MURANG'A COUNTY

HIV & AIDS STRATEGIC PLAN

2014/15 – 2018/19

My County, My Responsibility

maisha!
National AIDS Control Council

MURANG'A COUNTY

HIV & AIDS STRATEGIC PLAN

2014/15 – 2018/19

'A Multisectoral Response to HIV in a Devolved Government'

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Abbreviations and Acronyms

ACT	Accelerated Care and Treatment
ACU	AIDS Control Unit
AHF	AIDS Healthcare Foundation - Kenya
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
APHIA	AIDS Population and Health Integrated Assistance
ART	Antiretroviral Treatment/Therapy
ARV	Anti-Retroviral Drugs
BCC	Behaviour Change Communication
CACC	County AIDS Control Coordinator
CASCO	County AIDS and STI Coordinator
CASP	County AIDS Strategic Plan
CBO	Community Based Organization
CCC	Comprehensive Care Centre
CCM	Country Coordination Mechanism
CDM	Catholic Diocese of Murang'a
CDH	County Director of Health
CEC	County Executive Committee
CHEWs	Community Health Extension Workers
CHMT	County Health Management Team
CHPO	County Health Promotion Officer
CHRIO	County Health Records and Information Officer
CHS	Centre for Health Solutions-Kenya
CHV	Community Health Volunteer
CIDP	County Integrated Development Plan
COBPAR	Community Based Programme Activity Reporting
COH	Chief Officer of Health
CPSB	County Public Service Board
CRO	County Records Officer
CSO	Civil Society Organization
CTC	County Technical Committee
DHIS	District Health Information System
DICE	Drop In Centres
DQA	Data Quality Audits
EBI	Evidence Based Intervention
eMTCT	Elimination of Mother to Child Transmission
ETR	End Term Review
FBO	Faith Based Organization
FMS	Financial Management System
FSW	Female Sex Worker
GBV	Gender Based Violence
GoK	Government of Kenya
HAART	Highly Active Antiretroviral Therapy
HBC	Home Based Care
HBTC	Home Based Testing and Counseling
HCBC	Home and Community Based Care
HCW	Health Care Worker
HEI	HIV Exposed Infants
HIV	Human Immunodeficiency Virus
HIV+	HIV Positive
HMIS	Health Management Information System
HPV	Human Papilloma Virus
HR	Human Resources
HTC	HIV Testing and Counseling
HTS	HIV Testing Services
ICC	Interagency Coordinating Committee
ICT	Information Communication Technology

IDU	Intravenous Drug Users
IEC	Information, Education, and Communication
IGAD	Intergovernmental Authority on Development
ILO	International Labour Organization
IPC	Infection Prevention and Control
KAIS	Kenya AIDS Indicator Survey
KASF	Kenya AIDS Strategic Framework
KDHS	Kenya Demographic and Health Survey
KEMSA	Kenya Medical Supplies Authority
KEPH	Kenya Essential Package for Health
KNASP	Kenya National AIDS Strategic Plan
KPs	Key Populations
LGBT	Lesbian, Gay, Bisexual and Transgender
LHIV	Living with HIV
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MCA	Member of County Assembly
CASP	Murang'a County AIDS Strategic Plan
MCG	Murang'a County Government
MDAs	Ministries, Departments and Agencies
MoH	Ministry of Health
MoT	Modes of Transmission
MOU	Memorandum of Understanding
MSM	Men who have Sex with Men
MSW	Male Sex Worker
MTR	Mid-Term Review
NACC	National AIDS Control Council
NASCOP	National AIDS & STI Control Programme
NCDs	Non-Communicable Diseases
NCPI	National Composite Policy Instrument
NEPHAK	National Empowerment Network of People Living with HIV and AIDS in Kenya
NGO	Non-Governmental Organizations
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PHDP	Positive Health, Dignity and Prevention
PITC	Provider Initiated Testing and Counseling
PLHIV	People Living with HIV
PWD	People/Persons with Disabilities
PMS	Post Marketing Surveillance
PMTCT	Prevention of Mother to Child Transmission
PPP	Public-Private Partnership
PrEP	Pre-Exposure Prophylaxis
PSK	Population Services Kenya
PWID	People Who Inject Drugs
RBM	Results Based Management
SCACC	Sub-County AIDS Control Coordinators
SCASCO	Sub-County AIDS and STI Coordinators
SCMOH	Sub-County Medical Officer of Health
SD	Strategic Direction
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Workers
TAT	Turnaround Time
TB	Tuberculosis
TOWA	Total War against HIV and AIDS
TTI	Transfusion Transmissible Infection
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VMMC	Voluntary Medically Assisted Adult Male Circumcision
WHO	World Health Organization

Foreword

The HIV prevalence in Murang'a County currently stands at 5.2% with prevalence among women at 7.7% and 2.8% among men (KAIS 2012). Despite the efforts in combating the spread of HIV and AIDS, it continues to be among the leading causes of mortality and morbidity in the county.

The **Murang'a County AIDS Strategic Plan** will be the blueprint that offers a roadmap for the implementation of HIV response for the next three years. It is premised on evidence based interventions to address drivers of HIV and AIDS in the county while ensuring an all-inclusive approach for improved health outcomes.

This County AIDS Strategic Plan is aligned to the Constitution of Kenya 2010, the Vision 2030, and the African Union goals on HIV control. It is also aligned to the Kenya AIDS Strategic Framework (KASF), County Integrated Development Plan (CIDP) and the County Health Strategic Plan (CHSP). It recognizes the centrality of a multi-sectoral response to HIV and outlines roles and expected actions from different sectors and actors and the need for strengthened stakeholder accountability for results. It sets out a clear coordination and governance structure through the county implementation and oversight committees.

The County Government has prioritized increased domestic and sustainable financing for HIV. The County Strategic Plan outlines approaches to leverage funding and set up a County HIV kitty to ensure sustainable implementation of the HIV response.

Therefore, the County government is committed to facilitating achievement of the results outlined in this Strategic Plan to build on the progress made so far towards improving the health outcomes of persons living with HIV and AIDS, reducing new HIV infections and addressing HIV related stigma.

H. E. HON. MWANGI wa IRIA

GOVERNOR

MURANG'A COUNTY

Remarks

Murang'a County HIV and AIDS Strategic Plan is the blueprint that offers a roadmap for the implementation of HIV and AIDS health services in the County for the next 3 years. It has been guided overall by Vision 2030 that aims to transform Kenya into a globally competitive and prosperous country with a high quality of life by the year 2030. Health is under the social pillar in the Vision 2030 and the populations need to be healthy so as to be productive and therefore contribute to the development of the county. The county HIV prevalence is 5.2% (KAIS 2012) with an incidence of 0.03% which has made the county to be clustered under counties with medium HIV burden.

New infections continue to be recorded in adolescents and adults while the transmission rate of mother to child have reduced significantly over the last five years due to the successful PMTCT program. HIV however, continues to contribute to the high mortality rates, burdening households and straining county health systems. With this understanding, the Murang'a AIDS Strategic Plan exemplifies the firm commitment by key stakeholders to support the County government to deliver better health for all with a focus on cost effective and socially inclusive interventions to prevent and manage HIV and AIDS.

This plan focuses on leadership in the HIV response. It emphasizes an equitable HIV response that ensures no one is left behind. This is a priority for Murang'a to achieve her goals. It promotes calibration of our efforts through effective prioritisation of interventions, effective evidence-based investments, which target priority populations while ensuring that all citizens in the county are reached and stigma and discrimination are reduced for improved health outcomes. It recognizes 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 for results. Increasing domestic and sustainable financing for HIV is a priority for the county Government.

In this regard, therefore, my department is committed to facilitating achievement of the results articulated in this Strategic Plan.

Dr SUSAN MAGADA

COUNTY EXECUTIVE COMMITTEE MEMBER

DEPARTMENT OF HEALTH & SANITATION

Preface

The County AIDS Strategic Plan (2014/15-2018/19) marks a milestone in the county's response to the HIV epidemic. The new constitution bestows us the responsibility to lead our people in all areas of the economy including health so as to realize our full potential and secure our place in our beloved county Murang'a. We are fully committed to improving the quality of health of all people in the County and beyond. The Strategic Plan has been formulated to ensure that the county response to the AIDs pandemic is achieved by carefully laying down the objectives, activities and targets with a logical framework for monitoring and evaluation.

The County Department of Health understands the importance of engaging all stakeholders in developing the MCASP and further understands the great responsibility bestowed on it in the delivery of Strategic Direction 1 and Strategic direction 2 among the other strategic directions. Over the last several years together with our collaborators, partners and stakeholders, we have been able to register marked progress in a number of critical areas in our HIV response.

On its part, the County Government of Murang'a has created an enabling and secure environment that allows the county to build a fair and unified society by addressing some central factors that affect human capital including the health of its population.

This Strategic Plan requires that all actors in the HIV response granulate the HIV epidemic to intensify HIV prevention, care and treatment efforts to priority geographic regions within the county and populations. Further, this calls for the utilization of social, behavioural, cultural, biomedical, scientific, technological and implementation of scientific innovative interventions so as to make real progress in HIV prevention, treatment and impact mitigation. Our key strategic objectives in the next three years include the following:

1. Reduce new HIV infections by 50%
2. Reduce AIDS related mortality by 25%
3. Reduce HIV related stigma and discrimination to less than 25% (from medium to low cluster)
4. Increase domestic financing of the HIV response by allocating 5% of health budget to HIV program

Let us all join hands as we strengthen our response while seeking innovative ways to sustain the HIV response in our county.

MR JOSEPH MBAI

CHIEF OFFICER – HEALTH & SANITATION

MURANG'A COUNTY

Acknowledgement

I take this opportunity to thank the County Government of Murang'a ably headed by His Excellency the Governor Mwangi wa Iria for his wise leadership and great support in the health sector. I also want to thank the County Executive Committee Member for Health Dr. Susan Magada, and the Chief Officer Health, Mr. Joseph Mbai, and the National Government through the County Commissioner's office for their role in the development of the Murang'a County AIDS Strategic Plan. Further, I appreciate the technical and financial support from the National AIDS Control Council (NACC) in development, reviewing and printing of the document.

I thank the County Health Management Team (CHMT), various government agencies, public sector institutions, private sector players, civil society organisations, various technical working groups (TWGs), faith-based organizations and communities, and representatives from Key Populations, People Living with HIV (PLHIV), and Persons with Disabilities (PwD) for their contributions during the development of this HIV Strategic Plan. It is from these engagements that we have put forth a vision, setting us on a trajectory that will assure our achievement of both County and National HIV goals.

I also wish to acknowledge with deep gratitude the contribution of various partners during the development of this plan. Specifically, we thank, MEASURE Evaluation Pima, APHIA + KAMILI, NEPHAK, CHS, AHF Kenya, KMMP, PSK and CDM.

DR. WINNIE KANYI

COUNTY DIRECTOR FOR HEALTH

Executive Summary

THE KENYA AIDS STRATEGIC FRAMEWORK (KASF) 2014/15-2018/19, is the strategic guide for the country's response to HIV epidemic at the national level and it's from it that the Murang'a County AIDs Strategic Plan (MCASP) is derived. This plan addresses the drivers of the HIV epidemic and builds on achievements of the previous country strategic plans to achieve its goal of contributing to both the country's and county's vision towards universal access to comprehensive HIV prevention, treatment and care. MCASP is aligned with the Constitution of Kenya 2010, which guarantees the policy environment for the national HIV and AIDS response, while also presenting a major paradigm shift in the governance and response which is county led and specific.

Murang'a County AIDs Strategic Plan (MCASP) provides strategic policy, planning and implementation guidance and leadership for a coordinated multi-sectoral response to HIV and AIDS in the County. It succeeds KNASP III that came to an end in June 2014 which was a national plan towards HIV and AIDS response. It builds on past KNASP successes, partnerships, leadership and legislations.

This Strategic Plan is premised on Kenya's Vision 2030 description of HIV and AIDS as "one of the greatest threats to socio-economic development in Kenya". It marks a change in the approach of managing the County response from doing "business as usual" to evidence and results-based multi-sectoral and decentralized planning that cascades from county, sub-county, to the ward, village and households. MCASP has also mainstreamed gender and human rights in all aspects of HIV response.

The plan is aligned to the "Three Ones" principles that guide the country's authorities and their partners and investment case approach with emphasis on geographical, population and intervention prioritization, feasibility and sustainability for impact. Moreover, MCASP is aligned with international, regional and national obligations, commitments and targets related to HIV and AIDS. The CASP is driven by Kenya's long-term vision for HIV control by 2030 in line with Kenya's economic and development vision of creating a globally competitive and prosperous nation with a high quality of life by 2030.

CHAPTER 1

Background Information on the County

Murang'a County is one of the 47 counties created through the devolved system of government stipulated in the new constitution that was promulgated in 2010. Historically, Murang'a County is believed to be the cradle of the Kikuyu community, members of whom comprise the majority of the county population.

1.1 Geographical location

Murang'a County is one of the five counties in the central region which covers an area of 2558.8 sq km. It lies 85 km North of Nairobi and is bordered to the North by Nyeri County, to the South by Kiambu County, to the West by Nyandarua County and to the East by Kirinyaga, Embu and Machakos counties. Murang'a County comprises of seven sub-counties namely: Kiharu, Maragua, Kigumo, Kangema, Kandara, Gatanga and Mathioya.

1.2 Demographics

Murang'a County had an estimated population of 936,228 persons in 2009 comprising of 451,751 males and 484,477 females (KNBS, 2009). The county has an annual population growth rate of 0.4% per annum with the county population estimated at 1,037,515 in 2015. The size of the population is forecasted to reach 1,054, 249 in 2016 and 1,071,252 in 2017. The male-female sex ratio in the county is estimated at 48:52. The higher female population in relation to male is attributed to high male emigration to other counties and towns in search of employment and business opportunities. Life expectancy stands at 63.4 years overall, with female being at 67.2 years and male at 59.5 years against the national overall life expectancy of 56.6 years (Murang'a CIDP, 2014). According to the Murang'a County Integrated Development Plan (CIDP 2013-2018) the county literacy stands at 70.1% with 73.9% male and 66.7% female. County net primary school enrollment rate stands at 93.85 percent. While the secondary school enrollment currently stands at 67.2 % for both boys and girls.

