MANDERA COUNTY
HIV AND AIDS
STRATEGIC PLAN
2016-2019

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2016-2019

"A healthy and productive population"

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Acronyms and abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ART	Anti-Retroviral Therapy
CBO	Community-based Organisation
CCC	Comprehensive care clinic
DIC	Drop-In Centre
DRC	Drug Rehabilitation Centre
FBO	Faith Based Organisation
HAART	Highly Active Anti-Retroviral Therapy
HCBC	Home and Community Based Care
HIV	Human Immuno-deficiency Virus
IBBS	Integrated Bio-Behavioural Surveillance
HRBA	Human Right Based Approach
HRIO	Health Record Information Office
MARPs	Most At Risk Populations
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MOH	Ministry of Health
MSM	Men Who Have Sex with Men
NGO	Non-Governmental Organisation
PTCT	Parent-to-child transmission
NSP	National Strategic Plan on HIV and AIDS
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living With HIV
PMTCT	Prevention of Mother-to-Child Transmission
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TBD	To Be Determined
UA	Universal Access
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organisation

Foreword

HIV and AIDS was first diagnosed in Kenya in 1984 and by the end of 2013, there was a cumulative figure of 1.6 million people living with HIV in Kenya. The epidemic peaked in 2000 with the rate of national prevalence at 14%. Since then, there has been a steady decline. The country reached a prevalence rate of 6% in 2014. The Kenyan Government aims to reduce further the prevalence rate to 2% and then zero HIV incidences as indicated in the vision 2030.

In Mandera County the HIV prevalence is estimated to be on the increase from the 0.8% average in the North Eastern region to approximately 1.7% in 2013. It is estimated that there are more than 3,385 people living with HIV (PLHIV) while the incidence rate is at around 137 new HIV infections annually. Indeed, there is an urgent and great need for a more concerted and coordinated effort amongst all the sectors concerned. With this County HIV Strategic Plan 2016-2019 and the broader county health sector strategic and investment plan 2013-2018 commitments, we envisage that Mandera County will contribute to the realisation of the Kenya AIDS Strategic Framework (KASF) targets of reducing new HIV infections, HIV stigma and discrimination, AIDS related deaths and increasing domestic financing of HIV response will be reached within the next couple of years.

Mandera County is confident that the CASP will be able to guide it towards contributing and fulfilling the objectives of Universal Access (UA) of the highest standard of health. It is also intended to reflect the county's ownership and support of the HIV and AIDS response. Let there be a strong political will, comprehensive policies and full participation of the community.

Thank you.

AHMED SHEIKH MOHAMED
County Executive Commitee Member - Health

Preface

HIV and AIDS is taking a great toll on Kenyans resulting in both considerable human suffering as well as economic losses in many parts of the country. Several counties throughout Kenya have already been severely affected by the epidemic. Even though the overall prevalence of HIV in Mandera County remains low, the epidemic is by no means under control. HIV continues to spread and in specific segments of the population transmission is highly prevalent. The most recent data has resulted in increasing concerns of the possibility of a concentrated epidemic amongst more vulnerable groups in society. This may suggest that efforts in the past to address the spread of HIV and AIDS have not been sufficient in terms of the quality, comprehensiveness and coverage of the programmes.

HIV and AIDS does not only affects health, but also has linkages to many other aspects of society and development. Greater social and economic development brings with it many benefits, but it has also made us more vulnerable. Development can lead to increases in population mobility, internal and external labour migration and changes in the lifestyles or sexual behaviour of populations, all of which are ingredients for an accelerated spread of the epidemic. Low levels of HIV and AIDS knowledge, limited access to comprehensive services, unfavourable social and culture norms, low socio-economic status of women, and high levels of poverty serve to complicate the problem. Moreover, limited capacity and funding at the county level and limited involvement of the private sector create barriers that inhibit expansion of the HIV and AIDS programmes. If the low prevalence of HIV and AIDS is to be maintained over the coming years, fast and comprehensive action is required to effectively address the above mentioned challenges. As outlined in this document, the different strategies and approaches have to be implemented in order to increase the effectiveness and impact of the AIDS programme.

To achieve these goals, strong commitment and unified action is required from the public and private sectors, civil society groups and international organisations. I am sure that this document will serve as a tool to guide all partners engaged in the county response on HIV and AIDS. I look forward to the cooperation and support of all stakeholders in effectively implementing this strategic and operational plan. With comprehensive and effective prevention, treatment and care programmes, I believe that the spread of the HIV and AIDS epidemic in Mandera County can be contained and even reversed. The strategic framework provides direction on the implementation, coordination and monitoring of HIV prevention, care and treatment services in Mandera. The Mandera CASP's vision is "a Mandera free of new HIV infection, stigma and AIDS related death". Guided by the KASF, the county has outlined its objectives as follows:

Reduce new HIV infections by 75%.
Reduce AIDS related mortality by 25%.
Reduce HIV related stigma and discrimination by 60%.
Increase domestic financing of the HIV response to at least 10%.

MARYAM D. DAHIR
Chief Officer of Health

Acknowledgement

The development of the Mandera County HIV and AIDS Strategic Plan (2016–2019) involved a long consultative process with stakeholders. The county government wishes to acknowledge the valuable contribution of a number of individuals as well as organisations who made the entire process a success. We wish to express special thanks and appreciation to the members of the drafting team for their dedication, hard work and availability especially during times when they were called at a very short notice.

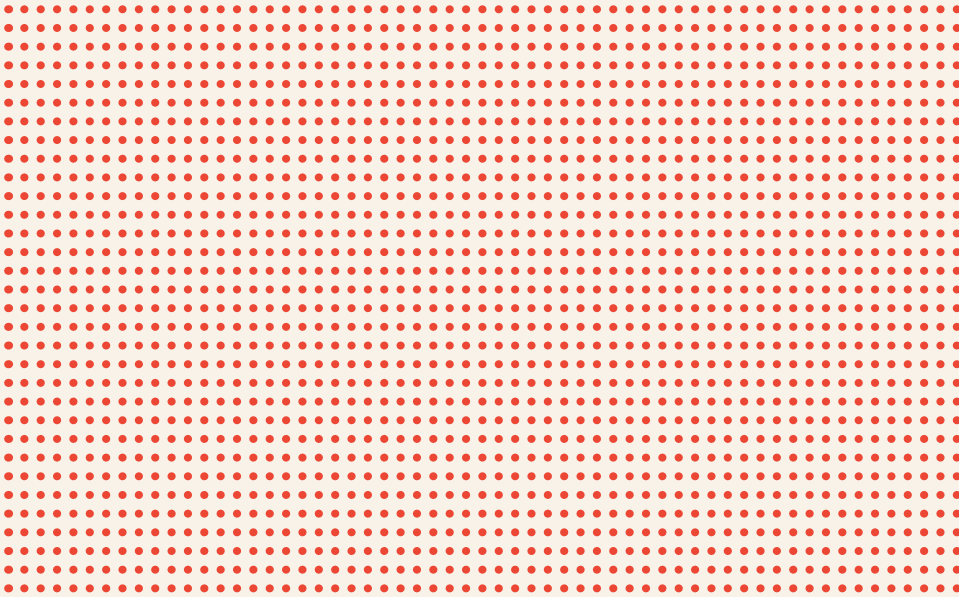
We would like to thank the Mandera County Government, Civil Society Organisations, network of PLHIV, Faith-Based Organisations and religious leaders for their valuable contributions towards completion of this document. Special appreciation also go to the National AIDS Control Council staff for their coordination and working tirelessly for long hours which was crucial to the success of this process.

We acknowledge the support from all county leaders under the guidance of His Excellency the Governor of Mandera County Capt. Ali I. Roba towards the development of this fundamental document. It is our expectation that the same support and effort will be provided during the implementation of the MCASP.

DR. ABDI MAALIM ISSAKOW
County Director of Health

01.

INTRODUCTION



1.1 Background information

Mandera County is one of the 47 counties in Kenya. It is located in the North Eastern part of Kenya and borders Ethiopia to the North, Somalia Republic to the East and Wajir County to the South. It is about 1,100km from the capital city of Nairobi by road. The county has an approximate population of 1,025,756 and covers an area of 25,991.5 kilometres squared. The county is administratively subdivided into six sub counties namely Mandera West, Mandera South, Banisa, Mandera North, Mandera East and Lafey. It is further subdivided into 30 administrative wards.

