MARSABIT COUNTY HIV & AIDS STRATEGIC PLAN

2015/2016 - 2018/2019

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Acronyms and abbreviations

ACU	AIDS Control Units
AIDS	Acquired Immuno-Deficiency Syndrome
APOC	Adolescent Package of Care
ART	Anti-Retroviral Therapy
ARVS	Anti-Retroviral medicines
CASCO	County HIV /AIDS STI Coordinator
CEC	County Executive Committee
CHC	County HIV Committee
CHEWS	Community Health Extension Workers
CHMT	County Health Management Team
CHV	Community Health Volunteers
CHW	Community Health Workers
COBPAR	Community Based Programme Activity Reporting
CSO	Civil Society Organization
DHIS	District Health Information System
EBIs	Evidence Based Interventions
EID	Early Infant Diagnosis
EIT	Early Infant Treatment
EMTCT	Elimination of Mother-to-Child Transmission
FBO	Faith Based Organization
FSW	Female Sex Workers
GBV	Gender Based Violence
HCWs	Health Care Workers
HIPROS	HIV Partner Reporting Online System
HPV	Human Papilloma virus
HTS	HIV Testing Services
IEC	Information, Education and Communication
IGA	Income Generating Activities
KAIS	Kenya AIDS Indicator Survey
KASF	Kenya AIDS Strategic Framework
KDHS	Kenya Demographic Health Survey
KEMSA	Kenya Medical supply Authority
KEMRI	Kenya Medical Research Institute
KEPH	Kenya Essential Package for Health
KP	Key Population
LMIS	Logistic Management Information System
MCH	Maternal Child Health

MCASP	Marsabit County AIDS Strategic Plan
MDAs	Ministries, Departments and Agencies
M&E	Monitoring and Evaluation
MoEST	Ministry of Educations, Science & Technology
MoH	Ministry of Health
MoT	Modes of Transmission
MSM	Men who have Sex with Men
NACC	National AIDS Control Council
NGO	Non-Governmental Organization
NASCOP	National AIDS and STI Control Programme
NSP	Needle and Syringe Program
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PHDP	Positive Health Dignity & Prevention
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre Exposure Prophylaxis
PWD	People with Disability
PWID	People Who Inject Drugs
PWP	Prevention with Positives
RTKs	Rapid Test Kits
SCACC	Sub-County AIDS Coordinating Committee
SD	Strategic Direction
SP	Strategic Plan
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SWs	Sex Workers
TAT	Turnaround Time
TB	Tuberculosis
TWG	Technical Working Group
VL	Viral Load

Foreword

HIV and AIDS remains one of the greatest public health concerns for Marsabit County, Kenya and the whole world. The scourge has continued causing deaths and suffering among members of the community, breaking social and community fabrics and reducing productivity. However, all is not lost. Marsabit County has reduced HIV prevalence from 2.1% (KAIS 2012) to the current estimated 1.5% in 2014. We have scaled up HIV awareness to 90%, testing and counselling to 65% and also ensured adult treatment coverage of over 50% of those in need of ARVs.

In order to improve on the service delivery, we need to mobilise more resources to upscale HIV testing services (HTS) and enrol more clients into HIV care, support and treatment. Despite the county having low HIV prevalence rate, the impact is higher when compared to the population. To reduce stigma and discrimination, psycho-social support mechanisms need to be put in place to reduce stigma.

The drivers of the epidemic in the county include Key Populations such as sex workers and their clients, isolated cases of men having sex with men, beading of young girls, uncircumcised men in certain communities, cross border population movements within and out of the country, wife inheritance, keeping concubines, gender based violence(GBV) and poverty among others.

The Marsabit HIV Strategic Plan is geared towards a multi–sectoral approach to effectively combat the HIV infections with increased county financing of sustainable interventions/ programs and increased involvement of all the county leaders and agencies. It provides the guidance on how the county can scale up relevant interventions which are geared towards achieving the set objectives and vision 2030.

The County Government of Marsabit will therefore make full commitment towards getting to zero new HIV infections, stigma and discrimination and HIV related deaths

H.E Ukur Yatani Kanacho
The Governor, Marsabit County

Preface

Marsabit County is one of the 47 counties in the country. Majority of the population, 80%, is predominantly pastoralist while 20% of the population is either engaged in farming, business or formal and informal employment. With the devolved system, the county is experiencing economic growth. The Constitution of Kenya helps this changing context with healthcare being a priority. Improving development in the county is particularly essential to building skilled and competitive workforce and lifting people's living standards.

Progress has been made in improving healthcare systems since devolution started. This includes provision of ART, PMTCT, HTS, laboratory services and condom distribution among other interventions. Marsabit County is one of the fast growing counties among previously hard to reach areas since devolution started. With increased road access due to construction of Marsabit –Moyale highway, there has been a population influx from other parts of the country. We expect increase in HIV prevalence in our county as a result of this. With this understanding, the Marsabit County AIDS Strategic Plan exemplifies the firm commitment by key stakeholders to support the county government to deliver better healthcare for all with a focus on cost effective and socially inclusive interventions to prevent and manage HIV and AIDS.

This Strategic Plan is aligned to the Constitution of Kenya and the Vision 2030 on HIV prevention and control. It recognises the centrality of a multi-sectoral response to HIV and outlines roles and expected actions from different sectors and actors. A co-ordination and governance structure led by the NACC takes cognisance of devolution and functions of different levels of government, roles of other government ministries and agencies and the need for strengthened stakeholder accountability in order to get results. Increasing domestic and sustainable financing for HIV is a priority for the two levels of governments. The MCASP outlines an innovative leverage funding approach based on implementation of the HIV fund. This will increase resources, access to universal healthcare for those living with HIV and AIDS and ultimately subsidise Marsabit County future liability for HIV prevention and treatment.

In this regard, therefore, my Department is committed to facilitating achievement of the results articulated in this strategic plan. In doing so, we will build on the progress made so far through decades of hard work, unity of purpose, courage and commitment to step up the momentum towards ending the AIDS pandemic.

Hon. Stephen Labarakwe
County Executive Committee Member-Health

Acknowledgement

Development of this strategic plan is the result of tireless and concerted efforts from various individuals. The process involved an all-inclusive and consultative process that utilised experts and stakeholders in reproductive health from both the public and private health sectors.

The County Government of Marsabit would like to thank all those who participated in this process in one way or another. The support of the National Aids Control Council Regional Office was quite instrumental in the development of this plan. Sincere gratitude are extended to the following task force members for their tireless efforts to guide the process of development of this plan through its various consultative forums and review of successive MCASP versions: Dr. Adano Kochi (CDOH), Dr M.S.Ndakalu (Deputy Director), Mrs. Batula Jaro (Assistant Director), Hassan Halakhe (Assistant Director), Dr. Boru Ali (SCMOH), Members of CHMT (Molu Waso, Bokayo Arero, Godana Doti, Abdub Liban, Andrew Bulyaar, Guyo Hirbo, Peter Mwangi, Abdullahi Konsole, Kussu Abduba, Molu Salesa, Mohammed Adan, Dida Halakhe, Liban Waqo), Fred Bosire APHIA Plus Imarisha.

We thank all team members and partners who contributed extensively in coming up with successive drafts of this strategic plan.

Mr. James Chiwe
County Chief Officer Health

Executive Summary

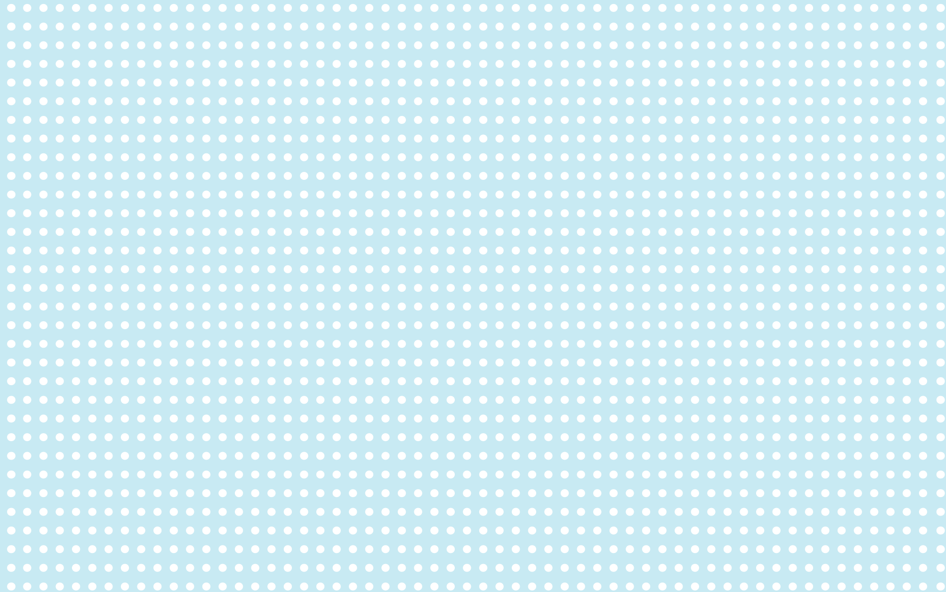
The Marsabit County AIDS Strategic plan (MCASP) 2015/16 – 2018/19 is a strategic guide for the county's response to HIV ad AIDS both at the county and sub-counties level. The framework specifically addresses drivers of HIV epidemic and builds on achievements of previous county health strategic plans so as to achieve its goal of contributing to the country's vision 2030 through universal access to comprehensive HIV prevention, treatment and care. MCASP envisions a new environment for the governance and management of national HIV and AIDS response. The Constitution of Kenya 2010 did not just change the policy environment for the national HIV and AIDS response, but also presented a major shift in governance framework for response. The MCASP 2015 – 2019 succeeds KNASP III that ended in June 2014. It builds on all past KNASP successes, leadership, partnership and legislations.

Kenya AIDS Strategic Framework Dissemination meeting was held on 18th and 22nd August, 2015 at Grande Hotel, Isiolo, where dissemination of the framework to the 40 key stakeholders drawn from Marsabit County was conducted. The stakeholders came up with an eight member technical working group to draft a county HIV strategic plan for 2015 – 2019. The TWG was urged to engage other key partners/stakeholders and keep the county leadership including county health management team informed on the progress.

MCASP is divided into eight strategic directions that addresses intervention and expected results of each direction by 2019. The intervention and results are also part of CIDP which was launched in December 2015. The framework is aligned to principles of a county free of HIV infection, stigma and AIDS. The objectives are: Reduce new HIV infections by 75%; reduce AIDS related mortality by 25%; reduce HIV related stigma and discrimination by 50% and increase domestic financing of HIV response by 40%. The goal of the county is to contribute to achieving vision 2030 through universal access to comprehensive HIV prevention, treatment and care.

01.

INTRODUCTION



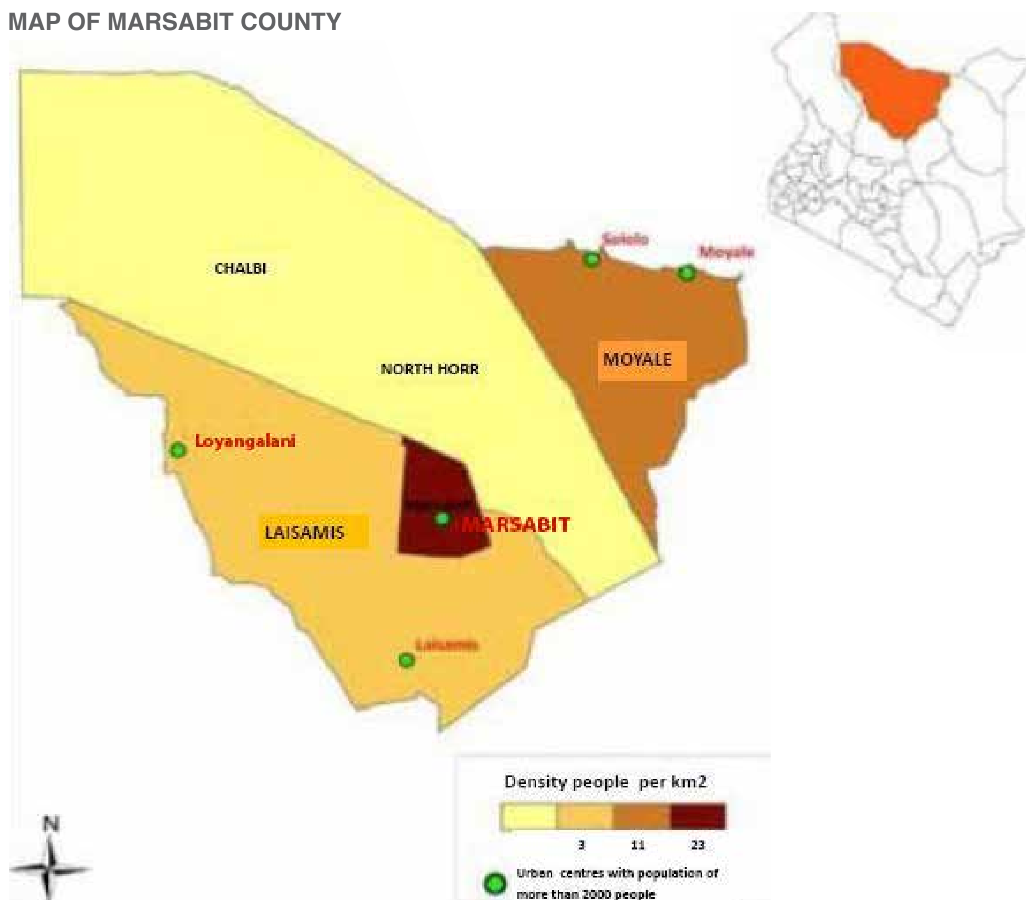
1.1 Background information on County

This chapter gives the background on the physical, socio-economic and infrastructural information that has a bearing on the development of the County Government of Marsabit. The chapter provides description of the county in terms of the location, size, physiographic and natural conditions, demographic profiles as well as the administrative and political units. In addition, it provides information on infrastructure and access; land and land use; community organisations/non-state actors; crop, livestock and fish production; forestry, environment and climate change; mining; tourism; employment and other sources of income; water and sanitation; health access and nutrition; education and literacy; trade; energy; housing; transport and communication; community development and Social Welfare.

1.2 Position and size

The County of Marsabit has a total area of 70,961.2Km^2 and occupies the extreme part of Northern Kenya. It has an international boundary with Ethiopia to the North, borders Turkana to the west, Isiolo and Samburu County to the South and Wajir County to the East. It lies between latitude 02° 45° North and 04° 27° North and longitude 37° 57° East and 39° 21° East.

MAP OF MARSABIT COUNTY



Source: Kenya bureau of statistics

1.3 Physical and Topographic Features

Most of the county constitutes an extensive plain lying between 300m and 900m above the sea level, sloping gently towards the south east. The plain is bordered to the west and north by hills and mountain ranges and is broken by volcanic cones and calderas. The most notable topographical features of the county are: Ol Donyo Ranges (2066m above sea level) in the South West, Mt. Marsabit (1865m above sea level) in the Central part of the county, Hurri Hills (1685m above sea level) in the North Eastern part of the county, Mt. Kulal [MAB] (2235m above sea level) in North West and the mountains around Sololo-Moyale escarpment (up to 1400m above sea level) in the North East.

Other physical features include the Chalbi Desert which forms a large depression covering an area of 948 Km^2. The depression is separated from Lake Turkana, which is 65-100m lower in elevation, by a ridge that rises to 700m. There are no permanent rivers in the county but four drainage systems exist, covering an area of 948 Km^2. Chalbi Desert is the largest of these drainage systems. The depression receives run-off from the surrounding lava and basement surfaces of Mt. Marsabit, Hurri Hills, Mt. Kulal and the Ethiopian plateau. The Melgis River, a seasonal river, drains to parts of Samburu District and flows through Kaisut Desert between Mount Marsabit and Oldonyo Lenkiyoi (Mathew Range) and Sorioadi flood plains then heads south eastwards until it joins Ewaso Ngiro. Laga Urr originating from Mathews Ranges drains through Korr and ends up in flood plains of Haleiwa. Other drainage systems include the Dida Galgalu plains which receive run-off from the eastern slopes of Hurri hills and Lake Turkana where seasonal rivers from Kulal and Nyiru Mountains drain their waters.

1.4 Ecological Conditions

Most predominant geological formation in the county is volcanic rocks. They extend both westward and eastward from the eastern part of the Rift Valley to Ethiopia border. These volcanic rocks are interrupted in a few areas by pockets of quaternary sediments and Mozambique belt. Other geological formations are associated with the old lake beds of Lake Turkana and Lake Chalbi. The south western and north eastern parts of the county are underlain by old, metamorphic rock of pre-Cambrian origin. These are covered by tertiary and Pleistocene sheets and cones of volcanic rock in the central and north eastern parts, especially in and around the central volcanic centres of Mt. Kulal, Hurri Hills and Mt. Marsabit.

