NAIROBI CITY COUNTY HIV & AIDS STRATEGIC PLAN

2015/2016 - 2018/2019

"Towards Ending the HIV Epidemic in Nairobi City County"

maisha!
National AIDS Control Council

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Cover photos (front right to back left)

- *NACC Director pays a courtesy call to Nairobi Governor Dr. Evans Kidero © NACC*
- *Nairobi, Kenya. March 5, 2016 © Darko Vrcan / Shutterstock.com*
- *HIV testing campaign targeting motorcycle taxi drivers in Nairobi. © UNAIDS*

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Acronyms and abbreviations

ACSM	Advocacy, Communication and Social Mobilisation
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
ARV	Antiretroviral
CACC	Constituency AIDS Control Coordinator
CASCO	County AIDS and Sexually Transmitted Infections Coordinator
CBD	Central Business District
CCC	Comprehensive Care Centre
CECM	County Executive Committee Member
CHA	Community Health Assistant
CHMT	County Health Management Team
CHTS	Community HIV Testing Services
CHU	Community Health Unit
CHV	Community Health Volunteer
CME	Continuing Medical Education
COBPAR	Community Based Programme Activity Report
CPMCT	Community Prevention of Mother-to-Child Transmission
CSO	Civil Society Organisation
DHIS	District Health Information System
DICE	Drop-in Centre
DQA	Data Quality Assessment
EMR	Electronic Medical Record
EMTCT	Elimination of Mother-to-Child Transmission
FBO	Faith-based Organisation
FSW	Female Sex Worker
HCW	Health Care Worker
HCBC	Home and Community Based Care
HEI	HIV-exposed Infant
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma virus
HRH	Human Resources for Health
HTC	HIV Testing and Counselling
HTS	HIV Testing and Services
ICC	Inter agency Coordinating Committee
ICF	Intensify Case Finding
ICT	Information and Communications Technologies
IPC	Infection Prevention Control
IPD	In-Patient Department
IPT	Isoniazid Preventive Therapy
KASF	Kenya AIDS Strategic Framework
KEPH	Kenya Essential Package for Health
KP	Key Populations

LMIS	Logistics Management Information System
MAT	Medication-Assisted Therapy
M&E	Monitoring and Evaluation
MCA	Member of the County Assembly
MNCAH	Maternal, New-born, Child and Adolescent Health
MoU	Memorandum of Understanding
MoT	Modes of Transmission
MSM	Men who have Sex with Men
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Program
NCCHASP	Nairobi City County HIV & AIDS Strategic Plan
NCCHSSIP	Nairobi City County Health Sector Strategic and Investment Plan
NCD	Non Communicable Disease
NGO	Non-Governmental Organization
OI	Opportunistic Infection
OJT	On-Job Training
OPD	Out Patient Department
ORMU	Operational Research Monitoring Unit
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV
PLWD	People Living with Disability
PPP	Public-Private Partnership
PrEP	Pre-Exposure Prophylaxis
PSSG	Psychosocial Support Group
PWID	People Who Inject Drugs
QI	Quality Improvement
QIT	Quality Improvement Team
RRI	Rapid Result Initiative
SCHMT	Sub-county Health Management Team
SDP	Service Delivery Point
SGBV	Sexual and Gender Based Violence.
STI	Sexually Transmitted Infections
SRH	Sexual and Reproductive Health
TB	Tuberculosis
TOWA	Total War against HIV and AIDS
TWG	Technical Working Group
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision
WIT	Work Improvement Team
VLU	Viral Load Uptake

Foreword

Nairobi City County is Kenya's main commercial centre with a well-developed infrastructure and modern financial and communications systems. It hosts the country's largest industrial centre, which accounts for almost 20 percent of the gross domestic product (GDP).

As one of the county leading in the contribution of the HIV burden in Kenya, there is need for a responsive mechanism to be put in place to address the epidemic. With close to 160,000 residents, including 11,104 children, out of a population of 3,517,325 who are living with HIV, this need is further exuberated.

Nairobi continues to host a highly mobile population comprised of regional refugees and rural to urban migrants and this has implications on the accessibility of health services. The transitional aspect of their health seeking behaviours can hinder the advancement of achieving the 90-90-90 targets. With additional factors such as poverty in the ever growing informal settlements and lingering stigma and discrimination particularly among key population and young girls, the risk of contracting HIV significantly increases.