Table 1.1: Population Projections for Murang'a Sub-Counties for 2014-2019

	Population Projections						
	Sub-Counties	2014	2015	2016	2017	2018	2019
1	**Kangema**	83,400	84,745	86,112	87,501	88,912	90,347
2	**Mathioya**	95,521	97,062	98,628	100,218	88,912	103,479
3	**Kiharu**	196,164	199,327	202,542	205,808	209,128	212,504
4	**Kigumo**	134,074	136,237	138,432	140,667	142,936	145,243
5	**Kandara**	169,711	172,448	175,229	178,056	180,927	183,848
6	**Murang'a South**	164,954	167,615	170,318	173,065	175,857	178,696
7	**Gatanga**	177,223	180,081	182,986	185,937	188,936	191,986
	Total	1,021,047	1,037,515	1,054,247	1,071,252	1,088,531	1,106,104

Source: *2009 Census projections*

Table 1.2: Population Description for Murang'a County for 2014-2019

	Description	**Share of Total Population %**	**TARGET POPULATIONS**					
			2014	**2015**	**2016**	**2017**	**2018**	**2019**
1	Total population		1,021,047	1037515	1054249	1071252	1088531	1106104
2	Total Number of Households		204,209	207,503	210,850	214,250	217,706	221,221
3	Children under 1 year (12 months)	2.21	22,560	22,924	23,294	23,669	24,051	24,439
4	Children under 5 years (60 months)	11.27	115,058	116,913	118,799	120,715	122,662	124,642
5	Under 15 year population	35.64	369,848	375,813	381,875	36,3978	388,034	394,298
6	Women of child bearing age (15 – 49 Years)	24.5	254,044	258,141	262,305	250,012	266,536	270,836
7	Estimated Number of Pregnant Women	2.21	22,924	23,294	23,669	22,560	24,051	24,438
8	Estimated Number of Deliveries	2.21	22,924	23,294	23,669	22,560	24,051	24,438
9	Estimated Live Births	2.21	22,924	23,294	23,669	22,560	24,051	24,438
10	Total number of Adolescent (15-24)	17.79	184,539	187,515	190,539	181,610	193,613	19,6738
11	Adults (25-59)	35.72	370,621	376,599	382,673	364,738	338,845	395,122
12	Elderly (60+)	10.80	112,092	113,900	115,737	110,313	117,604	119,502

Source: *2009 Census projections*

1.3 Economic activities

Murang'a County is endowed with favourable weather and rich soils that are conducive for farming. Consequently, Murang'a is one of the leading counties in terms of agricultural production especially tea, horticulture, avocados, coffee products and dairy products. However, the southern region of the County is a relatively dry rangeland with minimal rainfall and therefore farming is practiced mainly under irrigation. Subsistence farming is also common with maize, beans, bananas, tubers and vegetables being grown under small holder farms. The county is also home to few industries, most of them doing only semi processing of raw materials from the farming and animal industries. The county also has a number of multinational industries most notably Kakuzi and Del-Monte. The hospitality industry is also thriving in the county and employs a significant proportion of young people.

1.4 Health facilities in the county

The County has a total of 196 health facilities. While 134 of these health facilities are owned by GoK, 62 are FBOs and private health facilities distributed throughout the sub-counties. The major hospitals include Murang'a County referral hospital and six level four facilities namely: Maragua, Muriranjas, Kangema, Kirwara, Kigumo and Kandara sub-county hospitals. There are also three level four FBOs hospitals namely: Gaichanjiru, Githumu and Kiria-ini.

County Health Facility Distribution by Type

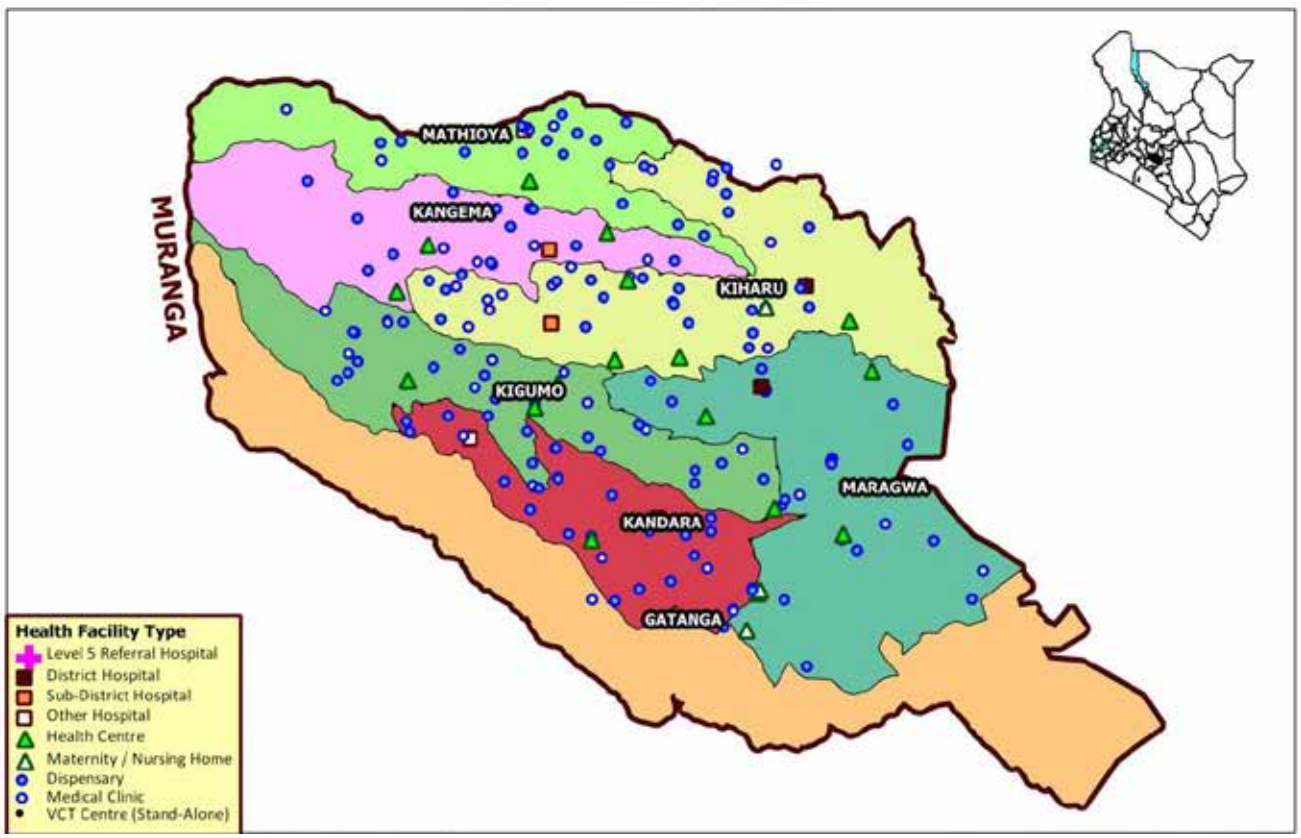


Figure 1: Health Facilities in Murang'a County

CHAPTER 2

Situational Analysis

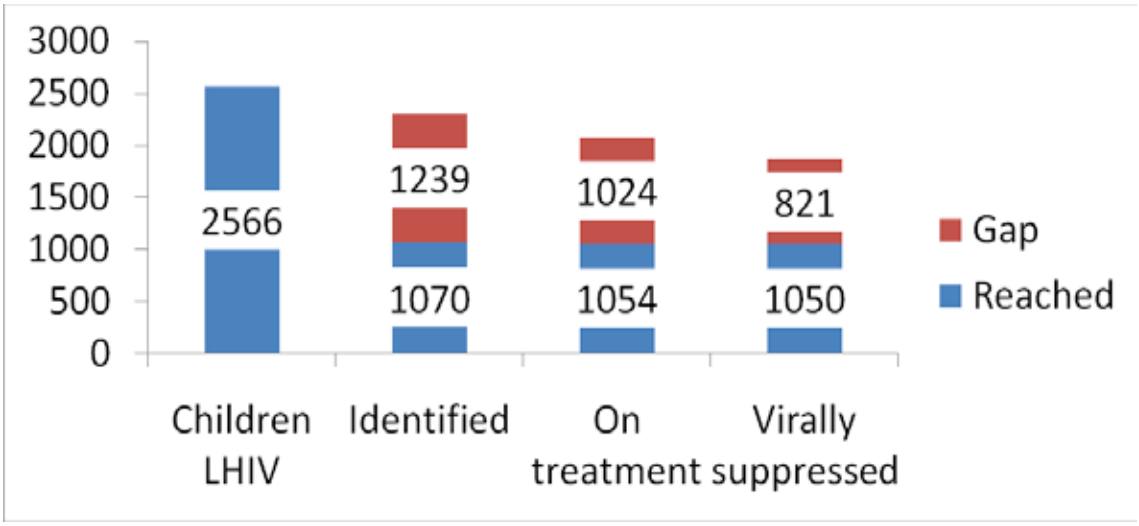
HIV and AIDS epidemic poses a serious threat to social-economic development of Murang'a County. The prevalence rate for the county is 5.2 % against the national prevalence rate of 5.6% (KAIS, 2012). According to the **Kenya HIV Prevention Revolution Roadmap,** all counties are classified into three clusters: high, medium and low according to their HIV incidence. Murang'a County is categorized as one of the 28 medium HIV prevalence counties. In 2013, the county recorded 1,984 new infections among the adults and 65 among the children. The new HIV infections increased to 2,020 for adults and 67 for children below the age of 14 years.

Around 31,581 individuals in the county were estimated to be living with HIV in 2013. Out of this figure, 28,700 were adults while 2,881 were children. From the 31,581 PLHIV, only 7,177 adults and 656 children were receiving ART. In 2014, 8,788 adults and 1,027 children were reported to be receiving ART which constituted a coverage of 45% for adults and 32% for children. By September 2015, 32,781 people in the county were estimated to be living with HIV, with 10,256 adults and 1,054 children being on ART.

Around 851 pregnant women lived with HIV in the county in 2013 and this figure rose to 1,015 in 2014. However, the county only managed to identify 562 positive pregnant women in 2014. 36% of these pregnant women delivered in health facilities; an improvement from the previous 22% in 2013. In 2014, the mother to child transmission rate stood at 5.9% against the national rate of 14%. The county however, strives to be below 5% as per the 2011 Global Plan.

It is also estimated that there were 979 HIV related deaths in the county according to HIV estimates for 2013. As a result, the county has prioritized identification of persons living with HIV and has targeted to test 90% of the total population. The county also expects to enroll 4,500 new HIV infected persons each year of the strategic plan, retain 90% of them on care and ensure that 90 % achieve viral suppression.

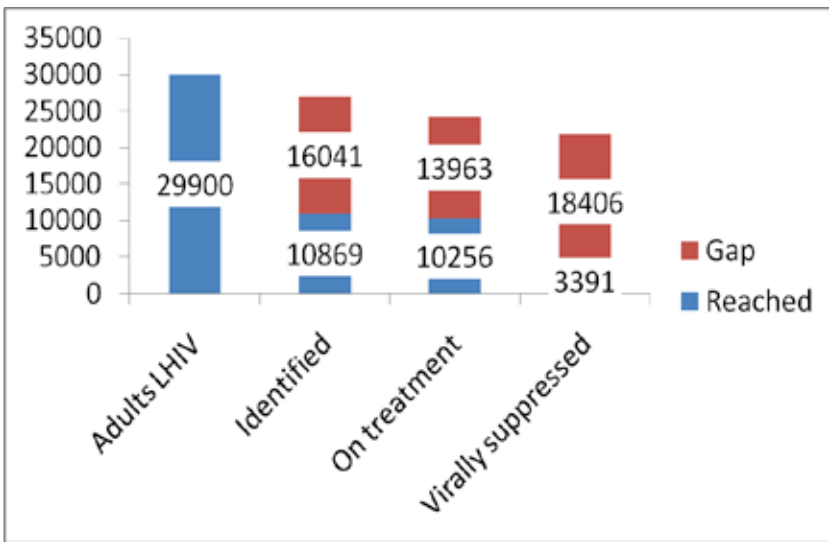
Figure 2.1: Paediatric HIV treatment cascade



Source: *NASCOP ACT Dashboard September 2015*

It is also estimated that 2,881 children live with HIV in Murang'a County. The county targets to identify 90% of them (2,593), enroll 90% (2,334) into care and ensure the 90% (2101) of the children attain viral suppression. However, out of the 2,593 to be identified only 1,086 (41.8%) have been identified leaving a gap of 1,507 (58.2%). Notably, there has been accelerated testing for children after the introduction of Accelerated Care and Treatment (ACT) in July 2015 from 14,065 in July 2014-June 2015 to 12,042 in one quarter (July- September 2015). This has further resulted to increased linkage and enrollment of children in the county. Despite this improvement, the county is still experiencing challenges hindering the achievements of targets such as low identification, delivery under unskilled attendants, low uptake of ANC services, stigma, and limited commodities amongst others.

Figure 2.2: Adult HIV treatment cascade



Source: *NASCOP ACT Dashboard September 2015*

It is estimated that 29,900 adults were living with HIV in 2015, but only 36.4% of them had been identified. This is mostly attributed to stigma, limited commodities, identification of PLHIV, mapping of key populations amongst others which forms the key priorities in this plan.