The South Western plains are covered by quaternary sediments washed out from the higher areas in more recent geological times. Between the hills of Mt. Marsabit, Mt. Kulal, Hurri Hills and the bed of the seasonal Lake Chalbi is also covered by recent sediments. The rest of the county is covered by rocky, stony and rugged lava plains with poor soil development. Some of these soils in the western part of the district have acidic moisture and are saline like in Chalbi Desert.

The area below 700m above sea level is a low potential range land and forms about 75 per cent of the total land area. As a result of low, unreliable rainfall and high rates of evaporation, the soils are shallow and poor. The areas at the foot of the mountains comprise of Moyale-Sololo escarpment, the slopes of the Hurri Hills, the lower slopes of Mt. Marsabit and the middle slope of Mt. Kulal. It also includes the plains of Dida Galgallu, Bure Dera, Kaisut and Milgis. These areas receive moderate rainfall of about 700mm annually. Livestock and crop production are the major economic activities with maize, sorghum, millet, beans, fruits and vegetables being the main crops cultivated.

The highlands areas in the county include Mt. Marsabit, Mt. Kulal and Ol Donyo Mara Range which have moderate rainfall and productive agricultural soils.

1.4.1 Climatic Conditions

Most parts of the county are arid, with the exception of high potential areas around Mt. Marsabit, Kulal, Hurri Hills and the Moyale-Sololo escarpment. The county experiences extreme temperatures ranging from a minimum of 10.1^{0} C to a maximum of 30.2^{o} C, with an annual average of 20.1^{0} C. Rainfall ranges between 200mm and 1,000mm per annum and its duration, amount and reliability increases with increase in altitude. North Horr (550m) has a mean annual rainfall of 150mm; Mt. Marsabit and Mt. Kulal 800mm while Moyale receives a mean annual rainfall of 700mm.

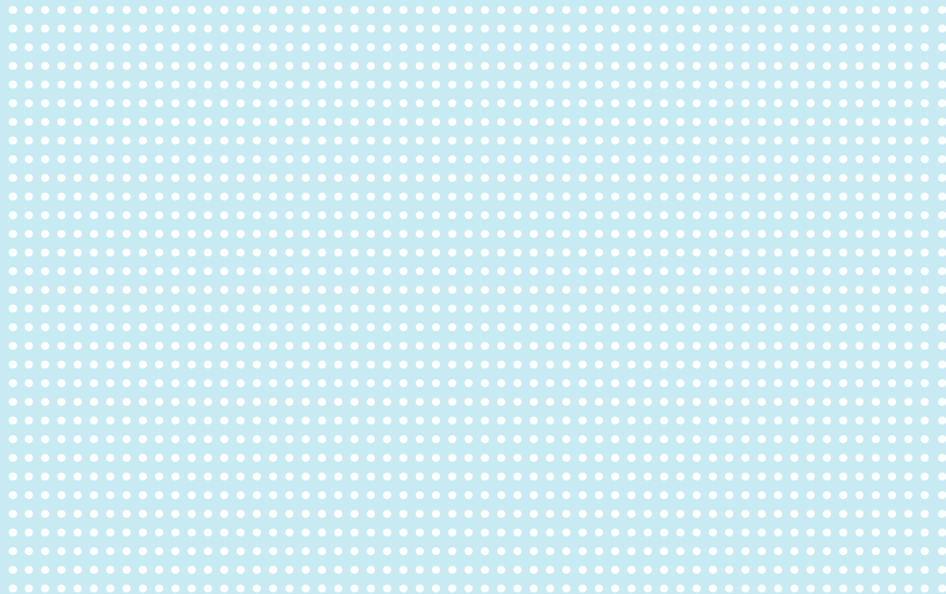
1.5 Administrative and Political Units

1.5.1 Administrative Sub-Divisions

The county is divided into four administrative sub counties namely: Saku, Laisamis, North Horr, and Moyale. Sub-counties are further divided into 20 wards and administrative villages. There are 4 sub-counties and 20 wards.

02.

SITUATION ANALYSIS

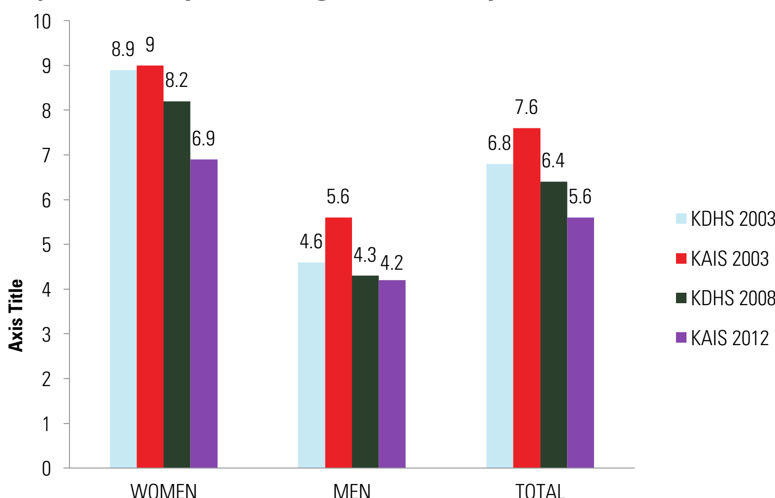


2.1 HIV burden in Kenya

Kenya is one of the six HIV 'high burden' countries in Africa where about 1.6 million people were living with HIV at the end of 2013. Women in Kenya are more vulnerable to HIV infection compared to men, with the national HIV prevalence standing at 7.6 per cent for women and 5.6 per cent for men. Total new HIV infections are estimated to have declined by about 15% in the last five years, from about 116,000 in 2009 to about 98,000 in 2013. As at 2014, new HIV infections were estimated to have stabilised at an average of 89,000 among adults and about 11,000 among children annually.

HIV prevalence in the general population reached a peak of 10.5% in 1995-96, after which it declined by about 40% to reach approximately 6.7% in 2003. Since then, the epidemic has remained relatively stable, with the prevalence ranging from 6.7% in 2003 to 5.6% in 2012. The stabilisation of the prevalence is largely attributed to the scale up of HIV treatment and care, while the reduction of new infections has been marginal.

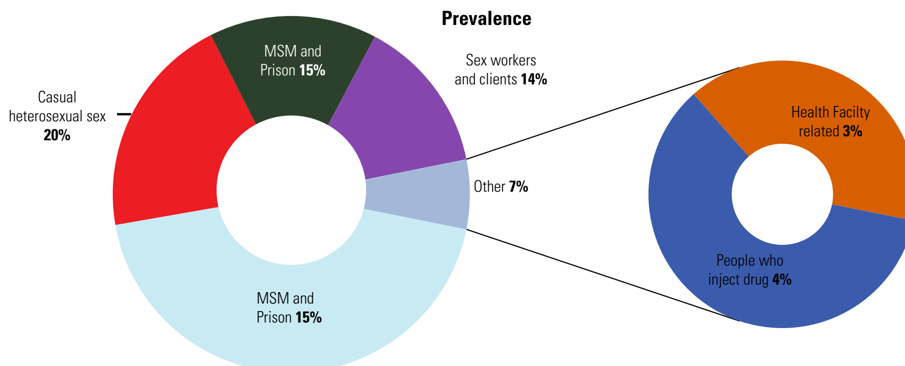
Figure 1: HIV prevalence by sex among adults in Kenya



Source: Kenya Demographic Health Survey 2003, 2008 and Kenya AIDS Indicator Survey 2007, 2012

2.1.1 Sources of New HIV Infection In Kenya

Figure 2: The sources of new HIV infections according to the Kenya Mode of Transmission (2009) segmented by populations.



2.2 HIV burden in Marsabit County

Marsabit County is a low incidence and prevalence county with about 1729 people living with HIV infection at the end of 2014. Women in Marsabit County are 8 times more vulnerable to HIV infection compared to men, with the County HIV prevalence standing at 1.6 per cent for women and 0.2 per cent for men.

Table 2.1: HIV burden in Marsabit County (County HIV Profile, 2014)

INDICATORS	TOTAL NUMBER
Total population (2013)	306,471
HIV adult prevalence (overall)	1.2%
HIV prevalence among women	1.6%
HIV prevalence among men	0.2%
Number of adults living with HIV	1500
Number of children living with HIV	229
Total Populations living with HIV	1729
Percentage of people never tested	73%
New adult HIV infections annually	81
New children HIV infections annually (0-14yrs)	4
New HIV infections among adolescent and young people (15-24yrs)	23

Marsabit county population (KNBS 2014) is as follows:

- Laisamis….79673
- Saku………..56419
- North Horr….91232
- Moyale…………125935
- Total …………353258

2.2.1 Factors contributing to new infections

Political: There has been a concerted effort through the leadership of the governor to open up new health facilities in hard to reach areas and also through employment of new medical staff to bridge existing gaps in each administrative ward in the county. However, despite all these efforts, there is still a gap that needs political goodwill especially in the area of resource mobilization towards enhancing HIV related programs that seek to reduce new infections and offer better services to both the infected and the affected.

Social: Marsabit is made up of a diverse population; nomadic people, sedentary livestock keepers, crop farmers and urban dwellers. However, due to increased human and livestock populations, pastoralism has become unsustainable. The pastoralists have to move from time to time in search of pastures and at times they leave behind their women and children. This situation makes it difficult for the government and development agencies to provide basic services including HIV services to the pastoral communities. The situation is worsened by high levels of poverty. According to the Kenya Integrated Household Survey (KIHBS) 2005/06, absolute poverty, food poverty and hardcore poverty in the county are 92 percent, 83 percent and 68 percent respectively.

There is a high incidence of poverty in urban areas (Marsabit and Moyale towns) where people who have lost their livestock settle for employment.

The illiteracy level is high and the population is unable to exploit the available natural resources such as land for their benefit.

Economic: The county has witnessed rapid urbanization with increased rural urban migration. There is also emergence of many small scale businesses, fish mongers, new tourist attraction sites, establishment of military bases along the border and cross

boarder movements which escalate HIV and AIDS pandemic.

Majority of the youth lack skills and, therefore, have limited means of eking out a living. However, high dependence ratio, lack of entrepreneurial skills and lack of a business culture has hindered the full utilization of the opportunities available.

Cultural: Cultural practices such as female genital mutilation (FGM), early marriages, traditional male circumcision and 'moranism' have also been identified as major challenges to HIV management. This calls for a concerted effort to persuade the communities practicing these cultural practices to abandon them. It has been noted that legislations like the Children Act have not stopped some practices like early marriages for girls as expected since communities still embrace the vice. There is need to intensify awareness creation and community sensitization especially targeting men to persuade them to support the initiatives.

Regulatory: Marsabit County has made its commitment to better the health of its population including PLHIV by adopting and implementing national policies including KASF. A County Health Service Bill which seeks to enhance equitable health services among all people living in the county is at the Marsabit County Assembly for further review and deliberation before it is enacted.

2.2.2 The drivers of the HIV epidemic in Marsabit County

An assessment done on the key drivers of the HIV epidemic in Marsabit County points to the following:

i) *Poverty* - This was found to be one of the key factors increasing the risk and vulnerability to HIV infection. Under poverty, food was the single most important risk factor. This was followed by poor nutrition, lack of school fees and inadequate access to health care, clothing and shelter. The emergence settlements for the poor brought about by internal tribal conflicts contributed to poverty.

ii) *Sexual attitude and behavior* - These include low perception of risk and multiple (concurrent) sexual partners; women's inability to negotiate for safe sex; casual heterosexual relationships; masculinity and conquest ideology prevalent in men and adolescents (men are generally considered strong or powerful); pleasure-loving lifestyle leading to risky sexual behaviors; intergenerational sex; and sexual permissiveness in young boys (boys being encouraged to have girlfriends) especially after circumcision to prove their manhood. There is early sexual debut in the county with 15% of the people having their first sexual experience before the age of 15 years (KAIS 2013).

iii) *Cultural practices* - Most communities in Marsabit County traditionally circumcise men. However, this is normally done under unsafe and unhygienic conditions. Boys are socialized to practice unsafe trial sex after circumcision. Tagging circumcision to the school holiday calendar leads to delay in male circumcision. There are pockets of non-circumcised communities with high prevalence of HIV in the county.

iv) *Alcohol, drug and substance abuse* - The county experiences abuse of alcohol & drugs. This is attributed to a number of factors, notably low knowledge regarding substance abuse among the youth; low level of enforcement of alcoholic laws leading to the sale of illicit alcohol; conflict of interest and poor social support networks. The influx of hard drugs in the county is on the increase with opening

up of the region due to infrastructural development. The business and uptake of miraa use by youths is on the increase.

v) *Low uptake of HIV services* - Despite the huge importance of HIV testing as a way to increase prevention and treatment, about 76% of the people in the county had never tested for HIV. According to a survey done in 2015, only 57% are on ART, while 43% of those tested HIV positive delayed being enrolled into the care and treatment programme. Despite the fact that consistent and proper use of condoms reduces the risk of contracting HIV and other STIs by more than 90%, there is low uptake of condom use posing a significant risk of HIV infection to the population. There were about 43 HIV positive pregnant women in the county identified between July 2015 and June 2016. HIV is most often transmitted from a mother to her child during pregnancy, delivery and breastfeeding. Forty six percent of HIV positive pregnant women in the county did not deliver in a health facility. Only 32% of pregnant women attended the recommended four antenatal visits. This could be attributed to the high levels of stigma and discrimination in the county which stands at 86% according to the Stigma Index Study of 2013. Approximately 70 adults and 8 children died of HIV and AIDS related conditions according to Kenya's estimate 2015. Eighty one percent of children living with HIV in Marsabit County who are in need of antiretroviral therapy (ART) are not under treatment.

vi) *High influx of population into the county* - Due to improved infrastructure there is high influx of increased population either as constructors of both road and wind power projects in the county, thus servicing as a contributing factor in increase of HIV and STI infections.

vii) H*igh numbers of unskilled deliveries* - The County profile (2014) indicates 86% of all pregnant mothers do not deliver in health facilities.

2.3 Elimination of Mother to Child Transmission

There were about 120 pregnant women living with HIV in Marsabit County in 2013. HIV is most often transmitted from a mother to her child during pregnancy, delivery and breastfeeding. Breastfeeding is crucial for children's survival, growth and development. Providing antiretroviral medicines to mothers throughout the breastfeeding period is critical to significantly reduce mother-to-child transmission rates. Kenya had committed to eliminate new HIV infections among children by 2015, while keeping their mothers alive.

The county profile indicates that 76% of HIV-positive pregnant women do not deliver in a health facility and only 41% of pregnant women attend the recommended four antenatal visits in Marsabit County because of poor health seeking behaviours and nomadic lifestyles.

2.4 OVCs and Social Welfare

Orphans and Vulnerable children beneficiaries	Estimates
No. of households with an orphan	8844
Poor household with an orphan	4333
Cash transfer benefiting poor households with an orphan	1930

- Only 45 per cent of poor households with orphans are beneficiaries of a cash transfer programme.
- Cash transfer programmes have proved that they can reduce HIV risk by delaying sexual debut, pregnancy and marriage among beneficiaries aged between 15 and 25.

2.5 SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
• Availability of ART in all facilities on a regular basis • Improved uptake in HIV testing services in ANC • Presence of functional community units where there is partners support.	• Inadequate human resource in all facilities • Poor availability and supply of test kits • Poor coordination and logistics of laboratory services • A weak M&E system	• County government funding towards health and HIV programs • Promotion of VMMC as most communities practice male circumcision	• Perceived low HIV prevalence level resulting in minimal resource allocation by county government and partners • Shifting focus from HIV to other emerging diseases • Retrogressive cultural practices like FGM, polygamy and early marriage are a threat to HIV control • Stigma hinders the uptake of HIV testing and counselling services

The current key challenges and programmatic gaps in the HIV response

- *Economic inequalities* - Poverty, economic inequalities, socio-cultural vulnerability of adolescents, women, men and children particularly the young people in learning institutions are fueling the transmission of HIV.

- *Inadequate access to health services* - Unnecessary deaths occurring due to inadequate access to the health facilities because of distance and lack of transport due to the pastoralist and nomadic lifestyle.

- *The health providers, their attitudes and skill sets* - Inadequate staffing in terms of cadre, appropriate provider/patient ratio, levels of training and attitude towards the youth and KPs seeking care in the health facilities.

- *The supply chain management* - The county frequently experiences delayed supply of drugs, RTK, other commodities and technologies due to long lead times. In addition, the county lacks a proper distribution mechanism of the same from the central sites within the county to the facilities leading to stock outs.

- *Inadequate funding* - The county budget allocation towards the HIV response has not been adequate and lacks external funding. The only partner, Aphia plus, is on transition hence compromising service delivery both at facility and community level.

