroviral therapy achieve viral suppression

The final goal of ART is to ensure that those infected with HIV attain undetectable levels of virus in their bodies. A suppressed viral load is critical in controlling the harmful effects of HIV infection on people's health and also reduces the risk of infecting others including sexual partners and children. The County Viral suppression gap for adults and children is 11,054 (59%) PLHIV[21].

d) Increase case notification of new TB cases to 85% of the previous year

Makueni County has a case notification rate of <175/100,000. Case notification rates are loosely, yet inversely-related to prevalence of poverty; suggesting missing cases among the poor[22]. The County has prioritized to put in measures to identify and treat all TB cases, and to find the missing cases.

e) Ensuring treatment success rate of at least 95% among all drug-susceptible forms of TB

Treatment outcomes in TB patients may be influenced by various patient and health system factors. The County will intensify efforts to mitigate these by enhancing access to health education on TB, improved services that enhance retention, and strengthening referral networks to improve access to diagnostic treatment services.

[19] UNAIDS. Ambitious treatment targets: writing the final chapter of the AIDS epidemic. In: UNAIDS, ed. Geneva: UNAIDS, 2014.

[20] NASCOP ACT Dash Board 2015

[21] NASCOP ACT Dash Board 2015

[22] National Strategic Plan for Tuberculosis, Leprosy and Lung Disease (2015-2018)

Table 4.5: Interventions to improve health outcomes and wellness of TB patients and PLHIV

MCHTSP Result	Key Activity/ Intervention on area	Sub-activity/Interventions			Target Population	Geographical areas by county/ Sub county	Responsi-bility
		Biomedical	Behavioural	Structural			
90% of all PLHIV diagnosed and linked to care	HTS for adolescents and young people and linkage to care	- Home-based HTS during school holidays - Parents follow up as index clients for testing adolescents - Same day enrollment for HIV-positive adolescent and young people - Scale up IPC in all facilities	- Integrate HIV care in youth-friendly sexual and reproductive health services - Behavior formation interventions - Utilise CHVs to escort newly-diagnosed HIV clients for enrollment - Intensify follow up of new diagnosed clients	- Education subsidy programmes to keep children in school - Adolescences and youth-friendly centres - Update school HIV Curriculum - Incorporate HIV messages in school health programmes - Use social media to encourage the youth to seek HTS	Guardians Adolescents and young people	All sub counties, schools, universities, TTIs and colleges	Health Facilities MoE CHMT CASCO/ SCASCO CSOs Imple-menting partners, KEMSA
	HTS –KP and linkages	-Intensify targeted HTS - Scale up STI screening and management -Offer moonlight HTS along the highway	-Implement snow balling to reach KP - Train peer educators in conducting accompanied referrals to healthcare facilities - Provide key messages to KP	-Stigma reduction campaigns - Establishment of more psychosocial support groups	KP General population	All sub counties	Health facilities HMT CASCO CSOs Partners

Interventions to improve health outcomes and wellness of TB patients and PLHIV

MCHTSP Result	Key Activity/ Intervention on area	Sub-activity/Interventions			Target Population	Geographical areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
90% of all PLHIV diagnosed and linked to care	HTS-Men, Children and pregnant women, and linkages	-Implement full package of eMTCT within ANC -Targeted testing in all entry points (ANC, Maternity and Postnatal clinic) -Increase access to DNA/PCR testing for infants in PMTCT -PITC for children at points of care i.e. OPD, paediatric wards, MCH, and other clinics. -Parent follow up as index clients for children testing -Offer HTS during immunization campaigns with parental consent	- Involve CHVs and mentor mothers in referring and follow up on ANC and postnatal mothers - Sensitise communities for update of HTS services - Utilise CHVs to escort new diagnosed HIV clients for enrollment -Follow up of new diagnosed clients	-Implement male friendly services - Challenge cultural practices that keep men from up taking SRH services	Pregnant women, Children,	All sub counties	Health facilities, CHMT CASCO, Partners CSOs Community gate keepers, Faith sector
	HTS General population and linkages	-Provide for HTS counselor supervision and mentorship. - Scale up prevention interventions for TB, OIs and other co-morbidities, water and sanitation related diseases, vaccinations for preventable diseases (cervical cancer, hepatitis, pneumococcal) --Targeted HTS in all inpatient wards - Same day enrolment for HIV positive clients (test and Treat)	- Scale-up facility and community linkages with inter- and intra-facility referral and linkages. Sensitise communities for update of HTS services. -Targeted HTS campaigns -Public education on HTS - Utilize CHVs to escort new diagnosed HIV clients for enrollment -Follow up of new diagnosed clients	- Stigma reduction campaigns - One stop-shop in all health facilities	General population	All sub counties	Health Facilities, CHMT, CASCO, partners, CSOs
	HTS targeting Migrant workers and townships/ informal settlements	-Offer HTS and TB screening in SGR camps and low Income settlements areas		-Stigma reduction campaigns	Townships, DWA sisal plantation	SGR camps-Kilome, Kibwezi E & W	Health Facilities, CHMT, CASCO, partners, CSOs

Interventions to improve health outcomes and wellness of TB patients and PLHIV

MCHTSP Result	Key Activity/ Intervention on area	Sub-activity/Interventions			Target Population	Geographical areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
90% of all PLHIV started and retained on ART	ART – Adolescent and young people and linkages	- Integrate HIV care and treatment into youth-friendly services - Implement APOC - Reduce pill burden through Fixed Dose Combination (FDCs) - Increase ART Central sites - Set special dedicated clinic days - Utilise technology including social media for education, recruitment and retention in care - Introduce electronic appointment cards	- School-based follow-up by HCWs - Provide care givers with HIV education, literacy and empowerment - Adolescent support groups linked up with health facilities - School-based treatment literacy programmes - Utilize teacher/ school support staff to provide support for adherence to ART in schools - Supportive disclosure	- Review teacher training curriculum to include updated HIV information	Care givers, Adolescents and young people	All sub counties	MoEST TSC CHMT Partners CSOs Faith Sector, County Director of Education
	ART–KP	- Integrate ART services in drop-in centres Sensitize HCWS on KP programming	-Reduce stigma to increase access to care and treatment -Address stigma and discrimination by health care providers. -Empower KP to negotiate for safer sex (safer sex negotiation skills)	-Address socio cultural barriers to drug adherences.	MSM PWID FSW and their clients	All sub counties	Health Facilities, CHMT, CASCO, partners, CSOs

Interventions to improve health outcomes and wellness of TB patients and PLHIV

MCHTSP Result	Key Activity/ Intervention on area	Sub-activity/Interventions			Target Population	Geographical areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
90% of all PLHIV started and retained on ART	ART General Population	- Address HIV/TB co-infections - Reduce pill burden through Fixed Dose Combination (FDCs) - Increase ART central sites - Develop an identification system (unique identifier) to identify and track patients across all services - Integration of services - Screen all pre-ART clients for hepatits B, CRAG, geneXpert for ART eligibility assessment - Conduct CD 4 Count RRI for all pre-ART clients	- Offer patient education on drug adherence - Establish and strengthen existing psychosocial support groups formation - Strengthen treatment partners (uddy system) - Mass media campaigns to increase uptake of ART services - Implement patient retention strategies (treatment literacy sessions, peer and psychosocial support) - Utilize technology including social media for education, recruitment and retention incare	-Hold stigma reduction and discrimination campaigns - Formulation and use of standard operating procedure (SOPs)	General population	All sub counties	Health facilities CHMT CASCO, Partners CSOs

Interventions to improve health outcomes and wellness of TB patients and PLHIV

MCHTSP Result	Key Activity/ Intervention on area	Sub-activity/Interventions			Target Population	Geographical areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
90% of all PLHIV started and retained on ART	ART - men, children and pregnant women	-Initiate ART as per national guidelines	- Offer family psychosocial support - Supportive disclosure - Offer ART adherence counseling - Offer nutritional counseling, support - Scale up the mother-infant pair models utilising community systems such as mentor mothers and CSOs to enhance retention in care as well as defaulter tracing	- Empower families to initiate and sustain livelihoods - Implement standard operating procedures	Men, Children and pregnant women	All sub counties	Health facilities CHMT CASCO Partners CSOs

Interventions to improve health outcomes and wellness of TB patients and PLHIV

MCHTSP Result	Key Activity/ Intervention on area	Sub-activity/Interventions			Target Population	Geographical areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
90% of all PLHIV on ART achieving viral suppre-ssion*	Conduct Viral Load	- Carry out viral load tests to newly ART-initiated, after six months, 12 months then annually - Capacity build HCWs on interpretation of viral load results - Revive Multi-Displinary Team (MDT) in patients management - Capacity build laboratory technologist in sample collection, handling and transportation - Scale up routine viral load monitoring in children to monitor ART failure and adherence - Line listing of all clients in pre-ART and ART registers to identify those eligible	- Promote ART adherence through adherence counselors and other HCWs - Strengthen psychosocial group meetings - Strengthen defaulter tracing mechanisms - Strengthen network systems for transporting samples and relaying reports - Involvement of treatment supporters and family members in HIV care and treatment	- Decentralize viral load tests to the County - Lobby for nutritional support	PLHIV	All sub-counties	Health facilities CHMT CASCO Partners CSOs KEMRI