Map of Mandera County

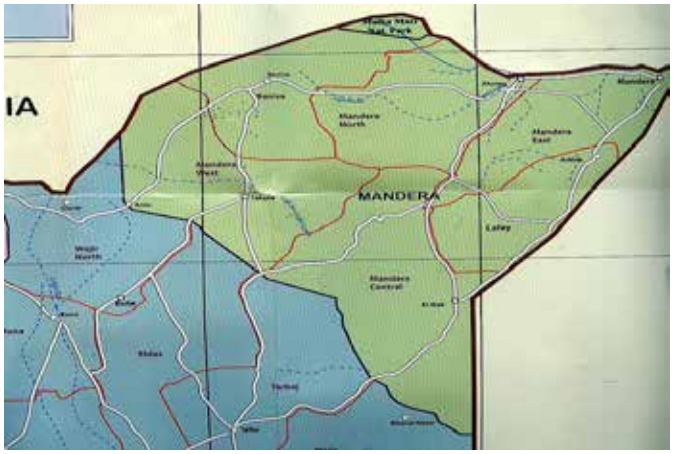


Table 1: Administrative and political units

SUB-COUNTIES	AREA (KM²)	DIVISIONS	AREA (KM²)	NO. OF LOCATIONS	NO. OF SUB-LOCATIONS
Banisa	3,356.1	Banisa	1179.5	4	9
		Malkamari	1864.3	5	6
		Kiliweheri	312.3	1	3
Mandera West	4,778.5	Takaba	3143.4	7	11
		Dandu	1635.1	6	7
Mandera East	2,797	Khalalio	495	9	17
		Hareri	580	3	3
		Libehiya	679	4	7
		Central	105	9	12
		Arabia	938	2	2
Lafey	3,378	Sala	618	1	1
		Fino	947	1	2
		Lafey	856	5	5
		Warankara	957	3	5
Mandera North	5,533.5	Rhamu Rhamu/Dimtu	147.3 935.2	3 4	4 5
		Ashabito	4,451	8	8
Mandera South	6,148.4	Elwak Shimbir Fatuma	814.1 1,324.4	5 4	7 6
		Wargadud	1,127.8	3	8
		Qalanqalesa	1,044.9	5	6
		Kotulo	1,837.2	5	7
TOTAL	**25,991.5**	**22**	**25,991.5**	**97**	**141**

Source: Mandera County Development Profile (2013)

1.2 Demographic characteristics

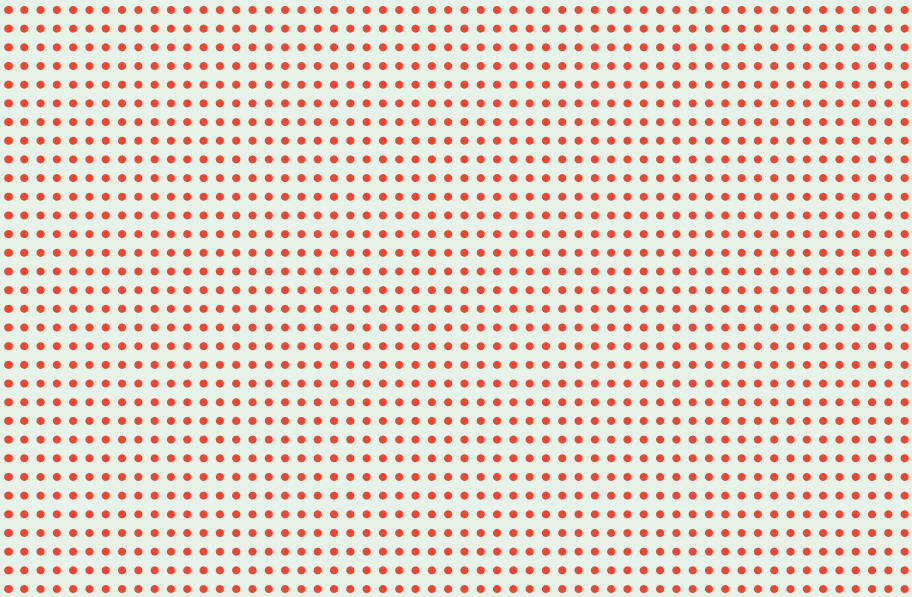
The Kenya Population and Housing Census (KPHC) of 2009 put the Mandera County's population at 1,025,756 persons- (559,943 Male and 465,813 Female). The population was projected to grow at 3.96% bringing it to 1,152,506 people in 2012. By 2015 and 2017, the population was projected to reach 1,294,917 and 1,399,503 people respectively. The increase in the overall population calls for more investment in economic and social facilities, education, agriculture, health as well as creating employment opportunities. The employment level was 307,375 persons which represented 73% of the 2012 projected total labour force. In addition, the county had a poverty rate of 89.1% compared with national average of 46%.

1.3 Land availability and use

According to Kenya Integrated Household Budget Survey (KIHBS 2005/06), over 90% of the land is communally owned and used for grazing. Some few areas (along River Daua) are used for rain fed and irrigation agriculture. Only five per cent of the land within urban centres had title deeds while a majority of rural households use ancestral rights to land without formalised tenure system. The county receives bi-modal rains with long rains occurring in the months of April and May while the short rains occur in October and November. Rainfall is scanty and unpredictable averaging 255 mm annually. Temperatures are relatively high with a minimum of 240C and a maximum of 420C in July and February respectively. However, due to climate change effects, the temperatures and precipitation in the county are expected to change and impact on agricultural development. About 95% of the county is semi-arid with dense vegetation of thorny shrubs and 'mathenge' trees (GoK, 2013).

02.

SITUATIONAL ANALYSIS



2.1 County HIV Profiles

The county has 64 active health facilities and two mobile clinics. Eight (8) facilities offer ART, 25 offer PMTCT and 18 offer TB/HIV services. The County had only 18 operational facilities before devolution. Before devolution Mandera County had about 157 healthcare workers. This has increased to more than 557 currently. The HIV prevalence in the county is estimated to be 1.7%. It is estimated that there are more than 3,385 People Living with HIV (PLHIV). The total adult and children incidence rate is at around 135 new HIV infections annually (2016 HIV estimates).

Table 2: HIV burden in Mandera County

HIV INDICATOR		COUNTY %	DATA SOURCE
Total population (2009)		**1,025,756**	**KNBS**
HIV Adult Prevalence		Women 2.9%, Men 0.6%	Kenya HIV Estimates, 2016
Adults	Living with HIV	2,884	
	New HIV infections annually	121	
	HIV related deaths	216	
	Receiving ART (CD4 Count < 500)	547	
	Need for ART	2,570	
	ART Coverage	38%	
Children	Living with HIV	501	
	New HIV infections annually	14	
	HIV related deaths	69	
	Receiving ART	73	
	Need for ART	755	
	Need for PMTCT	872	
Orphans and Vulnerable children beneficiaries	Households with an orphan	8,532	UNICEF, 2012; National Census, 2009
	Poor households with an orphan	4,181	
	Cash transfer beneficiary household	1,687	

There were about 40 pregnant women living with HIV in Mandera County by 2013. More than 52% of all HIV positive pregnant women in the county do not deliver in a health facility (County HIV Profiles 2014).

Table 3: County HIV granulation by Constituencies

CONSTITUENCY	NO. LIVING WITH HIV	MALE	FEMALE	CHILDREN
Mandera East	1,692	460	1,200	32
Lafey	134	51	81	2
Mandera south	677	266	397	14
Mandera west	307	124	176	7
Banisa	135	54	79	2
Rhamu	440	174	257	9
TOTAL	**3,385**	**1,129**	**2,190**	**66**

2.2 Priority population

The KASF defines the key population as groups who due to specific higher risk behaviour are at an increased risk of HIV infection, irrespective of the epidemic type or local context. They include people who inject drugs, sex workers and miraa dealers. This group contributes to more than 60% of the new infections in Mandera County (DHIS 2015).

Table 4: Key Populations

KEY POPULATION	JUSTIFICATION/ PROFILE	
Men and women who trade in miraa business, tea girls and house maids.	These are youth found along meta, tea kiosk and mirra markets	They are thought to be residing in the peri-urban areas within Mandera County. These are jobless and they sometimes engage in crimes
People who inject drugs and those using marijuana		
Sex workers	Move into the county and are attracted by high circulation of money due to various economic activities. – With devolution we have a lot of youth employed and money circulating in the county.	

Table 5: Vulnerable populations

TYPE OF POPULATION	RISK FACTOR
Adult women – above 24 years (account for 49% of the new infections)	High illiteracy level High divorce rate Low social economic status High marriage costs Re-marriages/inheritance
Adult men – above 24 years (account for 37% of the new HIV infections	Low HIV knowledge High illiteracy level Increased level of income High marriage costs Self-styled negative attitude
Young women age 15 – 24yr (account for 21% of new infections)	Peer influence Early marriage Coerced marriage/inheritance Illiteracy Poverty
Young men age 15 – 24yrs	Drugs and miraa Peer influence
Immigrant workers	Quarry business Uniformed personnel Maids

2.3 Gaps and challenges analysis

The implementation of HIV and AIDS programs in the County has encountered numerous challenges with several programmatic gaps which could easily be classified into biomedical, behavioural and structural factors as outlined.