- *Legal framework* - The respect for human rights requires a fair and efficient criminal justice system which is capable of deterring crimes such as rape, incest, sexual abuse and gender-based violence.

- *Political will* - Strategic leadership commitment and goodwill from the elected county leadership is required to provide adequate resources (from domestic sources and/or external partners) to ensure the county has healthy people to spur economic development.

2.6 Key Interventions

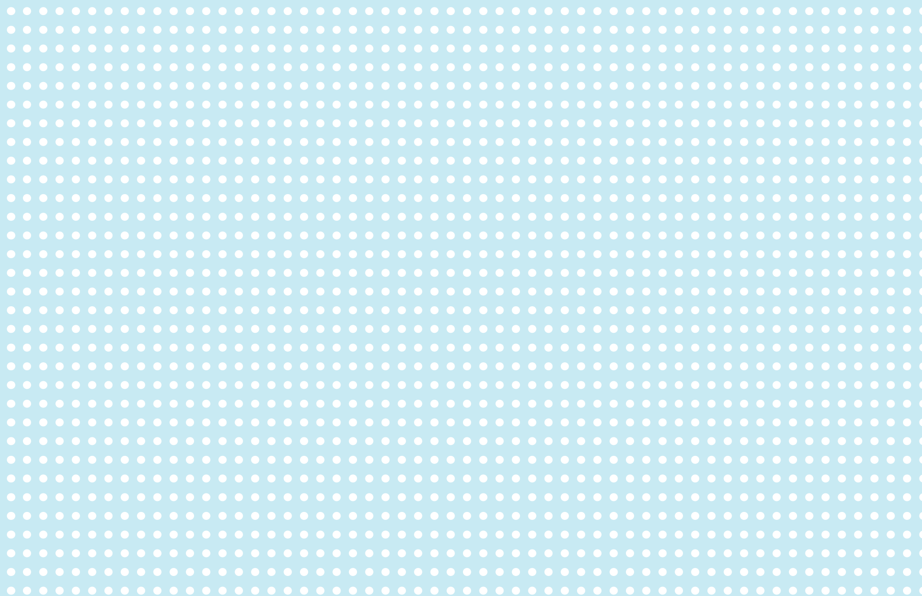
- Improve access to and uptake of sexual and reproductive health services for girls and women.
- Improve education among young people to reduce sexual risks by delaying sexual debut.
- Keep girls in school to help delay sexual debut, pregnancy and marriage.
- Promote and scale up universal access to voluntary medical male circumcision for HIV-negative men and boys.
- Mobilise the community and peer support to create demand for and increase women's access to antenatal care, as well as delivery in health facilities.
- Mobilise the community and partners to scale up access to paediatric antiretroviral therapy.
- Strong county political and community leadership for a multisectoral HIV response.
- Mobilising additional local resources to increase and sustain the HIV response.
- Expanding HIV treatment programmes and increasing community involvement in driving demand for increased uptake and adherence among both adults and children.
- Increasing social welfare services to HIV-positive persons and others affected by HIV.

2.7 Target population

- Migrant workers.
- The road construction workers.
- The long distance truck drivers.
- Uniformed personnel.
- Key population (Sex workers) in Moyale border, Laisamis and Marsabit town.
- Adolescent and young people (Morans).
- Prison population (Men Having Sex with men).
- General Population.

03.

RATIONALE, STRATEGIC PLAN DEVELOPMENT PROCESS AND THE GUIDING PRINCIPLES



3.1 Purpose

The MCASP has been developed to provide a strategic framework that will guide and inform the planning, coordination, implementation and monitoring and evaluation of the County multi-sectoral and decentralised HIV and AIDS response. It will also guide resource mobilisation, foster stakeholders' engagement, promote efficiency, promote county specific research approaches and ensure rights based and gender transformative approaches with the aim of achieving zero new infections, zero discrimination and zero AIDS related deaths.

3.2 Process of Developing Marsabit County HIV and AIDS Strategic Plan

This plan was developed through in-depth analysis of available data and a highly participatory process involving a wide range of stakeholders from county, civil society organisation, networks of people living with HIV and key populations.

The process of development of the Marsabit County HIV and AIDS Strategic Plan started with:

- The dissemination of Kenya AIDS Strategic Framework (KASF) to the key actors in the county between 18th and 22nd August 2015 and subsequent development of zero draft of MCASP.
- Development of the Terms of References and formation of Technical Working Group on 26th August 2015.
- De-briefing and consultation with County Health Management and the County Commissioner was done on 28th August 2015.
- The zero draft was compiled and reviewed from 11th-14th November, 2015 where consultation was done with the stake holders.
- Three days technical review and validation by County Technical Working Group took place from 14th to 16th June, 2016.

The following key activities to follow immediately after validation by the stakeholders.

- Printing and launching of MCASP
- Distribution and dissemination to stakeholders

3.3 MCASP Guiding Principles

The following principles will guide the County HIV and AIDS response.

Respect and fulfilment of basic human rights: Respect and fulfilment of human rights is a pre-requisite for an efficient and effective HIV and AIDS response. Efforts will be made to ensure that duty bearers and other service providers respect and fulfil their obligations to provide quality and comprehensive services to all people. Rights holders (beneficiaries) will be empowered to access and utilise such services.

Equity: Access to services is a basic human right. Efforts will be made to ensure equitable distribution, availability and access to services by all people especially most at risk and other key populations.

Evidence-based planning and results-based management: The planning and management of the county response will be informed by empirical qualitative and quantitative evidence and implementation will focus on measurable outcome, output and impact.

Integrated service delivery: The document will guide services integration as a strategy to improve synergy between interventions and optimised use of resources.

Meaningful involvement of people living with HIV (MIPA): PLHIV involvement will improve services uptake and address the challenges of stigma and discrimination, among other barriers to services uptake. The involvement of PLHIV will also enhance efforts on positive health, dignity and prevention.

Multi-sectoral accountability: This plan provides guidance for interventions and results for which stakeholders are responsible and accountable. This will serve to increase resources and accelerate results.

County ownership and partnership: All HIV stakeholders including county government, development partners, Faith Based Organisations, private sector and communities of PLHIV shall align their efforts towards the results envisioned.

Efficiency, effectiveness and innovation – The plan explores domestic funding options through improved efficiency in service delivery and innovative approaches aimed at achieving more at reduced costs without compromising on quality.

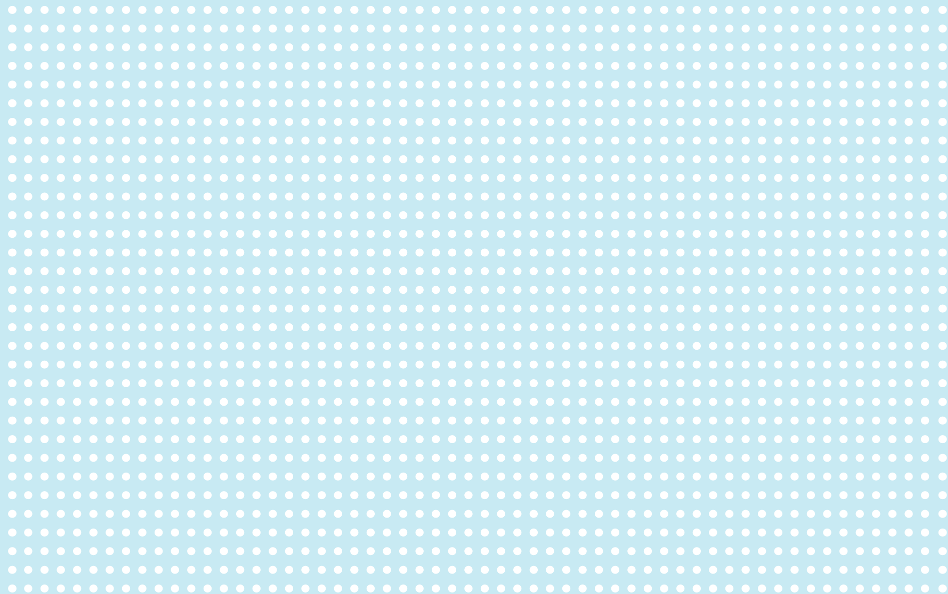
3.4 Alignment with other national and international strategic frameworks

The strategic plan will be aligned to the following national and international frameworks;

- Kenya AIDS Strategic Framework which outlines country's strategies in addressing HIV and AIDS.
- Vision 2030, which identifies health as a key building block for the transformation of Kenya into a successful middle income country.
- Health Sector Strategic plan (HSSP): MCASP outlines that health and community systems development priorities ensure effective health service delivery.
- UN High Level Meeting Commitments: MCASP aims at enabling Marsabit County to meet its international commitments to achieve universal access to HIV services and to reverse the impact of the epidemic.
- Regional HIV frameworks that contribute to the objectives of regional goals including IGAD, East African Community, African Union Global Commitment on HIV, Tuberculosis and Malaria.
- Global commission on human rights and law.
- Kenya fast-track plan to end HIV & AIDS among adolescents and young people.
- Stigma index.
- Kenya HIV and AIDS Research Agenda.
- Monitoring and Evaluation Framework.
- Kenya HIV Prevention Revolution roadmap.

04.

VISION, MISSION, GOALS, OBJECTIVES & COUNTY STRATEGIC DIRECTIONS



4.1 Vision

A County free from New HIV Infection, Stigma and AIDS Related Deaths.

4.2 Goal

To Provide Direction for HIV and AIDS Prevention, Care, Treatment and Mitigate Socio-Economic Impact in Marsabit County.

4.3 Objectives

Reduce new HIV infections by 75% in the county by 2019.

Reduce AIDS related mortality by 50% in the county by 2019.

Reduce HIV related stigma and discrimination by 30% in the county by 2019.

Increase Marsabit County financing of the HIV response to 20% in the county by 2019.

4.4. County Strategic Directions

4.4.1 Strategic Direction 1: Reducing New HIV infections

The goal of this strategic direction (SD) is to reduce the susceptibility of the population to new HIV infections. This is in recognition of the fact that despite current interventions, Marsabit County continues to record considerably high numbers of new HIV infections with annual estimated number of news infections among adults being 652 and 38 children. (County estimates, 2014). Information gaps, fewer testing and treatment sites, inadequate HIV related commodities, human resource gaps and gaps in policy need to be addressed. In this regard, a number of highly effective combination prevention strategies have been identified for implementation. In addition, given the concentration of the epidemic among some populations, specific interventions will be developed for key populations groups.

Key intervention areas

- Up scaling HIV testing and counselling.
- Behavioural change communication interventions including cultural adjustment to harmful sexual practices e.g. extramarital affairs, wife inheritance, polygamy, beading of young teenage girls.
- Granulate the HIV epidemic to intensify HIV Prevention efforts to priority geographies and populations.
- Adapt and scale up effective evidence-based combination prevention.
- Maximise efficiency in service delivery through integration.
- Leverage opportunities through creation of synergies with other sectors.

Expected results by 2019

- Reduced annual new HIV infections among adults by 75%.
- Reduced HIV transmission rates from mother to child from 14% to less than 5%.

Strategic Direction 1: Reducing new HIV infections

KASF objective	MCASP Results	Key Activity	Sub-Activity/Intervention	
Reduce new HIV infections by 75%	Reduced new HIV infections among adults by 45%	Reduce new HIV infections cases	Link those testing HIV positive to care and early ART initiation	
			Behavioural change and communication including cultural adjustment of harmful sexual practices e.g. extramarital affairs, wife inheritance, polygamy, beading of young teenage girls	
			Granulate the HIV epidemic to intensify HIV prevention efforts to priority geographies and populations	
			Provide key commodities including lubricants, condoms and other appropriate contraceptives to key and vulnerable populations	
			Promote consistent and correct condom use and disposal	
			Adapt and scale up effective evidence- based combination prevention.	
			Innovate culturally acceptable safe and early male circumcision before sexual debut	
			Maximise efficiency in service delivery through integration	
			Implement programs that will delay sexual debut among young people	
			Conduct regular outreaches to key populations	
			Strengthen workplace protection policies	
			Scale up STI management in all health facilities	
			Establish and maintain youth friendly centres in all major facilities and learning institutions	
			Scale up facility based PITC	
		Reduce HIV transmission rates from mother to child from 14% to less than 5%	Integrate ANC, early infant diagnosis with immunisation services	
			Upscale ART uptake to all HIV+ pregnant, lactating mothers and infants	
			Integrate EMTCT with MNCH services including beyond zero mobile clinic	

Target Population	Geographic areas by County/sub- county	Responsibility
PLHIV	County	CASCO, PARTNERS
general population	County	DEPT. HEALTH (R.H), DEPT. OF GENDER
General population	County	CASCO, APHIA PLUS
Key population	County	CASCO, R.H.C,
Key population-users	County	CASCO,NACC, CACC RHC
Partners and families of PLHIV	County	CASCO, DEPT. OH HEALTH
Young boys	County	CASCO, APHIA PLUS, FHK
general population	County	DEPT OF HEALTH, APHIA PLUS
Young people	County	Implementing partners
Key Populations, construction sites, border post	County	CASCO, COACC/CACCS
Workplaces	County	RELEVANT HR
General population	All health facilities	CASCO
Youth	Major health facilities and institution	DEPARTMENT OF HEALTH AND YOUTH, DOS
General population	County	CASCO
	County	CRHC
HIV + pregnant and lactating mothers	County	CDH, CASCO
Pregnant mothers and new born	County	CNO, CRHO

4.4.2 Strategic Direction 2: Improving Health Outcomes and Wellness of all People Living with HIV

HIV prevalence in the county stands at 1.2% which translates to 4010 people living with HIV. The rate is higher among the adult females (1.6%) when compared to male adults (0.7%). However by 2009, 73 % of the population did not know their HIV status. The goal of this SD is to ensure universal access to treatment, care and support for all persons living with HIV in the county. It also recognises treatment as prevention of new HIV infections, which is a critical component contributing to SD 1. The county experiences averagely low paediatric enrolment, low one year ART retention rate, low PMTCT uptake, late ART initiation attributed to fewer ART sites, high levels of HIV related stigma and discrimination impacting negatively on the county's HIV response.

Key intervention areas

- Improve timely linkage for people living with HIV and AID.
- Increase coverage of care and treatment and reduce loss in the cascade of care.

Strategic Direction 2: Improving Health Outcomes and Wellness of all People Living with HIV

KASF Objective	MCASP Results	Key Activity	
Reduce AIDS related mortality by 25%	Reduced AIDS related mortality by 30%	• Increase linkage of care of children to 90% • Increase ART coverage to 90% of children, adolescents and adults • Increase retention on ART at 12 months at 90% of children adolescents and adults • Increase Gene-expert for all PLHIV from 11 to 90% by 2019	

- Scale up interventions on curative, preventive and diagnostic to improve quality of care and health outcomes.

Expected results by 2019

- Increased linkage to care within 3 months of HIV diagnosis to 90% for children, adolescents and adults.
- Increased ART coverage to 90% for children, adolescents and adults.
- Increased retention on ART at 12 months to 90% for children, adolescents and adults.
- Increased viral suppression to 90% in children, adolescents and adults.
- Increased Gene-Expert test for all PLHIV from 11% to 90% by 2019.
- Improving health outcomes and wellness of people living with HIV.