The development of the Nairobi City County HIV & AIDS Strategic Plan 2015/2016 – 2018/2019 is a clear indication of Nairobi County Government's commitment to addressing the challenges of HIV and AIDS in the county in line with the Paris Declaration of 2014, where we signed up to fast track and end the HIV epidemic in cities by 2030.

This strategic plan is aligned with the recently launched National Kenya AIDS Strategic Framework (KASF) 2014/2015 – 2018/2019, the Kenya HIV Prevention Roadmap and the Nairobi City County Strategic and Investment Plan (NCCSIP).

The Nairobi City County government, under my leadership, is committed to facilitating the achievement of the goals of this strategic plan by allocating required resources as well as enhancing public private partnerships (PPPs), collaborating with the donor community and engaging the Nairobi City County community toward a City County free of new infections and AIDS-related deaths.

Nairobi City County will endeavour to provide quality health services to residents.

H.E. Dr. Evans Kidero
Governor, Nairobi City County

Preface

Nairobi City County is committed to providing quality and targeted health services that respond to the unique challenges that come with high and diverse populations in capital cities.

The development of the Nairobi City County HIV & AIDS Strategic Plan is one of the key steps towards this commitment. This strategy is guided by the National AIDS Control Council (NACC) strategic framework, which outlines the HIV and AIDS response in the country.

The County HIV & AIDS Strategic Plan builds on the gains made in the country's HIV and AIDS response before devolution and also addresses the current gaps in the county. In addition, the plan has set up a structure in line with the devolved government under the leadership of the Governor to ensure that HIV and AIDS control is entrenched in the devolved system of government.

The strategic framework provides direction on the implementation, coordination and monitoring of HIV prevention, care and treatment services in Nairobi City County. Guided by the Kenya AIDS Strategic Framework (KASF), the county has outlined its vision, goal and objectives as follows:

- Reduce new HIV infections by 75%
- Reduce AIDS-related mortality by 25%
- Reduce HIV-related stigma and discrimination by 50%
- Increase domestic financing of the HIV response by 50%

The overarching aim of this HIV & AIDS Strategic Plan is to see a county free of HIV infection, stigma and AIDS-related deaths. It will also contribute to achieving Vision 2030 through universal access to comprehensive HIV prevention, care and treatment services.

As a county we will be open to collaboration and work closely with the private sector, faith-based organisations, development partners and community-based organisations in addressing the goals of this strategic plan.

Dr. Bernard Muia
County Executive Member for Health Services, Nairobi City County

Acknowledgement

We wish to acknowledge the contributions by various individuals and organisations for their exceptional dedication to putting together this valuable document for Nairobi City County.

The Nairobi City County government, led by His Excellency the Governor Dr. Evans Kidero, provided the strategic leadership that guided the technical teams in their deliberations. Financial support to the technical teams to meet and discuss the HIV and AIDS response for the county is highly appreciated.

We extend our gratitude to the County Executive Committee Member for Health Services – Dr. Bernard Muia, and the County Director, Department of Health Services – Dr. Thomas Ogaro for their contribution and technical leadership in the development process of the HIV & AIDS Strategic Plan, a clear indication of their commitment towards realising the objectives of this plan.

Many thanks also go to the National AIDS Control Council (NACC) for initiating the Strategic Plan development process after the KASF dissemination meeting held in August 2015, and subsequent technical support in developing the county-based strategic plan for the HIV and AIDS response.

Special thanks also go to the Nairobi City County technical team under the leadership of Dr. Caroline Ngunu-Gituathi – Deputy Director for Preventive & Promotive County Health Services/CASCO, for their persistence to ensure that the HIV & AIDS Strategic Plan was developed.

We can also not forget to thank our development partners for their support. They include: USAID/Kenya, East Africa Afya Jijini program, University of Maryland-PACT program, LVCT and UNAIDS, who provided both technical and logistical support.

Dr. Samuel Ochola
County Chief Officer of Health, Nairobi City County.