Table 6: Behavioural, Biomedical and structural challenges

Programs	Current Status	Gaps
Biomedical Interventions		
Condom use	23% consistent condom use among men 15-24 years with partner of discordant or unknown HIV sero –status in the past 12 months	Consistent condom use is still low. A major factor is the absence of a conducive environment in some settings because of continuing opposition from some religious organisations and community groups. Low condom use with partners of unknown HIV status due to negative associating of condom use with promiscuity Weak distribution channels for condoms
HIV testing and Counselling	43% of men know their HIV status 50% of women know their HIV status 64% of people in Mandera County had never tested for HIV by 2015(County RRI 2015)	Identification of new testers Couple counselling and testing to identify sero-discordant couples Retesting of high risk individuals Identification and linkage to care for PLHIV
Elimination of mother to child transmission (EMTCT)	9,600 pregnancies annually 19% of HIV-positive pregnant women receiving maternal prophylaxis 14 new HIV infections among children annually Only 48% deliver in a medical facility	Low retention of mothers in ANC. Only 24% attend recommended four ANC visits 10% of positive ANC attendees not receiving PMTCT 17% of infants born to women living with HIV not tested for HIV
ART coverage	48% County ART coverage among adults (CD4 < 500cells/ml) 10% County ART coverage among children	HIV testing and linkage to care and treatment weak High number of persons in need of ART
STI treatment	1.34% of women tested positive for syphilis in ANC 51% of adults with HIV also have genital herpes	STI treatment for PLHIV and key populations Low coverage of HPV vaccination Low screening for STI
Health facility HIV Prevention	Incidental infections do occur in our health facilities	No infection prevention strategy in place in our health facilities.

Programs	Current Status	Gaps
Behavioural Interventions		
Behaviour change programmes	Average sexual debut for women is 16 years of age Average sexual debut for men is 18 years of Age 30% of men 15-24 reported having two or more sexual partners in the past 12 months Early sexual debut in adolescents and young people (55 per cent of individuals had their first experience of sexual intercourse before the age of 17)	Lack of targeted behavioural interventions Low coverage of behavioural interventions Inadequately addressed structural barriers to behaviour change Low comprehensive knowledge on HIV prevention
Interpersonal communication including peer to peer education in schools and workplaces	Low HIV knowledge in institutions and work places	Inadequate mainstreaming of HIV prevention, care and support in work place and schools.
Structural Interventions		
Social Protection Cash Transfers for Orphans and Vulnerable Children (CT-OVC)	Only less than 10% of poor households with orphans are beneficiaries of a cash transfer programme	Low coverage of Cash transfer beneficiaries. Only 1,687 out of 34 168 of Household s with a poor orphan benefited from Cash transfer program in 2013
Girls enrolled in secondary school	Lower secondary school enrolment for girls (40%) vs boys (60%)	High illiteracy levels
Building the Resilience of Women and Girls	Retrogressive social cultural practices	No Anti- FGM Campaign Coerced early marriages
Program sustainability	There are significant challenges in assuring availability of the resources needed to meet program targets at the county level	Program sustainability is uncertain Resources, both human and financial, are not yet sufficiently reliable to ensure program sustainability External support is unpredictable
Human rights, stigma and discrimination	High level of HIV stigma and discrimination	Low awareness on the HIV and AIDS Prevention and Control Act 2006 Absence of domestic/county laws on HIV and AIDS

03.

PURPOSE OF MCASP, STRATEGIC PLAN DEVELOPMENT PROCESS AND THE GUIDING PRINCIPLES

3.1 Purpose of the HIV Plan

The County HIV and AIDS Strategic Plan provides a roadmap for addressing the domestic HIV epidemic and a commitment of ownership of HIV and AIDS response by the County Government of Mandera. It is intended to be a concise plan that identifies a set of priorities and strategic action steps tied to measurable outcomes. The activities implementation work plan outlines the specific steps to be taken by various county agencies and stakeholders to support the high-level priority outcomes outlined in the strategic plan.

3.2 Process of developing the HIV and AIDS Strategic Plan

The planning for the 2016–2019 Mandera County AIDS Strategic Plan featured a participatory and broad-based, multi-partner process. Multi-sectoral consultation workshops took place in Nairobi and Mandera in 2015 to solicit inputs and feedback from civil society, government and bilateral and multilateral organisations. A drafting committee of ten members was responsible for obtaining stakeholder-specific inputs and consolidating these into the work plan. A consensus workshop was held in Mandera to agree on the strategies, programme priorities and coverage targets identified. The final plan was launched by the county leadership.

3.3 Guiding principles

Mandera County's **multi-sectoral response** to HIV and AIDS is built and guided by the following guiding principles:

- The spread of HIV is a challenge to the county's development and is a concern to be addressed by the county government.

- The HIV and AIDS response will be based on **evidence** and will prioritise interventions among key and those vulnerable to HIV infection due to risky behaviours and the environment.

- The HIV and AIDS response will be **comprehensive** and will focus on promoting healthy practices, disease prevention as well as treatment, care and support for People Living with HIV and people affected by HIV and AIDS.

- The response to HIV and AIDS should take into consideration **cultural, religious and societal values.**

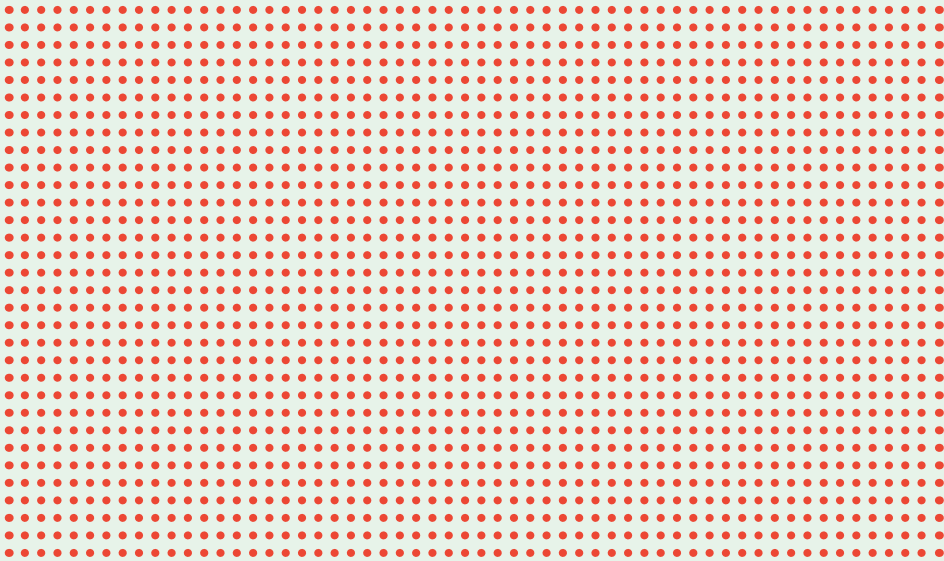
Government, civil society and private sector stakeholders will work together in a multi sectoral partnership to respond to the spread of HIV and AIDS in the county. Working in consultation and collaboration with relevant stakeholders, the government will provide policy direction, HIV treatment for those in need and financial resources in support of this effort. Civil society organisations including non-governmental organisations, community groups, People Living with HIV and those affected by HIV and AIDS will support and complement the Government in the prevention of HIV as well as care and support for those living with HIV and those affected.

All stakeholders will work together to create a conducive and enabling environment to ensure the effectiveness of interventions under the HIV response which respect human dignity, gender and sexuality.

Active and meaningful participation of key populations including most at risk communities, People Living with HIV and those affected will be integral to the development, implementation, monitoring and evaluation of all interventions.

04.

VISION, GOALS, OBJECTIVES AND STRATEGIC DIRECTIONS



4.1 The vision, goals and objectives of the county

4.1.1 Vision:

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

4.1.2 Goals:

The goals of the Mandera CASP 2016 - 2019, are:

1. To prevent and reduce the risk and spread of HIV infection.

2. Improve the quality of life for People Living with HIV.

3. Reduce the social and economic impact resulting from HIV and AIDS on the individual, family and society.

4.1.3 Objectives

- Reduce new HIV infections by 75%.

- Reduce AIDS related mortality by 25%.

- Reduce HIV related stigma and discrimination by 60%.

- Increase domestic financing of the HIV response to 10%.

4.1.4 Specific Objectives

1. To identify and target the priority populations for HIV services.

2. To increase equitable access to HIV services for PLHIV.

3. To strengthen linkage between health services and community systems for HIV response.

4. To strengthen research so as to have information for innovations/evidence based interventions.

5. To strengthen monitoring and evaluation of the Mandera County AIDS Strategic Plan.

6. To mobilise for resources for the implementation of the Mandera County AIDS Strategic Plan.

7. To strengthen the leadership and coordination of Mandera County AIDS Strategic Plan.

4.2 Strategic Directions

In order to address the HIV and AIDS issues in Mandera County, the MCASP adopted the KASF way of response by following the strategic directions from one to eight.