Table 4.6: Intervention to improve health outcomes of people with TB

MCHTSP Result	Key Activity/ Intervention on area	Sub-activity/Interventions			Target Population	Geographical areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
TB mortality reduced by 3%	Intensify TB Case finding (ICF)	- Build capacity of health workers and laboratory technicians to identify and diagnose TB - Strengthen implementation and monitoring of systematic TB screening at health facility, in-patient wards and community levels, with improved documentation of presumptive TB cases and linkages to diagnostic and care sites. - Ensure the availability of referral networks for sputum samples and patient care - Intensify technical assistance and supportive supervision from Centres of Excellence or the NTLD Programme - Enhance identification and linkages of TB and other Departments including OPD - HTS in chest clinics	- Expand commu-nication efforts in communities to stimulate care seeking behaviours - Strengthen CHEWs, CHVs and CSOs in TB prevention and case finding - Offer health education forums through baraza and media, national events including World TB Day - Carry out contact tracing of all TB patients - Integrate CBTBC in Community Units and CSO activities - Establish and strengthen TB expert support groups	- Address stigma and discrimination associated with TB - Lobby for inclusion of TB and HIV in County social protection strategies	General population Boarding school settings	All subcounties	Health facilities CHMT CASCO Partners CSOs

Intervention to improve health outcomes of people with TB

MCHTSP Result	Key Activity/ Intervention on area	Sub-activity/Interventions			Target Population	Geographical areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
TB mortality reduced by 3%	ICF targeting Prisoners and prison staff	- Implement TB infection controls in Prisons as per national guidelines - Carry out screening upon entry to prisons using P10 -Introduce diagnostic and DOT capacity on site -Introduce annual TB screening as part of routine/ periodic wellness examination for prison staff	-Enhance infection control in prison and detention settings -Develop IEC materials for prisoners and prison staff -Develop referral mechanisms for prisoners who are transferred or released	- Address stigma and discrimination associated with TB - Lobby for inclusion of TB and HIV in County social protection strategies	Inmate and prison staff	GK prisons-Makueni	CTLC Prison admini-stration, Partners
	ICF targeting Paediatric TB	-Integrate child TB services in MCH, PMCTC, OPD, pediatric outpatient clinics and pediatric inpatient wards clinics -Utilize GeneXpert, chest x-rays, and TST in diagnosis of pediatric TB. -Capacity build HCWs on child TB case detection, diagnosis and treatment	- Community engagement for contact tracing , supervision of DOT for TB patients and tracing defaulters - Increase community advocacy and awareness on childhood TB. - Conduct active contact tracing and screening for 100% of patients with DR-TB	- Initiate social support for OVCs on TB treatment. -Carry out awareness and TB screening in schools, colleges and orphanages to intensify detection of new cases. -Establish and equip chronic care clinic for asthma and other chronic lung conditions - Ensure uninterrupted supply of paediatric friendly DR_TB formulation for children - Eliminate diagnostic fee for children	Children of PTB+ guardians	All facilities (County, private and mission)	HCWs Partners CSOs CHEWS CTLC

Intervention to improve health outcomes of people with TB

MCHTSP Result	Key Activity/ Intervention on area	Sub-activity/Interventions			Target Population	Geographical areas by county/ Sub county	Responsi-bility
		BIOMEDICAL	BEHAVIOURAL	STRUCTURAL			
TB mortality reduced by 3 %	Workplace TB interventions	- Active screening of workers for TB. -IPC measures in all Health care settings	-Training and support of peer educators. -Develop and disseminate TB and HIV IEC materials -Implement occupational health safety measures	-Establish and implement work place policy that protects TB/ HIV workers from stigma and discrimination and the fear/ reality of loss of income - Ensure mandatory inclusion of TB benefits within the health insurance package	HCWS, employees	Work place settings	CTLC HCWS CPHO Employers
	TB treatment and Management	-Use mobile technology platforms to send SMS reminders for TB clinic attendance - Manage malnutrition in Children with TB - Offer TB treatment as per the national guidelines -Provide DOT by HCW for DRTB -Provide drug resistance surveillance to as per national guidelines. - Offer ART to TB and HIV co infected patients as per national guidelines-	Establish psychosocial support groups e.g. TB clubs, TB ambassadors. -Scale up treatment support strategy -Strengthen defaulter tracing by use of CHVs -Offer nutritional support for malnourished TB or TB and HIV patients -Workplace treatment support for patients on TB medications.	Initiate sustainable livelihood and food security imitative. -Lobby for policies to reduce direct costs on TB diagnosis and treatment -Offer DRTB patients support including food	TB Patients, TB and HIV co infected patients	TB Clinics	HCWs CTLC CSOs Partners

4.4.3 Strategic Direction 3:

Use a human rights-based approach to facilitate access to HIV and TB services

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

Certain groups are more vulnerable to contracting the HIV virus because they are unable to realize their civil, political, economic, social and cultural rights. Gender-Based Violence and gender inequality, for example, heighten the vulnerability of women and girls to HIV infection, particularly where access to education, age-appropriate HIV information as well as sexual and reproductive health services necessary to prevent HIV infection are unavailable or inaccessible. Promoting the full realization of all human rights and gender equality is therefore critical for preventing the spread of HIV, mitigating the social and economic impacts of the epidemic, and achieving an AIDS-free generation.

Strategies to address the HIV epidemic in the County are hampered by an environment where human rights are not respected. For example, stigmatization and discrimination against marginalized groups such as sex workers and MSM drive these populations underground. This impedes efforts to reach them with prevention initiatives, thereby increasing their vulnerability to HIV. Similarly, failure to provide access to appropriate information about HIV, or treatment, and care and support services further fuels the AIDS epidemic.[23]

The Constitution of Kenya 2010 in Article 27 recognizes that measures should be put in place to encourage affirmative action programmes and policies to address past inequalities. Economic and social rights to all are also recognized in Article 43. These include the right to health care services, adequate housing, and sanitation, adequate food of acceptable quality, clean and safe water and appropriate social security to vulnerable groups in the society.[24]

The MCHTSP seeks to:

- Remove barriers to access of HIV and TB rights information and services
- Improve County legal and policy environment for protection of the rights of priority populations and TB patients
- Reduce and monitor human rights violations including SGBV, IPV and stigma and discrimination

[23] UNAIDS 2014

[24] Kenya Constitution, 2010

Table 4.7: Interventions for using human rights-based approach to facilitate access to HIV and TB Services for PLHIV and TB patients

MCHTSP Result	Key Activity/ Intervention on area	Sub-activity/Interventions	Target Population	Geographical areas by county/ Sub county	Responsibility
Stigma and discrimination reduced by 50%	Remove barriers to access of HIV and TB rights information and services	- Promote uptake of HIV pre and post-exposure prophylaxis among survivors of sexual violence and priority population - Sensitize County assembly to enact laws that prohibit discrimination and against PLHIV/Key Populations - Train prisons personnel regarding HIV and TB prevention, health care needs and human rights of detainees infected with or at risk of TB and HIV, and support access to HIV care and treatment - Conduct legal literacy (know your rights) campaigns to improve legal and human rights literacy among KPs, PLHIV and TB patients and priority populations. - Train and sensitize HCWS to reduce stigmatizing attitudes in health care settings - Integrate HIV information and encourage service uptake in religious teachings - Facilitate campaigns on reduction of stigma and discrimination, GBV, IPV and promote uptake of HIV services and TB prevention interventions - Enroll OVCS, PLHIV and TB patients into social protection programmes - Roll out sustainable Income Generating Activities (IGAs) to empower vulnerable populations - Develop and disseminate 'know your rights' population-specific IEC materials - Integrate HIV and TB in religious teachings - Use of KP peer groups to enhance uptake of HTS and TB services	Key Populations Survivors of SGBV OVC TB Patients	All sub-counties	CEC Health CASCO CSOs Partners Faith sector, Media County social services

Interventions for using human rights-based approach to facilitate access to HIV and TB Services for PLHIV and TB patients