Major Drivers of New HIV Infections in the County

The drivers of HIV are those conditions that increase the risk of transmission of the virus to a large number of people and would continue to do so if no appropriate measures are taken. The identified HIV epidemic drivers in the county include the following:

(i) Alcoholism

According to the CIDP, majority of new HIV infections in the county are transmitted through unprotected sex and drug abuse particularly after consumption of illicit brews which is rampant in the county. Heavy drinking of alcohol is associated with increased HIV acquisition and transmission due to irresponsible sexual behaviour. Alcoholism reduces an individual's judgment and increases probability for risky behaviour such as engaging in unprotected sex, casual sex, having multiple sexual partners and sexual violence.

(ii) Poverty

Poverty is viewed as a major cause and consequence of HIV and AIDS. Poverty influences individuals to engage in transactional sex including cross-generational sex without the benefit of appropriate risk reduction ability. Poverty increases vulnerability of people living with HIV, hence there is need to redirect resources towards support services to poor households. The situation is further aggravated by the fact that HIV and AIDS mostly affects people of the productive age leaving minors and the elderly people to take care of households. Only 35% of poor households with orphans are beneficiaries of a cash transfer program. Cash transfer programs have shown they can reduce risks by reducing sexual debut, early pregnancy and early marriages among beneficiaries aged between 15 and 25 years.

(iii) Early sexual debut

According to the Kenya HIV county profiles, approximately 55% of young people in the county had their first experience of sexual intercourse before the age of 15, an indication of early sexual debut. With legal marriage age being 18 years, there are several years of pre-marital sex, often with multiple partners.

(iv) Migrant labour

A significant number of workers in the coffee, tea and flower farms as well as some workers in the formal sectors are from counties with high HIV burden and therefore are a major concern for fueling the HIV epidemic to the general population of the county. The long period of separation between migrant workers and their spouses in many cases leads to sexual relationships which are transactional and commercial in nature.

(v) Low condom use

Low condom use among the sexually active group in the county poses a significant risk of HIV infection. Only 56.3% of sexually active population is aware of condom use as a protection strategy against HIV infection.

(v) Key population

Certain KPs form a major driver of the epidemic. KPs here mainly comprise female sexual workers, men having sex with men and people who inject drugs. These groups of people engage in behaviour that is considered illegal, which leads to their disengagement from social programs and services. This means that they remain hidden and extremely hard to reach. This adds to the complexity of the prevention response (NASCOP, 2013). According to NASCOP (2013) it was estimated that there were 442 sex workers, 184 MSM and 123 IDUs in the county.

(vi) Multiple sexual partners

Multiple sexual partners especially among the married couples is exceptionally high in the county. The modern culture has started tolerating multiple sexual partnerships commonly dubbed '*mpango wa kando*'. This risky behaviour is exacerbated by labour migration which normally separates couples.

The SWOT analysis

In drafting of the MCASP, a **SWOT** (Strengths, Weaknesses, Opportunities and Threats) analysis was conducted. Table 2.1 below outlines the results of the analysis.

Strengths	Weaknesses	Opportunities	Threats
• Availability of skilled personnel	• Personnel not adequately trained on HIV issues • Lack of capacity to conduct comprehensive HIV services. • Knowledge gaps amongst HCWs (capacity building)	• Utilization of ICT • Presence of partners support for trainings	• High turnover of personnel
• Increased awareness on HIV prevention measures • Presence of implementing partners supporting HIV and AIDS activities	• Weak legislation on stigma and discrimination • Low disclosure rates • Low/poor health seeking behaviour in men • Limited financial resources for HIV programming • Parallel HIV reporting systems	• Existence of networks of PLWA • Supportive political environment • Established public private partnerships	• Limited behavior change and approaches towards HIV prevention, care and treatment. • Alcohol and substance abuse among the general population and among PLHIV • Presence of migrant populations • Inadequate stakeholder coordination mechanisms
• Consistent supply of ARVs from KEMSA	• Inadequate care and treatment centers	• Use of mobile HTS/ PMCTC services	• Erratic/inadequate supply of commodities
	• Inadequate data on OVCs in the county		• Religious and social cultural practices towards HIV and AIDS
• Presence of strong NACC structures in the county; CACCs	• Few Sub County - AIDs Control Units (ACUs implementing HIV and AIDS workplace policy	• Cash transfer support program for OVCs • HIV and AIDS mainstreaming in all sectors	• Frequent staff transfers
• Presence of functional psychosocial support groups at facility levels	• Lack of sustainability mechanism • Co-morbidities among PLHIV including NCDs leading to high mortality rates	• Community unit	• Low identification of PLHIV in the community
• Established community strategy system	• Inadequate community mobilization activities towards HIV response	• Using of innovation and best practice in HIV programming	• Lack of motivation of community health volunteers
• Presence of networks for PLHIV	• Lack of support for key population programs	• Establishment of Drop-in Centers	• Poverty leading to rise in high risk behaviour e.g. prostitution • Presence of prison communities and other confined persons • Lack of a robust GBV program
• Presence and use of reporting tools	• Data quality challenges • Limited data demand and use at the lower level	• Presence of implementing partners	• Parallel partner reporting
• Accessibility to health services	• Lack of water tight mechanism of linkage/referral of HIV positive clients • Low uptake of ANC services and number of deliveries conducted by skilled birth attendant	• Existence of good physical infrastructure	• Stigma

CHAPTER 3

Rationale, Strategic Plan Development Process and the Guiding Principles

3.1 Rationale

The policy environment of the HIV response is defined by the Constitution of Kenya (2010) which establishes the right "to the highest attainable standard of health" and the resulting devolution of the responsibilities for the implementation of most health services including the HIV response to the County level. Kenya Vision 2030 underscores the importance of health as a key building block in transforming Kenya into a successful middle income country by 2030. The HIV policy of 1999 defined HIV as a disaster and provides a framework for a multi-sectoral response. It was given a boost by the Kenya Health Policy (2014-2030) which prioritizes elimination of communicable diseases.

Since 2000 the country has been developing strategic plans for the HIV response which laid out specific results and strategies for delivering HIV services countrywide. The 2015-2019 Kenya AIDS Strategic Framework (KASF) was developed to guide the delivery of HIV response in the country and is customized to respond to county specific needs. This strategic plan is therefore an extract of the KASF customized to suit the needs of Murang'a County. The County will use the plan to respond to the epidemic through resource mobilization, allocation and accountability

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3.2 Development process

After the launch of the KASF on 1st December, 2014 the National AIDS Control Council supported a two days stakeholders meeting held in Thika whose agenda was dissemination of the KASF. Participants included the County Health Management Team (CHMT), the Sub-County Health Management Team and CACCs, the Murang'a County Assembly Health and Finance Committee chairpersons, HIV implementing partners, public sector institutions, private sector players, civil society organisations, various technical working groups (TWGs), representatives from faith-based organizations, community, key populations, people living with HIV (PLHIV), and persons with disabilities (PwD). After the dissemination, a team of 10 people were identified and tasked to develop the Murang'a County AIDS Strategic Plan that will guide the coordination and implementation of the HIV and AIDS epidemic and response in the next 5 years. The Chief Officer of Health (COH) appointed and tasked the team to prepare the plan and set 1st of December 2015 as the official date to launch the plan.

Under the leadership of the County Director of Health (CDH) the team held a three days workshop to draft the plan which was later sent for peer review by a technical

review team and NACC secretariat for input. The document was sent back to the team for finalization before publishing and launch.

The following policy documents were referred to while developing MCASP. The county HIV Estimates (2014), Kenya HIV County Profiles (2014), Kenya Aids Strategic Framework (2014), The First Lady Strategic Plan (2013-2017, The Global Plan (2003), the National Plan for Accelerating HIV Care and Treatment (2015-2017), the CS Health Performance Contract (2014/2015, Murang'a County Governor's Manifesto (2013) , County Integrated Development Plan (2014), County Health Strategic and Investment Plan (2015) and the CEC Health and Sanitation Performance Contract (2014) from where deliverable indicators are drawn from.

3.3 MCASP Guiding Principles

(i) **Results-based planning and delivery of the MCASP**: HIV programming shall be linked to the KASF and demonstrate contribution towards results.

(ii) **Evidence-based, high impact and scalable interventions**: Preference for resources and implementation shall be assigned to high-value, high-impact and scalable initiatives that are informed by evidence.

(iii) **Multi-sectoral accountability**: The MCASP shall provide guidance for interventions and results for which multiple sectors are responsible and accountability mechanisms will be established through developing memorandums of understanding (MOU) with both NACC/ County leadership and implementing partners. This will serve to increase resources and accelerate results.

(iv) **National HIV testing guidelines**: The policy document provides a framework for all HTS programmes in Kenya and was developed in the context of existing Kenyan laws and policies.

(v) **County specific plans**: The MCASP will guide the HIV response in the County.

(vi) **County ownership and partnership**: All HIV stakeholders including the government, development partners, private sector, faith-based organizations and communities of people living with HIV, and the Kenyan communities shall align their efforts towards the results envisioned.

(vii) **Rights-based and gender transformative approaches**: The success of the HIV response is dependent on protecting and promoting the rights of those who are socially excluded, marginalized and vulnerable. This MCASP is cognizant of this reality and will be rooted in a rights-based approach.

(viii) **Efficiency, effectiveness and innovation**: Kenya is now a low middle income country and thus donor resources may decline, further exacerbating the HIV funding situation. The MCASP will take active steps to explore and operationalise sustainable domestic funding options through improved efficiency in service delivery and innovative approaches aimed at achieving more at reduced cost without compromising on quality.

CHAPTER 4

Vision

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

Goal

A Universal access to comprehensive HIV prevention, care and treatment for all

Mission

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

Objectives

1. Reduce new HIV infections by (50%)
2. Reduce AIDS related morbidity and mortality by 25%
3. Reduce HIV related stigma and discrimination by 25%
4. Increase domestic financing of the HIV response to 5%

STRATEGIC DIRECTIONS

SD1

Reducing New HIV Infections

4.5 Strategic Directions

Strategic Direction 1:

Reducing New HIV Infections

Murang'a County has a prevalence rate of 5.2% with 2020 new infections in 2014. In the year 2015, Murang'a had an estimated population of 32,781 PLHIV with 29,900 adults and 2,881 children. Among these only 10,869 adults (that is 36.4% of the adults) had been identified and only 1,086 (that is 41.8% of the children) had been identified. This translates to a large gap of 63.6% among adults and 58.2% among children who had not been identified. The County reported 1,984 new adult infections and 65 new infections among children in 2014 (County profiles, 2014).

This Strategic direction is geared towards:

- Reduced annual new HIV infections among adults by 50 % by 2019. This translates to about 1010 new infections.
- Reduced HIV transmission rates from mother to child from 5.9% in 2014 to less than 5% as per the Global Plan.

The gaps in identification can be attributed to;

- low identification of PLHIV
- delivery under unskilled attendants
- low uptake of ANC services
- stigma and discrimination
- limited commodities/ erratic supplies
- lack of mapping of key populations

Priority intervention areas

KASF classifies all counties into three clusters based on their HIV incidence levels; high, medium and low incidence counties. According to KASF, 9 counties form the high incidence counties and they contribute 65% of all new HIV infections in the country. Twenty eight counties comprise the medium incidence counties and they contribute 34% of all new infections in the country. Murang'a County, with a HIV prevalence rate of 5.2%, falls under the medium incidence counties. KASF estimates that the county had 1,984 new HIV infections among adults in 2013.

Priority populations

KASF defines priority populations as individuals who disproportionately contribute a high number of new HIV infections in the country. The priority populations comprise both key and vulnerable populations. The key population is a group who because of their high risk behaviour, are at increased risk of HIV, irrespective of the epidemic type or local context. This group comprises sex workers (SW), men who have sex with other men (MSM), and people who inject drugs. This group contributes about 30% of all new HIV infections annually. The vulnerable population is the group whose social contexts increase their vulnerability to HIV risk. This group comprises women and girls aged 15-24 years who account for 21% of new sexual infections, prisoners and detainees, truck drivers, migrant population including migrant workers, people with disabilities and PLHIV (KASF, 2015).

Gaps

(i) Concurrent sexual partnership especially among married people and early sexual debut. Around 55% of individuals engage in sex before the age of 15 years (Kenya HIV County Profiles, 2014).

(ii) Low uptake of HIV Testing and Counseling among sexual partners and children. The Kenya HIV County Profiles (2014) estimated that close to 73% of the people of Murang'a County had not been tested for HIV by 2009.

(iii) Relatively high HIV infections among women of reproductive age and pregnant mothers. The HIV prevalence rate among women in Murang'a County is 7.7% compared to 2.8% for males (Kenya HIV County Profiles, 2014).