4.2.1 Strategic direction 1: Reducing new HIV infection

INTERVENTIONS FOR REDUCING NEW HIV INFECTIONS					
KASF objective	**MCASP Results**	**Key Activity**	**Sub-Activity/ Intervention**		
Reduce new HIV infections by 75%	Reduce new HIV infections by 75%	Identify and target the key populations for HIV services	**Biomedical**	**Behavioural**	
			Offer HIV services Provision of key commodities including lubricants and condoms Screening and management of HPV among FSW and Hepatitis B and C for PWID. Alcohol screening and addiction support Provide Pre- exposure prophylaxis services	Regular contact through peer education and treatment support Behaviour change intervention using specific interpersonal tools and techniques including Braille & sign language Offer harm reductions interventions	
			HTC Promote skilled birth attendance Cancer and HPV screening Offer outreach HIV services	Implement evidence based interventions like sister to sister & health choices Mother to mother support groups Conduct outreach activities Reach out the women through the women groups	
			Support campaign against FGM Integrate HIV services in health facilities within institutions of higher learning in Mandera Introduce HTS in schools and institutions of higher learning Offer age appropriate contraceptives, condoms, microbicides Offer HPV screening and education.	Life skills education Reproductive health awareness in schools	

		Target Population	Geographic areas by County/sub- county	Responsibility
	Structural	Key population (MSM, IDU and Sex workers)	Urban area, Rural area	County Department of Health, Partners FBOs
	Increased HIV surveillance Women economic empowerment Girl child retention in school Implement SGBV prevention and response program Address issues of violence against key population through appropriate crisis response mechanism Engage CHVs to strengthen linkage between community and facility/HCBC Male involvement in HIV prevention and EMTCT(Initiate male mentors)			
	Implement cash transfers to keep girls in school and social protection to vulnerable populations Initiate workplace protection policy Strengthen protection of rights and empower key and vulnerable populations e.g. create drop in centres Accelerate access to social equity and justice for priority population Address social cultural barriers that increase risk of HIV infection among communities	Vulnerable population (women above 24 years)	Rural areas	County Department of Health, Partners
	Engage private sector to formalise a system to complement service delivery	Adolescent and young women (15 to 24 years)	Urban areas	County Department of Health, Partners, Institutions of higher learning
	Develop innovative approaches for targeting vulnerable population with HIV services (truckers, prisoners, boda boda operators, sand harvester)	Vulnerable urban men above 15 years	Both rural and urban areas.	National Transport Safety Authority (NTSA), County Government, Ministry of Trade & Environment.
	Hold a consultative meeting with representative of institutions of higher learning to develop strategies for integrating HIV services in the institutions.	Vulnerable young men and women aged 15 – 24 years	Urban areas	County Department of Health, Partners, Institutions of higher learning

4.2.2 Strategic direction 2: Improving health outcomes and wellness of people living with HIV and AIDS

Context

While the county ART coverage is just below average, it is desirable that an increase to 90% is achieved. Inadequate access to health facilities due to distance coverage, commodities stock out, inadequate social support and nutrition are some of the barriers to uptake in ART. This is compounded by the fact that there are few ART sites within the county. Out of 64 health facilities in the county, it is only 10 that offer ART (Public Health facilities).

The low ART uptake among children is attributed to multiple factors including; inadequate capacity among health workers to collect samples and prescription of ART as per guidelines, lack of consistent information by care giver and lack of equipment for drug storage.

HIV testing: The quality of HIV testing can be described as good save for the delay in communicating results given that the HIV reference lab is over 1000 kilometres away in Nairobi. Stigma remains a big challenge to the fight against HIV. It manifests in various forms in the county e.g.: Self stigma, failure to adhere to ART, fear to seek/take medication or HIV test and worries leading to immuno-suppression.

INTERVENTION FOR IMPROVING HEALTH OUTCOMES AND WELLNESS OF PEOPLE LIVING WITH HIV					
KASF objective	**MCASP Results**	**Key Activity**	**Sub-Activity/ Intervention**		
Reduce AIDS related mortality by 25%	Increased coverage of care and treatment and reduced loss in the cascade of care	Scale up interventions to improve quality of care and improve health outcome	**Biomedical**	**Behavioural**	
			Increase the number of health facilities offering ART centres from 10 to 15	Sensitise the CCI network on HIV care and management among OVC	
			Train social workers on HIV management among the OVC	Sensitise care givers of OVC on HIV care and management	
			Build the capacity of healthcare workers on paediatric HIV management	Increase community awareness on the importance of ART adherence	
			Support partners to implement the minimum package for PWP activities	Sensitisation of community/ religious leaders and stakeholders	
			Increase access through community outreach services		

The table below summarises the county HIV treatment profile.

COUNTY ADULT HIV TREATMENT ACCESS ANNUALLY	
Adults in need of ART	1948
Adults receiving ART	540
County ART adult coverage	40%
National ART adult coverage	79%
Number of Adults who died of AIDS related conditions in 2013	655
COUNTY CHILDREN HIV TREATMENT ACCESS ANNUALLY	
Children in need of ART	892
Children receiving ART	37
County ART children coverage	10%
National ART children coverage	42%
Number of children who died of AIDS related conditions in 2013	18

		Target Population	Geographic areas by County/sub- county	Responsibility
	Structural	General population, OVCs,	Mandera West, sub- County Mandera South sub- County Banisa, sub- County Mandera North sub- County Mandera East sub- County Lafey sub- County	County Government and partners
	Improvement of the existing CCI to make them child friendly			
	Establish 3 model CCCs in Mandera.	Social workers		County Government, NASCOP and partners,
	Establish a HIV referral laboratory in Madera County.	General population, PLHIV		County Government, NPHLS, NASCOP and partners
	Develop innovative approaches to integrate the use of ICT in HIV services especially increasing adherence to ART.	Partners and PLHIV		County Government, Mobile Phone Service Providers and partners
	Establish an ART supplies store to strengthen the supply chain system "no stock outs"	Opinion leaders, CHVs, support groups		County Government, NASCOP, NACC, Partners

4.2.3 Strategic Direction 3: Using human rights based approach to facilitate access to services

Context

An enabling legal and policy environment is necessary for a robust HIV response at the county level to ensure access to services by PLHIV

INTERVENTION AREAS FOR USING HUMAN RIGHTS BASED APPROACH TO FACILITATE ACCESS TO SERVICES						
KASF objective	**MCASP Results**	**Key Activity**	**Sub-Activity/ Intervention**			
Reduce HIV related stigma and discrimination by 50%	HIV services accessed by all	Remove barriers to access to HIV services for PLHIV	**Biomedical**	**Behavioural**	**Structural**	
			Strengthen and establish DICs to offer HIV services to the key populations	Empower communities through various forums – support groups, IGAs	Form an ICC sub TWG to identify and address existing HRBA gaps in accessing HIV service.	
			Training of Health workers on HRBA to HIV services	Form support groups for PLHIV	Develop innovative approaches for providing PLWD with HIV services and programs including access to IEC materials	
				Sensitise the AAC on HRBA to HIV services	Improve the existing paediatric facilities to make them child friendly	
					Develop innovative strategies for providing youth friendly HIV services including the integration within the youth empowerment centres	
					Strengthen the legal and policy environment for HRBA to HIV services within the county	
					Domesticate the national policies and legal framework for county specific policies and laws	
					Establish a local arbitration mechanism within the ICC	

	Target Population	Geographic areas by County/ sub- county	Responsibility
	General population, OVCs, PLHIV	Mandera West, sub- County Mandera South sub- County Banisa, sub- County Mandera North sub- County Mandera East sub- County Lafey sub- County	County Government and partners
	Health workers, CHVs		National Council for Persons with Disabilities (NCPWD), Kenya Society for the Blind, Kenya Institute for Special Education
	AAC members		County Government and partners
	Health workers, CHVs, Partners working with youth		County Government and partners
	Victims of sex based violence, PLHIV		National Police Service, Ministry of Interior, Civil Society – , FIDA, KNHRC, Nairobi Women Gender Based Recovery Centre
	Policy makers, local leaders, law enforcement agencies, opinion leaders, PLHIV		County Government and partners
	Paralegals, counsellors, survivors of violence		County Government and partners

4.2.4 Strategic direction 4: Strengthening Integration of community and health systems

Context

Mandera County has embraced and implemented the community health strategy as an avenue of engaging communities in health issues. Through the CHS, community health units have been established and facilitated through regular training and supervision.