MCHTSP Result	Key Activity/ Intervention on area	Sub-activity/Interventions	Target Population	Geographical areas by county/ Sub county	Responsibility
Stigma and discrimination reduced by 50%	Improve county legal and policy environment for protection of the rights of priority populations and TB patients	- Lobby for County enactment and implementation of laws, regulations and policies that prohibit discrimination and support access to HIV and TB prevention, care and support - Provide legal services to those who face human rights violations - Facilitate access to justice and redress in cases of HIV-related discrimination or other legal matters - Capacity building to civil society to promote access to justice. - Hold County Government accountable to their constitutional and statutory obligations -Implement the TB patient Treatment charter - Decentralization of HIV/AIDS tribunal centre to County and sub-counties - Empower communities to participate in proposed County Bills - MIPA in policy formulation and planning including commemoration of World TB and AIDS day - Enforce PLHIV rights	Key Populations and peer groups PLHIV TB patients General population	All sub-counties	Judiciary, County Assembly CEC- Health NGOs/CSOs HIV tribunal Partners
	Reduce and monitor human rights violations including SGBV, IPV and stigma and discrimination	- Develop tools to monitor incidents of rights violation, including discrimination, GBV and denial of health care services for KP, PLHIV and TB patients - Sensitize communities/ populations on their rights - Invest in community programmes to change harmful gender norms and stereo types - Introduce SGBV desks in health facilities and train health personnel on SGBV - Lobby for a County legislation on SGBV - Establish SGBV rescue centres	Communities, Health settings Work place settings	All sub counties	Human rights institutions Employers CEC - Health HIV tribunal Partners CSOs

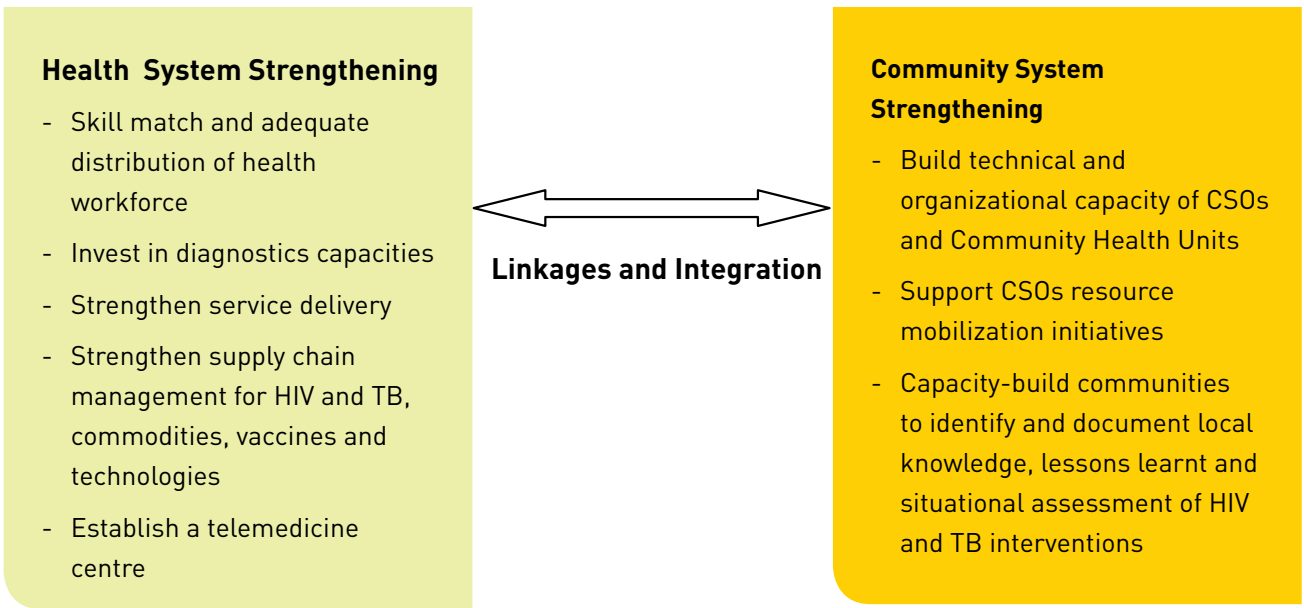
4.4.4 Strategic Direction 4:

Strengthen integration of community and health systems

The County is cognizant of the need to strengthen health systems through investing in diagnostic capacities and balancing the health facilities in existence with adequate personnel. One of the County health flagship projects is to establish a telemedicine centre at the County referral hospital and connected via media to other County hospitals. Doctors will be able to attend to medical cases by guiding medical officers on making diagnosis and eventual prescription. The telemedicine centre will be complete with a medical app providing integrated medical services[25].

The community is an under-utilized resource in HIV and TB response in the County, and the need to more closely coordinate facility and community activities and interactions has never been more apparent. Communities have a key role to play in identifying, promoting and facilitating service uptake among members of key and vulnerable populations. Increasingly, specific tasks (such as HIV screening and adherence support) can be shifted away from overburdened healthcare service providers to community and home-based service delivery models which have been demonstrated to be effective. Communities and civil society organizations play an additional role in working to ensure key enablers are in place so that service delivery achieves maximum impact. Therefore, strengthening social networks, CSOs and Community Strategy units will have a positive impact on the ability of populations including the key and vulnerable populations to engage in health care and effectively contribute to the achievement of MCHTSP.

Figure 4.3: Makueni County health and community systems integration model



[25] Makueni County Annual Development Plan 2016-17

Some sectors, for example the faith-based sector, have an extensive network of institutions and individuals in communities, from densely populated towns to the most remote rural areas in Makueni. This network is coupled with infrastructure, e.g. places of worship, halls, schools and hospitals, which can be used to enhance existing programmes and create new programmes and services; and to act as points of service delivery, information centres and points of referral to services.

In this regard, this plan seeks to achieve the following

- Provide a competent, motivated and adequately staffed health workforce at the County to deliver HIV services integrated in the essential health package.
- Strengthen health and community service delivery system.
- Improve supply chain management for HIV commodities.

Table 4.8: Interventions to strengthen integration of community and health systems

MCHTSP Result	Key Activity/ Intervention on area	Sub-activity/Interventions	Responsibility
Strengthen health and community systems	Recruit and retain competent, motivated and adequately staffed health workforce	-On job training of all HIV service providers -Implement Continuous Medical education(CME) on TB, DR/ TB and HIV - Create incentives in terms of remuneration, promotions, Provision of study leaves and sponsorships to HCWs - Implement staff recognition such as end of year awards for best performing HCW. - Recruit HCWs (HTS counselors, Laboratory technologies, Clinicians, social workers, nutritionists). - Train HCWS on HIV and TB collaborative, Paediatric TB, DRTB and PAL activities -Develop and implement a Health staff retention policy -Redistribution of HCWs to ensure availability of appropriated competent staff. -Build capacity of Public health workers in targeted intervention for sensitizing health workers to work with people living with HIV and TB patients. -Build capacity of the Laboratory Staff for HIV and TB screening. -Train laboratory HCWs on AFB microscopy, FM and GeneXpert -Train HCWS on APOC Ensure health workers have access to prevention and other HIV– and TB-related services, immunization against vaccine-preventable diseases, especially Hepatitis B. -Consider task shifting as a way of increasing the pool of knowledgeable HIV and TB-related service providers and more-to-less-specialized health workers. -Ensure package of HIV and TB prevention, treatment and care services to health workers and their families on a priority basis and should be tailored specifically to their needs. - Establish occupational health and safety procedures to reduce the risk of contracting HIV, TB, Hepatitis and other blood-borne diseases in health settings. -Address stress and burnout, prohibiting HIV, TB-related and other forms of discrimination	County Public Service Board CEC Health Partners

Interventions to strengthen integration of community and health systems

MCHTSP Result	Key Activity/ Intervention on area	Sub-activity/Interventions	Responsibility
Strengthen health and community systems	Service delivery	- Decentralize HIV comprehensive services to health centres and dispensaries - Implement task shifting and mentorship programmes - Train Community Health workers on home and community-Based Care (HCBC) - Establish and strengthen existing Community units as per the community strategy guidelines - Build the capacity of CSOs in HIV and TB interventions - Comply with and carry out all routine quality assurance and quality control measures for HIV and TB - Establish a telemedicine centre -Enhance community care financing by: - Enhancing ability of CSOs to attract funding from diverse funding agencies through organisational development mentoring, - Proactively linking CSOs with funding agencies, - Supporting sustainable income generating activities by CSOs. - Allocate County budgets for CSOs interventions	CEC - Health CHMT Partners CSOs County Social Services
	Supply chain management	- Strengthen capacity of the County, sub-county and facilities to appropriately plan for, procure, store. And distribute and manage inventories of commodities - Strengthen and link DHIS, TIBU and LMIS systems for better management of supplies -Timely distribution of HIV and TB commodities from County to sub-county level - Ensure quality of TB medicines and diagnostics in the County and sub-counties - Proper quantification and timely procurement of HIV and TB commodities from KEMSA by County - Timely distribution of HIV and TB commodities (OIs drugs, condoms, test kits, TB Drugs) from KEMSA to facilities - Establish commodity security committees at the County and sub-county levels - Build capacity of HIV and TB commodities management into exiting LMIS commodity management packages	KEMSA CEC Health CHMT CHTC NTLD programme NASCOP

4.4.5 Strategic Direction 5:

Strengthen research, innovation and information management

HIV and TB research specific on implementation will be strengthened as a critical component of HIV and TB strategic information to document the knowledge gap in terms of effectiveness of intervention and implementation approaches so that the coverage is improved.