Sub-Activity/Intervention	Target Population	Geographic areas by County/sub-county	Responsibility
Strengthen facility and community linkages with inter- and intra- facility referral protocols and linkage strategies	PLHIV	County	CDH, CASCO
Ensure the identified gaps in HIV prevention and treatment cascade are addressed immediately	PLHIV	County	CDH
Integrate HIV testing, care and treatment services into maternal, neonatal and child health settings and services	Expectant mothers/ nursing infants	County	CDH, CASCO
Scale up integrated youth friendly services	Youth(15-24)	County	CDH, CRHC
Utilise peer support and networks of adolescents living with HIV	Adolescents living with HIV	County	CRHC
Enhance peer mobilisation strategies for recruitment, enrolment and retention in care and extend flexible timings for care	Key and vulnerable populations	County	CASCO, Dept. of youth and sports.
Integrate alcohol and drug dependence reduction strategies in care services	Key and vulnerable populations	County	CDH
Provide screening and diagnostic equipment for TB, NCDs, malnutrition, opportunistic infections together with those for HIV	PLHIV	County	CDH
Scale up prevention interventions for TB, OIs and other co-morbidities, water and sanitation related diseases, vaccinations for preventable diseases (cervical cancer, hepatitis, pneumococcal)	General population	County	CDH
Cascade integrated HIV trainings for a skilled and competent workforce through innovative methods and technologies	Relevant healthcare workers providing clinical care	County	CDH
Use integrated and decentralised HIV delivery models that increase access to care and treatment at community and other non-ART service points	PLHIV	County	CSFP

KASF Objective	MCASP Results	Key Activity	
Reduce AIDS related mortality by 25%	Reduced AIDS related mortality by 30%	• Increase linkage of care of children to 90% • Increase ART coverage to 90% of children, adolescents and adults • Increase retention on ART at 12 months at 90% of children adolescents and adults • Increase Gene-expert for all PLHIV from 11 to 90% by 2019	

Sub-Activity/Intervention	Target Population	Geographic areas by County/sub-county	Responsibility
Enhance treatment literacy, patient empowerment, psychosocial and adherence support and disclosure interventions with full involvement of Civil Society and communities, especially PLHIV Provide care givers with HIV education, literacy and empowerment	PLHIV	County	CSFP
Integrate HIV care treatment into youth friendly services	Youth	County	CRHC
Scale up the Ministry of Education programme for HIV education and treatment literacy, adherence and retention	School going children	County	CDE (MOE)
Standardise methodologies for disclosure by and to adolescents living with HIV	Adolescents	County	CRHC
Scale up key population friendly HIV care and treatment services with peer mobilisation and support	KPs	County	CASCO
Reduce HIV stigma and discrimination to increase access to care and treatment	PLHIV	County	CDH
Strengthen capacity to monitor quality of care and utilise care data for decision making	HCWs	County	CDH
Continuous quality improvement initiatives through health worker training and use of electronic records management systems	Health Care Workers	County	CDH
Strengthen supply systems and ensure continuous availability of quality HIV commodities at the point of service delivery	Health facilities	County	CDH
Implement periodic monitoring for adherence and disclosure	ART sites	County	CASCO
Strengthen laboratory networks	Health facilities with lab	County	CDH,CMLT
Put in place systems to assure quality and monitor adherence to laboratory protocols	Health facilities with lab	County	CMLT
Reduce turnaround time for results and feedback	Health facilities with lab	County	CMLT

KASF Objective	MCASP Results	Key Activity
Reduce AIDS related mortality by 25%	Reduced AIDS related mortality by 30%	• Increase linkage of care of children to 90% • Increase ART coverage to 90% of children, adolescents and adults • Increase retention on ART at 12 months at 90% of children adolescents and adults • Increase Gene-expert for all PLHIV from 11 to 90% by 2019
		Improve quality of care and treatment outcomes

Sub-Activity/Intervention	Target Population	Geographic areas by County/sub-county	Responsibility
Use innovative mobile and web-based technology to increase adherence and follow up options (HIT system, EMR)	PMTCT sites, ART sites	County	CDH
Scale up use of people living with HIV peer support strategies	PLHIV	County	CHC
Provide screening and diagnostic equipment for TB, NCDs, malnutrition, opportunistic infections together with those for HIV	PLHIV	County	CASCO
Scale up prevention interventions for TB, OIs and other co-morbidities, water and sanitation related diseases, vaccinations for preventable diseases	PLHIV	County	CASCO
Cascade integrated HIV trainings for a skilled and competent workforce through innovative methods and technologies	Health care workers	County	CASCO,
Use integrated and decentralised HIV delivery models that increase access to care and treatment at community and other non-ART service points	PLHIV	County	CASCO, APHIA PLUS
Enhance treatment literacy, patient empowerment, psychosocial and adherence support and disclosure interventions with full involvement of Civil Society and communities, especially PLHIV	PLHIV	County	CASCO, APHIA PLUS
Provide care givers with HIV education, literacy and empowerment	Caregivers	County	CASCO, APHIA PLUS
Integrate HIV care treatment into youth friendly services	PLHIV	County	CASCO, APHIA PLUS
Scale up the Ministry of Education programme for HIV education and treatment literacy, adherence and retention	School going population	County	CASCO, MOE,APHIA PLUS
Standardise methodologies for disclosure by and to adolescents living with HIV	Adolescents LHIV	County	CASCO, APHIA PLUS
Scale up key population friendly HIV care and treatment services with peer mobilisation and support	Key populations	County	CASCO,APHIA PLUS,
Reduce HIV stigma and discrimination to increase access to care and treatment	PLHIV	County	CASCO, APHIA PLUS, FHK
Strengthen capacity to monitor quality of care and utilise care data for decision making	PLHIV	County	CASCO, APHIA PLUS

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

The Kenya Stigma Index Survey Report (2014) estimates the county's stigma index at 35% which is slightly lower than the national index (45%). These are contributed by a number of factors main one being cultural beliefs and practices that violates the health rights of people living with HIV hindering access to HIV related services. Therefore, there is need to mainstream and integrate into common knowledge, societal attitudes and caring behaviours around HIV in the society. A number of strategies, therefore, have been identified both at the facility and community levels to address stigma and discrimination targeting the different sub-populations. And also improved policy and legal environment for protection and promotion of the rights of key populations.

Key Intervention areas

- Remove barriers to access of HIV, SRH and rights information and services in public and private entities.
- Improve Marsabit County legal and policy environment for protection and promotion of the rights of priority and key populations and people living with HIV.

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

KASF objective	MCASP Results	Key Activity	
An enabling legal and policy environment necessary for a robust HIV response at the national and county level to ensure access to services by persons living with HIV	Reduced reported stigma by 30%	Sensitisation of general and targeted population on stigma reduction, sexual and gender based violence	
	Reduced levels of sexual and gender-based violence for PLHIV, key populations, women, men, boys and girls by 30%		
	Reduced levels of sexual and gender-based violence for PLHIV, key populations, women, men, boys and girls by 30%		
	Reduced levels of sexual and gender-based violence for PLHIV, key populations, women, men, boys and girls by 30%		
	Reduced levels of sexual and gender-based violence for PLHIV, key populations, women, men, boys and girls by 30%		
	Reduced levels of sexual and gender-based violence for PLHIV, key populations, women, men, boys and girls by 30%		

- Reduce and monitor stigma and discrimination, social exclusion and gender-based violence.
- Improve access to legal and social justice and protection from stigma and discrimination in the public and private sector in the county.

Expected Results by 2019

- Reduced self-reported stigma and discrimination related to HIV and AIDS by 30%.
- Reduced levels of sexual and gender-based violence for PLHIV, key populations, women, men, boys and girls by 30%.
- Increased protection of human rights and improved access to justice for PLHIV, key populations and other priority groups including women, boys and girls.
- Reduced social exclusion for PLHIV, key populations, women, men, boys and girls by.

Sub-Activity/Intervention	Target Population	Geographic areas by County/sub- county	Responsibility
The facility in charges to sensitise health care workers on reducing stigmatising attitudes in healthcare settings	Healthcare workers	County	CDH, COH
Conduct and adapt stigma-free HIV campaigns	General population	County	CSFP, CHPO,CACCs
Conduct targeted stigma reduction campaigns	KPs, PLHIVs	County	County First Lady, CSOs, CASCO.
Sensitise the community on harmful gender norms, negative stereotypes and concept of masculinity	Priority populations	County	CASCO, Partners
Encourage religious leaders to promote acceptance of priority groups as part of their community	Religious leaders	County	IRC
Work Closely with religious leaders to integrate their religious teaching with HIV information and service up take	Religious leaders	County	IRC, CASCO,
Strengthen linkage between Community units and supports groups to share information on HIV Creating public forums to be utilised by persons living positively to campaign against HIV-related stigma and discrimination through willingly disclosing their status	General population	County	CSFP, Implementing partners ,
Sensitize and engage religious leaders on KPs stigma reduction campaigns	Religious leaders	County,	IRG, CASCO,

KASF objective	MCASP Results	Key Activity	
An enabling legal and policy environment necessary for a robust HIV response at the national and county level to ensure access to services by persons living with HIV	Reduced self-reported HIV related stigma and discrimination by30%	Remove barriers to access of HIV, SRH and rights to information and services in private and public entities	
	Reduced levels of sexual and gender-based violence for PLHIV, key populations, women, men, boys and girls by 30%	Sensitization of communities on the SGBV rights	
	Reduced levels of sexual and gender-based violence for PLHIV, key populations, women, men, boys and girls by 30%	Improve county legal and policy environment for protection and promotion of the rights of priority, key populations and PLHIVs	

Sub-Activity/Intervention	Target Population	Geographic areas by County/sub- county	Responsibility
Promote the PLWHIV to enrol in support groups and ensure they register with the Department of Social Services	PLWHIV	County	CASCO, SOCIAL SERVICES
Empower women & girls socio-economically to enable them access HIV health services and information	Women	County	CDGSD
Establish DICEs to offer HIV services to the key populations	Key Population	County	County and implementing partners
The CEC health to formulate a policy to protect priority populations when accessing HIV and health services.	Key and vulnerable populations	County	CEC Health, CHC
Empower communities through various forums and provision of IEC	General Population	County	County and Implementing Partners
Promote use of peer counsellors/educators and mentor mothers to enhance uptake of HIV services	PLHIV	County	CHC, CASCO
Male engagement in HIV, SRH programs and interventions and offer them services	Male partners of women living with HIV and ANC clients	County	CRHC
Integrate HIV information and encourage service uptake in religious settings	Religious institutions	County	IRC
Encourage religious leaders to confirm faith healings through scientific tests	Religious leaders	County	CASCO,COAC, IRC
Sensitise law makers on the need to enact non-discriminatory regulations and services	County Assembly members	County	CEC (HEALTH)
Develop and disseminate population specific and user friendly information including through Braille, Kiswahili and vernacular	General population	County	CHC
Work closely with regional religious leaders to integrate their religious teachings with HIV information and service uptake	General population	County	IRC
Utilise county publications and local media channels to disseminate HIV information. (County Journal, County News)	General population	County	CHC
Educate communities on gender and legal issues	Communities	County	IMPLEMENTING PARTNERS
Educate communities on legal issues, rights and gender during barazas and social gatherings	General population	County	CSFP CHPO
Utilise community units to discourage negative traditional beliefs and practices	General population	County	CSFP
Sensitise county assembly members and executives on the need to enact laws, regulations and policies that prohibit discrimination and support access to HIV prevention, treatment, care and support.	County Assembly members, executives	County	CHC, CEC Health, CASCO
The county assembly to review the existing laws and execute the existing policies to ensure they impact the response to HIV positively. These should be consistent with the Constitution, national laws and policies	County Assembly members, executives	County	CHC, CEC Health

KASF objective	MCASP Results	Key Activity	
An enabling legal and policy environment necessary for a robust HIV response at the national and county level to ensure access to services by persons living with HIV	Reduced levels of sexual and gender-based violence for PLHIV, key populations, women, men, boys and girls by 30%	Improve county legal and policy environment for protection and promotion of the rights of priority, key populations and PLHIVs	
	Reduced and monitor stigma and discrimination, social and GBV		

Sub-Activity/Intervention	Target Population	Geographic areas by County/sub- county	Responsibility
Sensitise law makers and law enforcement agencies on HIV and consequences of their implementation and implementation of laws in the provision of HIV services to priority populations	County Assembly members, executives	County	CHC, CEC Health
Enrol PLHIV, OVCs, Key Populations and other priority groups into the social protection programmes	PLHIV, OVCs, Key Populations and other priority groups	County	Social services department, CSOs, SCACC
Facilitate discussions and negotiations among HIV service providers, those who access services and law enforcement agencies to address law enforcement practices that impede HIV prevention, treatment, care and support services.	General population	County	CHC, CSOs
Ensure implementation of HIV workplace programs for law makers and enforcers	General population	County	CHC, CSOs
Sensitise individual healthcare workers, healthcare administrators and healthcare regulators on their own human rights and skill and tools necessary to ensure patient rights are upheld	Healthcare workers and administrators	County	COH
Hold the county government accountable for their constitutional and statutory obligations	County government administrators	County	CHC, CSOs
Advocate for decentralisation of HIV Tribunal to the county	HIV Tribunal	County	The HIV Tribunal
In collaboration with other stakeholders, non-state actors to implement programs aimed at upholding their rights of priority populations	General population	County	CHC
Sensitisation of police, health care workers, civil societies and legal groups on SGBV support	Police, health care workers, civil societies and legal groups	County	CSOs and public entities CRHC
Strengthen linkages with psychosocial support groups for SGBV survivors	SGBV survivors		CASCO
Link SGBV survivors to gender response units within the county	SGBV survivors		CACC, CSOs,
Conduct stigma index survey in both healthcare settings and community	PLHIV	County	CHC
Conduct a county baseline survey to document the magnitude and nature of human rights violation and gender disparities in the context of HIV	PLHIV	County	CHC
Educate communities on gender and legal issues affecting HIV	Communities	County	CDGSS

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

Marsabit County has 44 community units (20%) out of the expected 90 units. The existing units are linked to 44 health facilities out of the expected 90 health facilities. The key gaps that ail community strategy are: Inadequate funding, unmotivated staff due to lack of remuneration, limited capacity, equipment, and essential commodities and inadequate workforce. This strategic direction mainly focuses on key intervention areas namely: Provide a competent, motivated and adequately staffed workforce; strengthen health service delivery system; and improve access to and rational use of essential HIV products. The identified strategies will seek to ensure that county staffing ratio attains the minimum requirement and ensure enhanced linkages between the health and community systems.

Key Intervention Areas

- Ensure availability of competent skilled motivated health workforce across board. Also include relevant task sharing.
- Ensure county health facilities infrastructure are able to deliver on:

Strategic Direction 4: Strengthening Integration of Health and Community Systems

KASF objective	MCASP Results	Key Activity	
Build a strong and suitable system for HIV service delivery through specific health and community systems approaches, actions and interventions to support HIV response	Improved health workforce for the HIV response in the county by 40%	Provision of competent, motivated and adequately staffed health workforce Strengthen health service delivery system for the provision of HIV service integrated in the essential health package	

- Quality, integrated, comprehensive services and adequate referral and linkages
- Strengthen lab networking.
- Ensure non- discrimination in service delivery.

- Improve access to and rational use of quality essential products and technologies for HIV prevention, treatment and care services.

Expected Results

- Improved health workforce for HIV response at county levels by 40%.
- Increased no. of health facilities ready to provide KEPH defined HIV and AIDS services from 6% to 90%.
- Strengthened HIV commodity management through effective and efficient management of medicines and medicinal products.
- Strengthened community level awareness on HIV and AIDS.

Sub-Activity/Intervention	Target Population	Geographic areas by County/sub-county	Responsibility
Recruitment of staff by the County government to improve the overall staff: population ratio in line with the Kenya Staffing Norms, with a special focus on ensuring availability of adequate, competent and skilled health personnel in all tiers of health care.	Health care workers	County	COH
Redistribution of staff by the county government to ensure availability of appropriate and skilled health personnel in line with Kenya Staffing Norms	Health care workers	County	COH
Develop& implement health staff retention policy that takes into account the additional HIV burden	Health care workers	County	COH
Integration of HIV referral and linkage services into mainstream health services	Health facilities	County	CDH
Empower communities and workplaces to ensure improved capacity and capability to take charge of their health	Workplace and CHEWs, CHVs, CHCs	County	CDH
Institute mechanisms for task sharing and mentorship for skilled transfer to ensure delivery of the health package, including HIV prevention, treatment and care services	Health care workers	County	COH
Improve the human resource performance management system to ensure efficient and effective use of available human resource in delivery of health services, including HIV services	Health care workers	County	COH
Support the development /revision of Health Resource Development Plan to guide HR needs of the health sector, taking into account additional needs to provide HIV prevention, treatment and care	Health care workers	County	COH
Develop and implement a system for caring for caregivers especially in areas with a high burden of HIV	Health care workers	County	COH

KASF objective	MCASP Results	Key Activity	
Build a strong and suitable system for HIV service delivery through specific health and community systems approaches, actions and interventions to support HIV response	Improved health workforce for the HIV response in the county by 40%	Provision of competent, motivated and adequately staffed health workforce Strengthen health service delivery system for the provision of HIV service integrated in the essential health package	
	Strengthened HIV commodity management	Improve access to and promote rational use of quality essential health products and technologies	
	Improved health workforce for the HIV response in the county by 40%	Provision of competent, motivated and adequately staffed health workforce Strengthen health service delivery system for the provision of HIV service integrated in the essential health package	

	Sub-Activity/Intervention	Target Population	Geographic areas by County/sub-county	Responsibility
	Create incentives for health staff in terms of training, remuneration and other rewards, with a particular focus on high HIV burdened and disadvantaged areas	Health care workers	County	COH
	Integrate and improve capacity building in HIV management and leadership in general in-service health training	Health care workers	County	COH
	Support the development/ revision of Health Resource Development Plan to guide HR needs of the health sector, taking into account additional needs to provide HIV prevention, treatment and care	Health care workers	County	COH
	Adoption of strategies to make comprehensive HIV services more accessible to key populations	Health care workers	County	COH
	Integration of HIV services in primary health care services, including hospital services, to allow meaningful and routine engagement of all cadres of health personnel in HIV prevention, treatment and care service provision	Health care workers	County	COH
	Integration of HIV referral and linkage services into mainstream health service referral and linkage network including community linkages	Health care workers	County	COH
	Upgrading of health facility infrastructure to meet basic standards for HIV services provision.	Health care workers	County	COH
	Adapt legal framework that creates an enabling environment to enhance access to HIV services by KPs	Health care workers	County	COH
	Strengthen HIV commodity management and supply chain monitoring at county and health facilities level including pharmacovigilance (drug safety) and post marketing surveillance (PMS)	Health care workers	County	COH
	Promote timely forecasting and quantification and periodic supply/procurement planning for HIV commodities	Health care workers	County	COH
	Promote procurement efficiency for HIV commodities	Healthcare workers	County	COH
	Infrastructural support for effective distribution and appropriate storage at county and health facility level	Healthcare workers	County	COH
	Promote appropriate prescription practices and rational use of HIV commodities	Health care workers	County	COH
	Develop a robust LMIS to facilitate timely collection and transmission of quality commodity consumption and stock status data that is integrated into the HMIS	CHRIO	County	COH
	Provision of adequate and functional HIV diagnostic equipment (VL, CD4) that are well maintained (service contracts) in conjunction with partners	Healthcare workers	County	COH
	Introduction of facility based IT systems to manage and monitor HPT supplies and linked to national and county MOH information System	Healthcare workers	County	COH
	Establishment of county systems for coordinating and managing EHPT investments	Healthcare workers	County	CHMT

KASF objective	MCASP Results	Key Activity	
Build a strong and suitable system for HIV service delivery through specific health and community systems approaches, actions and interventions to support HIV response	Improved health workforce for the HIV response in the county by 40%	Provision of competent, motivated and adequately staffed health workforce Strengthen health service delivery system for the provision of HIV service integrated in the essential health package	
	Strengthen community-driven HIV response	Strengthened community and workplace service delivery system at county level for the provision of HIV prevention, treatment and care services	

4.4.5 Strategic Direction 5: Research Innovation and Information Management to Meet MCASP Goals

Evidence based planning and programming ensures cost effectiveness, innovativeness, efficiency and accuracy in improving accessibility to quality HIV services. Marsabit County lags behind in terms of data collection and management system, hence hindering prioritisation and distribution of resources towards specific HIV interventions. Currently, the county is not able to carry out research activities due to lack of capacity and adequate resource such as to support TWGs.