Community members are involved in the management of health facilities. All these efforts are

INTERVENTION AREAS IN INTEGRATION OF COMMUNITY AND HEALTH SYSTEMS					
KASF objective	**MCASP Results**	**Key Activity**	**Sub-Activity/ Intervention**		
Reduce new HIV infections by 75% Reduce AIDS related mortality by 25% Reduce HIV related stigma and discrimination by 50% Increase domestic financing of the HIV response to 50%	An integrated community and health system	Strengthen the integration of community and health system.	**Biomedical**	**Behavioural**	
			Scale up the provision of home based care for HIV through Community Units	Develop a HIV communication strategy for Mandera	
			Conduct regular outreach HIV services for the hard to reach	Organize events aimed at integrating HIV services with the annual initiation ceremony	

geared towards integrating the community and health systems. The community health units offer HIV services such as the implementation of HCBC and PMTCT. The county also conducts outreach health services for those who cannot access health facilities.

Inadequate staffing needs to be addressed so that quality of service is guaranteed. Other factor that contribute to poor health systems in the county include inadequate health facilities, work overload, poor working environment that lacks the necessary infrastructure and an erratic supply chain.

		Target Population	Geographic areas by County/sub- county	Responsibility
	Structural	PLHIV, opinion leaders, health workers, CHVs	Mandera West, sub- County Mandera South sub- County Banisa, sub- County Mandera North sub- County Mandera East sub- County Lafey sub- County	County Government and partners
	Develop innovative approaches for increasing access to skilled birth attendants including the establishment of delivery Manyattas to improve Maternal and Infant Child Health.			
	Establish more community health units	MARPs, morans, women 14-49 years		County Government and partners
	Integrate HIV information and education as part of the school health program	Health workers, teachers, pupils and partners		County Government and partners
	Lobby for employment of more health workers	Unemployed health workers (New graduates/ qualified but not employed)		County Government and partners
	Strengthen the supply chain	Health workers		County Government and partners
	Lobby for construction of more health facilities.	General population (All the people are the target beneficiaries)		County Government and partners

4.2.5 Strategic Direction 5: Strengthen Research innovation and information management to meet the Mandera County HIV Strategy goals.

Context

Much of the data used in developing this strategy has been drawn from the national surveys notably the Kenya AIDS Indicator Survey, Health Survey and the County profile. Within the county,

INTERVENTION AREAS IN STRENGTHENING RESEARCH INNOVATION AND INFORMATION MANAGEMENT TO MEET THE				
KASF objective	**MCASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	
Reduce new HIV infections by 75% Reduce AIDS related mortality by 25% Reduce HIV related stigma and discrimination by 50% Increase domestic financing of the HIV response to 50%	Research – backed HIV activities implementation	Increase evidence-based planning, programming and policy changes	**Structural**	
			Form the County Monitoring Unit to coordinate research, monitoring and evaluation activities.	
			Undertake a Mandera HIV baseline survey	
			Undertake a mid-line review of the MCASP	
			Undertake an end line review of the MCASP	

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

Context

M&E activities on HIV have largely been supported from NACC in terms of HIV specific data collection and reporting on a routine basis including community based activities through

INTERVENTIONS FOR PROMOTING THE UTILISATION OF STRATEGIC INFORMATION FOR RESEARCH AND MONITORING				
KASF objective	**MCASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	
Reduce new HIV infections by 75% Reduce AIDS related mortality by 25% Reduce HIV related stigma and discrimination by 50% Increase domestic financing of the HIV response to 50%	Enhanced County M&E system	Strengthen the M&E system	**Structural**	
			Undertake quarterly supervision and monitoring	
			Print and distribute M&E tools for collection of HIV data	
			Hold quarterly M&E meetings and report to the County ICC	

apart from the use of health facility data, there was a realisation that there exists little information on the HIV status in Mandera and if any information exists, it is not available at the disposal of the county's Department of Health.

MANDERA COUNTY HIV STRATEGIC GOALS			
	Target Population	**Geographic areas by County/sub- county**	**Responsibility**
	Health workers	Mandera West, sub- County Mandera South sub- County Banisa, sub- County Mandera North sub- County Mandera East sub- County Lafey sub- County	County Government and partners
	Health workers		County Government and partners
	Stakeholders		County Government and partners
	Stakeholders		County Government and partners

Community Based Programme Reporting (COBPAR form) as completed by CSOs on a quarterly basis. Through NASCOP, health facility based data is collected and submitted on a monthly basis. In the absence of a well structured M&E unit at the county level, there is an obvious gap in the collection and use of strategic information to enhance programming.

AND EVALUATION TO ENHANCE PROGRAMMING			
	Target Population	**Geographic areas by County/sub- county**	**Responsibility**
	CDH, CHMT, CASCOs	All sub counties in Mandera County	County government, NASCOP, NACC
	CDH, CHMT, CASCO	All sub counties in Mandera County	County government, NASCOP, NACC
	CDH, CHMT CASCO	All sub counties in Mandera County	County government, NASCOP, NACC

4.2.7 Strategic direction 7: Increasing domestic financing for sustainable HIV response

Context

Due to dwindling resources from partners for HIV programming, smarter investments of every

INTERVENTIONS FOR INNOVATIVE AND SUSTAINABLE DOMESTIC HIV FINANCING OPTIONS FOR MANDERA COUNTY.			
KASF objective	**MCASP Results**	**Key Activity**	
Increase domestic financing of the HIV response to 50%	Increased domestic financing for HIV response to 10%	Hold innovative activities to raise domestic financing for HIV	

4.2.8 Strategic Direction 8: Strengthening the County Coordination Mechanism (Accountable leadership).

Context

Good governance practice shall be promoted by identifying, developing and nurturing effective

INTERVENTIONS FOR STRENGTHENING COUNTY HIV COORDINATION MECHANISM				
KASF objective	**MCASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	
Reduce new HIV infections by 75% Reduce AIDS related mortality by 25% Reduce HIV related stigma and discrimination by 50% Increase domestic financing of the HIV response to 50%	A well-coordinated HIV response in the county	Disseminate the MCASP	**Structural**	
			Hold a meeting to disseminate the MCASP to the Mandera County Executive Committee and leadership	
			Hold a meeting to disseminate the MCASP to the private sector	
		Formation of the relevant county HIV coordinating committee	Establish the County HIV Committee	
			Hold bi-annual HIV ICC coordination meetings	
			Support sub county / constituency HIV committees	

shilling is paramount. Therefore, there is need for the county government to prioritise and budget for the HIV interventions.

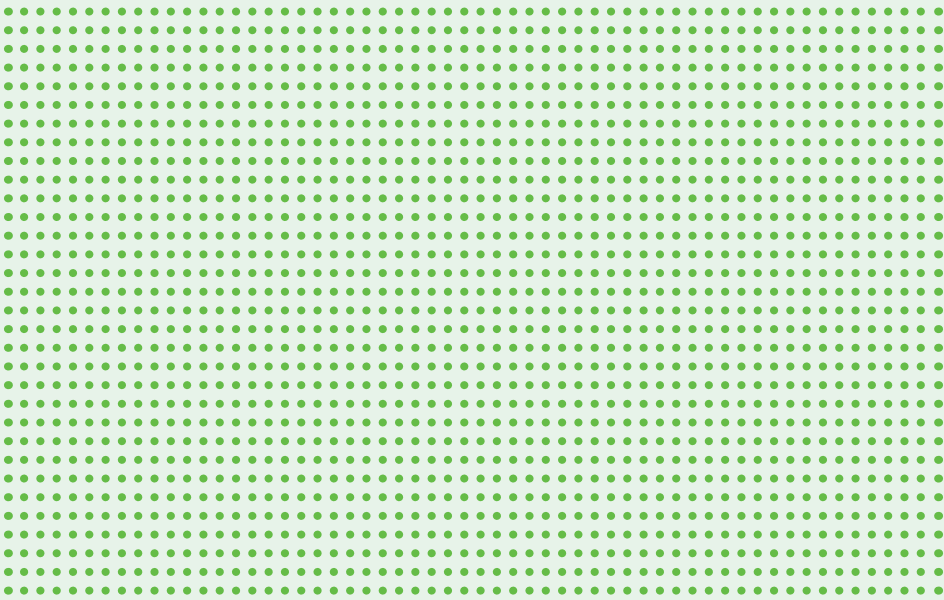
	Sub-Activity/ Intervention		Target Population	Geographic areas by County/sub- county	Responsibility
	Behavioural	**Structural**	MPs, MCAs, GVN, CECs, partners	All sub counties in Mandera County	County government, NASCOP, NACC
	Hold an annual dinner gala for raising funds for HIV activities	Prepare and present a sessional paper on increasing domestic funding of HIV activities to the County Executive Committee			

and committed leaders for the HIV response.