STRATEGIC DIRECTION 1: REDUCING NEW HIV INFECTIONS								
KASF objective	**CASP Results**	**Key Activity**	**Sub-Activity/ Intervention**			**Target Population**	**Geographic areas by County/ sub- county**	**Responsibility**
			Biomedical Interventions	**Behavioural Interventions**	**Structural Interventions**			
Reduce new HIV infections by 75%	Reduce new HIV infection from 2087 to 1040 by the year 2019	Promote HIV testing HIV and AIDS advocacy Behaviour change commu-nication Address alcoholism Empower young women and adolescents discrimination Increase retention to care Increase viral suppression among PLHIV	Scale up HIV testing services as per the HTS guidelines (2015) and National Plan for Accelerating HIV care and Treatment 2015-2017 Conduct door to door testing, mobile testing, increase PITC and couple testing. Targeted HTS during activities planned by different departments/ sectors in the county. ART for all HIV positive pregnant women for PMCT. Increase / promote early infant diagnosis ARVs for all HIV positive children. Establish HIV and Sexual and reproductive health education clubs.	Prevention campaigns such as condom use stay negative campaigns partner disclosure Life skills education in school Behaviour Change and Communi-cation campaign Alcohol reduction campaigns Gender Based Violence prevention programs. Peer training among the youth	Life skills education among young women and adolescents Programs to retain children in school-boys/ girls. Legislate alcoholic bill Reduce stigma and misplaced discrimination by laws GBV prevention and response programmes Stigma reduction campaigns Psycho-social support mechanisms Increased surveillance Economic empowerment. Strengthen cash transfer programme to enroll more poor households with orphans and keep girls in school County performance contracts to focus on HIV	Men and adolescents, Children, HIV exposed children (HEI), Youth, Key populations, Pregnant and breast feeding women Schools and higher institutions of learning	All sub counties, Urban centers, schools, colleges, youth centers, Health facilities	Local administration Teachers, FBOs tea factories Flower farm CACCs community leaders MOH Implementing Partners County assembly, National Government departments and devolved departments in the county, formal and informal sectors

KASF objective	CASP Results	Key Activity	Sub-Activity/ Intervention			Target Population	Geographic areas by County/ sub- county	Responsibility
			Biomedical Interventions	Behavioural Interventions	Structural Interventions			
Reduce new HIV infections by 75%	Reduce new HIV infection from 2087 to 1040 by the year 2019	Promote HIV testing HIV and AIDS advocacy Behaviour change commu-nication Address alcoholism Empower young women and adolescents discrimination Increase retention to care Increase viral suppression among PLHIV	Promote correct and consistent use of male and female condoms STI screening and treatment Offer (PEP) Post Exposure Prophylaxis Provision of HAART negative partner in a discordant relationship Offer Post rape care Establish DICES with comprehensive services for key population. departments in the County	Encourage male involvement Stigma reduction through advocacy and health promotion	To revamp ACUs at various sectors Strengthen community strategy Male involvement programmes	Men and adolescents, Children, HIV exposed children (HEI), Youth, Key populations, Pregnant and breast feeding women Schools and higher institutions of learning	All sub counties, Urban centers, schools, colleges, youth centers, Health	Local administration, Teachers, FBOs, tea factories Flower farm CACCs community leaders, MOH, implementing Partners, county assembly, National Government departments and devolved departments in the county, formal and informal sectors

SD2

Improving Health Outcomes and Wellness of PLHIV

Strategic Direction 2:

Improving Health Outcomes and Wellness of PLHIV

This SD focuses on the cascade of care. It is geared towards ensuring the identified clients are linked to care, initiated on treatment, retained on treatment and achieve maximum viral suppression in order to reduce HIV associated morbidity and mortality amongst PLHIV.

KASF (2014) aims to enroll 80% of infected adults on ART by 2017 and 90% by 2019. To achieve this, it is prioritized timely identification, linkage and retention in care for HIV infected persons. It plans to scale up the detection rate of HIV cases by having a targeted HIV testing and counseling program. This will also be done by linking identified HIV infected persons to HIV treatment and retention in care and treatment. KASF also aims to increase coverage to care and treatment and reduce the loss in the cascade of care.

The main results will be:

1. Scale up linkage to care within 3 months of HIV diagnosis to 90% for all age groups.
2. Scale up ART coverage to 90% of all identified HIV positive clients.
3. Ensure there is 90% retention for 12 months for all age groups.
4. Increase viral suppression to 90% in children, adolescents and adults on ART.
5. To achieve this it will be important to identify the points of loss within the cascade of care.

Table 4.1: Annual HIV treatment in Murang'a County

County adults HIV treatment access annually	
Adults in need of ART	16,074
Adults receiving ART	7,177
County ART adult coverage	45%
National ART adult coverage	79%
Number of Adults who died of AIDS related conditions in 2013	817

Source: County profile, 2014

Table 4.2: County children HIV treatment access annually

County children HIV treatment access annually	
Children in need of ART	2,058
Children receiving ART	656
County ART children coverage	32%
National ART children coverage	42%
Number of Children who died of AIDS related conditions in 2013	122

Source: County profile, 2014

Gaps

(i) Lack and late identification of PLHIV

(ii) Poor linkage and referral systems for PLHIV.

(iii) Stigma and discrimination for PLHIV which is estimated at 40% for the county according to the Kenya Stigma Index Survey (2013) is a barrier to uptake of care and treatment services.

(iv) Low retention of PLHIV in healthcare

STRATEGIC DIRECTION 2: Improving health outcomes and wellness of people living with HIV

STRATEGIC DIRECTION 2: IMPROVING HEALTH OUTCOMES AND WELLNESS OF PEOPLE LIVING WITH HIV						
KASF objective	**CASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographic areas by County/sub-county**	**Responsibility**
Reduce AIDS related mortality by 25%	Increase ART coverage to 90% for children adolescents and adults	Effective identification, referral and linkage Increase coverage and access to care and treatment Address stigma and discrimination Increase retention to care Increase viral suppression among PLHIV	Anti-stigma campaigns Create a safe environment for health seeking behaviours Promote HTS and ART adherence Creation of a county referral directory Enrollment and initiation of ART within three months of HIV diagnosis. Strengthen psychosocial support groups in all care and treatment centers Treatment literacy for all PLHIV Nutritional counseling and support Early diagnosis and management of opportunistic infections and Non Communicable diseases(NCDs) Strengthen community health workers role in referral, linkage, defaulter tracing and home based care Capacity building on sample collection, handling ,storage and transportation and address the (Turnaround time) TAT	PLHIV, pregnant HIV+ women General population	All sub-counties All care and treatment sites	MoH Implementing partners Religious leaders PLHIV advocates Private sector FBOs CACCs Local celebrities or local HIV champions to help change attitudes

SD3

Using a Human Rights Approach to Facilitate Access to Services for PLHIV, Key Populations and Other Groups in all Sectors

Strategic Direction 3:

Using a Human Rights Approach to Facilitate Access to Services for PLHIV, Key Populations and Other Groups in all Sectors

Background Information

This strategic direction aims at creating an enabling and free for all environment in the County to ensure access to services by PLHIV especially the priority populations. Constitution of Kenya (2010) Article 43 guarantees every citizen the right to the highest attainable standard of health. Article 27 of the constitution outlaws discrimination on the basis of one's health status and also provides for equality between men and women. An enabling legal and policy environment is necessary for a robust HIV response at the county level to ensure access to services by persons living with HIV. Stigma and discrimination remain some of the biggest impediments to HIV services provision in Kenya.

Stigma and discrimination levels against PLHIV in Murang'a County are moderately high and are estimated to be at 40% (Kenya Stigma Index Report, 2013). Stigma and discrimination of PLHIV may directly impact on access to HIV care and treatment. According to Kenya Stigma Index Report (2013), an estimated 15% of PLHIV reported discrimination by a health professional through disclosure of their sero-status without their consent. The report also shows that female PLHIV face more discrimination compared to infected males.

Gaps

(i) High levels of self-reported stigma and discrimination for PLHIV in the county.

(ii) Barriers to access of HIV, SRH and rights information and services in public and private entities.

(iii) Lack of a county legal and policy framework for protection and promotion of the rights, reducing and monitoring stigma and discrimination.

(v) Social exclusion and gender-based violence and impeded access to legal and social justice and protection from stigma and discrimination in the public and private sector.

STRATEGIC DIRECTION 3:

Strategic Direction 3: Using a Human rights approach to facilitate access to services for PLHIV, key populations and other priority groups in all sectors						
KASF objective	**CASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographical Areas by county/Sub-County**	**Responsibility**
Reduce HIV related stigma and discrimination by 50%	Reduce self-reported stigma and GBV for PLHIV, key populations, men, women, boys and girls by 25%	Empower service providers, recipients and the general population on human rights	Conduct anti stigma campaigns Capacity building of health care providers, PLHIV and key populations Community sensitizations on violations of rights and stigma - know your rights campaigns Disseminate HIV & GBV policy documents Meaningful involvement of PLHIV. Establish drop–in centers for key populations in Murang'a town and Kenol. Enroll PLHIVs, OVCs, Key populations and other priority groups into the social protection programs and provide HIV services Support networks of people living with HIV and key population Engage religious men/ women in HIV, sexual and reproductive health programs and interventions Facilitate campaigns through the media to reduce stigma and discrimination, reduce gender violence and promote uptake of HIV services and prevention interventions Review existing laws and policies and develop county specific ones to ensure they impact in the response to HIV positively	Service providers, PLHIV, Key populations and vulnerable populations General population	All sub-counties Hot spots	MoH MCAs Religious leaders Groups of PLHIV KPs Vulnerable populations Implementing partners Education sector

SD4

Strengthening Integration of Health and Community Systems

Strategic Direction 4:

Strengthening Integration of Health and Community Systems

Background Information

KASF (2015) aims to build a strong and sustainable system for HIV service delivery at both national and county level through specific health and community systems approaches, actions and interventions to support the HIV response. Enhancing effective and efficient HIV prevention, care and treatment through integration of health system and community is key in the fight against HIV. KASF (2015) has identified two priority areas: (i) provision of a competent and adequately staffed workforce at the National and County levels to deliver HIV services integrated in the essential health package (ii) strengthen health service delivery at National and County levels for the provision of HIV services integrated with essential health package.

Gaps

(i) Inadequate number of technically competent and skilled personnel and skewed distribution of health workers

(ii) Inadequate health facilities and inability of most existing health facilities to offer comprehensive HIV services including treatment.

(iii) Low access to commodities and HIV technologies

(iv) Weak health service delivery system at the county for the delivery of HIV services integrated in the essential health package.

Strategic Direction 4: Strengthening Integration of Health and Community Systems

STRATEGIC DIRECTION 4: STRENGTHENING INTEGRATION OF HEALTH AND COMMUNITY SYSTEMS						
KASF objective	**CASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographical Areas by county/Sub-County**	**Responsibility**
Reduce new HIV infections by 75% Reduce AIDS related morbidity and mortality by 25% Reduce HIV related stigma and discrimination by 50% Increase domestic financing of the HIV response to 50%	Improve health workforce for HIV response by 40% Increase number of health facilities to provide KEPH-defined HIV and AIDS services from 30% to 60%	Strengthen community strategy Provide competent, motivated and adequately staffed workforce to deliver HIV services integrated in the essential health package Strengthen community-level competency	Recruit more staff Promote timely forecasting and quantification and periodic supply / procurement planning for HIV commodities Train and retain community health workers	Health workers, Community Units, Health facilities, CSOs	All sub-counties	Departments under National and county governments, MoH, Implementing partners

SD5

Strengthening Research, Innovation and Information Management to meet the CASP Goals

Strategic Direction 5:

Strengthening Research, Innovation and Information Management to meet the CASP Goals

Background information

HIV and AIDS interventions in the county have largely been informed by national surveillance studies such as KAIS KDHS. There are research gaps in understanding the drivers of the epidemic in the different populations at the county level and translation of the research findings into practice. Hence, there is need for more evidence-based programming that will be operationalized by establishing a research hub in the county. This will leverage on the skills of existing institutions of higher learning in the county as well as operational research. Establishing a research committee will help in evaluating effectiveness of different interventions and hence guiding the efforts of various stakeholders towards achieving a county free of HIV infections, stigma and AIDS- related deaths.

The research gaps in understanding drivers of the epidemic in the different populations at the county level and translation of the research findings into practice will be addressed by:

- Development of the County research agenda.
- Increasing funding for the HIV/ TB related research. Currently most research is determined by the donor agencies agenda.
- Stakeholder involvement in the development of the research agenda and joint programming to ensure developed programmes take into consideration the latest information.

Research Plan

The research plan will guide implementation of HIV and AIDS plan in the county. It is based on research priorities identified from drivers of the infection and the weaknesses as identified in SWOT analysis. The research plan is intended to lead to evidence-based planning and provide a mechanism for knowledge generation and information sharing.

The following are some of the research priorities identified;

1. Impact of alcohol on HIV prevention by different populations in Murang'a County
2. Determine effective models to increase uptake of HTC linkage of OVCs to Care & Treatment
3. Determine the impact of HIV workplace programmes in averting new infections among the immigrant populations in the tea factories.
4. Effectiveness of structural interventions on early sexual debut in preventing new HIV infections and re-infections.
5. Uptake of correct and consistent condom use among key populations (FSWs & MSMs)
6. Determine the impact of poverty-related factors hindering access to care and treatment
7. ARV drug resistance and suspected treatment failure in Murang'a County.

Strategic Direction 5: Strengthening Research and Innovation to Inform the CASP Goal

SD 5: Strengthening research and innovation to inform the CASP goal						
KASF objective	**CASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographical Areas by county/Sub-County**	**Responsibility**
Reduce new HIV infections by 75% Reduce AIDS related morbidity and mortality by 25% Reduce HIV related stigma and discrimination by 50% Increase domestic financing of the HIV response to 50%	Increase capacity to conduct HIV research at the County and sub-County level	Increase Capacity for research and research funding	Establish and operationalize a research committee	National & County governments, Partners, private sector, tertiary institutions	All sub-counties	County Government,
			Develop and implement the County research agenda			County government, NACC, Partners, Research Committee
			Foster multi agency collaboration			
			Ensure public participation in setting the research agenda			
			Partner with institutions of higher learning and research bodies			
			Capacity build health workers to carry out research			
			Establish a kitty to fund researches in the county			
	Implementation of research on increase identified MCASP related HIV priorities by 50%	Impleme-ntation of research	Conduct operational research on various thematic areas	County government, Tertiary institutions, research bodies, Partners		
	Increase evidence based planning, programming and policy changes	Application of research findings in decision making	Dissemination of HIV research findings	County government, Partners		

SD6

Promote Utilization of Strategic Information for Research and Monitoring and Evaluation to Enhance Programming

Strategic Direction 6:

Promote Utilization of Strategic Information for Research and Monitoring and Evaluation to Enhance Programming

Quality data is necessary for evidence-informed decisions at all levels hence the need for adequate M&E capacity to generate and use quality data in a timely manner. Monitoring of the HIV and AIDS epidemic in Murang'a County relies on various data systems at the facility level (DHIS) , community level (COPBAR) and at the public sector level (Public Sector System) supported by different stakeholders.

However, the M&E system has been faced with various challenges that hamper use of meaningful data for decision making. The County will form an M&E TWG that will be responsible for implementing the M&E plan at the County level. Similar M&E units at the sub-county level will be formed and assume the same responsibility at that level and ensure timely provision of feedback and accurate and relevant information to users.