The main goal of research on HIV and TB in Makueni County is to provide scientific evidence to guide and enhance the County's response. Four main streams of research are presented as the basis for generating the knowledge needed to support the objectives of the MCHTSP namely:

- Surveillance and vital statistics
- Health systems and operations research
- Research for innovation
- Policy, social and public health research

Makueni county research gaps and challenges

The County faces the following research gaps and challenges:

- Inadequate data on barriers to access to HIV and TB services.
- Inadequate information on the existing sexual networks and HIV granulation in sub-counties/ ward levels.
- Limited engagement and involvement of other sectors in HIV and TB response.
- Inadequate information on effectiveness of community capacities to address HIV and TB.
- Inadequate information on cost effectiveness and efficiencies of HIV and TB programmes.
- Frequently changing guidelines – not allowing for adequate implementation research.

County research priorities

Table 4.9: County research priorities

Strategic Direction	Research Priority
SD1: Reduce new HIV and TB infections	• Understanding drivers of epidemic by population and geography • Map HIV sub-types and sexual networks • Identify barriers to testing and access to intervention services by populations
SD2: Improve health outcomes and wellness of TB patients and people living with HIV	• Barriers to initiation, linkage and adherence into care for TB and PLHIV • Determine effective models for increasing adherence in different populations • Correlation of nutritional status of TB patients and their treatment outcomes • Review of IPT efficacy in preventing new TB infections among PLHIV
SD3: Use a human right-based approach to facilitate access to HIV and TB services	• Establish determinants of access to justice for sub-populations
SD4: Strengthen integration of health and community systems	• Determine suitable models of community systems to support delivery of cost-effective HIV,TB and SRH responses
SD7: Increase domestic financing for a suitable HIV and TB response	• Determine the most effective and suitable model of domestic. • Determine the factors that would facilitate ownership and accountability for HIV response. • Evaluate effectiveness of existing HIV coordinating mechanisms
SD8: Promote accountable leadership for delivery of the results by all sectors and actors	

In order to strengthen the County research, innovation and information agenda, this Plan proposes to:

- Resource and implement County HIV research priorities
- Increase evidence planning and programming

Table 4.10: Interventions to strengthen research, innovation and information management

MCHTSP Result	Key Activity/ Intervention on area	Sub-activity/Interventions	Responsibility
Strengthened County Research, innovation and information management	Resource for Research	Partner with universities and colleges to prioritise HIV research. -Lobby for HIV research budget line in the HIV budget.	CHMT CEC Health Partners Academic institutions
	Build Capacity of HCWs on research	Train HCWs including laboratory personnel on HIV and TB research Enhance collaboration with local training institutions establish a HIV and TB research coordinating unit Conduct operational research Develop a County research agenda on the basis of detailed knowledge of the burden of disease	CEC Health CHMT Partners Local training institutions
	Application of research in decision making	-Disseminate research finding to county stakeholders to policy makers -Establish a resource centre -Publication of research findings in pamphlets and postings in the county web page for wider dissemination	CHMT Partners CEC Health

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

The County data sources are:

- Facility-based data/ information system - DHIS
- Community-Based interventions - COPBAR and Community Strategy Reporting
- School-Based Interventions - School Health Reports
- Social protection - conditional cash transfers reports
- Workplace intervention - Work place reporting system
- TB response - TIBU
- Commodity management - LMIS

This plan will utilize data generated from the various sub-systems using HIS in five key areas:

1. Information generation – the different forms of information and how they are collected and stored.
2. Information validation – the process of reviewing the information to improve its accuracy and representativeness.
3. Information analysis – the process of understanding what the information is saying.
4. Information dissemination – the process of sharing the emerging information from the analysis with relevant stakeholders.
5. Information utilization – the process of ensuring information available is informing the decision making process.

This Strategic Direction seeks to:

- Strengthen M & E capacity to track MCHTSP performance.
- Ensure harmonised, timely and comprehensive routine and non-routine monitoring systems for quality HIV and TB data.
- Establish Multi-sectoral and integrated real-time HIV platform for HIV response updates

Table 4.11: Interventions to promote utilization of strategic information for HIV and TB programming

MCHTSP Result	Key Activity/ Intervention on area	Sub-activity/Interventions	Responsibility
Strategic information in programming utilised	Strengthen M/E capacity to track the MCHTSP performance	- Conduct M&E capacity assessment and capacity development needs - Capacity building HCWs and community-based implementers on M & E - Establish and strengthen functional multi-sectoral HIV M& E coordination structure and partnerships - Conduct periodic trainings and OJT on M&E identified gaps - Provide the relevant data/M&E tools for health, community-based and workplace interventions - Orient the HCWS and CSOs on the use of the tools - Ensure regular monitoring and supervision- Equip all health facilities with EMR systems and infrastructure - Establish County information resource centre - Lobby for sustainable financing of HIV M & E planned activities - Conduct quarterly Data Quality Audits (DQA) - Improve TB surveillance data tools to capture child TB nutritional assessment data	CEC - Health CHMT CTLC CHRIO CSOs Partners
	Harmonise routine and non-routine monitoring systems for quality HIV data	- Harmonise the County and implementing partners reporting tools - Develop comprehensive HIV M& E systems guideline, tools and Standard Operating Procedures - Create linkages between data collection tools and database - Strengthen HIV data management - Conduct periodic data quality audits - Conduct M & E supervision - Honour national and County HIV reporting obligations - Introduce a register for presumptive TB and allow capturing of screening and referral results, and to enable treatment follow up - Revise and update facility chalkboards to include comprehensive TB indicators - Integrate Community-based TB indicators in the TIBU and DHIS systems Develop and disseminate TB data capturing tools for use by CSOs and CHEWS Include TB indicators in the situation room platform	CEC - Health CHMT Partners NASCOP NTLD programme NACC CSOs Partners
	Establish Multi-sectoral and integrated Real time HIV platform for response updates	- Establish and utilise County HIV Situation Room - Create data demand and use of HIV and TB strategic information in programming - Create and strengthen M & E information hub - Integrate TB indicators in the HIV Situation Room	CEC - Health CHMT Partners

4.4.7: Strategic Direction 7: Increase domestic financing for sustainable HIV and TB response

The County health department was allocated approximately 31% (Ksh1,872,556,029) of County budget in the Financial Year 2014/2015. Most of these funds were consumed by recurrent expenditure (83%) with 266,941,110 (17%) utilized for development. The 2015/16 Financial Year also saw no funds directly allocated for HIV and TB response. This calls for affirmative action aimed at increasing domestic financing for HIV and TB response from zero to 50% by the year 2019. The county government envisages an allocation of 3% of health budget to HIV and TB response in the 2016/17 Financial Year.

Table 4.12: County Health Budget Allocation Trend[26]

Financial Year	Allocation	Recurrent Expenditure	Development	Allocation for HIV and TB
2015/ 2016	2,128,759,687.39	1,599,941,627.54	528,818,059.85	Nil
2014/ 2015	1,872,556,029.27	1,605,614,919	266,941,110.02	Nil
2013/ 2014	1,458,575,274.94	1,216,136.770.94	242,438,504.00	Nil

Sustainable Financing of HIV and TB

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

The MCHTSP Seeks to:

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

[26] Makueni County Budget 2013/14, 2014/15 and 2015/16

Table 4.13: Interventions to increase domestic financing for sustainable HIV and TB response

MCHTSP Result	Key Activity/ Intervention on area	Sub-activity/Interventions	Responsibility
Increased domestic financing for sustainable HIV and TB response	Maximize efficiency of existing delivery options for increased value and results within existing resources	- Implement on-job-training (OJT) models utilizing National HIV Integrated Training Curriculum (NHITC). This could reduce training cost by up to 70% - Rationalize HIV commodities distribution and reduce cost of laboratory referrals - Implement NHITC in training of HCWs to reduce absenteeism in health facilities - Integration of HIV/RH/TB and MNCH services - Promote resource allocation that has the greatest impact on achieving the Strategy objectives - Map out development partners in the County (Location of operation and their interventions) to minimize duplication of efforts	CEC Health CHMT Partners CHTC
	Promote innovative and sustainable domestic HIV and TB financing options	- Lobby for clients to take up NHIF insurance - Initiate Community-Based Health care Financing (CBHF) - Lobby for HIV trust fund - Contribute 3% of the County health budget to HIV and TB intervention - Establish a HIV budget line in the Health allocation) - Initiate Public Private Partnerships (PPP) for HIV and TB response - Appeal to philanthropists - Undertake charitable events, e.g. marathons, charity walk - Establish a HIV lottery - Apportion interests from dormant funds (unclaimed assets) to HIV and TB response - Encourage organized informal sector contribution - Tax holiday for individuals and corporate in HIV and TB philanthropists - Float health bonds - County to encourage financing of HIV and Tb initiatives by legislating rebate on county taxes for traders	CEC Health, CEC Finance CHMT Partners Chair health committee, CHTC County treasury
	Align HIV resources/ investments to MCHTSP priorities	- Track government allocations towards HIV response to the different County Government departments - Engage County assembly to consider HIV as an added parameter in resource allocation - Facilitate implementation of deliberate measures to unblock the financial, human, infrastructural, institutional, and structural bottlenecks that impact absorptive capacity to financing HIV programmes - Facilitate quantification of County resource needs - Implement a partnership accountability (MoU) to ensure alignment of resources to MCHTSP priorities - Facilitate planning by reporting contribution to MCHTSP annually	CEC Health, CHMT Partners Chair health Committee CHTC

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

Political will, vision and leadership are essential, especially at the highest level of government. Such leadership should recognize that practical steps must be taken to allocate county resources to HIV and TB-related priorities and to marshal institutions and actors beyond the health sector.