	Target Population	Geographic areas by County/sub- county	Responsibility
	CECs, County leaders	Mandera County	CEC-Health, NACC, GVN-Office, County Secretary.
	Key Partners	Mandera County	CEC-Health, NACC, GVN-Office, County Secretary.
	CEC-Health, CHMT, Key partners	Mandera County	CEC-Health, NACC, GVN-Office, County Secretary
	Key stakeholders and partners	Mandera County	County government, NASCOP, NACC, partners
	Sub-County HIV Committees	Mandera County	County government, NASCOP, NACC, partners

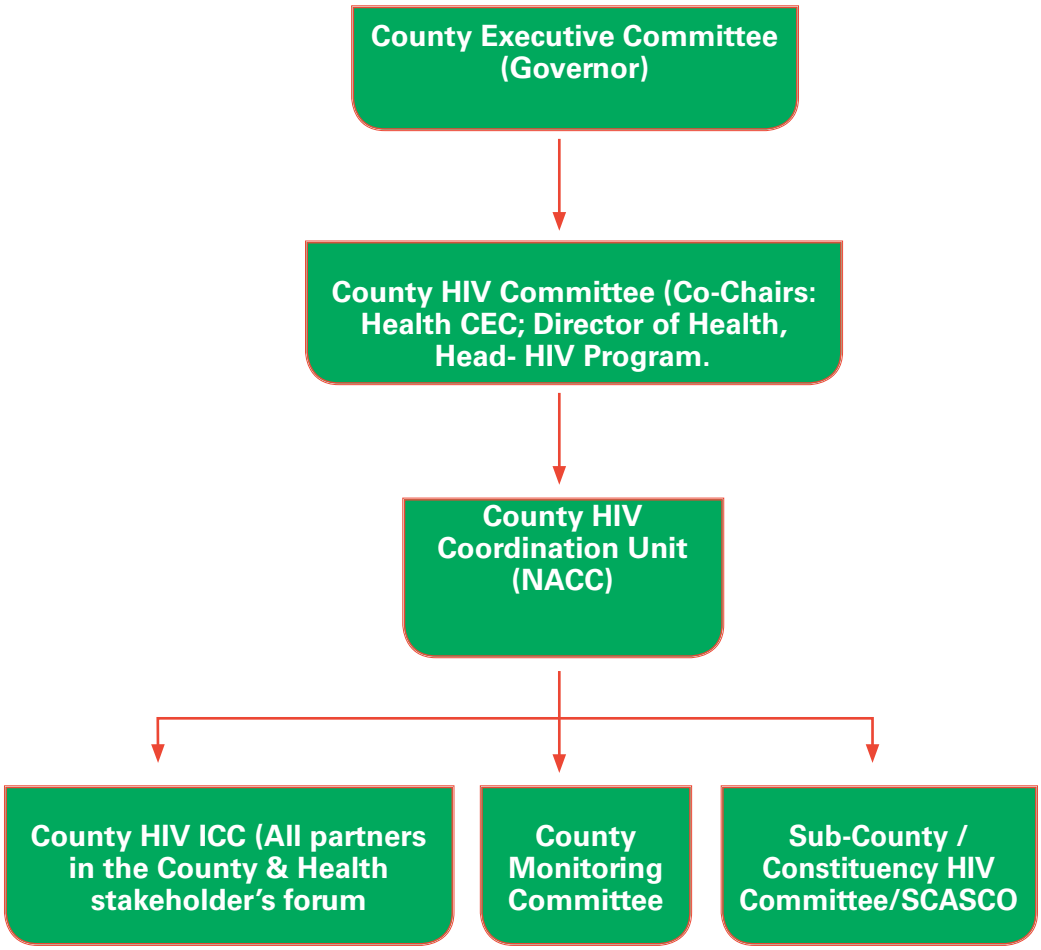
05.

IMPLEMENTATION ARRANGEMENTS



The KASF recognises that counties are responsible for implementation of HIV services and programmes across different sectors. It has within its coordination structure singled out the county governments as providing the link with the sub counties, HIV committees, implementers, PLHIV and special interest groups hence the need to provide a strategic communication framework to coordinate the efforts of all stakeholders.

Figure 1: The HIV Coordination organogram for delivery of the MCASP



5.1 Roles and responsibilities

5.1.1 Governor

The Governor shall be responsible for implementation of National and County legislation to the extent that the legislation require and is responsible for the delivery of a range of services and planning and prioritisation of resource allocation to address HIV burden in Mandera County.

5.1.2 County HIV Committee

It shall be accountable to the County executives - Mandera County for the performance of their functions and the exercise of their powers on matters relating to HIV.

5.1.3 Membership

The committee shall be co-chaired by the County Health Executive and the County Director of Health/Head-HIV with membership from the sub county HIV committee, HIV partners, implementers, PLHIV and other special interest groups in Mandera.

5.1.3.1 Terms of reference: The county HIV committee shall be:

- The custodian of the MCASP.
- Holding meetings on a quarterly basis to review implementation plan.
- Responsible for the effective delivery of the HIV response at the county level through periodic review and monitoring of the MCASP.
- Approving the County HIV targets and plans.
- Reviewing and presenting County HIV budget.
- Setting the County HIV agenda.
- Receiving reports on MCASP progress from the monitoring committee.
- Forming sub TWG to review and advice on issues HRBA to HIV services.
- Receiving reports from County ICC, MCASP and routine monitoring committee.

5.1.4 County HIV Coordination Unit

This will be the responsibility of the County ministry of health. The unit shall coordinate the day to day implementation of the strategic framework at County level, working closely with the County Health Management Team and the various line departments at the County level with a direct link with the NACC secretariat at the national level.

5.1.4.1 Terms of reference

- Ensure quarterly County ICC HIV meetings are held and follow through on County ICC HIV actions.
- Ensure HIV agenda is active in the CHMT.
- Regular engagement of all state and non-state actors within the county in planning, prioritisation, implementation, monitoring and evaluation of HIV and AIDS programmes.
- Strengthening linkages and networking among stakeholders and providing technical assistance, facilitation and support for KASF delivery.
- Monitor county legislation to ensure all Bills are HIV non-discrimination compliant

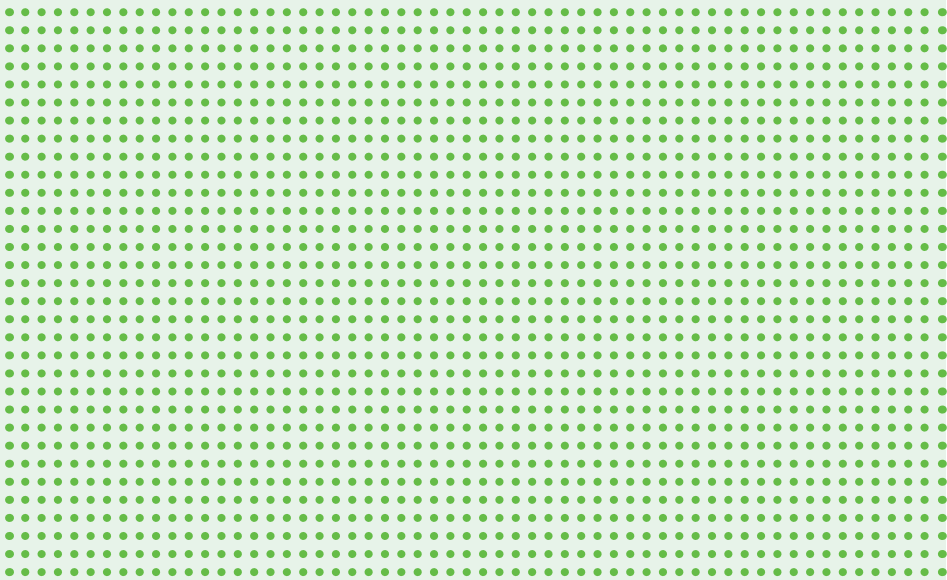
5.1.5 M&E Unit

Once established, the unit will have terms of reference that will include:

- Ensure that all the prerequisite tools and materials for data collection are available at the point of collection at all times.
- Building the capacity of health workers on data collection and transmission.
- Ensuring the data collection, quality control, consolidation, interpretation and dissemination.
- Ensure the preparation and publication of County Department of Health newsletter on a bi-annual basis for dissemination of health articles, data and human interest stories, songs including HIV possibly through vernacular languages.

06.

MONITORING, EVALUATION AND REPORTING OF THE PLAN



6.1 Overview of Monitoring & Evaluation

The overall the purpose of monitoring and evaluation is to track activities and indicators of the County Strategic Plan as its being implemented. The process will ensure that resources are spent as planned within the framework of the strategic plan projections and budgets; and that activities take place as planned within the specific time frames to realize the stated strategic objectives. At the end an evaluation will be conducted to determine the impact of the activities in general.

6.1.1 Monitoring mechanism

The Mandera County HIV and AIDS Strategic Plan has clearly defined activities with specific timelines for implementation. For ease of monitoring, the plan is aligned to the Kenya AIDS Strategic Framework (KASF) objectives and strategies and the national M&E indicators. The realization of the strategic plan will feed into the overall objectives of the KASF.