Executive Summary

The Nairobi City County (NCC) HIV & AIDS Strategic Plan seeks to provide direction in the overall coordination and delivery of the HIV response to effectively and efficiently deliver HIV programming in the county. It focuses on cost-effective and socially inclusive interventions towards prevention, treatment and management of HIV and AIDS. The Nairobi City HIV& AIDS Strategic Plan has been developed in line with the Kenya AIDS Strategic Framework (KASF) 2014/2015 – 2018/2019, addressing the unique challenges of the county in HIV programming. The following are the objectives of the KASF that have been adopted by the strategy:

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

NCC is one of the leading counties contributing to the HIV burden in Kenya, with close to 160,000 people living with the virus, including 11,104 children. Being the capital city, Nairobi hosts highly mobile populations. The in-and-out population flows due to internal migration and refugees (external migration notwithstanding), are factors that put people at increased risk of contracting HIV.

Although the last decade has seen a consistent decrease in HIV prevalence rates – from a high of 14% at the peak of the epidemic to the current rate of 8% – the number of new infections in Nairobi remains high, at about 3,200 a year, with 39% HIV-TB co-infection and nearly 4,000 AIDS-related deaths. In addition, Nairobi hosts a large proportion of Key Populations (KPs), which includes sex workers, men having sex with men and injecting drug users. There is high HIV prevalence rates in these populations ranging from 18 to 30%. The HIV prevalence among women in Nairobi City County is at (8.4%) while that of men is at (5.3%). Low adult condom use of less than 50% (KDHS 2014) contributes to the risk of infection among the general population.

This plan establishes strategies to address the high rate of HIV infections, especially among key populations, adolescents and pregnant women. This HIV & AIDS Strategic Plan also contains a review of past HIV control activities, with the program strengths, weaknesses, opportunities and threats documented to help in choosing the best approaches and implications to HIV control in the county.

The strategic plan considered implementing a multi-faceted approach to address HIV infections due to the unique environment of the City County. This involves: Increasing the number of drop-in centres for key populations; integrating HIV services with reproductive health (RH) and Maternal, New Born, Child and Adolescent Health (MNCAH) services to ensure mothers'/women access to HIV services; focusing on orphans and vulnerable children (OVC) to ensure that adolescents remain HIV-negative; and enhancing school health programs to include HIV testing, treatment and support groups, among others. The City County will also enhance community health systems to ensure retention in HIV care and treatment, as well as improve the referral system for follow-up.

In addition, the county will enhance research to support evidence-based programming, as well as scaling up best practices, e.g. Mentor Mothers, Drop-in Centres (DICs) and Youth Friendly Services.

The following is a summary of the strategic directions for the response to HIV in Nairobi City County.

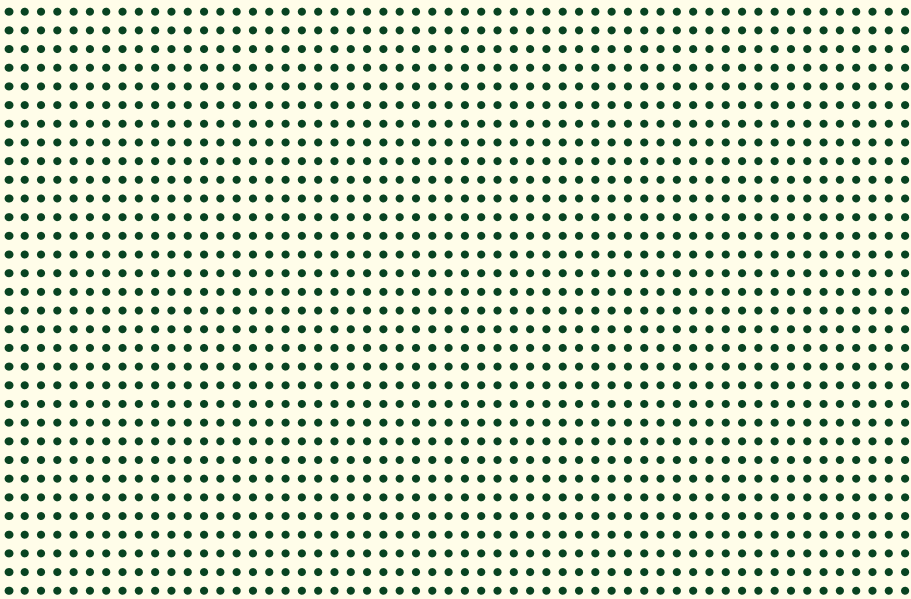
The strategic plan also provides a results framework and implementation plan that will support monitoring of implementation. This strategic plan will be disseminated to the County Assembly, private sector and development partners for mobilisation of resources as well as implementation of activities.