The County Government Act, 2012, requires the County Executive Committee to design a performance management plan to evaluate implementation of county policies by the county public service. It further requires that the County Governor submits the county plans and policies to the county assembly for approval together with an annual report on the implementation status[27].

In Strategic Direction 8, the MCHTSP seeks to:

- Build and sustain high level political and technical commitment for strengthened County ownership of the HIV and TB response.
- Entrench good governance and strengthen multi-sector and multi-partner accountability for delivery of MCHTSP results.
- Establish and strengthen functional and competent HIV and TB co-ordination mechanisms.

[27] KASF 2014/15 – 2018/19

Table 4.14: Interventions to promote accountable leadership for delivery of MCHTSP results by all sectors and actors

MCHTSP Result	Key Activity/ Intervention on area	Sub-activity/Interventions	Responsibility
Accountable leadership and governance	Build and sustain high level political and technical commitment for strengthened county ownership of the HIV and TB response	- Provide effective leadership and support for multi-sectoral HIV and TB response - Lobby for high level political support and commitment to county HIV and TB response - Give feedback and reports to county leadership on the progress of MCHTSP implementation - Lobby for equitable distribution and access to HIV and TB services - Coordinate stakeholders in implementing MCHTSP - Mobilize local communities to participate in HIV and TB response - Lobby for enabling county level policies, legislation or guidelines for HIV and TB response - Mobilise and allocate adequate resources for HIV and TB response - Include PLHIV representatives in the county decision making hierarchy	CEC Health CSO CHMT CHTC Chair Health committee
	Entrench good governance and strengthen multi-sector and multi-partner accountability for delivery of MCHTSP results	- Build capacity of partners for resource management and accountability through institutionalised technical support mechanisms - Build capacity of stakeholder networks of faith communities, civil society, key populations and persons living with HIV and TB patients to promote strong accountable institutions that hold duty bearers accountable for the HIV and TB response - Strengthen development partners HIV and TB forum focusing on alignment of activities to MCHTSP priorities - Develop and implement a partnership accountability mechanism based on targets and results for sub county level interventions - Review reporting mechanisms to leverage on regulatory institutions in order to capture private sector contribution to the HIV and TB response - Reform performance contracting to facilitate target setting and align sector reporting to MCHTSP results against targets	CHMT CHTC Partners CEC Health Private sector
Strengthen functional and competent HIV and TB co-ordination mechanism	Establish and strengthen functional and competent HIV and TB co-ordination mechanism	- Establish a County HIV and TB Committee (CHTC) - Establish and support County Interagency coordinating committee (ICC) - Establish and support County MCHTSP monitoring committee and TB committee - Establish and support Sub-county HIV co-ordination committees	CEC Health

Chapter 5

Monitoring and Evaluation Plan

5.1 M&E systems

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

5.2 Data Quality

Challenges exist in the management of data quality as there is no standardization in the manner in which data is maintained by the different sub-systems. While some services/facilities use electronic and/ web-based systems, others still utilise paper-based/ manual systems. Some developmental partners have in the past used separate parallel data collection tools and methodologies. The plan will seek to consolidate the different systems into a single County M& E system that will be used by all parties in the County response. A uniform system, coupled with capacity building and exchange of ideas, should significantly improve the reliability of data produced.

5.3 Baseline Information

Given that this strategic plan proposes to decrease the number of new HIV and TB infections, baseline data will be used to set mid and end term targets. For those indicators where County-specific baseline data is not available, the MCHTSP will be guided by national data.

5.4 Indicators

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

5.5 MCHTSP Reviews

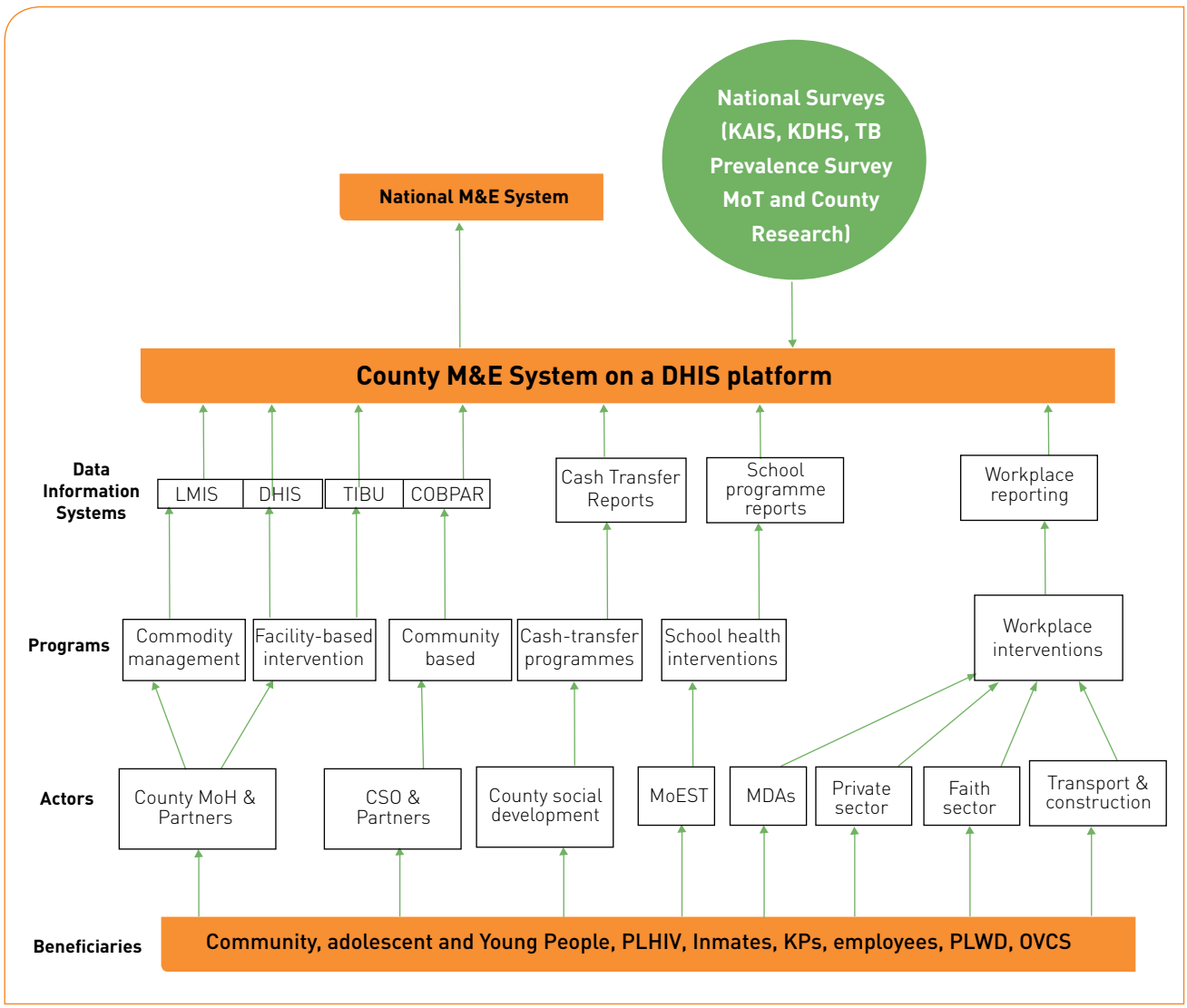
Given the multi-sectoral nature of HIV and TB response, there are varied data sources from diverse stakeholders hence the need for quarterly and bi-annual stakeholders data review forums. Midterm and end term reviews of the plan will be conducted in 2017, 2019 respectively, led by the KASF/MCHTSP - M&E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

important opportunities to review plan strategies and indicators and where necessary make evidence-based adjustments to the interventions.

5.6 Data Flow and Archiving

Data from different subsystems will be consolidated into the County M & E systems. The County will establish M&E system which would feed into the national system. Data from different actors will be collected using the existing data collection tools for each sector/actor.