6.1.2 Supervision

The MCASP monitoring committee will carry out supervision of the overall Plan implementation and prepare quarterly reports. This will require the cooperation of all stakeholders. Findings from the supervision missions will be presented to the CHC and follow-up actions discussed. The CHC will ensure prompt submission of the reports to the county executive and other relevant persons.

6.1.3 Activity assessments

County stakeholders meetings to review progress of the plan will be held annually with representatives from the various HIV and AIDS implementers and stakeholders. This will enable the stakeholders to identify and take necessary actions to address emerging challenges.

6.2.0 Evaluation

The Plan will be subjected to two evaluations, Mid- and End-term Evaluation and Reviews. The evaluations will be done using an indicator monitoring tool under the guidance of a strategic planning expert.

6.2.1 Mid-term evaluation and review (MER)

The purpose of the Mid-term evaluation and review will be to assess the extent to which the Plan is meeting its implementation objectives and timelines. The mer will be carried out at the end of 2017 after an internal evaluation which will provide an opportunity to:

(i) Establish the extent to which the strategy has realized the planned objectives and expected results.

(ii) Assess management and coordination strategy and the extent to which these structures support effective implementation of the strategy. This will include the extent to which key stakeholders have been involved in implementation.

(iii) Assess the strategy outcomes in the community in terms of efficiency, effectiveness, relevance and sustainability.

(iv) Identify and document key lessons learnt and best practices that can be used for advocacy to influence relevant policies and practices.

(v) Give recommendations on ways of addressing identified gaps and advise on possible areas that need to be changed in the remaining strategy period to ensure realization of the objectives.

6.2.2 End-term evaluation

The purpose of the end term evaluation for the MCASP is expected to be carried out at the end of 2019 and is expected to address the following issues:

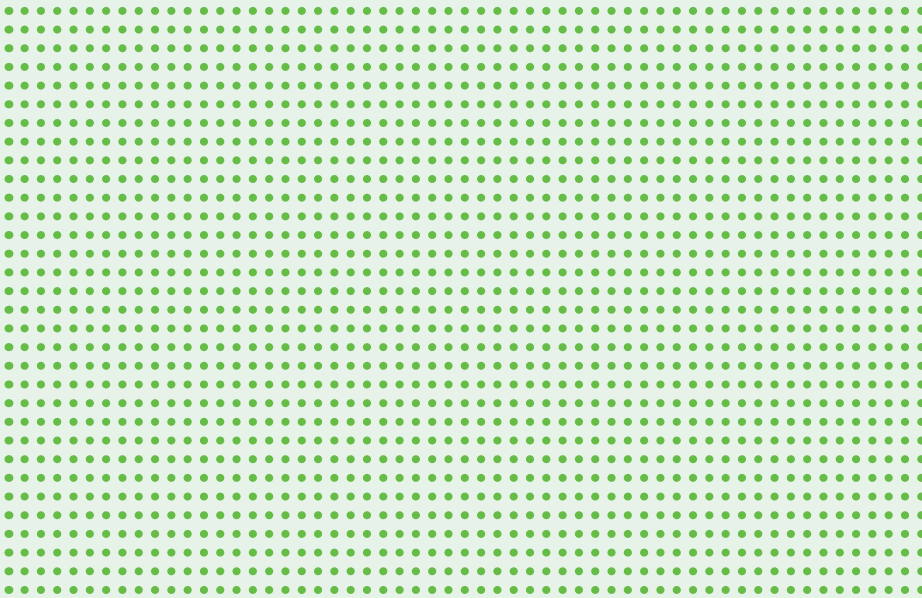
1. Establish the extent to which the County has realized the planned objectives and expected results.
2. Assess the County's outcome in terms sustainability of programmes.
3. Identify and document key lessons learnt and best practices that can be used for advocacy to influence relevant policies and practices as well as for replication in new programmes.

6.3 Reporting and information dissemination

Reporting the progress of implementation will be critical in adjusting strategic directions and measuring performance. Progress reports will be made on quarterly basis. The reports will outline in summary the projected targets, achievements and challenges. The reports will be prepared and submitted by the monitoring committee through the CHC of Mandera County Government.

07.

RISK AND MITIGATION PLAN



7.0 Risk and mitigation plan

Risk Category	Risk Name	Status	Probability (1-5)	Impact (1-5)	Response	Responsibility	When
Technological	Partners lack capacity to implement HIV activities	Active- risk is being actively monitored	3/5	4/5	Mitigate- budget moneys for training	County HIV coordinating Unit	Y1
Political	2017 General election and change of County leadership	Mild	2/5	3/5	Risk will be monitored	County government	Y2
Operational	Little support and few staff in place	Active	3/5	3/5	Lobby to strengthen the unit	CDH/ County HIV oversight committee	Y1
Legislation	No legislation addressing HIV	Active	3/5	3/5	Lobby for relevant legislations	CEC- Health	Y2
Financial	No/inadequate HIV response funds	Active	4/5	4/5	Resource mobilization	County Government -CDH	Y1

08.

ANNEXES

8.0 RESULTS FRAMEWORK

STRATEGIC DIRECTION 1: REDUCING NEW HIV INFECTIONS				
KASF objective	MCASP Results	Key Activity	Indicators	
Reduce new HIV infections by 75%	Reduce new HIV infections by 75%	Offer HIV services to the general population at facility level (55% have not been tested)	Percentage of people that know their HIV status.	
		Establish 3 more DICs to offer HIV services to the key population in urban centres	Number of the targeted key population using DICs.	
		Increase outreach for the hard to reach for HTS including use of the Beyond Zero Campaign	Percentage of people reached with HTS services through outreach campaigns.	
		Implement EMTCT in all health facilities	Percentage of pregnant women and children reached by EMTCT services.	
		Develop innovative approaches for targeting vulnerable population with HIV services (truckers, prisoners, boda boda operators, sand harvester)	Percentage of the vulnerable population (truckers, prisoners, boda boda operators, sand harvester) reached with HIV services	
		Hold a consultative meeting with representative of institutions of higher learning to develop strategies for integrating HIV services in the institutions.	Percentage of vulnerable population in institutions of higher learning reached with HIV services	

	Baseline	Mid Term Target	End Term Target	Responsibility
	45%	60%	80%	County Government & Partner (Private clinics and hospitals)
	0	2	3	County Government & Partners
	28%	65%	80%	County Government & Partners
	45%	60%	90%	County Government & Partners
	-TBD	30%	50%	County Government & Partners
	-TBD	30%	50%	County Government & Partners

STRATEGIC DIRECTION 2: IMPROVING HEALTH OUTCOMES FOR PLHIV			
KASF objective	**MCASP Results**	**Key Activity**	
Reduce AIDS related mortality by 25%	Increased coverage of care and treatment and reduced loss in the cascade of care	Increase the number of health facilities offering ART centres	
		Increase the number of PLHIV on ART (540 receiving) ART, 1948 in need of ART)	
		Build the capacity of healthcare workers on paediatric HIV management	
		Establish 3 model CCCs in Mandera.	
		Establish a HIV referral laboratory in Mandera County.	
		Develop innovative approaches to integrate the use of ICT in HIV services especially increasing adherence to ART.	
		Support partners to implement the minimum package for PWP activities	

STRATEGIC DIRECTION 3: USING HRBA TO FACILITATE ACCESS TO SERVICES FOR PLHIV, KEY POPULATION AND OTHER			
KASF objective	**MCASP Results**	**Key Activity**	
Increase access to equitable HIV services	HIV services accessed by all	Formation of a sub TWG to review and advice on strengthening a HRBA to HIV services	
		Hold a consultative meeting to strengthen the medico-legal structures to address SGBV cases in the county	
		Training of Health workers on HRBA to HIV services	
		Develop innovative approaches for increasing access to youth friendly HIV services including integrating HIV services to youth empowerment centres	
		Develop innovative approaches of increasing access to HIV services for PWD.	
		Establish a local arbitration mechanism within the ICC	

	Indicators	Baseline	Mid Term Target	End Term Target	Responsibility
	Number of health facilities offering ART services	10	15	21	County Government & Partners
	Number of persons receiving ART.	540	850	1500	County Government & Partners
	Number of paediatric receiving HIV services.	27	320	513	County Government & Partners
	Number of PLHIV reached/served with HIV services through the model CCCs.	900	2000	3000	County Government & Partners
	Number of HIV lab specimens examined and reported on.	591	1400	2000	County Government & Partners
	Number of PLHIV that are reached through ICT.	363	800	1550	County Government & Partners
	Number of PLHIV reached with minimum PWP.	534	1040	2000	County Government & Partners

PRIORITY GROUPS IN ALL SECTOR

	Indicators	Baseline	Mid Term Target	End Term Target	Responsibility
	HRBA to HIV services being implemented.	Not implemented	Implemented	implemented	County Government & Partners
	Number of SGBV cases handled by the sub TWG.	65	42	18	County Government & Partners
	No. HW trained on HRBA to HIV services	20	46	190	County Government & Partners
	Number of OVCs receiving HIV services.	85	160	220	County Government & Partners
	Number of youths reached with HIV services through the youth friendly clinic / centres.	0	50	160	County Government & Partners
	Percentage of PWD reached with HIV services.	3%	5%	10%	County Government & Partners
	Percentage of cases related to abuse of HR related to HIV arbitrated.	20%	10%	5%	County Government & Partners

STRATEGIC DIRECTION 4: STRENGTHENING INTEGRATION OF HEALTH AND COMMUNITY SYSTEMS.			
KASF objective	**MCASP Results**	**Key Activity**	
Reduce new HIV infections by 75% Reduce AIDS related mortality by 25% Reduce HIV related stigma and discrimination by 50% Increase domestic financing of the HIV response to 50%	An integrated community and health system	Develop innovative approaches for increasing access to skilled birth attendants including the establishment of delivery Manyattas to improve Maternal and Infant Child Health.	
		Develop a HIV communication strategy for Mandera.	
		Organize events aimed at integrating HIV services with the annual initiation ceremony.	
		Establish more community health units	
		Integrate HIV information and education as part of the school health program.	