Table 1: Summary of strategic directions for the response to HIV in Nairobi City County.

Strategic Direction Area	Specific objective	Key intervention area
SDA 1: Reducing new HIV infections	• To identify and target the priority populations for HIV services	• Increase coverage of combination HIV prevention services, especially in the informal settlements and among key populations
SDA 2: Improving health outcomes and well-being of all people living with HIV	• To improve HIV services for people living with HIV (PLHIV)	• Increase HIV testing services (HTS) and enhance retention to HIV care and treatment. Strengthen community health systems and linkages
SDA 3: Using a human rights-based approach to facilitate services for PLHIV, key populations and other priority groups in all sectors	• To increase equitable access to HIV services to PLHIV	• Identify and remove barriers to HIV services through sensitisation/ training of healthcare workers on offering HIV services to priority groups. Increase access to services by establishing additional DIC and youth friendly services
SDA 4: Strengthening integration of health services and community systems	• To strengthen linkage between health services and community systems for the HIV response	• Strengthen HIV information education activities and strengthen the activities of CHAs and CHVs through training/updates. Improve the reporting and referral systems
SDA 5: Strengthening research and innovation and information management	• To strengthen research to encourage evidence-based HIV planning and programming	Enhance data capture and capacity building in operational research
SDA 6: Promoting the utilisation of strategic information for research and monitoring and evaluation (M&E) to enhance programming	• To strengthen monitoring and evaluation of the HIV program	• Strengthen monitoring and evaluation (M&E) capacity and data use for decision-making and scale-up Electronic Medical Records (EMR) • Develop comprehensive HIV M&E systems, guidelines and standard operating procedures
SDA 7: Increasing domestic financing for a sustainable HIV response	• Promote innovative and sustainable domestic HIV financing options in the county	• Policy/legislation on financing of HIV activities at the county level, including fundraising activities
SDA 8: Promoting accountable leadership for delivery of the HIV strategy	• To strengthen the leadership and coordination of the Nairobi City County HIV Strategic Plan	• Dissemination of the HIV strategy, establishment of the County HIV coordinating committees, and establishment of the County HIV TWG and ICC

01

NAIROBI CITY COUNTY BACKGROUND



Location

Nairobi City County is one of the 47 counties in the Republic of Kenya. It borders Kiambu County to the North, Kajiado County to the South and Machakos County to the East. Among the three neighbouring counties, Kiambu County shares the longest boundary with Nairobi City County. The County has a total area of 696.1 km^2 and is located between longitudes 36"45 East and Latitude 1"18 South.

Demographics

From the 2009 population census, the NCC population is estimated at 3,517,325, comprising 1,718,267 females and 1,799,058 males. It has an annual growth rate of 3.8%. The population distribution shows the age group of under-15s accounting for 30.3% of the total population, the young adult age groups of 15-29 years accounting for 38.6%. The reproductive age groups of 15-49 years accounts for 40.2%, with figures of 22% and 18% for males and females respectively. Those over 60 years old are 2% of the population.

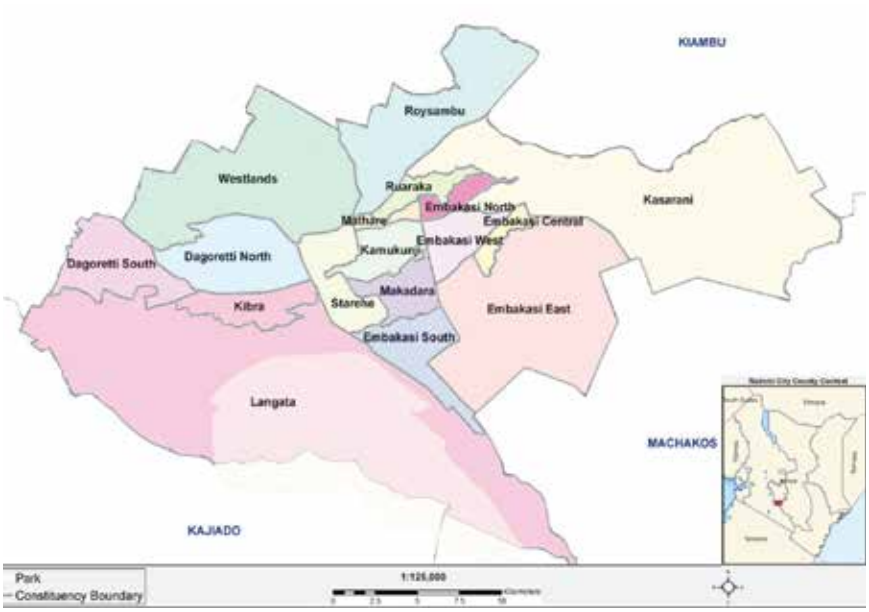
Many citizens work in the city during the day but reside in neighbouring counties such as Machakos, Kiambu and Kajiado.