This direction targets intervention areas in resourcing and implementing a HIV research agenda informed by MCASP and increase evidence-based planning, programming and policy changes.

The above targeting is expected by 2019 to have delivered increased evidence-based planning, programming and policy changes by 50%, increased implementation of research on the identified MCASP related HIV priorities by 50% and increased capacity to conduct HIV research at county levels by 10%.

Sub-Activity/Intervention	Target Population	Geographic areas by County/sub-county	Responsibility
Review and strengthen laboratory systems for effective diagnosis and monitoring of ART, especially for early toxicities and treatment failure	Healthcare workers	County	CMLT,
Decentralisation of HIV services including laboratory networks to all health facilities especially the lower level tiers	Health care workers	County	COH, CMLT,
Strengthen governance and leadership for community and workplace health actions at all levels	General population	County	CSFP, CASCO
Enhance human resource capacity for development and implementation of community and workplace health at all levels	General population	County	CSFP, CASCO
Strengthen institutional capacity for implementation of community and workplace actions and services at all levels	CUs, workplaces	County	CSFP, CASCO
Adopt national standards for guiding community and workplace health implementation and practice	General population	County	CSFP, CASCO
Empower communities and workplaces to ensure improved capacity and capability to take charge of their health	General population	County	CSFP, CASCO
Articulate an integrated, comprehensive and quality community and workplace health package for HIV prevention, treatment and care	General population	County	CSFP, CASCO
Strengthen AIDS control units in learning institutions and resources be allocated for behaviour change communication (BCC) programs	Learning institutions	County	CHC
Mainstream HIV and AIDS activities into community strategy and map CSOs capacities	CUs,	County	CSFP, CPHO

A collective approach to the research component on HIV is important in addressing the challenges, both current and emerging, and gaps hence promoting evidence-based policy and programming. There is a critical need to identify and implement high-impact research priorities, innovative programming and capacity strengthening to conduct research.

Key Intervention Areas

- Resource and implement a HIV research agenda informed by research outcomes.
- Increase evidence-based planning, programming and policy changes.

Expected Results by 2019

- Increased implementation of research on the identified KASF-related HIV priorities by 50%.
- Increased capacity to conduct HIV research at county levels by 10%.
- Increased evidence- based planning, programming and policy changes by 50%.

Strategic Direction 5: Strengthening Research and Innovations to Inform the MCASP Goals

KASF objective	CASP Results	Key Activity	
Increase capacity to conduct research at country and county levels by 10%	Improved evidence-based planning and programming	Build Capacity for research	
	Enhanced capacity to conduct HIV research	Funding for research	

4.4.6: Strategic Direction 6: Promote Utilisation of Strategic Information for Research and Monitoring and Evaluation.

Competent HIV response is dependent and influenced by timely availing of data for effective evidence based informed decision making thus a need for strengthened M&E capacity. The country's constitution requires good practices of people's participation in decision making and transparent accountability and stewardship.

The M & E of national and county multi-sectoral response to HIV and AIDS rely on a variety of systems including data sources and routine and periodic collection and collation systems that are supported and maintained by stakeholders.

The main challenges facing M&E are strategic approach on coordination, ownership and meaningful use of data for decision making and planning among stakeholders at different levels and sectors. Similarly, the M & E gap in programmatic data availability for routine monitoring of programmes and sentinel surveillance that enable modelling trend-analysis are non-sensitive thus cannot detect emerging issues in HIV response.

The analytical capacities at the county level remain weak thus requiring strengthening to enable them address the needs of strategic data. The county, therefore, needs to establish, recognise and own efficient M & E systems that are linked to surveys, studies and programmatic data sources. The existing county M & E, require strengthening so as to flex and respond to data needs by national and county governments and facilitate generation of high quality and timely strategic information for HIV response at all levels.

The other core M & E challenge is non-allocation of funds for M&E department that often results in delays or partial implementation of planned M&E activities.

	Sub-Activity/ Intervention	Target Population	Geographic areas by County/sub-county	Responsibility
	Operationalize Marsabit research TWG Create a county information data bank for use at all levels including the community Create effective systems to enhance feedback to communities on HIV data	Research TWG	County	CEC
	Conduct operational research in the county on various thematic areas of HIV County publications on operational research	Research stakeholders	County	CDH
	Conduct county dissemination forum of HIV research in the county	HIV stakeholders	County	CDH
	Strengthen county HIV research capacities including epidemiological surveillance, good laboratory, clinical practice and ethics	Research stakeholders	County	CDH

Key Intervention Areas

- Strengthen M&E capacity to effectively track the KASF performance and HIV epidemic dynamics at the county level.
- Ensure harmonised, timely and comprehensive routine and non-routine monitoring systems to provide quality HIV data as per national, county and sector priority information needs.
- Establish multi-sectoral and integrated real time HIV platform to provide updates on HIV epidemic response accountability at county level.

Expected Results by 2019

- Increased availability of strategic information to inform HIV response at county level.
- Planned evaluations, reviews and surveys implemented and results disseminated in a timely manner.
- M&E information hubs established at county level and providing comprehensive information package on key KASF and MCASP indicators for decision making.

Strategic Direction 6: Promoting Utilization of Strategic Information for Research and Monitoring and Evaluation to Enhance Programing

KASF objective	CASP Results	Key Activity	
Improve data quality, demand, access and use of data for decision making	Strengthened M&E capacity to effectively track the KASF performance and HIV epidemics at county levels	Increase availability of strategic information to inform HIV response at county level	
	Harmonised, timely and comprehensive routine and non–routine monitoring systems to provide quality HIV data at county level	Conduct evaluations, reviews and surveys and disseminate results in a timely manner	
Improve data quality, demand, access and use of data for decision making	Strengthened M&E capacity to effectively track the KASF performance and HIV epidemics at county levels		

Sub-Activity/Intervention	Target Population	Geographic areas by County/sub-county	Responsibility
- Align the county M&E system to the new governance structures	Implementers County government	County	CASCO,CHRIO,SCASCO, SCACC,SCHRIO, Partners and County Govt.
-Conduct county M&E engagements, (data quality audit)	Implementers	County	CASCO,CHRIO,SCASCO,SCACC,NACC, Partners and CG
-Conduct M&E capacity assessment and capacity development at county level	Implementers	County	CASCO,CHRIO,SCASCO,SCACC,NACC, Partners and CG
-Establish and strengthen functional multi-sectoral HIV M&E co-ordination structure and partnerships at county level	County government and partners	County	• CASCO • CACC CHRIO
-Develop comprehensive HIV M&E systems guidelines, tools and standard operating procedures	County M&E dept.	County	• CASCO • CACC CHRIO
-Put in place sustainable financing for HIV M&E planned activities in the county	County government and partners	County	• CASCO • CACC CHRIO
-Strengthen HIV M&E data management at county level	County Government and partners	County	• CASCO, • Partner • CHRIO • CACC
Harmonise and create linkages between data collection tools and databases	County government and partners	County	• CASCO, • Partner • CHRIO
Conduct periodic data quality audits and verification	County government and partners	County	• County government, • CASCO, • Partners • CHRIO • CACC
Conduct M&E supervision	County Government and partners	County	• County government • Development partners • CASCO • NACC • NASCOP
Scale up coverage of ongoing HIV program surveillance and surveys	County government and partners	County	CASCO/SCASCO CQIO CHRIO/SCHRIO County pharmacist
Honour global, regional, national and county HIV reporting obligations	County government and partners	County	• CASCO/SCASCO • CQIO • CHRIO/SCHRIO • County pharmacist

KASF objective	CASP Results	Key Activity	
Improve data quality, demand, access and use of data for decision making	Strengthened M&E capacity to effectively track the KASF performance and HIV epidemics at county levels	Planned evaluations, reviews and surveys implemented and results disseminated in a timely manner	
	A multi-sectoral and integrated real-time HIV platform to provide updates on HIV epidemic response accountability established	Establish M&E Information Hubs at county level and providing comprehensive information package on key KASF Indicators for decision making	

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

Marsabit County heavily relies on donor funding for its HIV and AIDS related interventions. With the reduced investment by the donor community over the recent years, sustainable domestic HIV and AIDS financing mechanisms are needed to accelerate focused interventions and ownership by the county government. Currently the county government has not allocated any budget for HIV and AIDS response hence the need to lobby for domestic funding through county government and partners.

Key Intervention Areas

- Maximise efficiency of the existing delivery options for increased value and results.
- Promote innovative and sustainable domestic financing options.
- Align HIV resources/investment to strategic framework priorities.

Expected Results by 2019

- Increased domestic financing for HIV response to 20%

Sub-Activity/Intervention	Target Population	Geographic areas by County/sub-county	Responsibility
Strengthen routine and non-routine HIV information systems	County government and partners	County	• CASCO/ SCASCO • CQIO • CRHIO/SCHRIO • County pharmacist
Establish a multi-sectoral HIV programming web-based data management system	County government and partners	County	CHMT, Partners, CASCO
Promote data demand and use of HIV strategic information to inform policy and programming Develop and implement KASF evaluation agenda	County government and partners	County	• County government • CASCO • SCASCO • CQIO • CRHIO • County pharmacist • SCASCO
Create and strengthen M&E Information Hubs at county level	County government and partners	County	• County government • CASCO • SCASCO • CQIO • CRHIO • County pharmacist • CACC

Strategic Direction 7: Increasing Domestic Financing for Sustainable HIV Response

KASF OBJECTIVES	MCASP RESULTS	KEY ACTIVITY	
Increased domestic financing for HIV response to 50%	Increased domestic financing for HIV response to 20%	Resource allocation by the county government	
		Coordination of partners and stakeholders at county and sub county levels	
		Implementing effective cost saving model of HIV and AIDS service delivery	
		Leverage on Key Sectors	

SUB ACTIVITY / INTERVENTION	TARGET POPULATION	RESPONSIBILITY
Engage the Marsabit county government to allocate adequate funds for HIV and AIDS activities(HTS, Lab networking, ECSM, BCC, BCE, Referral mechanisms, trainings and monitoring of health care workers)	Office of the governor County Assembly County Department of Health	CECM - Health CECM- Finance
Develop HIV investment criteria for resource allocation by the county	County HIV Committee	CECM – Health CECM- Finance
Facilitate implementation of deliberate measures to unblock the financial, human and infrastructural institution within health system	County Assembly County HIV Committee	CECM- Health CECM - Finance
Strengthen HIV stakeholders forums to facilitate alignment with MCASP	Stakeholders and partners	County HIV Committee
Facilitate quantification of county resources needs through relevant information on county support	County Assembly	CECM – Health CECM- Finance County HIV Committee
Implement a partnership accountability framework at county level to ensure alignment of resources to Marsabit AIDS Strategic Plan's priorities	Stakeholders and partners	County HIV Committee CECM – Health
Facilitate planning by reporting contribution to MCASP annually	Stakeholders and partners	County HIV Committee CECM – Health
HIV and AIDS on job training and monitoring for health workers	Healthcare workers	CASCO SCASCO
Rationalise ART collection system to reduce the distribution and referral costs associated with laboratory	Pharmacy and laboratory	County Pharmacists County laboratory Coordinator
Create a conducive working environment for health workers to perform and maximise their potential	Healthcare workers	Chief Officer of Health
Integration of HIV&AIDS/RH and MNCAH services	Healthcare workers	County Director of Health
Leverage on Transport sector, Livestock, Construction, Energy, Fishing, Trade and Banking	Transport Sector Livestock farming Road Construction by Turkey and Chinese Loiyangalani windmill Fishing at Lake Turkana Cooperative, KCB, Equity and Teachers Sacco	County HIV Committee

4.4.8: Strategic Direction 8: Promoting Accountable Leadership for Delivery of MCASP Results by All Sectors

The county lacks a well-established and strengthened functional and competent HIV co-ordination mechanism at the county and sub -county levels therefore having a low multi-sector and multi-partner accountability.

Enhanced political goodwill, sound technical expertise and functional governance structures at both county and sub county levels will promote multi-sector and multi-partner accountability towards achieving the objectives of the County AIDS strategic plan. This will be enhanced by performance contracting as signed by the county leadership. Lack of a functional CHAC and associated technical working groups and lack of laws and policy formulation, enactment and implementation pose a challenge to HIV response in Marsabit.

Strategic Direction 8: Promoting Accountable Leadership for Delivery of MCASP Results by All Sectors

KASF objective	MCASP Results	Key Activity
To create an enabling policy, legal and regulatory framework for multisectoral HIV&AIDS response	Good governance practices and accountable leadership for HIV and AIDS response in the county	Promote good governance practices and accountable leadership
	Effective and well-functioning stakeholder co-ordination mechanisms in the county	Advocacy and lobbying
	80% of HIV stakeholders in the county participating in quarterly stakeholder coordination forums	Hold dissemination meetings
		Resource mobilisation

Key Intervention Areas

- Entrench good governance and strengthen multi-sector and multi-partner accountability for delivery of MCASP results.
- Establish and strengthen functional and competent HIV co-ordination mechanism at the county and sub -county levels.
- Build and sustain high level political and technical commitment for strengthened county and sub counties' ownership of the HIV response.

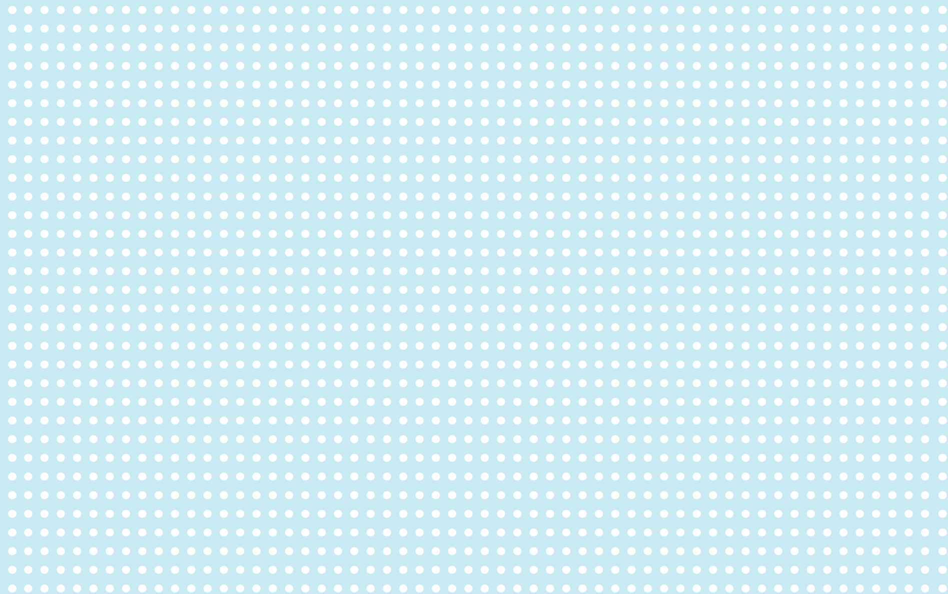
Expected Results by 2019

- Good governance practices and accountable leadership entrenched for the multi-sectoral HIV and AIDS response at all levels.
- Effective and well-functioning stakeholder co-ordination and accountability mechanisms in place and fully operationalized at county and sub county levels.
- An enabling policy, legal and regulatory framework for the multi-sectoral HIV and AIDS response strengthened and fully aligned to the Constitution of Kenya 2010.