STRATEGIC DIRECTION 5: STRENGTHENING RESEARCH AND INNOVATION TO INFORM ON THE MCHASP			
KASF objective	**MCASP Results**	**Key Activity**	
Reduce new HIV infections by 75% Reduce AIDS related mortality by 25% Reduce HIV related stigma and discrimination by 50% Increase domestic financing of the HIV response to 50%	Research – backed HIV activities implementation	Form the County Monitoring Unit to coordinate research, monitoring and evaluation activities.	
		Undertake a Mandera HIV baseline survey	
		Undertake a mid line review of the MCASP	
		Undertake an end line review of the MCASP	

STRATEGIC DIRECTION 6: PROMOTING UTILISATION OF STRATEGIC INFORMATION FOR RESEARCH AND MONITORING AND			
KASF objective	**MCASP Results**	**Key Activity**	
Reduce new HIV infections by 75% Reduce AIDS related mortality by 25% Reduce HIV related stigma and discrimination by 50% Increase domestic financing of the HIV response to 50%	Enhanced County M&E system	Undertake quarterly supervision and monitoring	
		Print and distribute M&E tools for collection of HIV data	
		Hold quarterly M&E meetings and report to the County ICC	

	Indicators	Baseline	Mid Term Target	End Term Target	Responsibility
	Percentage of deliveries performed through skilled birth attendance.	27%	40%	50%	County Government & Partners
	Percentage of the population reached through HIV advocacy, communication and social mobilisation activities.	-TBD	50%	80%	County Government & Partners
	Number of young adults reached with HIV services during the annual ceremony.	10,000	50,000	120,000	County Government & Partners
	Number of people reached with HIV services through the community health units	20,000	36,000	84,000	County Government & Partners
	Number of school going children reached with HIV information through schools.	12,000	31,000	40,000	County Government & Partners, Schools

	Indicators	Baseline	Mid Term Target	End Term Target	Responsibility
	Number of county HIV monitoring units established	0	1	1	County Government & Partners
	Number of HIV baseline survey conducted	0	1	1	County Government & Partners
	Results of the mid line review used to track progress of the implementation of the MCASP.	Midterm review conducted			County Government & Partners
	Results of the end line review used to inform on the program achievement.	End term review conducted			County Government & Partners

EVALUATION TO ENHANCE PROGRAMMING.

	Indicators	Baseline	Mid Term Target	End Term Target	Responsibility
	Number of reports of the supervision and monitoring visits used to inform on the program	0	4	8	County Government & Partners
	Number of health facilities submitting HIV data on a monthly basis.	64	70	84	County Government & Partners, HRIOs
	Number of reports of the M&E submitted to the County ICC and used to inform on the MCASP progress.	0	4	8	County Government & Partners

STRATEGIC DIRECTION 7: INCREASING DOMESTIC FINANCING FOR A SUSTAINABLE HIV RESPONSE IN MANDERA COUNTY.			
KASF objective	**MCASP Results**	**Key Activity**	
Reduce new HIV infections by 75% Reduce AIDS related mortality by 25% Reduce HIV related stigma and discrimination by 50% Increase domestic financing of the HIV response to 50%	Increased domestic financing for HIV response to 10%	Prepare and present a sessional paper on increasing domestic funding of HIV activities to the County Executive Committee	
		Undertake mapping of HIV partners' representation in Mandera to identify gap areas and evenly distribute the partners in the county.	

STRATEGIC DIRECTION 8: PROMOTING ACCOUNTABLE LEADERSHIP FOR DELIVERY OF THE MCASP RESULTS BY ALL SECTORS AND AC			
KASF objective	**MCASP Results**	**Key Activity**	
Reduce new HIV infections by 75% Reduce AIDS related mortality by 25% Reduce HIV related stigma and discrimination by 50% Increase domestic financing of the HIV response to 50%	A well-coordinated HIV response in the county	Disseminate the MCASP	
		Formation of the relevant county HIV coordinating committee	

	Indicators	Baseline	Mid Term Target	End Term Target	Responsibility
	Amount of funds generated through domestic financing.	4m	67m	200m	County Government & Partners, CEC
	Number of HIV implementing partners in the county per sub-county	1	6	18	County Government & Partners

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	Indicators	Baseline	Mid Term Target	End Term Target	Responsibility
	Number of meetings held with County Executive members on HIV advocacy activities.	1	3	2	NACC, County Government & Partners
	Number of meetings held to disseminate the MCASP to the private sector	0	2	2	NACC, County Government & Partners
	Number of County HIV Committee established	0	1	1	NACC, County Government & Partners
	Number of HIV ICC coordination meetings held	0	2	2	NACC, County Government & Partners
	Number of county / sub-county / constituency HIV committees strengthened or constituted	4	6	8	County Government & Partners, Private Sector.

8.2 RESOURCE NEEDS

The table below indicates the estimated cost of implementing the strategic plan of the county. The funds are in millions of Kenya shillings

STRATEGIC DIRECTION	KEY ACTIVITIES	Y1	Y2	Y3	Y4
STRATEGIC DIRECTION 1	Identify and target and offer HIV services to the key populations and general population.	25m	40m	40m	30m
STRATEGIC DIRECTION 2	Scale up interventions to improve quality of care and improve health outcome	35m	50m	42m	32m
STRATEGIC DIRECTION 3	Remove barriers to access HIV services for PLHIV	5m	7m	7.5m	6m
STRATEGIC DIRECTION 4	Strengthen the integration of community and health system.	4m	6m	5.5m	4.5m
STRATEGIC DIRECTION 5	Increase evidence-based planning, programming and policy changes	2m	7m	3m	2m
STRATEGIC DIRECTION 6	Strengthen the M&E system	2m	6m	5m	7m
STRATEGIC DIRECTION 7	Hold innovative activities to raise domestic financing for HIV.	1m	1.5m	1m	0.8m
STRATEGIC DIRECTION 8	Formation of the relevant county HIV coordinating committee	1m	3m	2m	1.8m
Total (KSHS)		**75m**	**114.5m**	**106m**	**84.8m**

8.3 DRAFTING MEMBERS

MANDERA COUNTY GOVERNMENT HIV and AIDS STRATEGIC PLAN DRAFTING TEAM

S/NO	NAME	DESIGNATION
1	ABDI HASSAN GEDI	COUNTY HEAD HIV/MALARIA
2	ABDIKADIR ABDULLAHI	SCASCO-MDR EAST
3	DR. ABDIRAHMAN MAALIM	COUNTY PHARMACIST
4	DERROW M GAMOW	PHO – MCRH
5	MOHAMED ADAWA	DEPUTY DIRECTOR – HEALTH
6	HASSAN M. ODO	HEAD OF REPRODUCTIVE HEALTH
7	AHMED SHEIKH	CEC – HEALTH
8	MARIYAM DUBOW DAHIR	CO – HEALTH
9	ADAN ABDIKADIR HAJI	CACC- MDR SOUTH
10	ABUKAR SHEIKH	HEAD OF PUBLIC HEALTH
11	OSMAN ABDULLAHI ISSACK	CCC IN-CHARGE MCRH
12	DR. ISMAIL SHEIKH	HEAD, SUPPLY CHAIN-PHARMACEUTICAL
13	DR. ABDI MAALIM ISSAKOW	COUNTY DIRECTOR – HEALTH
14	OMARI MWANJAMA	NACC – RHC
15.	MOHAMUD H. MAMO	HEAD – HMIS

8.4 TECHNICAL REVIEW TEAM

ROHIN ONYANGO - RESEARCH, M&E EXPERT AFRICA CAPACITY ALLIANCE
PETER ODENYO - NEPHAK
STEVEN J. OYUGI - NACC

maisha!
National AIDS Control Council
The Global Fund
To Fight AIDS, Tuberculosis and Malaria