Figure 5.1: Data flow in County HIV and TB response



Chapter 6

Coordination and Implementation Arrangement

6.1 Stakeholder Management and Accountability

One of the guiding principles towards achieving the County HIV objectives is multi-sectoral accountability. The success of the HIV plan relies on identification and involvement of all the stakeholders at the community, MDAs, workplace, schools and health facility levels. The MCHTSP provides guidance for interventions and assigns responsibilities to various stakeholders. Stakeholders will be coordinated and held accountable by the County HIV and TB Committee. For the multi-sectoral engagement and effective implementation of this strategy, the following roles and responsibilities are designed. It, however, recognizes that given the complex nature of HIV and TB, strong collaboration, mutual ownership and accountability is required for effective response.

Table 6.1: Stakeholders' roles and responsibilities

National agencies	Roles and responsibilities
National AIDS Control Council	- Coordinate the multi-sectoral HIV response in the country - Provide policy and guidelines for HIV response - Offer technical support to the County - Monitoring and evaluation of the country HIV response
National TB, Leprosy and Lung Disease program	- Provide guidelines in TB response - Offer support supervisor and trainings to the County - Carry out research and offer M & E to the County
NBTS	- Supply safe blood products - Set up a satellite in the County
NASCOP	- Continually improve the DHIS systems - Review, print and distribute data collection registers to capture emerging issue, e.g. adolescent disaggregated data. - Provide Support and technical assistance in implementing facility-based EMR system - Review and disseminate HIV guidelines - Ensure commodity availability
KEMSA	- Timely distribution of HIV and TB commodities to the County as per her needs. - Strengthen and improve LMIS
KEMRI and National Laboratories	- Support the County in VL testing and sputum for culture - Expeditious relay of results
Prisons	- Enhance infection control programmes - Uphold human rights of detainees

Stakeholders' roles and responsibilities

County departments/Sectors	Roles and responsibilities
County Department of Health	- Champion County HIV and TB legislations - Scale up HIV and TB interventions targeting priority populations - Offer non-discriminatory HIV and TB services in health facilities - Use strategic information to inform programming - Resource mobilization for scaling up of interventions - Procure HIV commodities and infrastructures - Coordinate inter-departmental County HIV and TB committee - Ensure that HIV and TB line budget is not diverted to other activities
County Departments	- Allocate appropriate resources per the work plans of line ministries and departments for HIV interventions - Streamline audit mechanisms to ensure efficiency and effectiveness of allocated funds
County Department of Agriculture	- To provide leadership in integration of HIV and TB in livelihood programmes
County Department of Education	- Ensure that the rights of infected and affected children are protected - Strengthen school health programmes to include life skills, drug adherence and abstinence - Put in place policies to keep boys and girls in school - Address stigma and discrimination in school/ college settings - Implement infection control in school/college settings - Initiate and sustain school feeding programmes
County Legislative Arm	- Legislate appropriate policies and laws - Mobilize communities to participate in HIV and TB response
County Department of Youth and Sports	- Integrate HIV and TB prevention care and treatment into sporting activities and other youth forums - Establish resource centres - Initiate sustainable IGAS for youths out-of-school young people
County Department of Labour and Social Services	- Implement OVC social protection programmes - Incorporate TB and HIV into existing social protection schemes, including nutritional support platforms - Implement structural interventions that empower vulnerable populations, especially OVCs, PWD, youth and women,e.g IGAs
County Department of Tourism	- Encourage free condom outlets in hotels, bars and lodgings - Incorporate HIV in internal and external training programme including tourists training institution - Promote HIV prevention in bars, hotel and lodges - Enforce laws that protect the minors in lodges and bars
County Department of Transport	- Use public transport systems for HIV/ TB prevention and health promotion messaging
County Public Service Board	- Ensure that all County Departments have HIV and TB related work-plan programmes

Stakeholders' roles and responsibilities

Key partnerships	Roles and responsibilities
CSOs	- Actively engage in demand creation for HIV and TB services - Support adherence and defaulter tracing - Work as "watch dog" of the County Government to ensure accountability of results - Participate in the County budgeting process (MTEF) and resource mobilization - Educate communities on legal issues, rights and gender
Development Partners	- Promote locally-owned programmes in a coherent manner - Promote and rely on the county M&E system - Advocate for and support the County initiatives for resource mobilization to sustain programmes beyond external funding - Strengthen County capacity and provide technical assistance for coordinated harmonized and evidence-informed HIV and TB response
Media	- Scale up anti-stigma and discrimination campaigns - Encourage journalists to identify issues in HIV and TB - Support CSR of corporate media houses - Media monitoring of content (quality and up-to-date HIV and TB information) - Provide secondary data to complement sector data
Academic institutions	- Undertake research in HIV and TB to inform County planning and decision making - Mainstream HIV and TB in curriculum development - Support HIV and TB trainings - Address stigma and discrimination in their settings - Offer psychosocial support to students and staff living with HIV and TB
Private sector	- Prioritize HIV and TB response as CSR agenda - Invest in HIV and TB response programmes
Faith Sector	- Offer psychosocial support to PLHIV and support to OVCs - Mobilize communities to access HTS, care and treatment services

6.2 County Committees

Various committees with multi-sectoral representations from technical experts, partners, networks of PLHIV, County departments, Faith sector, private sector and CSOs will be set up to provide coordination and oversight in the County HIV and TB response. These committees include:

County HIV and TB Committee: The County Executive Committee Member for Health will chair the County HIV and TB Committee. The County HIV and TB Committee will provide leadership, mobilize resources, set the County HIV and TB agenda, approve County HIV and TB targets, approve County HIV and TB Plans/Strategy, present County HIV and TB budgets to Health Sector working Group and County Assembly, receive and approve reports on County HIV and TB plan performance and routine M&E from County HIV and TB Monitoring Committee, receive reports from the County HIV and TB ICC/ Stakeholder Forum and Receive and approve work-plans and reports of Sub-county HIV committees.

County HIV Co-ordination Unit: This is the NACC County office and is the repository, point of reference on HIV matters. It is the Secretariat office of the County

HIV Committee. It is responsible for coordinating the multi-sectoral HIV response.

MCHTSP Monitoring Committee: Chaired by the CASCO. Will provide M&E functions during the implementation of the MCHTSP

Sub-county/constituency committees: Membership and functions will be guided by national field operation guidelines.

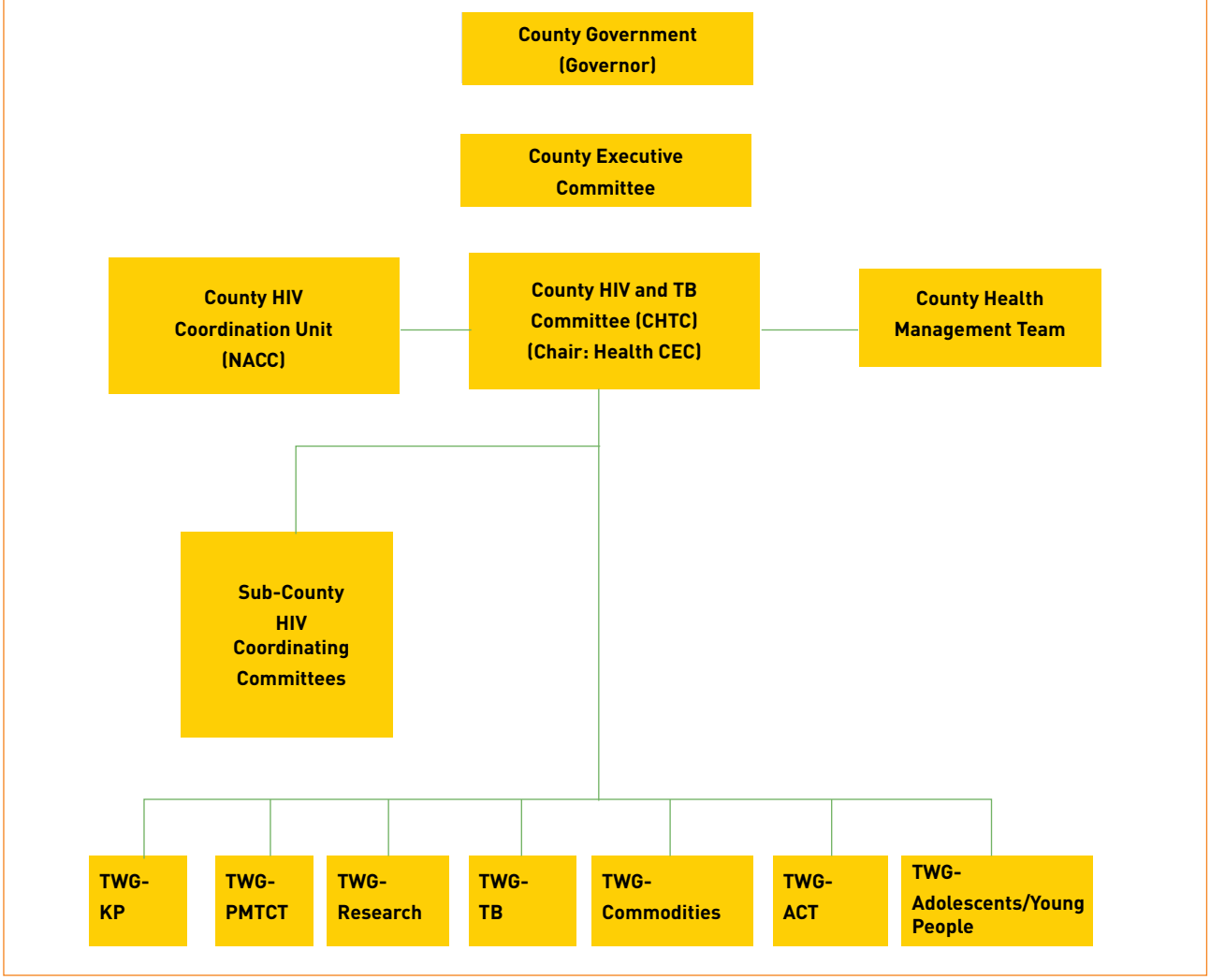
HIV and TB ICC: Its the primary forum for deliberating on HIV issues at the County. It will have membership drawn from County Government, CSOs, private sector, Network of PLHIV and partners. The CEC-Health shall chair while the NACC will provide secretarial role.