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

SD 6: Promote utilization of strategic information for research and monitoring and evaluation to enhance programming						
KASF objective	**CASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographical Areas by county/Sub-County**	**Responsibility**
Reduce new HIV infections by 75% Reduce AIDS related morbidity and mortality by 25% Reduce HIV related stigma and discrimination by 50% Increase domestic financing of the HIV response to 50%	Increase availability of strategic information to inform the HIV response at county level	Establish and strengthen functional multi-sectoral HIV M&E coordination structures	Identify relevant stakeholders in the County	National and County government, Partners, NASCOP, NACC	All Sub Counties	County Government NACC
			Establish the TWG to plan and lead M&E activities in the County			
			Develop and implement an M&E plan for the HIV response in line with the MCASP			County government M&E TWG, NACC CDH
			Conduct sensitization to the County leadership on the M&E system			
			Develop implementation guidelines for the implementing partners			
		Strengthen M&E data management	Develop the SOPs and guidelines	Healthcare and community workers		
			Develop, harmonize and provide the relevant M&E tools			

KASF objective	CASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographical Areas by county/Sub-County	Responsibility
Reduce new HIV infections by 75% Reduce AIDS related morbidity and mortality by 25% Reduce HIV related stigma and discrimination by 50% Increase domestic financing of the HIV response to 50%	Increase availability of strategic information to inform the HIV response at county level	Strengthen M&E data management	Distribute and orient staff on the tools	County government, Tertiary institutions, research bodies, Partners	All Sub Counties	County government M&E TWG, NACC CDH
			Provide EMR systems to facilities	Healthcare workers		County government
			Train staff on the management and use of the EMR system			
			Provide information security systems			
		Carry out M&E capacity assessment and capacity development at all levels	Assess the capacity of relevant personnel and facilities	Healthcare and community workers		M&E TWG, Partners, CDH
			Carry out capacity programs on the gaps identified			
			Capacity build facilities as appropriate			
			Develop an audit tool and train on its use			
		HIV data audit and review.	Conduct periodic audits and supervisory visits			
			Hold periodic meetings with stakeholders for updates of the system and review of progress			
		Create a County information and research hub	Create a sub county/county HIV resource and information center accessible to the HIV stakeholders	Community, Stakeholders, County government		County government Community, Partners Private sector
			Sensitize stakeholders and community for usage of the information			

SD7

Increase Domestic Financing for Sustainable HIV Response

Strategic Direction 7:

Increase Domestic Financing for Sustainable HIV Response

Background information and Gaps

The cost of HIV and AIDS response in the country is swelling against a backdrop of declining global allocation of funds for HIV and AIDS. Thus, the gap between resource needs and available funding continue to expand raising concerns for overall sustainability of the national response. As a result, there is a likelihood of compromising the health results in the prevention of new infections, ART, eMTCT and treatment of TB/HIV co-infections through services interruptions.

Under the Kenya Constitution 2010, health is now a devolved function. Consequently the national government has released health funds to the counties. However, the lion share of the health expenditure has been devoted to infrastructure development, procurement of the vital medical supplies and on settling wages and salaries for the various personnel in the health sector in the county. Currently, the existing fund allocation and resource gap remains unknown. However, the County is working on tracking this information to inform its planning and resource mobilization.

Whilst Murang'a County acknowledges that donor funding is important for the various interventions outlined in the MCASP, it also recognizes that domestic and innovative financing is key to the sustainability of its HIV programmes. The County commits to put emphasis on three key intervention areas, namely: maximize efficiency of existing service delivery options, promote innovative and sustainable domestic HIV financing options and align resources/investment to strategic plan priorities.

To deliver on this strategy, the County together with its partners will have to re-strategize so as to achieve an increased funding allocation internally from government resources and externally from other innovative initiatives. Some of the proposed resource mobilization strategies will include but not limited to:

1. Advocate for MoH budgetary allocation for the HIV and AIDS unit at the central and county level through the governors summit.
2. Engage with private sector and industry stakeholders to develop co-financing strategies for some HIV activities through PPP, e.g. the manufacture and production of HIV consumables; advocacy initiatives, and HCWs capacity-building initiatives.
3. Sensitize county-level, sub-county, community and facility-level health managers to include HIV and AIDS budget line items during their regular planning and budgeting processes.
4. Strengthen coordination of partner- and donor-supported HIV initiatives to enhance resource maximization.

SD 7: INCREASE DOMESTIC FINANCING FOR HIV SUSTAINABLE HIV RESPONSE

KASF objective	CASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographical Areas by county/Sub-County	Responsibility
Reduce new HIV infections by 75% Reduce AIDS related morbidity and mortality by 25% Reduce HIV related stigma and discrimination by 50% Increase domestic financing of the HIV response to 50%	Increase domestic financing for HIV response by 5% of the county health budget	Maximize efficiency of existing service delivery	Identify and address inefficiency in the service delivery	National & County government, development partners, private sector, Community	All Sub Counties	County HIV Committee CDH Implementing partners
			Integration of HIV/TB services in the health facilities			
		Promote innovative and sustainable domestic HIV financing options	Explore Public Private Partnerships			County government Private sector Partners Community
			Develop proposals for fund raising to development partners			
			Increase membership of the community to NHIF			
			Spearhead an annual charity walk/run to raise funds for HIV programmes			
		Align resources/ investment to strategic framework priorities	Track government and donor allocations for the HIV response to the various government units/ departments	County government, County Assembly, Partners		CDH Partners NACC
			Develop and implement a partnership accountability framework that ensures alignment of resources to the MCASP priorities			
			Lobby for increased financing from the County government			
			Develop a policy document increasing domestic funding of HIV approved and implemented by County government.			

SD8

Promote Accountable Leadership for Delivery of MCASP Results by all Sectors and Actors

Strategic Direction 8:

Promote Accountable Leadership for Delivery of CASP Results by all Sectors and Actors

The Constitution of Kenya 2010 provides the environment for the national HIV and AIDS response. Articles 10(2) and 73 define the fundamentals of good governance and leadership while Article 21(3) assigns all public institutions responsibility to address the needs of vulnerable groups within the society. In this case, the vulnerable groups include those infected and affected by HIV and AIDS.

Similarly, the County Government Act, 2012 describe the roles of county governments in planning, prioritisation, implementation, monitoring, resource allocation and budgeting for programmes and interventions under the devolved governance. Health is a devolved function; thus, the county governments are obliged to guarantee residents access quality health care services. Delivery of quality HIV and AIDS related services; prevention, care, treatment and mitigation of related impact are provided for in the Murang'a County development plans.

Key interventions

1. Build and maintain high-level political commitment
2. Establish a functional HIV coordination mechanism
3. Entrench good governance and strengthen multi-sector and multi-partner accountability to delivery of MCASP results

Strategic Direction 8: Promote Accountable Leadership for Delivery of CASP Results by all Sectors and Actors

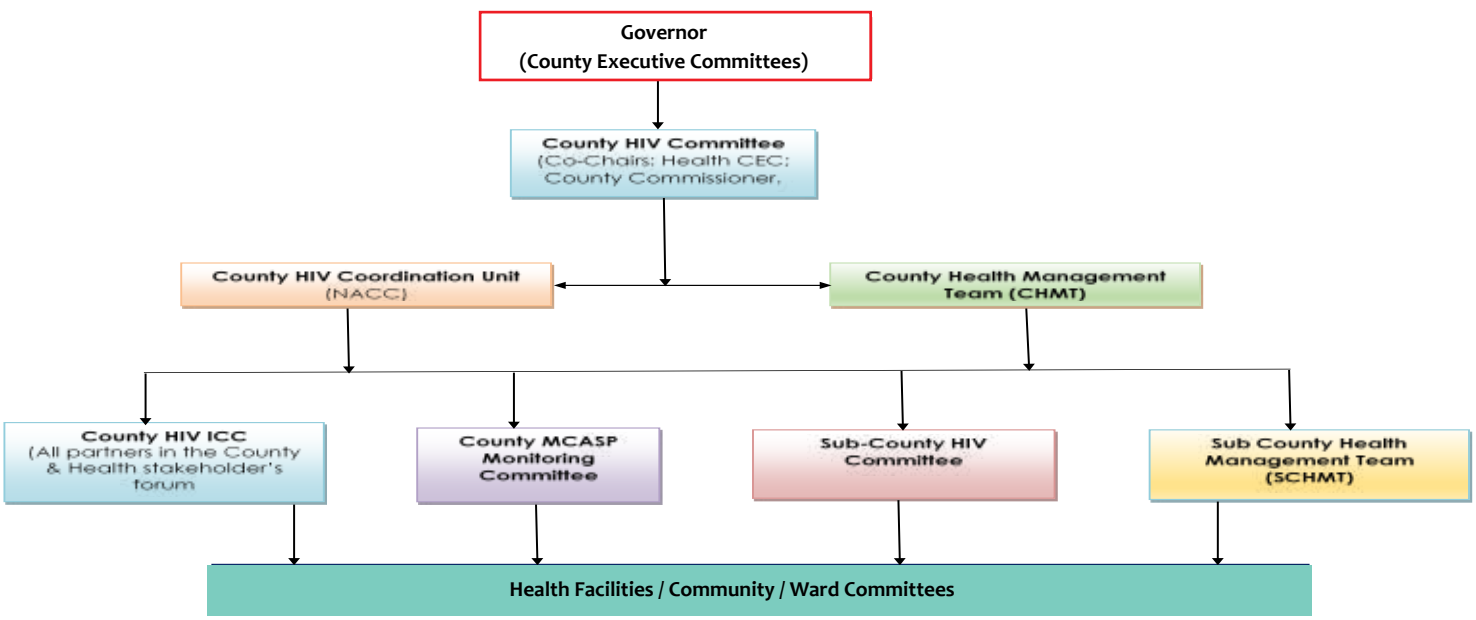
STRATEGIC DIRECTION 8: PROMOTE ACCOUNTABLE LEADERSHIP FOR DELIVERY OF CASP RESULTS BY ALL SECTORS AND ACTORS						
KASF objective	**CASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographical Areas by county/Sub-County**	**Responsibility**
Reduce new HIV infections by 75% Reduce AIDS related morbidity and mortality by 25% Reduce HIV related stigma and discrimination by 50% Increase domestic financing of the HIV response to 50%	Increase county ownership of HIV response	Build and maintain high-level political commitment	Engagement of the County executive and legislature for political goodwill, support and commitment for implementation of the MCASP	County Government, County Assembly	All Sub Counties	County Government County Assembly CDH Partners NACC
			Establishing high level political partnerships for resource mobilization			
			Develop enabling County policies and/or legislation for the HIV response			
			Mobilize resources for the HIV response			
		Establish a functional HIV coordination mechanism	Establish and operationalize relevant committees to plan, monitor and review the implementation of the MCASP	County government, Partners, Community		County government County HIV Committee Partners NACC
			Create awareness on the key HIV interventions outlined in the MCASP			
			Mobilize the community to participate in the HIV response			
			Capacity build networks to promote accountability			
			Mainstream HIV response in the various County departments			
		Entrench good governance and strengthen multi-sectoral and multi-partner accountability of the MCASP results	Develop and implement a partnership accountability framework			
			Develop and implement a performance management system to strengthen good governance			
			Hold periodic stakeholder meetings to plan, review and monitor the implementation of the MCASP			

CHAPTER 5

Coordination Structures

THE KASF recognizes that counties are responsible for implementation of HIV services and programmes across different sector and has within its coordination structure singled out the County Governments as providing the link with the sub counties, HIV committees, implementers, PLHIV and special interest groups hence the need to provide a strategic communication framework to coordinate the efforts of all stakeholders. To effectively fulfill the aspirations of this strategic plan, the NACC and county health department will set up several key institutions to facilitate in its implementation.

The HIV Coordination organogram for delivery of the MCASP is as below:



Roles and responsibilities

(i) Governor

The Governor shall implement national and county legislation to the extent that the legislation require and is responsible for the delivery of a range of services, planning and prioritization of resource allocation to address HIV burden in Murang'a County.

(ii) County HIV Committee

It shall be accountable to the Governor Murang'a County for the performance of their functions and the exercise of their powers on matters relating to HIV.

Membership

Shall be chaired by the Health CEC, with the County Commissioner as alternate Chair, and the NACC County Coordination Unit as the secretary. Other members include;

- Representatives of county assembly (from health, budget, planning committees)
- Chief Officer health
- Director health
- Director social services,
- Director planning and finance
- Representative of PLHIV
- Representative of private sector
- CACCs (2) sub-counties
- Faith communities-(1)
- CASCO
- Partners (2)

Terms of reference:

The county HIV committee shall be:

- The custodian of the MCASP
- Holding meeting on a quarterly basis to review implementation plan
- Responsible for the effective delivery of the HIV response at the county level through periodic review and monitoring of the MCASP.
- Approving the county HIV targets and plan
- Reviewing and presenting County HIV Budget
- Setting the County HIV agenda
- Receiving reports on MCASP progress from the monitoring committee
- Receive reports from County ICC MCASP and routine Monitoring Committee

(iii) County HIV Coordination Unit

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

Terms of reference

- Ensure Quarterly County ICC HIV meetings are held and follow through on County ICC HIV actions
- Ensure HIV agenda is active in the CHMT
- Regular engagement of all state and non-state actors within the county in planning, prioritization, implementation, monitoring, and evaluation of HIV and AIDS programmes.
- Strengthening linkages and networking among stakeholders and providing technical assistance, facilitation, support for MCASP delivery
- Monitor County Legislation to ensure all Bills are HIV compliant
- Ensure performance contract reporting in the county has HIV as a key indicator
- Deliver quarterly reports on MCASP progress.
- Coordinate activities planned by NACC in the county and deliver on NACC work plan

(iv) Monitoring & Evaluation Committee

The committee will be convened by the county HIV coordination unit and shall consist of persons with M&E expertise drawn from across all sectors and partners-public, private and civil society including key affected population and PLHIV in the county. The role of the Monitoring and Evaluation Committee shall include;

- Reviewing and analyzing data received at the county level
- Advising the HIV coordination unit, ICC and the county HIV committee on improvement of MCASP implementation
- Facilitating implementation of the decision of the HIV committee and the county ICC related to M&E
- Support the overall operationalization of MCASP M&E framework at the county
- Maintain linkage with the national M&E committee
- Ensure that all the perquisite tool and materials for data collection are available at the point of collection at all times.
- Building the capacity of health workers on data collection and transmission.
- Ensuring the data collection, quality control, consolidation, interpretation and dissemination.
- Ensure the preparation and publication of County Department of Health newsletter on a bi-annual basis for dissemination of health articles, data and human interest stories including HIV.