Sub-Activity/Intervention	Target Population	Geographic areas by County/sub- county	Responsibility
-Conduct sensitisation forums for county assembly and the public , law enforcers and administrative officers -Capacity building sessions for CHAC on leadership, governance and accountability - Operationalized HIV technical working groups at the county level -Enhance regular monitoring of HIV related performance Indicator with subsequent reviews	County Assembly Public CHAC CHTWG	County	CHAC
-Conduct advocacy meetings with the county leadership to build and sustain high-level political commitment in HIV response -Develop and operationalize stakeholders coordination guidelines	County leadership CHAC	County	CHAC, CSOs
Disseminate policy guidelines to strengthen good governance of county HIV response -Regularly updating HIV stakeholders in the county	County leadership	County	CHAC, CSOs
Mobilise and allocate adequate resources for HIV and AIDS response	Public Private partners	County	CHAC, CSOs

05.

IMPLEMENTATION ARRANGEMENT



Marsabit County AIDS Strategic Plan implementation shall be multi-sectoral. Public, private and civil society institutions (CSOs) shall be involved in planning and implementation. Measures shall be put in place to ensure all stakeholders are accountable both financially and programmatically. The County HIV&AIDS committees shall be fully in charge of coordination of stakeholder response in the fight against HIV.

The committee shall convene regular stakeholder forums and all stakeholders will have an opportunity to share what they do and in which areas. In case of duplication of activities and gaps in other geographical zones, the committee shall recommend and redistribute implementers so as to ensure equitable distribution of services with more emphasis on high burden zones and sub counties.

Committees and their Roles

I. County HIV Committee (CHAC)

This committee is responsible for HIV response in the County

Composition

- Chair: County secretary.
- Alternate Chair: Health CEC.
- Secretary: RHC/CASCO.

Members:

1. 2 Rep County Assembly (from Health and budget committees).
2. 3 COs – 1health, 1social services, 1 planning and finance.
3. Health Directors (2).
4. SCACCs (4) sub-Counties.
5. Faith communities (2).
6. Chair-HMT.
7. Rep: County Commissioner's office.
8. PLHIV Representative (1).
9. Rep. of the implementing partners.

Roles of the County HIV Committee (CHAC)

- Set the county HIV agenda.
- Approve County HIV targets.
- Approve County HIV Plans/Strategy.
- Present County HIV budgets to County Assembly.
- Receive and approve reports on MCASP performance and routine M & E from MCASP

Monitoring Committee.

- Receive reports from the County HIV ICC/ Stakeholder Forum.

II. County HIV Coordinating Unit

NACC Regional HIV Coordinator and the County Director of Health are in charge. This is the point of reference and point for seeking assistance by citizens and stakeholders on any matter related to HIV. This is the secretariat office of the HIV County Committee. It is the office in the county responsible for coordinating the HIV multi-sectoral response. It is the office where all partners coalesce around for HIV related issues and data.

Roles

1. Secretariat to the County HIV Committee and implement HIV Committee resolutions.

2. Ensure delivery of county HIV plans and strategies.

3. Ensure performance contract reporting in the county has HIV as a key indicator.

4. Deliver quarterly reports on MCASP progress as per M & E instructions.

5. Advocate for the inclusion of HIV funds in county budgets (health and other sectors).

6. Ensure quarterly county ICC HIV meetings are held and follow through on county ICC HIV actions.

7. Be a member of the County Health Management Team (CHMT) and ensure HIV agenda is active

8. Facilitate regular engagement of all state and non-state actors within the county in planning, prioritisation, implementation, monitoring, and evaluation of HIV and AIDS programmes.

9. Strengthening linkages and networking among stakeholders support for MCASP delivery.

10. Monitor county legislation to ensure all bills are HIV compliant.

11. Coordinate activities planned in the county and deliver on work-plans.

12. Report administratively to the NACC HIV regional officer/NACC HQ/developing partners.

III. The County Inter Coordinating Committee (County ICC)

The County ICC - HIV will mirror the national ICC HIV. It is the primary forum for deliberating on AIDS issues at county level. It has broad stakeholder membership including senior representatives from county government, civil society, the private sector and development partners within the county. NACC County HIV Coordinator is the secretary while the County CEC (Health) is the facilitator/chair.

Role of the County HIV-ICC

1. Coordinate and oversee the development of a collaborative and comprehensive strategy to rollout MCASP and subsequently monitor its implementation.
2. Ensure harmonisation, coordination and resource mobilisation and allocation and tracking progress of HIV and AIDS programmes within the county.

3. Ensure coordination in information sharing within and across partners in the county.

4. Advocate for implementation of MCASP M&E tools, and activities in members and partners own work-plans within the county.

5. Offer technical support in implementation of MCASP.

6. Advocate for MCASP appropriately and as agreed with the county government.

7. Reviewing programs and projects supporting MCASP implementation.

Meetings

County ICC - HIV Committee will convene at least four meetings annually to report on MCASP implementation progress, planned activities and future priority areas. Meetings to discuss specific issues will be called as appropriate. Other communication between meetings will be through emails. Decisions will be made by consensus.

Secretariat

County HIV Coordination Unit will be the secretariat with the primary role of facilitating communication between ICC - HIV members and partners and/or individuals.

Membership composition

i. Membership of the County ICC – HIV.

ii. Representative from the county government.

iii Key HIV partners within the county (including PWD, youth and faith based organisations).

iv. NACC County AIDS Coordinator.

v. Representative of the County Commissioner's office.

IV. Sub County/Constituency AIDS Coordinating Committees (SCACCs).

Role

i. Stakeholder mobilisation to respond to HIV issues in the community.

ii. Monitor communities' response to HIV issues and submit biannual reports to the HIV Committee.

iii. Receive and disseminate appropriate national and county policies, guidelines and strategies on HIV and AIDS. In particular, MCASP, County HIV Profiles etc.

iv. Account for any funds advanced to the SCACC.

Membership of SCACC

The membership is as follows:

i. The national government official at the sub county level – Deputy County Commissioner.

ii. One person nominated from among the active Civil Society Organisations (CSO) in the constituency.

iii. Representative of PLHIV (1).

iv. Representative of Person with Disability (PWD) (1).

v. One person representing interest of women (1).

vi. Representative of Youth who is a youth at the date of appointment (1).

vii. SCACC Coordinator –County MOH (1).

viii. Representative of faith community.

ix. Area MP (patron).

X. Rep. MCA.

xi. Sub county administrator.

The committee will elect the chair during its first meeting. The term of office of the SCACC members shall be five (5) years irrespective of a parliamentary term.

Account Signatories:

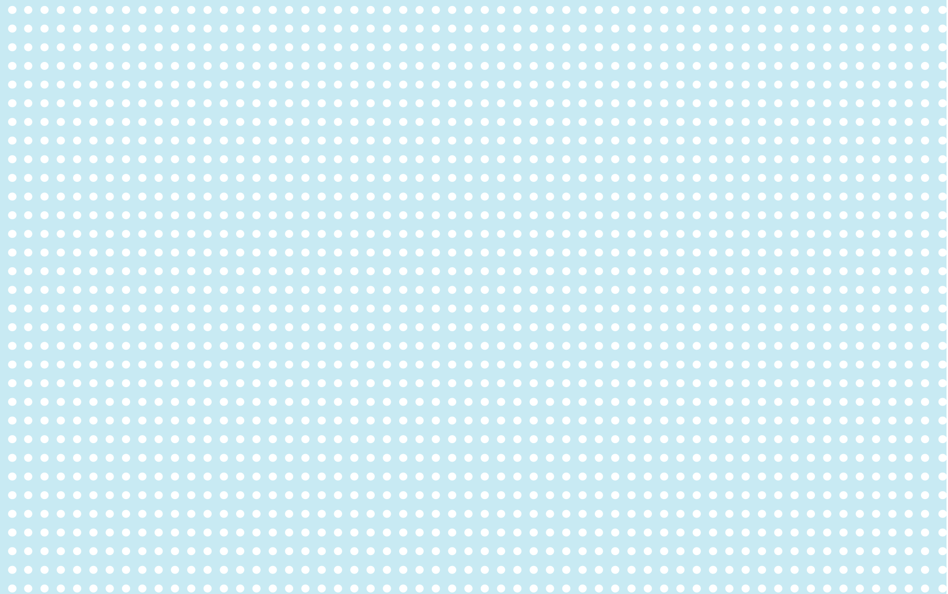
1. The Chair (alternate 1).

2. SCACC (Mandatory) also secretary of committee.

3. Deputy County commissioner (alternate 2).

06.

MONITORING AND EVALUATION PLAN



The HIV Monitoring and Evaluation (M&E) system is primarily divided into health facility-based and non- facility-based or community-based components of monitoring and evaluating the county HIV response. The county will utilise the following essential components to ensure a functional M & E system:

a) Establish a MCASP Monitoring Committee with clear Terms of Reference.

b) Invest in human capacity and M & E. - Recruit and capacity build existing M & E staff for facility and community based systems.

c) Establish and strengthen Technical Working Groups (TWGs) (i.e. KP, PMCTC, adolescents and young People, HIV commodities, Acceleration of Care and Treatment(ACT) and Research)

d) Annual costed county HIV M & E work plan.

e) Routine HIV program monitoring. - Strengthen Standard Operating Procedures (SOPs) guiding data collection and management.

f) Strengthen routine reporting of facility and community based activities. - Strengthen DHIS, COBPAR and HIRPOS.

g) Survey and surveillance. - The county will benefit from national surveys and surveillance (KDHS, KAIS, MoT, and KNASA) in tracking some indicators.

h) County HIV database. - The situation room will be used to generate data consolidated from different subsystems to include DHIS, LMIS, COBPAR and HIPROS.

i) Support supervision and data auditing. - Quarterly support supervision and data audits in facility and community based M & E systems.

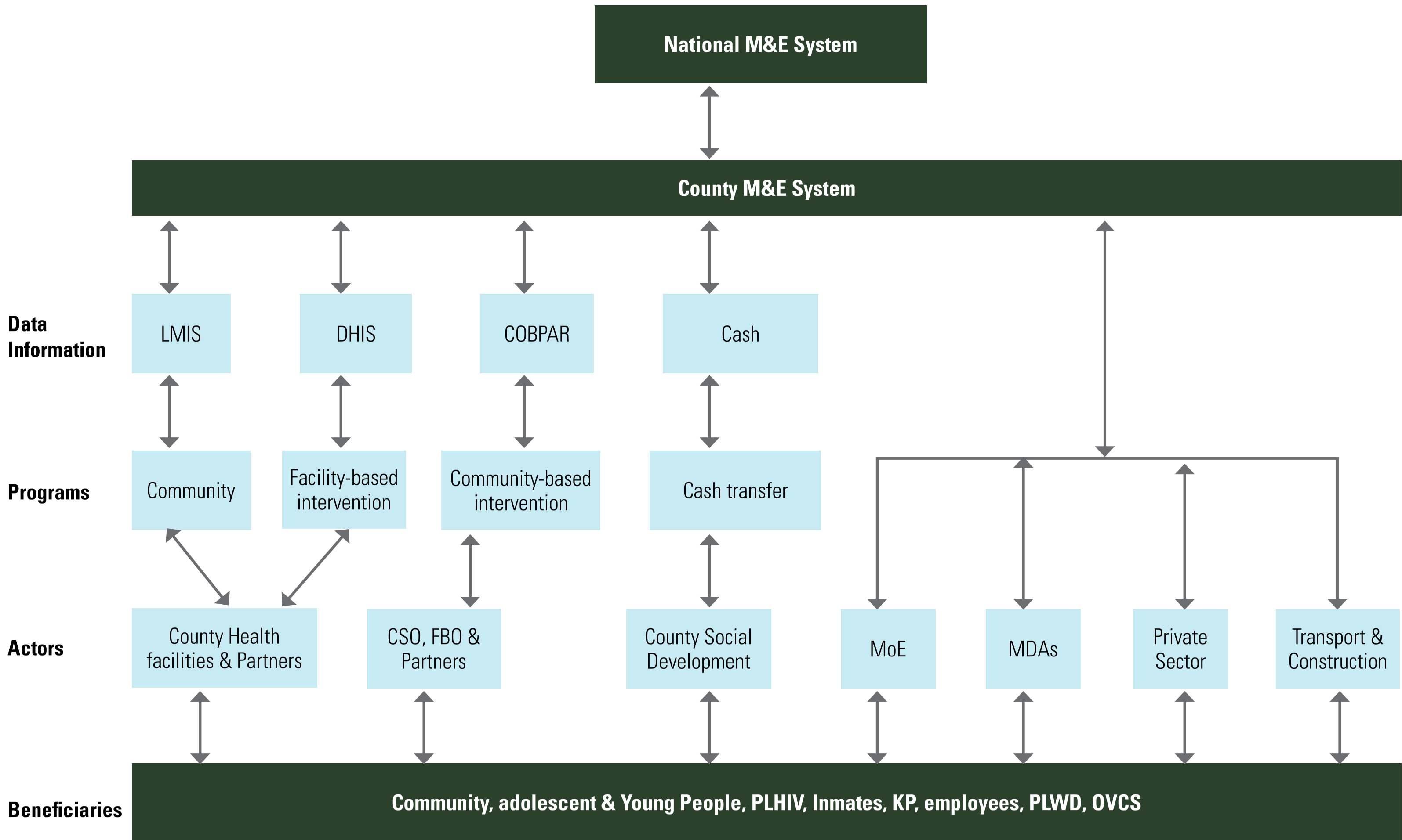
j) HIV Research. - The research TWG will develop coordination mechanism for HIV research in the county to be adopted by partners and universities in conducting HIV research in the county.

k) Data dissemination and use. - The M & E Committee will develop data dissemination mechanisms to ensure all stakeholders have access to the most up-to date information available that can inform program decisions. The information products will include quarterly HIV reports, dashboards and MCASP indicators snapshot.

l) Midterm and End term review. -There will be a midterm and end term review of the MCASP.

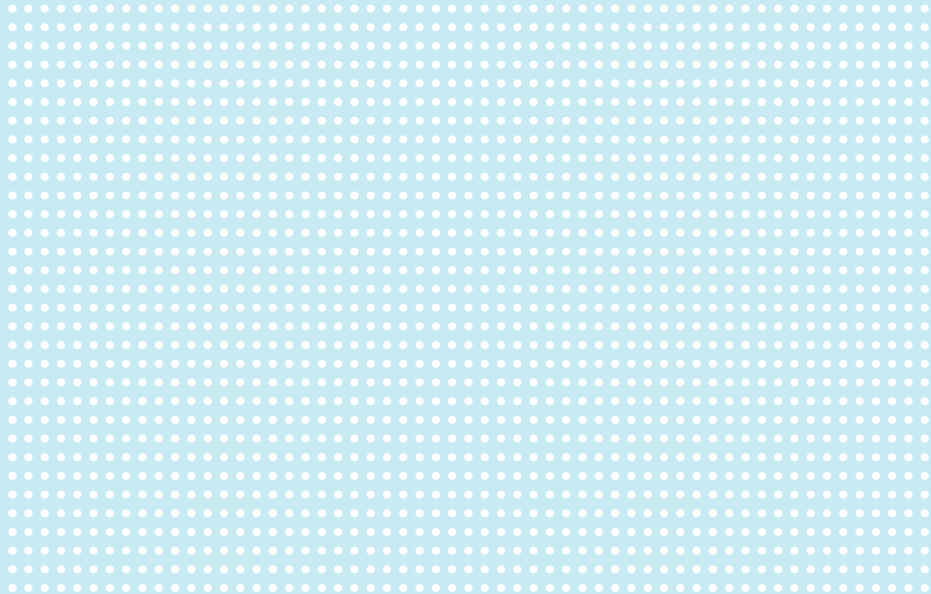
Data from various reporting systems will be consolidated at the County M & E system below

Data and Information Flow



07.

RISK AND MITIGATION PLAN



Risk and Mitigation Plan

The risk management plan is a tool to assist in identifying risks that have the 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.