6.3 Critical assumptions

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

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

Figure 6.1: County Coordination infrastructure for HIV and TB delivery[28]



[28] Adopted from KASF 2014/15-2018/19

Chapter 7

Risk and Mitigation Plan

The Risk Management Plan serves to identify risks with potential to impact on the successful outcomes of the strategic plan as a whole. By identifying these risks and especially by presenting possible strategy to prevent or mitigate them, the matrix becomes a reference document for both the funding mechanisms and monitoring and evaluating the plan.

Table 7.1: Risk and mitigation plan

Risk Category	Risk Name	Status	Probability (1-5)	Impact (1-5)	Risk Average Score	Response	Responsibility	When
Technological	-Loss of data	Low	2/5	4/5	3/5	- Install data back up - Give user rights	CEC Health	Year 1-Year 4
	Inadequate capacity to roll out EMR	Medium	3/5	2/5	2.5/5	Allocate money for training and infrastructure	CEC Health	Year 1-Year 4
	Sustainability challenges of EMR in the 16 facilities supported by partners	High	4/5	4/5	4/5	County ownership and commitment	CEC Health	Year 1-Year 4
Political	Displacement of populations	Low	1/5	4/5	3/5	-Set up a Disaster management kit	CEC Health, CEC Finance	Year 1-Year 4
Operational	Partner dependency	High	4/5	5/5	4.5/5	Establish HIV budget line in county budget	CEC Health, CEC Finance, Chair of health committee	Year 1-Year 4
	Uncoordinated interventions from various actors/partners	Medium	2/5	2/5	2/5	Establish a county coordinating committee	CEC Health	Year 1-Year 4
	Herbalist and Faith healing	Medium	3/5	4/5	3.5/5	-County legislation on herbal medicine to include vetting and licensing -Community empowerment in health decisions	CEC Health, Chair Health committee	Year 1

Risk Category	Risk Name	Status	Probability (1-5)	Impact (1-5)	Risk Average Score	Response	Responsibility	When
	Extraction of false teeth practices	Low	1/5	1/5	1/5	Community empowerment in health decisions	Community strategy focal office	Year 1- Year 4
Legislative	Stigmatizing county HIV laws/ legislations	Medium	2/5	4/5	3/5	Technical assistance of MCAs on HIV programming for sound policies/ legislations	CEC Health	Year 1 & 2
	Lack /weak legislation Weak enforcement	Medium	2/5	3/5	2.5/5	-Review of existing legislation -Enactment of county HIV/AIDS Act -Strengthen enforcement of legislation	CEC Health, Chair County Assembly Health Committee	Year 1 & 2

Chapter 8

Costing and Resource Mobilization

The finances to implement the MCHTSP have been estimated with the view of achieving the best within a resource-constrained setting. The County Resource Needs for this strategic plan period was calculated using Stover - County HIV Resource model. The template utilizes EPI and programme data to form the baselines and projects the resource needs over a period of time. The model assumes that medical service costs are included in the health budget rather than the HIV budget.

Data and assumptions

Epidemiological data used in the model are from the Kenya Country HIV estimates, 2014. This includes programme data on coverage of PMTCT and ART programmes.

Table 8.1: Baseline information utilized in this model

EPI and Programme Data	Revised value	Default value
HIV prevalence among 15-49 year old adults	5.6%	5.6%
Adults receiving ART	13,451	9,705
Children receiving ART	1,622	1,480
Number receiving PMTCT	703	825
Number receiving HTC	145,308	145,308

Table 8.1: Baseline information utilized in this model

Interventions	Current	Unit costs of service		
	Coverage	Revised value	Default value	Units
ART	69.0%	KSh 51,612	KSh51,612	per patient
PMTCT	50.4%	KSh 1,748	KSh1,748	per mother/baby
HTC	27.7%	KSh 513	KSh513	per person tested
Adolescent friendly services		KSh 6	KSh6	per service
Key populations		KSh 6,440	KSh6,440	per person reached
Behavior change		KSh 138	KSh138	per person reached
Program support		15.5%	15.5%	% of other services

Where: Default values = national level costs

Program costs are calculated as a percentage of other costs

8.1 Projected cost of HIV programming

Table 8.2 : MCHTSP resource needs

Resource Needs (Millions of Kenyan Shillings)					
	2015	2016	2017	2018	2019
ART	KSh 768	KSh742	KSh 716	KSh 690	KSh 664
PMTCT	KSh 1	KSh1	KSh 2	KSh 2	KSh 2
HTS	KSh 39	KSh48	KSh 57	KSh 66	KSh 75
Condoms	KSh 31	KSh34	KSh 38	KSh 42	KSh 47
Key populations	KSh 5	KSh7	KSh 9	KSh 12	KSh 14
Behavior change	KSh 115	KSh141	KSh 168	KSh 198	KSh 231
Medical services	KSh 0	KSh0	KSh 0	KSh 0	KSh 0
OVC	KSh 98	KSh111	KSh 111	KSh 112	KSh 114
Program support	KSh 162	KSh171	KSh 174	KSh 177	KSh 181
Total	KSh 1,219	KSh1,256	KSh 1,275	KSh 1,301	KSh 1,329

Note

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

8.2 Financing the MCHTSP

Health is a devolved function. The County Government has the responsibility to provide quality health care services to her citizens. The responsibility for financing this MCHTSP therefore requires contributions from County Government. Development Partners and non-state actors including the private sector, civil society and local communities will complement and supplement the County allocations in HIV and TB response.

Annexes

Annexe 1 Results Framework

STRATEGIC DIRECTION 1: REDUCE NEW HIV AND TB INFECTIONS						
MCHTSP Results	**Service Delivery Area**	**Indicators**	**Baseline**	**Data Source**	**Mid Term Target**	**End Term Target**
Reduce new HIV infection in adults and children by 80%		Annual Number of new adult HIV infections	1,193	County Estimate 2013	596	238
		Annual Number of new child HIV infections	65	County Estimate 2013	33	13
	Key population	Percentage of new infections from Key Populations (Sex Workers, MSM, prison population, PWID)	35%*	MoT study (2008)	20%	15%
		Number of syringes distributed per person who injects drugs by the needle and syringe program	0	Partner data	NA	NA
		% of FSW reporting the use of condom during penetrative sex with their most recent client	88%*	PBS	90%	95%
		Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	77%*	IBBF	80%	85%
	Adolescent programme	Percentage of young women and men aged 15-24 who have had sexual intercourse before age 15	55%	County Estimate 2013	28%	13%
		Percentage of schools that provide life skills-based HIV education	52%	County MoE records	70%	100%
	HTS	Percentage of the population counseled and tested	15%	DHIS - 2015	35%	50%
	PEP	Number of Health facilities providing PEP services	50	DHIS	100	150
	General Population	Percentage of people aged 15-49 who had sexual intercourse with more than one partner in the last 12 months	8.4%*	KAIS 2012	6%	4%
		Percentage of people aged 15-49 who had sexual intercourse with more than one partner in the last 12 months and reported condom use during the last sexual intercourse	37.7%*	KAIS 2012	50%	75%

* National Data

MCHTSP Results	Service Delivery Area	Indicators	Baseline	Data Source	Mid Term Target	End Term Target
Reduce new HIV infection in adults and children by 80%	PMTCT	Number of pregnant women attending ANC whose male partner was tested for HIV	612	DHIS 2015	1000	1600
		Percentage of infants born to HIV-infected women starting on cotrimoxazole prophylaxis within 2 months of birth	96%	DHIS	98%	100%
		Percentage of infants born to HIV infected women who receive DNA-PCR test for HIV within 2 months of birth.	70%	DHIS	80%	100%
		Percentage of pregnant women who know their HIV status (1ST ANC Visit).	100%	DHIS	100%	100%
		Percentage of HIV positive women who receive anti-retroviral to reduce risk of mother-to-child transmission (ANC- PMCT)	94%	DHIS 2015	96%	100%
		Percentage of health facilities providing EID	86%	DHIS 2015	93%	100%
		Percentage of clients who finished four ANC visits	38%	DHIS 2015	42%	50%