(v) The County HIV ICC Committee:

This shall be accountable to the county governor for the performance of their functions and the exercise of their powers on matters relating to HIV. This shall be the primary forum for deliberating on AIDS issues in the county. It shall be chaired by the CEC health and the NACC county HIV coordinator will be the secretary. It will comprise of senior representatives in the county government, civil society, private sector and development partner, various Stakeholder Working Groups representing the various constituencies e.g. CSO, FBOs, Youth, PwD, PLHIV. The committee will convene at least four meetings annually to report on MCASP implementation progress, planned activities and future priority areas

Roles

- Responsible for the effective delivery of the HIV response at the county level.
- Approval of county HIV targets/plan
- Present County HIV Budget
- Set County HIV agenda
- Receive reports on MCASP progress from the monitoring
- Monitor and address emerging issues,
- Engagement with school systems, coordinate and oversee the development of a collaborative and comprehensive strategy to rollout MCASP and subsequently monitor its implementation.
- Ensure linkages, harmonization, coordination and resource mobilization and allocation, and tracking of progress AIDS programmes within sub counties
- Facilitate information sharing in information sharing within and across partners in the county
- Advocate for implementation of MCASP M&E tools and activities into members and partners own work plans within the county
- Offer technical support in implementation of MCASP
- Reviewing programmes and projects supporting MCASP implementation

(vi) Sub-County/Constituency HIV committees

There will be seven (7) constituency/sub-county committees in Murangá County. The chair will be elected at the first meeting where SCACCs are secretaries to the committee. It shall comprise of the;

- National government official at the sub county level- deputy county commissioner
- One person nominated from among the active civil society organization
- Representative of PLHIV
- Representative of PWD
- One person representing interest of women
- Representative of youth
- SCACC
- County MOH

Roles

- Stakeholder mobilization to respond to HIV issues in the community
- Monitor community response to HIV issues and submit biannual reports to HIV committee
- Receive and disseminate appropriate national and county policies, guidelines and strategies on HIV and AIDS.
- Monitor and address emerging issues,
- Engagement with school systems, coordinate and oversee the development of a collaborative and comprehensive strategy to rollout MCASP and subsequently monitor its implementation.
- Ensure linkages, harmonization, coordination and resource mobilization and allocation, and tracking of progress AIDS programmes within sub counties
- Facilitate information sharing in information sharing within and across partners in the county

(vii) Facility Level/Ward/community Unit HIV Committees:

Will be charged with the responsibility of planning, budgeting, implementation and monitoring of all HIV interventions at the facility level, ward and community unit.

CHAPTER 6

Research, Monitoring and Evaluation of the Plan

6.1 Monitoring and Evaluation Plan

Monitoring and evaluation (M&E) is critical and helps to ensure quality in our programming. This plan draws from the Kenya Monitoring and Evaluation Framework 2014/15 – 2018/19. It will guide all the stakeholders, implementers and partners in the HIV response in the county, in monitoring and evaluation of programmes in order to: a) provide the required information for decision making at all levels and, b) track progress and continuously measure results towards achieving the objectives of the Murang'a AIDS Strategic Plan (MCASP) 2014/15 - 2018/19. It will allow a rational and evidence-driven process of implementation aimed at identification of priorities for implementation and financing providing a basis for efficient allocation and use of resources.

To respond to HIV and AIDS information needs at the county, the health facilities submit monthly data to the District Health Information System (DHIS). The data is used to guide interventions and inform decision-making at the county level. An M&E technical working group (TWG) exists and meets on quarterly basis to interrogate the data for completeness, and reliability. Community based activities are reported through the COPBAR form, the data is entered into the COPBAR system at the NACC regional office. Data on workplace programme in the public sector is collected through the public sector reporting tool. Due to the parallel reporting systems, there is need for a harmonized county TWG to ensure all data generated is used for decision-making.

The County government will thus work towards complete, accurate and timely data capture at the various point of service delivery to inform the monitoring and evaluation aspects of this plan. MCASP will embrace a harmonized data management approach and in order to promote integration and information sharing through a common architecture, understanding and approach as defined in the Framework. All this is aimed at improving efficiency of the response, enhancing transparency of all players and strengthening accountability in the implementation of MCASP. Some of the HIV and AIDS specific M&E initiatives to be undertaken will include:

- Annual facility assessment and appraisal on implementation of HIV and AIDS programs
- Mid-term and end-term evaluation of the implementation of the MCASP strategic plan
- Community units' reports to facilities
- Assessment of routine data in the DHIS

Data Collection

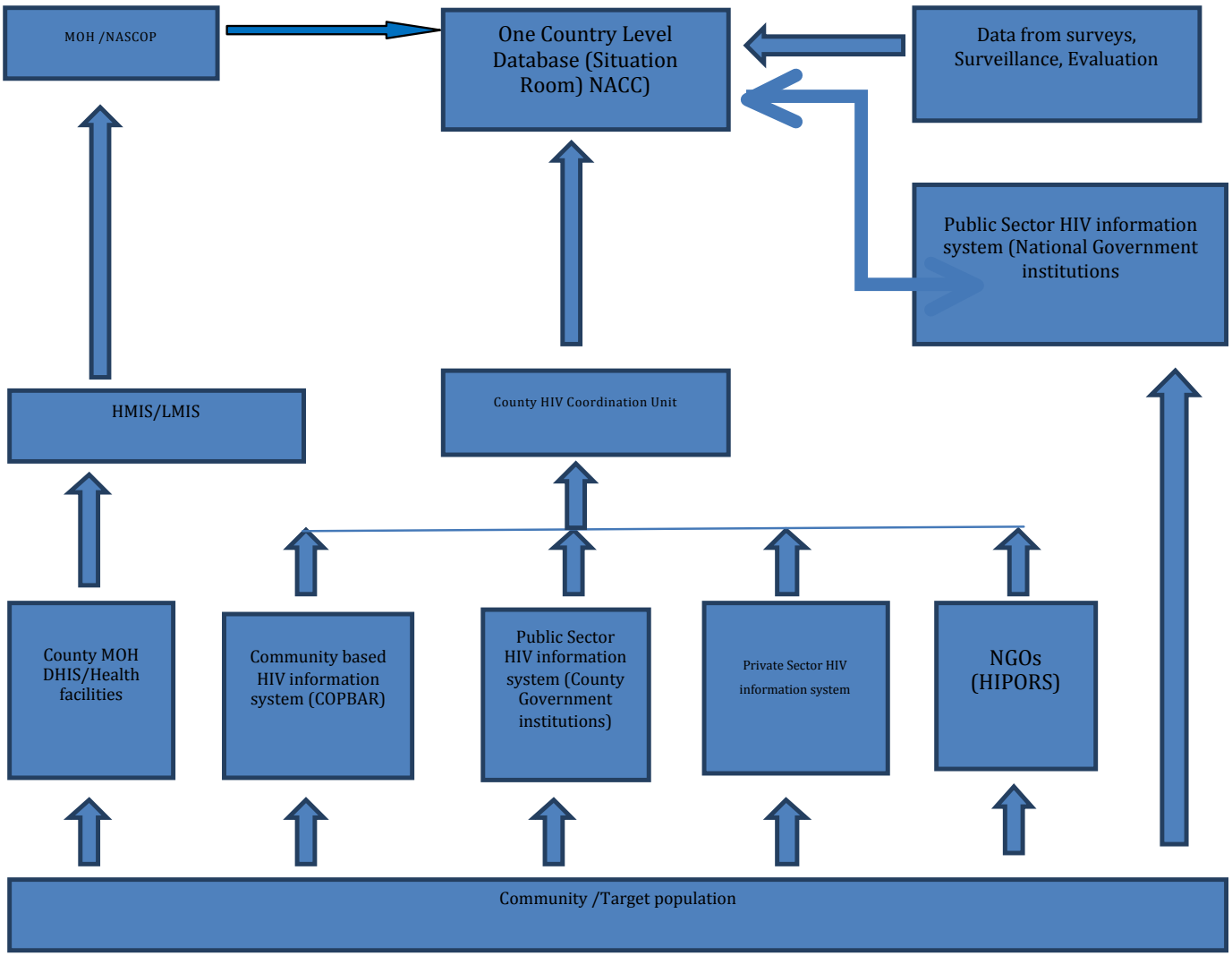
The Plan provides for routine service delivery data and non-routine implementation report data.

Table 6.1: Some high impact indicators

County Objective	Indicator	Data Source	Responsible persons	Frequency
Reduce new infections by 50%	Number of new adult HIV infections disaggregated by gender and age	DHIS,KDHS, KAIS, surveys	CDH, CASCO and Sc.CASCOs	Annually
	Percentage of young women and men ages 15–24 who are HIV infected	DHIS,KDHS, KAIS, surveys	CDH, CASCO and Sc.CASCOs	
	Percentage of child infections from HIV-infected women delivering in the past 12	DHIS,KDHS, KAIS, surveys	CDH, CASCO and Sc.CASCOs	
	Number of new child HIV infections	DHIS,KDHS, KAIS, surveys	CDH, CASCO and Sc.CASCOs	
	Estimated annual number of new infections from KP's (sex workers, men who have sex with men [MSMs], prison populations, PWIDs)	Mode of transmission study	CDH, CASCO and Sc.CASCOs	
Reduce HIV-related mortality by 25%	Number of HIV-related deaths disaggregated by gender and age	DHIS,KDHS, KAIS, surveys, Mortality statistics from dept. of Civil registration	CDH, CASCO, Sc.CASCOs &CRO	
Reduction of stigma and discrimination by 25%	Percentage of women and men aged 15–49 who report discriminatory attitudes towards persons living with HIV and AIDS (PLHIV)	KDHS, KAIS	CDH, CASCO and Sc.CASCOs CDH, CASCO and Sc.CASCOs	
Increase domestic funding for the HIV response by 5% of the county health budget	Percentage of funding for the HIV response coming from the government	Approved annual county budget	Governor, CEC, COH, CDH and CASCO	

Unified HIV Response Information System

The figure below show the unified HIV response information system the county will employ to receive data from sub systems used at different data collection points. This data will then be consolidated, analyzed and various products derived for decision-making and research.



6. 2 Research Plan

The research plan will guide implementation of HIV & AIDs plan in the county. It is based on research priorities identified from drivers of the infection and the weaknesses as identified in SWOT analysis.

The research plan is intended to lead to evidence-based planning and provide a mechanism for knowledge generation and information sharing.

The following research priorities have been identified;

i. Impact of alcohol on HIV prevention by different populations in Murang'a County

ii. Determine effective models to increase uptake of HTC linkage of OVCs to Care & Treatment

iii. Determine the impact of HIV workplace programmes in averting new infections among the immigrant populations in the tea factories.

iv. Effectiveness of structural interventions on early sexual debut in preventing new HIV infections and re-infections.

v. Uptake of correct and consistent condom use among key populations (FSWs & MSMs)

vi. Determine the impact of poverty-related factors hindering access Care and Treatment

vii. ARV drug resistance and suspected treatment failure in Murang'a County.

CHAPTER 7

Risk and Mitigation Plan

The section show the proposed interventions to be put in place to mitigate against foreseeable risks. In addition it details the probability of the risk happening and potential impact to the HIV response.