Risk Category	Risk Name	Status	Probability (1-5)	Impact(1-5)	
Technological	-Loss of data	Medium	3.5/5	4/5	
Political	Displacement of populations	Low	2/5	4/5	
Operational	Partner dependency	High	4/5	4/5	
	Herbalist and faith healing	Medium	4/5	4/5	
	Existence of "briefcase CBOs/NGOs	Low	3/5	2/5	
	Uncertainty of program support	High	3/5	4/5	
Legislation	-Lack /weak legislation -Weak enforcement	Medium	2.5/5	3/5	

Risk Average Score	Response	Responsibility	When
3.75/5	-Install data back up - Give user rights	CEC Health	Yr. 1
3/5	-Set up a disaster management kit	CEC Health, CEC Finance	Yr1-Yr4
4/5	- Establish HIV budget line in county budget	CEC Health, CEC Finance, Chair of health committee	Yr1-Yr4
4/5	-County legislation on herbal medicine to include vetting and licensing -Community empowerment in health decisions	CEC Health, Chair Health committee	Yr1
2.5/5	-Vetting of CBOs/NGOs -County legislation on CBO and NGOs	County social service, Chair Health committee	Yr. 1-4
3.5/5	-Establish a County HIV Kitty	CHC	Yr. 1
2.75/5	-Review of existing legislation -Enactment of county HIV and AIDS Act -Enhance enforcement of legislation	CEC Health, Chair Health Committee, CHC	YR 1&2

ANNEXES

ANNEX 1: RESULTS FRAMEWORK

Strategic Direction 1: Reducing new HIV infections

Priority Intervention 1: Behavioural			
Recommended Actions	**Geographic areas by County/sub- county**	**Target Population**	**Targets (Numbers)**
Social behaviour change communication (SBCC)	All 4 sub counties in Marsabit	General population	332,654(100%)
		Key populations	4325
		Adolescents	29113
Priority Intervention 2: Biomedical		Target Population	Targets
Provision of Condoms and lubricants	All 4 sub counties	Key populations	4325 (100%)
		Adolescents (18 – 24 years)*	29113 (60%)
HIV counselling and testing	All 4 sub counties	General population	332654 (90%)
		Key populations	4325 (100%)
		Adolescents	29113
Voluntary Medical Male Circumcision	All 4 sub counties	Uncircumcised men above 10 years	1536
Elimination of Mother to Child Transmission of HIV (EMTCT)	All 4 sub counties	All pregnant women	14970
Positive Health Dignity and Prevention (PHDP)	All 4 sub counties	All PLHIV	3992
Post Exposure Prophylaxis	All 4 sub counties	General population	332654
TB prevention and control	All 4 sub counties	All PLHIV	3992
Blood safety	All 4 sub counties	All 4 sub county hospitals	4 (100%)
Medical waste and IPC management	All 4 sub counties	All 47 health facilities	98 (100%)
STI prevention and treatment	All 4 sub counties	Key populations	4325 (100%)
		Adolescents	29113
Priority Intervention 2: Structural		Target Population	Targets
Work place HIV prevention	All 4 sub counties	All county departments and private sector	10

Milestones (Years)				Responsibility
Yr. 1 2016	**Yr. 2 2017**	**Yr. 3 2018**	**Yr. 4 2019**	
84134	84163	84163	84163	County Health Promotion Officer
4325	4325	4325	4325	CASCO
7274	7273	7273	7273	County Reproductive Health Coordinator, Imarisha Danida
Yr. 1	**Yr. 2**	**Yr. 3**	**Yr. 4**	
4325	4325	4325	4325	CACC, CASCO
7274	7273	7273	7273	Facility dispensaries point
84164	84163	84163	84163	CASCO, APHIA Imarisha
4325	4325	4325	4325	CASCO
7274	7274	7274	7274	CASCO
434	434	434	434	MoH
3743	3742	3742	3742	MoH, APHIA Imarisha, PMTCT, NACC
998	998	998	998	PWP, CASCO, NACC
83164	83163	83163	83163	MoH
998	998	998	998	MoH
4	4	4	4	MoH
98	98	98	98	MoH
1081	1082	1081	1081	CASCO
7274	7274	7274	7274	CASCO/ RPH
Yr. 1	**Yr. 2**	**Yr. 3**	**Yr. 4**	
10	10	10	10	NACC, MoH

Strategic Direction 2: Improving Health Outcomes and Wellness of People Living With HIV

Recommended Actions	Geographic areas by County/sub- county	Target Population	Targets (Numbers)	
General ART Care	All 4sub counties	General population	(90%)	
		Key populations	90%	
		Adolescents	90%	
Pre-ART services	All 4 sub counties	General population	100%	
		Key populations	100%	
		Adolescents	60%	
Children, Adolescent and Youth	All 4 sub counties	All children and adolescents	100%	
Key and vulnerable populations	All 4 sub counties	All key and vulnerable persons	100%	
Improving quality of care and treatment outcomes				
Quality of care and monitoring treatment outcomes	All 4 sub counties	General population	70%	
Laboratory capacity	All 4 sub counties	General population	60%	
Community based adherence support	All 4 sub counties	General population	60%	

Milestones (Years)				Responsibility
Yr. 1	Yr. 2	Yr. 3	Yr. 4	
20%	25%	25%	20%	MoH
20%	25%	25%	20%	MoH
20%	25%	25%	20%	MoH
25%	25%	25%	25%	MoH
25%	25%	25%	25%	MoH
15%	15%	15%	15%	MoH
25%	25%	25%	25%	Children Department, MoE, Social Services, Provincial Administration
25%	25%	25%	25%	MoH
10%	20%	20%	20%	MoH
15%	15%	15%	15%	MoH
15%	15%	15%	15%	MoH

Strategic Direction 3: using human rights based approach to facilitate access to services for PLHIV, key populations and other priority groups.

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

Recommended Actions	Geographic areas by County/sub- county	Target Population	
Sensitise health workers to reduce stigmatising attitudes in healthcare settings	All the 4 sub counties	Management staff Clinical staff Support staff	
Train peer educators among key populations to enhance uptake of services	All the 4 sub counties	Sex workers, MARPs and MSMs	
Develop and disseminate population specific and user friendly information	All the 4 sub counties	General population (15+ years)	
Establish GBV recovery centres for sexual violence victims	All the 4 sub counties	GBV centres	
Sensitise school management boards, teachers, students, Parents-teachers association and pupils on SGBV	All the 4 sub counties	Board members, Teachers and learners	
Mentor health club patrons in schools on handling adolescents living with HIV	All the 4 sub counties	Health club patrons	
Sensitise school management boards, teachers, pupils, students and other school fraternity on stigma and discrimination reduction	All the 4 sub counties	Health club patrons	
Enrol eligible OVCs into the social protection programs and provide HIV services	All the 4 sub counties	OVCs	
Implement structural interventions that empower vulnerable populations especially women, adolescents and youths	All the 4 sub counties	Vulnerable Women	
Integrate HIV information and encourage service uptake in religious teachings	All the 4 sub counties	Religious leaders	
Recommend and emphasise confirmation of faith healing as well as herbalists claims through scientific tests*	All the 4 sub counties	Religious leaders	
Promote acceptance of key population as part of the community for increased service uptake.	All the 4 sub counties	Religious leaders	
Enhance male involvement in HIV, sexual and reproductive health programmes and also offer those services	All the 4 sub counties	CSO leaders (100 CSOs)	
Develop community groups and forums, and utilise persons living positively to campaign against HIV-related stigma and discrimination	All the 4 sub counties	CSO leaders (100 CSOs)	
Sensitise communities on legal issues, rights and gender	All the 4 sub counties	CSO leaders (100 CSOs)	
Sensitise the community on harmful gender norms, negative stereotypes and concept of masculinity	All the 4 sub counties	CSO leaders (150 CSOs)	
Facilitate campaigns to reduce stigma and discrimination, reduce gender violence and promote uptake of HIV services and preventive interventions	All the 4 sub counties	CSO leaders (150 CSOs)	

Targets (Numbers)	Milestones (Years)				Responsibility
	Yr. 1	Yr. 2	Yr. 3	Yr. 4	
200(100%)	65	57	48	30	County director of health services
72	72	72	72	72	County Government APHIA-plus Imarisha and other partners
4	4	4	4	4	CASCO, MoH, NACC
6	6	6	6	6	APHIA Danida, County Government, MoH
29754	7438	7438	7438	7438	Ministry of Health and education Kenya Red Cross FBOs
100	30	30	20	20	Ministry of Health and education, Kenya Red Cross, FBOs
400	180	140	100	80	Children Department, Judiciary, Security, Ministry of Education/ Education boards
124	124	124	124	124	Social services sector
849	213	212	212	212	Ministry of gender and social services, MCAs
300	95	85	70	50	NACC, Ministry of Information, Inter faith organisations
300	95	85	70	50	County Government(to fund), Research Institution Partnership
200	70	50	45	35	CASCO, NASCOP
100	45	25	20	10	CASCO, all service providers of HIV services
100	45	25	20	10	CASCO, NEPHAK, support groups/ community units
100	45	25	20	10	Para legal, Judiciary, Administration
150	60	50	25	15	Ministry of culture and gender, Administration
150	60	50	25	15	Development partners,

ii) Improve Legal And Policy Environment For Protection of PLHIV, Key Populations and Other Priority Groups Including Women, Adolescents, Girls And			
Recommended Actions	**Geographic areas by County/sub- county**	**Target Population**	
Sensitise health care workers, on their own rights, attitudes and tools necessary to ensure patient/client rights are upheld	All the 4 sub counties	Management staff Clinical staff Support staff	
Sensitise law and policy makers on the need to enact laws, regulations and policies that prohibit discrimination and support access to HIV prevention, treatment, care and support	County	MCAs and County Executives	
Review existing laws and policies to ensure they impact positively on the HIV response	County	MCAs and County Executives	
Sensitise law makers and law enforcement agencies on HIV and the consequences of enactment of laws in the provision of HIV services to priority groups	County	MCAs and County Executives	
Facilitate discussion and negotiation among providers, those who access the service and law enforcement agencies to address law enforcement practices that impede HIV prevention, treatment, care and support	County	MCAs and County Executives	
Hold the county governments accountable to their constitutional and statutory obligations	County	County review meetings across the 10 departments	
Implement programmes that uphold the rights of priority populations	All the 4 sub counties	CSO leaders and government departments (100 CSOs)	
Facilitate access to justice in cases of rights violation	All the 4 sub counties	CSO leaders (100 CSOs)	
Undertake legal literacy programmes to teach those who are living with or affected by HIV about human rights and the laws relevant to HIV	All the 4 sub counties	CSO leaders (100 CSOs)	

iii) Monitoring and Evaluation for Stigma and Discrimination and GBV.			
Recommended Actions	**Geographic areas by County/sub- county**	**Target Population**	
Conduct HIV stigma index survey including in health care settings and communities	County	Public and private institutions	
Conduct baseline survey to document the magnitude and nature of human rights violations in the context of HIV	County	Public and private institutions	
Conduct baseline survey to document the magnitude and nature of gender disparities in the context of HIV	County	Public and private institutions	
Implementation of programmes aimed at reducing stigma and discrimination against priority populations	County	CSOs, Public and private institutions	

Boys.

	Targets (Numbers)	Milestones (Years)				Responsibility
		Yr. 1	Yr. 2	Yr. 3	Yr. 4	
	4	4	4	4	4	County director of health services.
	30	30	30	30	30	Office of the Governor, CECs, Office of the speaker
	30	30	30	30	30	Office of the Governor, CECs, Office of the speaker
	30	30	30	30	30	Office of the Governor, CECs, Office of the speaker
	30	30	30	30	30	CASCO, NACC, APHIA Imarisha, Other partners
	4 meetings	1	1	1	1	Key CSOs
	100	25	25	25	25	CASCO
	100	25	25	25	25	Para legal, Judiciary
	100	25	25	25	25	NEPHAK, Other partners, CASCO

	Targets (Numbers)	Milestones (Years)				Responsibility
		Yr. 1	Yr. 2	Yr. 3	Yr. 4	
	1	1	1	1	1	ICC (HIV)
	1	1	1	1	1	ICC (HIV)
	1	1	1	1	1	ICC (HIV)
	1	1	1	1	1	ICC (HIV), CSOs

Strategic Direction 4: Strengthening Integration of Community and Health Systems

Recommended Actions	Geographic areas by County/ sub- county	Target Population	
Priority Intervention 1; Provision of a competent, motivated and adequately staffed health workforce to deliver HIV services integrated in the essential health package			
Recruitment of enough skilled health care staff at all levels	All 4 sub counties	Management staff Clinical officers Support Staffs	
Capacity building of health care workers in HIV and AIDS management	All 4 sub counties	Management staff Clinical officers Support Staffs	
Create avenues for staff motivation e.g. in service trainings, certificates of recognitions, improving the working environment	All 4 sub counties of Marsabit County	Management staff Clinical officers Support Staffs	
Put in place health care workers retention policy	County	MCAs County Executives	
Correct placement of staff based on their skills and competences e.g. CCC staff being rotated to OP	County	Management staff CHMT	
Training of health managers in HR	All 4 sub counties	Management staff	
Priority Intervention 2; Strengthen health service delivery systems for the provision of HIV services integrated in the essential health package			
Need to integrate all health service	All 4 sub counties	Management staff Clinical officers Support staff	
Adoption and implementation of Kenya HIV quality improvement framework as well as implementation of health workforce intervention that improves HIV technical skills and competencies		Management staff Clinical officers Support staff	
Develop strategies for availability of comprehensive HIV services more accessible to key population	All 4 sub counties	Management staff Clinical officers Support staff	
Strengthen referrals and linkages between public and private facilities and community	All the 4 sub-counties	Management staff Clinical officers Support staff	
Improve on health facilities infrastructure to be able to meet basic standards for HIV service provision	All 4 sub counties	Health managers	
Priority Intervention 3; Improve access to and rational use of quality essential products and technologies for HIV prevention, treatment and care services			
Provision of HIV and AIDs commodities based on the consumption rates in the sub counties	All 4 sub counties	Clinical officers	
Conduct regular data review meetings	All 4 sub counties	Health managers Clinical officers	
Capacity building of health care staff on commodity management	All 4 sub counties	Management staff Clinical officer Support staff	
Support county commodity technical working group	County	Commodity technical working group	

Milestones (Years)				Responsibility
Yr. 1	Yr. 2	Yr. 3	Yr. 4	
70	50	45	35	County Health Department
70	50	45	35	County Government, CASCO, NACC
80	60	40	20	CEC health, Chief officer health, Director health and CHMT
80	60	40	20	Office of the Governor, CECs, County assembly
40	30	20	10	Director of health, CHMT
40	30	20	10	CEC health
160	150	70	70	MoH
80	60	40	20	CASCO, CHMT, HMT
80	60	40	20	CASCO, NASCOP, Partners
80	60	40	20	CASCO, CHMT, HMT, Service providers
20	10	10	10	County Government, MoH
20	20	20	20	CASCO, Sub Counties, HMT, CHMT
70	70	70	70	MoH, Partners
220	220	220	220	MoH, Partners
22	22	22	22	County Government, MoH, Partners

Recommended Actions	Geographic areas by County/ sub- county	Target Population
Establish a pharmaceutical management information system (PMIS)	All 4 sub counties	Pharmacists
Priority Intervention 4; Strengthened community and workplace service delivery systems for HIV prevention, treatment and care services		
Capacity build and empower communities and work places to take charge of their health	All 4 sub counties	County Departmental heads CSOs
Engage and motivate CHVs	All 4 sub counties	CHVs
Strengthen governance and leadership for community and work place health actions at all levels	All 4 sub counties	County Departmental heads CSOs
Strengthen Public Private Partnerships	All 4 sub counties	County departmental heads CSOs

Strategic Direction 5: Strengthening Research, Innovation and Information Management to Meet MCASP Goals

Recommended Actions	Geographic areas by County/ sub- county	Target Population
Resource and implement a HIV research agenda informed by MCASP		
Implementation Research Priorities	All 4 sub counties Marsabit, Garba Tulla and Merti	General population
Interventions for Implementation of research on MCASP- related priorities		
County HIV research agenda	All 4 sub counties	General population
Implement research agenda in the county	All 4 sub counties	General population
Resource the HIV agenda	All 4 sub counties	General population
Interventions for increasing evidence planning and programming		
HIV information portal Marsabit County	All 4 sub counties	General population
Reviews of research	All 4 sub counties	General population
Communities of practices	All 4 sub counties	General population

	Milestones (Years)				Responsibility
	Yr. 1	**Yr. 2**	**Yr. 3**	**Yr. 4**	
	20	20	10	10	MoH, County Pharmacist
	40	40	40	30	County Departmental heads, CSOs
	130	120	100	100	CHVs
	40	30	40	40	County Departmental heads CSOs
	40	40	40	30	County departmental heads CSOs

	Targets (Numbers)	Milestones (Years)				Responsibility
		Yr. 1	Yr. 2	Yr. 3	Yr. 4	
	1 county research department	25%	25%	`25%	25%	County Government
	Annual county research agenda	1	1	1	1	County Government
	Half of the annual county research agenda implemented	25%	25%	25%	25%	County Government
	1	1	1	1	1	County Government, Partners
	1	1	1	1	1	County Government, Partners
	100%	100%	100%	100%	100%	County Government, Partners
	3	3	3	3	3	County Government, Partners