Nairobi City County consists of 17 sub-counties and 85 wards. Four (4) sub-counties have population densities of over 20,000 people per square kilometre. These are: Mathare, Embakasi North, Ruaraka and Kamukunji. The least densely populated sub-counties are Westlands, Lang'ata, Kasarani and Embakasi East. It is estimated that about 58% of Nairobi's population lives in slums or slum-like conditions (UN Habitat 2010) and that there are about 55,000 refugees and asylum seekers living in the city (UNHCR 2013).

Socio-Economic Background

Nairobi is the main commercial centre of the country, with leading domestic and international banks operating out of Nairobi, and hosting the country's largest industrial centre, which accounts for around 20 percent of the gross domestic product (GDP).

Figure 1: Map of Nairobi City County - Constituency Boundary



Additionally, NCC has a well-developed infrastructure, including modern financial and communications systems. Real estate entrepreneurs have contributed to the development of the county, building many residential houses that provide accommodation to people who live and work in the capital city. Other enterprises include hotels and entertainment businesses, mostly located along the major roads and highways. Industries that deal with food processing and manufacturing of various products, principally processed food, beer, vehicles, soaps, construction materials, engineering, textiles, and chemicals are also located in the industrial area of Nairobi, and these sectors offer employment to many people. There is also a thriving sector that provides employment to carpenters, metal workers, furniture makers, vehicle repairmen, and retailers.

Areas around Nairobi have prime agricultural land. Horticulture is a new agricultural growth sector. The principal food crops grown in the neighbouring areas are maize, sorghum, cassava, beans and fruits. Cash crops such as coffee are grown by small-scale farmers. Flower export is an important source of foreign exchange revenue.

Nairobi is the centre for many tour companies and travel agencies which contribute to the well-developed system of hotels, top-rated tour companies and the country's spectacular game parks and the beautiful coast. Tourism is an important part of Kenya's economy. City hotels range from low-cost budget hostels to luxury hotels which offer good value and excellent services. Nairobi also has a diverse and multicultural population. There are a number of churches, mosques, temples and gurdwaras within the city. Prominent places of worship in Nairobi include the Cathedral Basilica of the Holy Family, All Saints Cathedral, Ismaili Jamat Khana and Jamia Mosque.

Education and Literacy

Literacy is the ability to read for knowledge, write coherently and think critically about the written word. It involves, at all levels, the ability to use and communicate in a diverse range of technologies. Education is very critical for economic development. This section describes the pre-school education, primary education, literacy levels, secondary education and tertiary education situation in Nairobi City County.