Table 7: Risk and Mitigation Plan based on the SWOT analysis conducted

Risk Category	Risk Name	Status	Probability (1-5)	Impact (1-5)	Risk Average score	Response	Responsibility	When
Technological	Weak integration of ICT into HIV programming	Active- risk is being actively monitored	3	3	3	Adopt and strengthen use of ICT in HIV programming	County Government, NASCOP, Implementing partners	Year 1 to Year 3
Financial	Limited financial resources for HIV programming	Active- risk is being actively monitored	3	4	3.5	Explore innovative financing options	COH	Year 1 to Year 3
Political	Weak Political accountability	Active- risk is being actively monitored	2	2	2	Motivate political accountability by involvement of the political class in the HIV response Lobby with the county assembly for budgetary allocation	County Government, NACC, Partners	Year 1 to Year 3
Legislation	Weak legislation on stigma and discrimination	Active –Risk NOT being actively monitored	2	3	2.5	Customize and operationalize the HIV prevention and control act 2006	Department of Health, Networks of PLHIV	Year 1 to Year 3

Risk Category	Risk Name	Status	Probability (1-5)	Impact (1-5)	Risk Average score	Response	Responsibility	When
Operational	Inadequate trained personnel to offer HIV services in the health facilities- All cadres	Active- risk is being actively monitored	2	3	2.5	Continuous capacity building, recruit new staff, deploy rightfully and	CPSB, COH, CDH, CASCO	Year 1 to Year 3
	Parallel HIV reporting systems	Active- risk is being actively monitored	2	3	2.5	Harmonize County HIV reporting	NACC, HMIS	Year 1
	Inadequate care and treatment centers	Active- risk is being actively monitored	2	3	2.5	Increase the number of Care and treatment centers in the county to improve access	National and County governments, Implementing Partners	Year 1 to Year 3
	Inadequate data on OVCs in the county	Active- risk is being actively monitored	3	3	3	Conduct an audit of OVCs in the county	National and County governments, Implementing partners	Year 1, Year 3
	Inactive AIDS Control Units (ACUs) implementing HIV and AIDS workplace policy	Active- risk is being actively monitored	4	3	3.5	Establish and operationalize the ACUs at County level	County Commissioner, County Secretary, NACC	Year 1
	Knowledge gaps amongst HCWs (capacity building)	Active- risk is being actively monitored	2	3	2.5	Continuous capacity building and mentorship	CASCO, Implementing partners	
	Inadequate community mobilization activities towards HIV response	Active- risk is being actively monitored	2	2	2	Strengthen the community health strategy	County government, Implementing partners	Year 1 to Year 3
	Lack of support for key population programs	Inactive –No monitoring in place	4	4	4	Initiate and sustain programs for key populations	County Government, Implementing partner	Year 1 to Year 3
	Data quality / data utilization challenges	Active- risk is being actively monitored	2	3	2.5	Conduct regular DQAs and quarterly M&E review meeting, establish and operationalize the M&E TWG	COH, CASCO, CHRIO,	Year 1 to Year 3
	Stigma and discrimination	Active- risk is being actively monitored	4	4	4	Conduct anti stigma campaigns	Implementing partners	Year 1 to Year 3

Risk Category	Risk Name	Status	Probability (1-5)	Impact (1-5)	Risk Average score	Response	Responsibility	When
Operational	Youth and adolescent friendly services	Active- risk is being actively monitored	2	3	2.5	Integrate and strengthen youth / adolescent friendly services	County government, Networks of PLHIV, Community, FBOs,	Year 1 to Year 3
	Co-morbidities among PLHIV including NCDs leading to high mortality rates	Active- risk is being actively monitored	2	2	2	Prompt screening, Provision of OI drugs and treatment of NCDs	CDH, Implementing partners	Year 1 to Year 3
	Low identification rates of person living with HIV in the community	Active- risk is being actively monitored	3	5	4	Implementation of the acceleration plan (Identify 90% of PLHIV in the community)	CDH, Implementing partners, community, NASCOP	Year 1 to Year 3
	ART commodities stock outs	Active- risk is being actively monitored	2	4	3	Regular stock count and restocking, right forecasting, quantification and procurement	County government, NASCOP, KEMSA, Implementing partners	Year 1 to Year 3

CHAPTER 8

Annexes

Annexe 1: Results Framework

Strategic Directions	MCASP Objectives	MCASP Results	Key activity	Indicators	Baseline	Mid Term Target	End Term Target	Responsibility
I. Reducing New HIV Infections	To reduce new HIV infections by 50%	Reduced HIV new infections by 50%	HIV counseling and Testing services	Number of people tested and received results	2020 new infections in 2014	1010 new infections	505 new infections	Health department, implementing partners, community
			Strengthen health education programmes, including schools	Number of targeted audience/people given information on life skills based on HIV education and BCC	Minimal	Half of schools in sub counties covered	90% of schools reached	County Government, CDH, CASCO, CHPO
			Implement Key population programmes in the county	Number and percentage of key population reached with HIV preventive programmes	10%	50%	85%	County government, CASCO, implementing partners, community
			Condom distribution in the county	No of condoms distributed. Number of persons receiving condoms	2,000,000	3,000,000	3,500,000	County Health Department, communities.
			Provision of PEP in health facilities	No. of persons who received PEP	50	100	150	County Health Department, communities.
			Provision of PrEP	No. of people provided with PrEP	0	2,500	5,000	County Health Department, communities
				Percentage of health facilities providing PEP services	30%	50%	90%	CASCO, CHRIO
			Leverage opportunities through creation of synergies with county and other sectors for HIV prevention	No. of National and county government ministries, departments and Agencies (MDAs) with results based HIV plans aligned to MCASP	0	20%	50%	County Health Department NACC

Strategic Directions	MCASP Objectives	MCASP Results	Key activity	Indicators	Baseline	Mid Term Target	End Term Target	Responsibility
I. Reducing New HIV Infections	To reduce HIV transmission rates from mother to child from 14% to less than 5%	Reduced HIV transmission rates from mother to child from 14% to less than 5%	Strengthen PMTCT Programme in all health facilities	Estimated percentage of child infections from HIV infected women during the past 12 months	7%	5%	<5%	County Health Department, communities
				No. and percentage of pregnant women attending ANC and know their HIV status	94%	98%	100%	County Health Department, communities
			Avail well trained HCW in the facilities for PMTCT and HEI	No. and percentage of infants born to HIV infected women who receive HEI	90%	95%	96%	County government, CASCO, implementing partners, community
				No. and percentage of infants born to HIV infected women who received prophylaxis	83%	90%	100%	County government, CASCO, implementing partners, community
				Percentage of HIV positive pregnant women who received ARVs to reduce the risk of mother to child transmission	86%	95%	96%	County government, CASCO, implementing partners, community
II. Improving health outcomes and wellness of PLHIV	To improve health outcomes and wellness of all PLHIV	Increase linkage to care and treatment within 3 months of HIV diagnosis to 90% for children, Adolescents, Adults and Key populations	Percentage of people linked into care and treatment within 3 months of HIV diagnosis	Percentage of people linked into care and treatment within 3 months of HIV diagnosis	81%	90%	100%	County Health Department, communities
		Increased art coverage to 90% for children, adolescents, adults and key populations	Increase access to ART	- Percentageof eligible clients newly initiated to ART - Percentage of Adults and children currently receiving ART among all eligible PLHIV (using national ART guidelines)	45%	80%	90%	County government, CASCO, implementing partners, community
		Increased retention on ART at 12 months to 90% in children, Adolescents, Adults and key population	- Ensure timely drug pick ups - Strengthen dispensing mechanisms	Percentage of children, adolescents and adults with known HIV positive to be on treatment at 12 months after initiation to ARVs 24, 36 and 60 months	65%	80%	90%	County government, CASCO, implementing partners, community

Strategic Directions	MCASP Objectives	MCASP Results	Key activity	Indicators	Baseline	Mid Term Target	End Term Target	Responsibility
Improving health outcomes and wellness of PLHIV	To improve health outcomes and wellness of all PLHIV	Increase ART coverage to 90% for children, adolescents and adults	Effective identification, referral and linkage Address stigma and discrimination	Percentage of PLHIV who have been identified	50%	80%	90%	County government, implementing partners, community
		Increased viral suppression to 90% 12 months after initiation of art for children, adolescents, adults and key populations	Train HCW to handle viral load Improve on turnaround time Increase retention to care	Percentage of PLHIV on ART tested for viral load and with suppressed viral load in the reporting period	50%	80%	90%	County government, CASCO, implementing partners, community
		Improved quality of care and treatment outcomes	Capacity build HCW Strengthen Mentorship programmes	Percentage of health facilities providing care and treatment services and also implementing CQI according to MOH standard protocols	43%	80%	90%	County government, CASCO, implementing partners, community
			Improve commodity management	Percentage of health facilities dispensing ART that have experienced a stock out of at least one required drug in the last 12 months	0%	0%	0%	County government, CASCO, implementing partners, community
		Improved community based adherence support	HIV treatment literacy strengthening	Percentage of organizations reporting on HIV treatment education programmes	25%	30%	35%	County government, implementing partners, community
III. Using a Human Rights based Approach to Facilitate Access to Services	Use a Human Rights based approach to facilitate access to services for PLHIV, Key populations and other priority groups in all sectors	Reduced self-reported stigma and discri-mination related to HIV and AIDS by 50%	Implement anti-stigma and anti-discrimination measures as recommended in MCASP	Percentage of PLHIV who self-reported that they experienced discrimination and/or stigma due to their HIV status	49.2%	43%	37%	County Government, Network of PLHIV, NACC, Partners
		Increased protection of human rights and improved access to justice for PLHIV, key populations, women, boys and girls	Educate general population on Human rights Work with civil society groups, law makers and the police force to ensure protection of human rights and access to justice	Percentage of women and men ages 15–49 expressing accepting attitudes towards people living with HIV	49.2%	43%	37%	County Government, Network of PLHIV, NACC, Partners

Strategic Directions	MCASP Objectives	MCASP Results	Key activity	Indicators	Baseline	Mid Term Target	End Term Target	Responsibility
Using a Human Rights based Approach to Facilitate Access to Services	Reduced levels of sexual and gender-based violence against PLHIV, key populations, women, men, boys and girls by 50%	Work with civil society groups, law makers and the police force to ensure reduction and prevention of sexual and gender-based violence and improve access to justice for victims	Percentage of PLHIV who experienced sexual and/or gender-based violence Percentage of sexual and gender-based violence cases tried in court	Percentage of PLHIV who experienced sexual and/or gender-based violence	0%	40%	70%	County government, National Police Service, Judiciary
		Increased protection of human rights and improved access to justice for PLHIV, key populations, women, boys and girls	Implement national and county legal and policy environment for protection of PLHIV, key populations, women, boys and girls	Percentage of laws, regulations, and policies reviewed or enacted at county level that impact on the HIV response positively	0%	30%	60%	County government, County Assembly, Networks of PLHIV, partners
		Reduced social exclusion for PLHIV, key populations, women, men, boys and girls by 50%	Remove barriers to access of HIV, SRH, and rights information and services in public and private entities	Percentage of PLHIV and key affected populations reached with information on HIV, SRH, and rights	20%	50%	90%	County government, County Assembly, Networks of PLHIV, partners
				Percentage of PLHIV and key populations reached with targeted HIV prevention treatment and social protection programmes	20%	50%	90%	County government, County Assembly, Networks of PLHIV, partners
IV. Strengthening Integration of Community and Health Systems	To strengthen integration of Community and Health Systems	Increased health workforce for the HIV response at both county and national levels by 40%	Increase Health Care Workforce and CHVs	- Ratio of cadres of health care staff to population in line with staffing norms - Percentage of health facilities providing KEPH-defined HIV&AIDS services	35%	35%	40%	County government
		Increased number of health facilities ready to provide KEPH-defined HIV services from 67% to 90%	Health Facilities –Increase care and treatment sites in the county Establish community linkage desks	Percentage of health facilities providing KEPH-defined HIV&AIDS services	35%	50%	80%	County government

Strategic Directions	MCASP Objectives	MCASP Results	Key activity	Indicators	Baseline	Mid Term Target	End Term Target	Responsibility
Strengthening Integration of Community and Health Systems	To strengthen integration of Community and Health Systems	Strengthened HIV commodity management through effective and efficiency management of medicine and medical products	Management-strengthening	Percentage of health facilities dispensing ART that experienced a stock-out of ARVs at least once in the last 12 months	0%	0%	0%	County government
		Strengthened community-level AIDS competency	Increase the number of Community Units implementing AIDS competency guidelines	Number of community units implementing AIDS competency guidelines	12%	50	121	County government
			Train more Community Health Units (Volunteers) on HIV module	Number of Community Health Units (volunteers) given training on HIV module		150	250	County government
			Increase number of Community Health Workers reporting on HIV programmes	Number of Community Health Workers reporting on HIV programmes		150	250	County government
			Increase number and percentage of community-based organizations that submit timely, complete, and accurate reports according to guidelines	Percentage and percentage of community-based organizations that submit timely, complete, and accurate reports according to guidelines	45%	60%	100%	CACCs, Partners, NACC
			Health system strengthening	Percentage of health facilities providing integrated HIV services	40%	70%	90%	County government
				Number of health facilities implementing universal precautions to prevent HIV infection	30%	50%	100%	County government
V. Strengthening Research and Innovation to inform MCASP Goals	Strengthen research and innovation to inform the MCASP Goals	Increased capacity to conduct HIV research at sub-county and county level by 10%	Increase capacity for Research and Research finding	- Percentage of prioritized biomedical and behavioral research conducted - Number of people trained in HIV related research - Proportion of HIV funds utilized on research	20%	60%	90%	County government

Strategic Directions	MCASP Objectives	MCASP Results	Key activity	Indicators	Baseline	Mid Term Target	End Term Target	Responsibility
Strengthening and Research and Innovation to inform MCASP Goals	Strengthen research and innovation to inform the MCASP Goals	Increased implementation of research on identified MCASP -related HIV priorities by 50%	Undertake research	Percentage of planned research implemented in line with the research agenda and MCASP priorities at sub-county and county level	No data	30%	60%	County government, Institutions of higher learning
		Increased evidence-based planning, programming and policy changes	Application of research findings in decision making	Percentage of research products disseminated to inform policy, planning and programming	No data	30%	60%	County government, Institutions of higher learning
VI. Promote Utilization of Strategic Information for Research and Monitoring and Evaluation to enhance Programming	Promote use of strategic information for research and monitoring and evaluation to enhance programming	Increased availability of strategic information to inform HIV response at national and county levels	Increase Access to Strategic Information at all levels	- Percentage of planned M&E reports disseminated at national and county levels - Percentage of planned M&E reports disseminated at the county level - Number of functional HIV dashboards in the county	30%	60%	90%	County government, Partners, NACC
		Planned evaluations, reviews, surveys implemented and results disseminated in timely manner	Implementing M&E Activities as Planned	Percentage of planned evaluations, reviews, and surveys conducted in line with set timelines	10%	40%	80%	County government, Partners
		M&E information hubs established at facility and county level	Establishment and linkage of M&E hubs	Number of M&E hubs established at sub-county and county levels	0	1	1	County government, Partners
		Comprehensive information package on key MCASP indicators provided for decision making	Private Sector, Public Sector, Development and Implementing Partners M&E Reporting	Percentage of facilities submitting timely, complete, and accurate reports based on targets set in their HIV plans	80%	90%	100%	County government, Partners