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

Recommended Actions	Geographic areas by County/sub- county	Target Population	
Interventions for the M&E priority areas			
Strengthening M/E capacity to effectively track MCASP performance and HIV epidemic at all levels	All 4sub counties	General population	
Ensure harmonised, timely and comprehensive routine and non-routine monitoring system to provide quality HIV data at national and county levels	All 4 sub counties	General population	
Establish multi-sectoral and integrated real-time HIV platform to provide updates on HIV epidemic response accountability	All 4 sub counties	General population	

Strategic Direction 7: Increasing domestic financing for sustainable HIV response

Priority Intervention 1; Align HIV resources/investments to MCASP priorities			
Recommended Actions	**Geographic areas by County/sub- county**	**Target Population**	
All contracts in the county should include a sum of 2% of the contract towards HIV and AIDS program	County	Contractors	
Most of the funding should go to priority areas	County	ICC	
Track county government HIV and AIDS allocations to the various county departments	County	ICC	
Engage the county budget committee allocation to consider 1% of county budget to HIV as an added parameter or consideration in resource allocation	County	MCAs	
Create a county HIV investment fund with a clear management structure	County	ICC	
Lobbying with the development partners to fund MCASP	County	Development partners	
Organise development partners HIV forum to facilitate alignment with MCASP	County	Development partners	
Give them responsibility to fund part of HIV response in the county	All 4 sub counties	Development partners CSOs	
Facilitate quantification of county resource needs through relevant information on county support	County	ICC	
Implement a partnership accountability framework to ensure alignment of resources to MCASP priorities.	County	ICC	
Facilitate annual review meetings to give feedback of development partner's contribution towards MCASP implementation	County	CSOs Development partners	

Targets (Numbers)	Milestones (Years)				Responsibility
	Yr. 1	Yr. 2	Yr. 3	Yr. 4	
70%	20%	20%	20%	10%	MoH, County HIV Committee
70%	20%	20%	20%	10%	CHC
1	1	1	1	1	County Government

Milestones (Years)				Responsibility
Yr. 1	Yr. 2	Yr. 3	Yr. 4	
240	240	240	120	Line Departments
10	10	10	10	ICC
1	1	1	1	ICC
1	1	1	1	MCAs
1	-	-	-	ICC
1	1	1	1	Development partners
1	1	1	1	Development partners
60	50	20	20	Development partners, CSO
1	1	1	1	ICC
	1			ICC
1	1	1	1	Development partners, CSOs

Strategic Direction 8: promoting accountable leadership for delivery of the MCASP results by all sectors

Recommended Actions	Geographic areas by County/ sub- county	Target Population	Targets (Numbers)	
Policies and systems	County	ICC	4 (Review meetings)	
Build and sustain high-level political commitment	County	County assembly	4 (Review meetings)	
Stakeholder accountability	County	ICC	4 (Review meetings)	
Development partners accountability	County	ICC	4 (Review meetings)	
Implementing partners accountability	County	ICC	4 (Review meetings)	
Private Sector accountability	County	ICC	4 (Review meetings)	
Multi-sectoral accountability	County	ICC	4 (Review meetings)	
MCASP Governance	County	ICC	4 (Review meetings)	

Milestones (Years)				Responsibility
Yr. 1	Yr. 2	Yr. 3	Yr. 4	
1	1	1	1	Office of the speaker
1	1	1	1	Office of the speaker
1	1	1	1	CDH
1	1	1	1	CDH
1	1	1	1	CDH
1	1	1	1	CDH
1	1	1	1	CDH
1	1	1	1	CDH

ANNEX 2: M&E FRAMEWORK

Strategic Direction 1: Reducing new HIV infections

MCASP Results	Service Delivery Area	Indicators
Reduce new HIV infection in adults and children by 75%	Community adherence to care and treatment	Number of new HIV infections in adults (15+)
	Improved reproductive health services	Number of new HIV infection in children (0-14)
	Early infant treatment	Number of new infections among infants (0-12 months
	Retention on ART	Annual number of HIV related deaths
	Early infant diagnosis	Percentage of Infants born to HIV-Infected mothers that are HIV positive at 8 weeks
	Adolescent Programme	Percentage of young women and men aged 15-25 who have had sexual intercourse before age 15
	HTC	Percentage of the population counselled and tested
	PEP	Number of Health facilities providing PEP services
	General Population	Percentage of people aged 15-49 years who had sexual intercourse with more than one partner in the last 12 months
		Percentage of people aged 15-49 who had sexual intercourse with more than one partner in the last 12 months and reported condom use during the last sexual intercourse
	PMTCT	Number of pregnant women attending ANC whose male partner was tested for HIV
		Number and percentage of infants born to HIV infected women starting on Cotrimoxazole prophylaxis within 2 months of birth
		Number and % of infants born to HIV infected women who receive DNA- PCR test for HIV within 2 months of birth
		Number and % of pregnant women who know their HIV status (1ST ANC Visit)
		Percentage of HIV positive women who receive anti-retroviral to reduce risk of mother to child transmission (ANC- PMCT)
		% of new ANC clients seen at health facilities (1st ANC Visit)
		Percentage and Number of clients whose male partners were tested in MCH
		Percentage of clients who finished four ANC visits
	Key Population	Number of targeted tests for high risk populations
		Number and percentage of KP reached with HIV prevention programmes
		Number of syringes distributed to PWID by Needle and Syringe Program (NSP)
	Leverage opportunity for HIV prevention	Percentage of County Government ministries, departments and agencies (MDAs) with result based HIV plans aligned to MCASP

Baseline	Data Source	Mid Term Target	End Term Target
407	DHIS 2014	204	102
38	County Estimate 2014	19	10
50	DHIS2014	25	13
110	County Estimate 2014	55	28
1	DHIS2014	0	0
10.%	KAIS 2012	5.0%	2.5%
50%	DHIS - 2014	62%	75%
21/98	DHIS 2014	40	75
8.4%	KAIS 2012	6%	4%
37.7%	KAIS 2012	50%	75%
404/9735	DHIS 2014	606	707
12/39(30.7%)	DHIS2014	46.2%	51.3%
1/39(2.6%)	DHIS2014	5.1%	7.7%
8999/14970 (60.1%)	DHIS	95%)	(100%)
18/39 (46.2%)	DHIS 2014	100%	100%
8999/14970 (60.1 %)	DHIS 2014	95%	100%
4.1%	DHIS2014	6-2%	7.3%
46.7%	DHIS 2014	75%	80%
50	DHIS 2014	60	70
50 (50%)	DHIS 2014	60%	70%
0	0	0	0
30%	Public sector reports (2014/2015)	100%	100%

Strategic Direction 2: Improve Health outcomes of PLHIV

MCASP Results	Service Delivery Area	Indicators
Diagnosis of 90% of all PLHIV	ART Program	Percentage of people diagnosed HIV positive linked with care within 3 months
		Percentage of PLHIV receiving HIV care services
90% of those diagnosed started and retained on ART	ART Program	Number and percentage of adults and children enrolled in HIV care and eligible for cotrimoxazole prophylaxis currently receiving cotrimoxazole prophylaxis
	PMCT Program	Number and percentage of eligible clients newly initiated on highly active ART in the last 12 months
	ART Program	Percentage of adults and children currently receiving ART among all eligible people living with HIV (using national criteria)
		Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (24 months, 36 months, 60 months)
	HIV/TB Co morbidity	Percentage of TB/HIV co-infected clients who are receiving ARTs
		Percentage of HIV patients screened for TB
Increased viral load suppression	ART Program	Percentage of ART patients with an undetectable viral load at 12 months after initiation of ART
		Percentage of people on ART tested for viral load who have a suppressed viral load in the reporting period
Structural interventions		
Improved quality of care treatment	Capacity building	Percentage of health facilities providing HIV care and treatment services
		Percentage of health facilities implementing continuous quality improvement activities according to MoH standardised protocols
	ART program	Percentage of health facilities dispensing ART that have experienced a stock out of at least one required antiretroviral drug in the last 12 months
		Number of health facilities providing care and treatment according to MoH standardised protocols

Baseline	Data source	Mid Term Target	End Term Target
23% (80/348)	DHIS 2014	34.5%	51.5%
23%	DHIS 2014	34.5%	51.5%
99.8%	DHIS 2014	100%	100%
80/348 (23%)	DHIS 2014	34.5%	52%
99.7%	DHIS 2014	100%	100%
12 Months 53.2% (148/348)	DHIS 2014	81.8%	90%
24 Months	DHIS 2014	76.5%	90%
36 Months	DHIS 2015	73%	90%
60 Months	DHIS 2015	70%	90%
98%	DHIS 2015	100%	100%
100%	DHIS	100%	100%
TBD	DHIS	TBD	TBD
41%	NASCOP Report Dec2015	80%	90%
53/245=21%	RHIS	50%	75%
91%	RHIS	100%	100%
0	RHIS	0	0
21/98	RHIS	75/98	100/98

Strategic Direction 3: Using a human rights approach to facilitate access to services for PLHIV, KPs and other priority group.

MCASP Results	Service Delivery Area	Indicators
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
		Percentage of women and men ages 15–49 expressing accepting attitudes towards people living with HIV
	General population	Percentage of ever married or partnered women and men ages 15–49 who experienced sexual and/or gender based violence
	PLHIV	Percentage of PLHIV who experienced sexual and/or gender-based violence
	KP	Percentage of MSM who experienced sexual and/or gender-based violence
		Percentage of sex workers who experienced sexual and/or gender-based violence
		Percentage of OVCs reached with social protection programs
Structural Interventions		
Improved protection of human rights	Human rights and improved access to justice	Number of cases filed by PLHIV at the HIV Tribunal
		Number of PLHIV and key population accessing legal services at the HIV tribunal

Strategic Direction 4: Strengthening integration of health and community systems

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

	Baseline	Data Source	Mid Term Target	End Term Target
	45%*	Stigma index survey	20%	0%
	Men: 32.6%* Women: 46.9%*	KDHS 2009	75%	80%
	6.6%*	KDHS 2009	3%	0%
	0%	KDHS/KAIS	0%	0%
	24%*	IBBS	15%	10%
	44%*	IBBS	25%	10%
	31%	County estimate	50%	75%
	0	HIV Tribunal	2	2
	0	HIV tribunal	4	4

	Baseline	Data Source	Mid Term Target	End Term Target
	1.69/1000*	RHIS	2.0/1000	2.4/1000
	70/98 (71.4%)	RHIS	60%	80%
	5%	RHIS	0	0
	0/44	County Focal office	22/44	44/44
	0/44	County Focal office	22/44	44/44
	440/1320	County Focal office	740/1320	1100/1320
	30%*	COBPAR	55%	80%
	4/98	RHIS	20/98	35/98
	75	RHIS	84	98

Strategic Direction 5: Strengthening research and innovation to inform county priorities

MCSP Results	Service Delivery Area	Indicators	
Increased capacity to conduct HIV research at county level	Build Capacity for research	Number of prioritised biomedical and behavioural research conducted	
		Number of people trained in HIV related research	
		Number of HIV related studies undertaken at postgraduate levels in tertiary institutions	
	Funding for research	Proportion of HIV funds utilised on research	
Increased evidence based planning and programming	Application of research finding in decision making	Number of research products disseminated to inform policy, planning and programming	

Strategic Direction 6: Promoting utilisation of strategic information for research and monitoring and evaluation to enhance programming

MCASP Results	Service Delivery Area	Indicators	
Increase availability of strategic information to inform HIV response	Increase access and strengthen strategic information	Number of planned M & E reports generated	
		Number of planned M & E reports disseminated	
		Established and functional MCASP/CASF monitoring committee	
		Number of Partners reporting through DHIS and HIRPOS	

Strategic Direction 7: Increasing Domestic Financing for Sustainable HIV Response

MCASP Results	Service Delivery Area	Indicators	
Increase domestic financing to 50%	Government funding	Establishment of specific budget lines and funding for HIV	

Strategic Direction 8: Promoting accountable leadership for delivery of the MCASP result by all sectors

MCASP Results	Service Delivery Area	Indicators	
Functional Coordination framework	Establishment of coordination framework	County HIV coordinating committees in place	

	Baseline	Data Source	Mid Term Target	End Term Target
	0	KARSCOM/NACC	1	2
	0		20	24
	0		4	8
	0		5%	7%
	0		100%	100%

	Baseline Data	Data Source	Mid Term Target	End Term Target
	3	RHIS	8	16
	3		8	16
	1		1	1
	1		1	1

	Baseline Data	Data Source	Mid Term Target	End Term Target
	4 SCACCs	RHIS	4	4

	Baseline Data	Data Source	Mid Term Target	End Term Target
	4 SCACCs	RHIS	4 SCACCs	4 SCACCs
	County HIV Committee-0	RHIS	County HIV Committee-1	County HIV Committee-1
	County M& E Committee-0	RHIS	County M&E Committee-1	County M& E Committee-1
	County ICC-0	RHIS	County ICC-1	County ICC-1

ANNEX 3: COSTING AND RESOURCE MOBILISATION

The county resource needs for this strategic plan period was calculated using a county HIV resource model. The model assumes that the medical services are included in the health budget rather than the HIV budget. The baseline information utilised in this model is as follows:

EPI and Program Data	As at Dec 2015	Default value
HIV prevalence among 15-49 year old adults	1.2%	1.2%
Adults receiving ART	746	—
Children receiving ART	93	—
Number receiving PMTCT	8999	—
Number receiving HTS	25825	—

Interventions		Unit costs of services		
	Coverage as at Dec 2015	Revised value	Default value	Units
ART	71%	KSh51,612	KSh51,612	per patient
PMTCT	61%	KSh1,748	KSh1,748	per mother/baby
HTS	62%	KSh513	KSh513	per person tested
VMMC	98.1%	KSh1,500	KSh1,500	per circumcision
Adolescent friendly services	0%	KSh6	KSh6	per condom
Key populations	0.2%	KSh6,440	KSh6,440	per person reached
Behaviour change	-	KSh138	KSh138	per person reached
OVC support	45%	Ksh 2000	Ksh 2000	Per child reached per month
Program support	-	15.5%	15.5%	% of other services

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

MCASP RESOURCE NEEDS

Resource Needs (Millions of Kenyan Shillings)					
	2015	2016	2017	2018	2019
ART	KSh63	KSh63.2	KSh63.4	KSh63.5	KSh63.7
PMTCT	KSh15.9	KSh16	KSh16.1	KSh16.15	KSh16.2
HTC	KSh105	KSh105.1	KSh105.3	KSh105.6	KSh105.7
Condoms	KSh41	KSh41	KSh46	KSh52	KSh58
Key populations	KSh5	KSh5.7	KSh6.1	KSh14	KSh18
Behaviour change	KSh140	KSh173	KSh206	KSh243	KSh283
OVC	KSh120	KSh136	KSh136	KSh138	KSh140
Program support	KSh211	KSh219	KSh219	KSh220	KSh222
Total	KSh700.9	KSh759	KSh797.9	KSh852.25	KSh906.6

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

ANNEX 4: REFERENCES

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ANNEX 5: MARSABIT CASP DRAFTING AND TECHNICAL TEAM

MARSABIT CASP DRAFTING TEAM

NAME	DESIGNATION	PLACE OF WORK/STATION
Dr. Adano Kochi	CDOH	MARSABIT COUNTY
Dr M.S.Ndakalu	Deputy Director	MARSABIT COUNTY
Mrs Batula Jaro	Assistant Director	MARSABIT COUNTY
Hassan Halakhe	Assistant Director	MARSABIT COUNTY
Dr. Boru Ali	SCMOH	SAKU SUB COUNTY
Molu Waso	CHMT	MARSABIT COUNTY
Bokayo Arero	CHMT	MARSABIT COUNTY
Abdub Liban	CHMT	MARSABIT COUNTY
Godana Doti	CHMT	MARSABIT COUNTY
Andrew Bulyaar	CACC	LAISAMIS SUB COUNTY
Guyo Hirbo	SCASCO	SAKU SUB COUNTY
Peter Mwangi	SCHRIO	SAKU SUB COUNTY
Abdullahi Konsole	CACC	SAKU SUB COUNTY
Kussu Abduba	SCASCO	MOYALE SUB COUNTY
Molu Salesa	SCASCO	NORTH HORR SUB COUNTY
Mohammed Adan	SCASCO	LAISAMIS SUB COUNTY
Dida Halakhe	CACC	MOYALE SUB COUNTY
Liban Waqo	CHMT	MARSABIT COUNTY
Fred Bosire	APHIA Plus Imarisha	MARSABIT COUNTY

TECHNICAL SUPPORT TEAM

1. James Kiiru	NACC
2. Marion Massawe	NACC
3. Patricia Sakana	NACC
4. Philip Nyakwana	NACC

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