STRATEGIC DIRECTION 2: IMPROVE HEALTH OUTCOMES AND WELLNESS OF TB PATIENTS AND PLHIV						
MCHTSP Results	**Service Delivery Area**	**Indicators**	**Baseline**	**Data Source**	**Mid Term Target**	**End Term Target**
Reduce AIDS related mortality by 30%	ART Program	Annual number of HIV related deaths (Adults)	751	County Estimate 2013	638	525
		Annual number of HIV related deaths (children)	145	County Estimate 2013	123	101
		Percentage of people diagnosed HIV positive linked with care within 3 months.	84%	DHIS 2015	85%	90%
		Percentage of PLHIV receiving HIV care services.	61%	DHIS 2015	70%	81%
		Percentage and number of adults and children enrolled in HIV care and eligible for cotrimoxazole prophylaxis currently receiving cotrimoxazole prophylaxis.	100% (15273)	DHIS 2015	100%	100%
		Percentage of adults and children currently receiving ART among all eligible people living with HIV (using national criteria).	64%	DHIS 2015	70%	80%
		Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (24 months, 36 months, 60 months).	TBD	DHIS 2015	85%	90%
	PMTCT Program	Percentage and number of eligible clients newly initiated on highly active ART in the last 12 months.	92% (1852)	DHIS 2015	97%	100%
	HIV/TB Co morbidity	Percentage of TB/HIV co-infected clients who are receiving ARTs.	97%	DHIS 2015	98%	100%
		Percentage of HIV patients screened for TB.	100%	DHIS	100%	100%
	ART Program	Percentage of ART patients with an undetectable viral load at 12 months after initiation of ART	NO DATA	DHIS	85%	90%
		Percentage of people on ART tested for viral load who have a suppressed viral load in the reporting period	41%	NASCOP Report Dec2015	75%	90%
	Capacity building	Percentage of health facilities providing HIV care and treatment services	35%	RHIS	40%	50%
		Percentage of health facilities implementing continuous quality improvement activities according to MoH standardized protocols	86%	RHIS	93%	100%
		Number of health facilities providing care and treatment according to MoH standardized protocols	75	RHIS	86	107

STRATEGIC DIRECTION 3: USE A HUMAN RIGHTS APPROACH TO FACILITATE ACCESS TO HIV AND TB SERVICES						
MCHTSP Results	**Service Delivery Area**	**Indicators**	**Baseline**	**Data Source**	**Mid Term Target**	**End Term Target**
Reduced Stigma and discrimination by 50%	Stigma and discrimination	Percentage of PLHIV who self-reported that they experienced discrimination and/or stigma due to their HIV status	49.2%	Stigma index survey (2013)	35%	25%
		Percentage of women and men ages 15–49 expressing accepting attitudes towards people living with HIV	Men: 32.6%* Women: 46.9%*	KDHS 2009	75%	80%
	General population	Percentage of ever married or partnered women and men ages 15–49 who experienced sexual and/or gender based violence	6.6%*	KDHS 2009	3%	0%
	KP	Percentage of MSM who experienced sexual and/or gender-based violence	24%*	IBBS	15%	10%
		Percentage of sex workers who experienced sexual and/or gender-based violence	44%*	IBBS	25%	10%
	OVCs	Percentage of OVCS reached with social protection programs	31%	County estimate	50%	75%

* National Data

STRATEGIC DIRECTION 4: STRENGTHEN INTEGRATION OF HEALTH AND COMMUNITY SYSTEMS						
MCHTSP Results	**Service Delivery Area**	**Indicators**	**Baseline**	**Data Source**	**Mid Term Target**	**End Term Target**
Adequately staffed workforce	Health Care Workforce	Ratio of cadres of health care staff to population in line with staffing norms	1.69/1000*		2.0/1000	2.4/1000
Improved access to HIV commodities and services	Commodity Management	Percentage of health facilities providing KEPH defined HIV&AIDS services	62/223 (28)	RHIS	32%	35%
		Percentage of health facilities dispensing ART that experienced a stock-out of ARVs at least once in the last 12 months	0	RHIS	0%	0%
Strengthened community service delivery of HIV prevention, treatment, care and support	Community Units	Number of community units implementing AIDS competency guidelines	9	County Focal office	20	50
	Community Based Organizations	Number of Community Health Units given training on HIV module	9	County Focal office	20	50
		Number of Community Health Workers reporting on HIV programmes	9	County Focal office	20	50
		Number and percentage of community-based organizations that submit timely, complete, and accurate reports according to guidelines	47%*	COBPAR	75%	80%
Health Systems Strengthening	Health Systems Strengthening	Number of health facilities providing integrated HIV services	32	RHIS	40	50
		Number of health facilities implementing universal precautions to prevent HIV infection	214	RHIS	214	214

STRATEGIC DIRECTION 5: STRENGTHEN RESEARCH AND INNOVATION TO INFORM MCHTSP OBJECTIVES						
MCHTSP Results	**Service Delivery Area**	**Indicators**	**Baseline**	**Data Source**	**Mid Term Target**	**End Term Target**
Adequately staffed workforce	Build Capacity for Research	Number of prioritized research conducted	0		2	4
		Number of people trained in HIV related research	0		10	20
	Funding for Research	Number of HIV related studies undertaken at postgraduate levels in tertiary institutions	0		2	4
		Proportion of HIV funds utilized on research	0*	KNASA	5%	7%
Increased evidence based planning and programming	Application of research finding in decision making	Percentage of research products disseminated to inform policy, planning, and programming	TBD		100%	100%

STRATEGIC DIRECTION 6: PROMOTE UTILIZATION OF STRATEGIC INFORMATION FOR HIV AND TB PROGRAMMING						
MCHTSP Results	**Service Delivery Area**	**Indicators**	**Baseline**	**Data Source**	**Mid Term Target**	**End Term Target**
Increase availability of strategic information to inform HIV response	Increase access and strengthen to Strategic information	Number of planned M & E reports generated	-	RHIS	8	16
		Percentage of planned M & E reports disseminated	-	RHIS	100%	100%
		Established and functional MCHTSP /KASF monitoring committee	0		1	1
		Number of sub counties submitting timely, complete and accurate reports	6		6	6
		Percentage of implementing partners reporting through DHIS	-		90%	100%

SD 7: INCREASE DOMESTIC FINANCING FOR SUSTAINABLE HIV AND TB RESPONSE						
MCHTSP Results	**Service Delivery Area**	**Indicators**	**Baseline**	**Data Source**	**Mid Term Target**	**End Term Target**
Increase domestic financing to 50%	Government funding	Establishment of specific budget lines and funding for HIV	0		1	1
		Percentage of government funding for the HIV response	17%*	KNASA (2014)	30%	40%

* National Data

STRATEGIC DIRECTION 8:

PROMOTE ACCOUNTABLE LEADERSHIP FOR DELIVERY OF MCHTSP RESULTS BY ALL SECTORS AND ACTORS

MCHTSP Results	Service Delivery Area	Indicators	Baseline	Data Source	Mid Term Target	End Term Target
Increase domestic financing to 50%	Establishment of coordination framework	County HIV coordinating committees in place	SCACCs-6	RHIS	SCACCs-6	SCACCs-6
			County HIV and TB Committee-0		County HIV and TB Committee-1	County HIV and TB Committee-1
		Percentage of county MDAS with result based HIV plans aligned to MCHTSP	0	Public sector reporting tool	90%	100%

TB INDICATORS						
MCHTSP Results	**Service Delivery Area**	**Indicators**	**Baseline Data**	**Data Source**	**Mid Term Target**	**End Term Target**
Increased case notification of new TB cases to 85%	Case notification	Number of TB patients reported to the National TB program.	1606 (82%)	TIBU 2014	84	85
		Percentage of TB case notification referred by CHWs	0.8	TIBU 2014	5	10
	HIV TB co infection	Percentage of TB cases offered DOT by CHWs	0.2	TIBU 2014	2	4
		Percentage of all registered TB patients tested for HIV	97	TIBU 2014	98	100
		Percentage of TB/HIV co-infected on CPT	99	TIBU 2014	100	100
		Percentage of TB/HIV co infected on ART	96	TIBU 2014	98	100
		Percentage of HIV TB cases whose partners were tested for HIV	75.5	TIBU 2014	80	95
		Percentage of HIV patients initiated on IPT	29.2	TIBU 2014	50	80
	IPT	Percentage of children under 5yrs exposed to smear positive TB initiated on IPT	18	TIBU 2015	30	50
Treatment success of at least 95% among all Drug Susceptible (DS) forms of TB	TB outcomes	Percentage of TB patients offered nutritional support	26	TIBU 2014	40	60
		Treatment success rate	92	TIBU 2014	94	95
		Cure rate	90	TIBU 2014	94	95

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Location Map of Makueni