Strategic Directions	MCASP Objectives	MCASP Results	Key activity	Indicators	Baseline	Mid Term Target	End Term Target	Responsibility
Promote Utilization of Strategic Information for Research and Monitoring and Evaluation to enhance Programming	Promote use of strategic information for research and monitoring and evaluation to enhance programming	Comprehensive information package on key MCASP indicators provided for decision making	Private Sector, Public Sector, Development and Implementing Partners M&E Reporting	Percentage of private sector entities submitting timely, complete, and accurate reports	30%	60%	90%	County government, Institutions of learning, NACC, partners
				Percentage of implementing and development partners submitting timely, complete, and accurate reports	50%	70%	90%	County government, Institutions of learning, NACC, partners
			Operalisationa-lisation of M&E Hubs	Number of M&E Hubs with comprehensive and up to date information on MCASP Indicators	0	1	1	County government, Institutions of learning, NACC, partners
VII. Increasing domestic financing for sustainable HIV response	Increase domestic financing for sustainable HIV response by 50%	Increased domestic financing for HIV response by 50%	Prepare County HIV response budget Lobby for political good-will in prioritization of HIV response budgetary allocation Lobby for NGOs, community and private sector funding of HIV response budget	Percentage of County government funding out of the total health budget for the HIV response	5%	5%	7.5%	County government, County assembly, partners
				Percentage of HIV domestic funding coming from private sector, including households	10%	30%	50%	County government, partners
				Percentage of HIV funding coming from the public sector	15%	30%	50%	County government, partners
				Proportion of funds allocation to MCASP by strategic direction	5%	30%	50%	County government, partners
		Establish HIV Investment Fund		HIV investment fund (trust fund) in place and operational	0	1	1	County government, partners

Strategic Directions	MCASP Objectives	MCASP Results	Key activity	Indicators	Baseline	Mid Term Target	End Term Target	Responsibility
VIII. Promoting accountable leadership for delivery of the MCASP Results by all sectors	To promote accountable leadership for delivery of the MCASP results by all sectors.	Good governance practices and accountable leadership entrenched in the multi-sectoral HIV and AIDS response at all levels	Promote good governance and accountability for multi-sectoral response Ensure accountability and inclusiveness in management of HIV related issues in the county by all stakeholders Create an enabling environment for multi-sectoral collaboration	National composite policy instrument (NCPI) rating on political support for HIV and AIDS response	40%	70%	90%	County government, partners, NACC
		Effective and well-functioning stakeholder coordination and accountability mechanisms in place and fully operationalised in the country	Strengthen coordination and accountability mechanisms	Percentage of implementing organizations reporting at county and national levels as per M&E guidelines	40%	70%	90%	County government, partners, NACC
				Number of sub counties with county HIV coordination units	7	7	7	County government, NACC
				Percentage of county MDAs with sector specific HIV plans	30%	60%	90%	
		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	Develop County Policy, Legal and Regulatory Framework for Multi-sectoral HIV and AIDS Response	Percentage of planned policy, legal and guidelines developed or reviewed	10%	50%	90%	

Annexe 2: Implementation Plan

Partners	Intervention Areas	Outputs	Outcomes
Ministry Of Health	• Policy, Guidelines, Standards and Norms Development • Training And Capacity Building • Regulatory Role • Commodity supply • Service delivery	• Uniformity in implementation of Health Services • Skilled Health Workforce • Consistent commodity supply • Quality care	• Client Satisfaction • Quality Health Care • Achievement of MCASP Goal • Quality HIV Health Care service provision
Development Partners (WHO, USAID, World Bank)	• Monitoring And Evaluation • Capacity Building • Infrastructure Development • Program Funding	• Skilled Health Workforce • Improved Access To Quality Health Services • Improved Workplace Environment • Available Resources	• Achievement of MCASP Goal • Timely Interventions • Client Satisfaction • Quality HIV Health Care service provision
Implementing Partners (APHIA Plus, MEASURE Evaluation Pima,CHS e.t.c)	• Supporting Community Strategy Implementation • Capacity Building • Staff Employment • Infrastructure Development • HMIS Support • Health Products Management	• Empowered Community • Skilled Health Workforce • Improved health care Access • Timely And Quality Data • Availability And Rational Use Of Health Products	• Quality Healthcare • Client Satisfaction • Prompt and Evidence Based Decision Making • Attainment of the MCASP objectives
Government Ministries And Departments (Agriculture, Water, Roads, Environment, Education e.t.c.)	• Community Mobilization • Financial support • Testing	• Resource availability • Timely And Quality Data	• Evidence Based Decision Making • Attainment of the MCASP
Roads, Environment, Education e.t.c.)	• Advocacy • Monitoring and evaluation	• Number of staff reached with HIV services	• HIV mainstreamed internally and externally
County Political Leadership (Governor, County Reps, M.Ps, Senators)	• Political Goodwill • Projects And Commitments, • Approval of Budgets • Resource Mobilization • Resource Allocation	• Political Support • Resource Availability	• Achievement of MCASP Goals
Internal Security (County Commissioner, Chiefs)	• Community Mobilization • Security • Resource Mobilization • Emergency Response • Intergovernmental Linkage	• Community Empowerment • Secure Environment • Resource Availability • Timely Interventions	• Informed Decision Making • Healthy Population • Emergency Preparedness • Improved Service Delivery
Business Community (Hotels, Banks, Industries etc.)	• Financial and Material Aid • Projects Support	• Resources availability	• Improved Quality Of Care

Annexe 3: Resource Needs

This three year investment plan will be funded with resources from diverse sources. These include the county government, the national government, donors and partners. The county management team will endeavor to mobilize resources from other potential sources like philanthropists and individuals.

STRATEGIC DIRECTION	MCASP OBJECTIVE	KEY ACTIVITY	Amounts in Kshs		
			Year 1 2016-2017	Year 2 2017-2018	Year 3 2018-2019
Reduce new HIV infections	To reduce new HIV infections by 50%	Conduct targeted HIV counseling and Testing services to 240,000 pediatrics, adults adolescents and youth per year @ Ksh250 per persons and key populations	60,000,000	60,000,000	60,000,000
		Implement Key population programmes to 7200 KP in the county @Ksh 1100/= per person	8,000,000	8,000,000	6,000,000
		Condom distribution and awareness in the county @50,000/= per sub county per quarter	1,400,000	1,4,000,000	1,400,000
		Create awareness among health workers on Provision of PEP in health facilities both occupation and non-occupational PEP 60 HCWs @ Ksh 3000/=	180,000	180,000	180,000
		Print EIC materials	500,000	500,000	500,000
		Create awareness among health workers and the community on provision of PrEP	500,000	500,000	500,000
		Strengthen health education programmes while intensifying awareness creation, behavior change and adoption of healthy lifestyles	2,000,000	2,000,000	2,000,000
	Strengthen prevention programs for adolescents youth and young persons	Strengthen school health programs and also target youth out of schools	3,000,000	3,000,000	3,000,000
		Youth friendly services,	100,000	100,000	100,000
		Hold APOC trainings	1,000,000	1,000,000	1,000,000

STRATEGIC DIRECTION	MCASP OBJECTIVE	KEY ACTIVITY	Amounts in Kshs		
			Yr 1 2016-2017	Yr 2 2017-2018	Yr 3 2018-2019
		Leverage opportunities through creation of synergies with county and other sectors for HIV prevention (ACU coordination and collaborations)	500,000	500,000	500,000
	Reduce mother to child transmission of HIV in line with the EMTCT targets of achieving transmission rate to less than 5%	Strengthen PMTCT Programme in all health facilities	5,000,000	5,000,000	5,000,000
		Train HCW in the facilities for HIV testing services, PMTCT, HEI STIs	5,000,000	5,000,000	5,000,000
II. Improving health outcomes and wellness of PLHIV	To improve health outcomes and wellness of all PLHIV	Increase linkage to ensure 90% of the identified HIV positive persons adults and children as well as the Key populations are enrolled for care and treatment within 3 months of HIV diagnosis	400,000	400,000	400,000
		Increase access to ART by opening 8 more comprehensive care centres (CCCs) @ Ksh 1M	8,000,000	1,500,000	1,500,000
		Invest on HIV treatment literacy for PLHIV including adherence (8 peer educators and 8 mentor mothers) @ Ksh 7000/= per month	1,500,000	1,500,000	1,500,000
	Retain 90% of PLHIV and on treatment	Strengthen defaulter tracing mechanism (transport and airtime). Ksh 3000/= per CCC per month per CCC.	1,300,000	1,300,000	1,300,000
		Capacity building of HCW on viral load sample handling and transport 120 HCWs @ Ksh 3000/=	360,000	360,000	360,000
		Strengthen mentorship programmes. 10 mentees per quarter @ 6000, 3 mentors @ 3000 for 5 days	1,000,000	1,000,000	1,000,000
III. Using a Human Rights based Approach to Facilitate Access to Services	Use a Human Rights Based Approach to Facilitate Access to Services for PLHIV, Key Populations, and Other Priority Groups in All Sectors	Conduct anti-stigma sensitization in schools and other learning institutions, churches, places of work, barazas, community dialogue forums .Ksh 350,000/= per sub county per year	2,450,000	2,450,000	2,450,000
	Conduct sensitization and awareness campaigns	Sensitize the general population and PLHIV on rights of PLHIV Ksh 150,000/= per sub county per year.	1,050,000	1,050,000	1,050,000
	Advocacy and lobbying	Work with civil society groups, law makers and the police force to ensure protection of human rights and access to justice through sensitization (need based)	500,000	500,000	500,000

STRATEGIC DIRECTION	MCASP OBJECTIVE	KEY ACTIVITY	Amounts in Kshs		
			Year 1 2016-2017	Year 2 2017-2018	Year 3 2018-2019
		Promote and implement national and county legal and policy guidelines for protection of PLHIV, key populations, women, men, boys, and girls by sensitization on policy guidelines.	500,000	500,000	500,000
IV. Strengthening Integration of Community and Health Systems	To Strengthen Integration of Community and Health Systems	Increase health workforce for the HIV response at county levels by 40% (40 officers in different cadres)	14,400,000	14,400,000	14,400,000
	Increased number of health facilities ready to provide KEPH-defined HIV and AIDS services from 67% to 90%	Establish community linkage desks in all care and treatment sites. Ksh 10,000/= per site	350,000	50,000	50,000
	Strengthened HIV commodity management through effective and efficiency management of medicine and medical products	Conduct training on HIV-Commodity Management. (2 day Conference package for 120 HCWs)	720,000	-	-
	Strengthened community-level AIDS competency	Training of community health volunteers on community-level AIDS competency (700 CHVs @Ksh 1000/=)	700,000	-	-
V. Strengthening Research and Innovation to Inform the MCASP Goals	Strengthen Research and Innovation to Inform the MCASP Goals	Conduct HIV research at sub-county and county level	3,000,000	4,000,000	5,000,000
	Increased implementation of research on identified MCASP-related HIV priorities by 50%	Hold a stakeholders meeting to prioritize research areas and define research agendas – one meeting per year	500,000	500,000	500,000
	Increased evidence-based planning, programming and policy changes	Use the research findings in decision making and for policy formulation.	-	-	-
VI. Promote Utilization of Strategic Information for Research and Monitoring	Promote use of strategic information for research and monitoring and evaluation to enhance programming	County government and other stakeholders/partners to jointly support quarterly HIV data (county plan) audit and review meetings. Ksh 150,000/= per quarter	600,000	600,000	600,000
		Conduct M&E technical supervisory visit at the facility level Ksh 100,000/= per quarter	400,000	400,000	400,000

STRATEGIC DIRECTION	MCASP OBJECTIVE	KEY ACTIVITY	Amounts in Kshs		
			Year 1 2016-2017	Year 2 2017-2018	Year 3 2018-2019
		Formation of M&E Technical committee at facility, sub-county and county level to track county HIV plan	200,000	200,000	200,000
	Comprehensive information package on key MCASP indicators provided for decision making	Create a county HIV M&E information hub accessible to the HIV stakeholders providing comprehensive information package on key MCASP indicators for decision making.	500,000	-	-
		Carrying out M&E capacity assessment and capacity development at all levels	-	-	-
VII. Increasing Domestic Financing for Sustainable HIV Response	To have a sustainable local financing mechanism for HIV response	Lobby the county government to allocate 10% of county budgetary allocation on health to HIV and AIDS response.	1,000,000	1,000,000	1,000,000
		Establish innovative funding mechanisms within the county for instance levies on road construction and alcoholic products	-	-	-
		Lobby county government, NGOs and implementing partners to increase funding	500,000	500,000	500,000
VIII. Promoting Accountable Leadership for Delivery of the MCASP Results by All sectors	To promote accountable leadership for delivery of the MCASP results by all sectors	Good governance practices and accountable leadership entrenched in the multi-sectoral HIV and AIDS response at all levels	3,000,000	3,000,000	3,000,000
		To promote Good governance practices and accountable leadership entrenched in the multi-sectoral HIV and AIDS response at all levels	Ensure accountability and inclusiveness in management of HIV related issues in the county by all stakeholders	-	-
			Create an enabling environment for multi-sectoral collaboration	-	-
			Strengthen coordination and accountability mechanisms	-	-
TOTALS			**154,610,000**	**146,890,000**	**145,890,000**

Annexe 4: References

- The Constitution of Kenya, 2010
- The National HIV and AIDS Monitoring, and Evaluation and Research Framework 2014/15 – 2018/19
- Kenya HIV County Profiles NACC, NASCOP, 2014
- Kenya Revolution Prevention Road Map Countdown to 2030; NACC, NASCOP, UNAIDS, 2013
- Kenya HIV and AIDS Research Agenda – 2014/15- 2018/19
- Murang'a County Governors Manifesto
- NACC, 2014: Kenya Aids Strategic Framework, 2014/2015-2018/2019
- NACC, NASCOP, 2014: Kenya HIV Estimates Report, Nairobi
- Murang'a County integrated development plan 2013/14 to 2017/2018
- Murang'a County Health Strategic and investment plan 2013/14 to 2017/2018
- The National HIV and AIDS Stigma and Discrimination Index Summary Report, NACC, 2015

Annexe 5: MCASP Drafting Team

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Annexe 6: List of the Technical Review Team

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