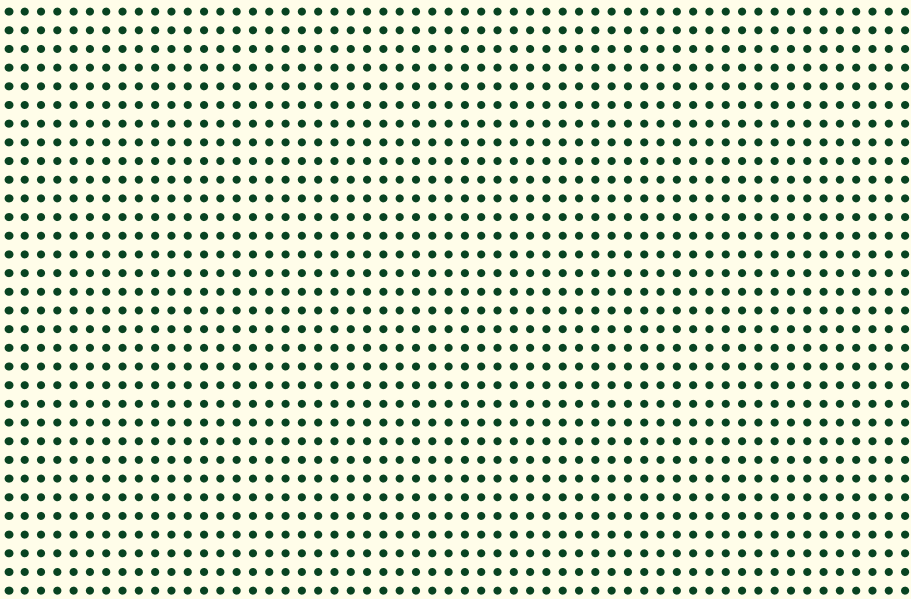
The county has 2,906 Early Childhood Education (ECD) centres with a total of 8,470 ECD teachers. The teacher-pupil ratio in the pre-primary school setting stands at 1:34.

The County has 1,235 primary schools and a total enrolment of 429,280; with 207,056 boys and 222,224 girls. The average years of attendance for primary school are 8 years, while the retention rate is 96.4 percent. The transition rate to secondary school is currently at 65.7 percent. (Nairobi County Integrated Development Plan, 2014.)

Nairobi City County has 319 secondary schools with 2,359 teachers. The total enrolment is 49,728; with 26,755 boys and 22,973 girls. The county hosts two public universities: University of Nairobi and the Technical University of Kenya. There are ten private universities and 16 campuses operated by both public and private universities in the county. Most of the campuses are located within the Central Business District (CBD). In addition, the county has 237 science and technology institutes. Nairobi has a total of 5,015 adult literacy centres, where enrolment for male learners is 2,627 and 2,388 for female learners. Concerning the literacy level, 96.1 percent of the population can read and write, while 2.8 percent of the population cannot read and write (Nairobi County Integrated Development Plan 2014).

02.

SITUATION ANALYSIS



Nairobi City County is one of the leading counties contributing to the HIV burden in Kenya. As a capital city, Nairobi hosts highly mobile populations with in-and-out population flows due to internal migration and refugees (external migration notwithstanding). The county also features factors that put people at increased risk of contracting HIV, particularly among key populations and young girls. These factors include rapid urbanisation, high levels of poverty in ever-growing informal settlements and lingering stigma and discrimination.

Nairobi hosts a large proportion of key populations (KPs), including sex workers men having sex with men (MSMs) and injecting drug users who have the highest HIV prevalence rates.

The main modes of HIV transmission in Nairobi are through heterosexual liaison within unions, sex between regular partners, casual sex among men who have sex with men (MSM)/ prison populations and between sex workers and their clients. These four groups account for over 90% of new infections. People who inject drugs (PWID) also contribute a high number of new infections nationally.

Despite the importance of HIV testing as a way to increase prevention and treatment, about a third of people in Nairobi City County had never tested for HIV by 2009 (KDHS, 2008/9). More than half of individuals in Nairobi County had their first sexual intercourse before the age of 18, an indication of early sexual debut, which increases vulnerability to HIV infection, especially among women. (KDHS 2014).

Cash transfer programmes have shown that they can reduce HIV risk by delaying sexual debut, pregnancy and marriage among beneficiaries aged between 15 and 25. However, only a small fraction of poor households with orphans are beneficiaries of a cash transfer programme in NCC.

Most communities in Nairobi practice male circumcision, with majority of men who participated in a national survey in 2009 reporting that they had been circumcised. This has been proven to reduce the risk of female to male transmission of HIV.

Table 2: Health and HIV Indicators as at 2015

			Data source
Total population (2013)		3,781,394	National Census, 2009
% Population growth rate(between 1999-2009)		2.9	Kenya National Bureau of Statistics (KNBS,2009)
HIV Adult Prevalence		**8%**	Kenya HIV Estimates Report, 2014
Adults	Living with HIV	145,668	NASCOP Program Data,2015
	New HIV infections annually	3,098	Kenya HIV Estimates Report, 2014
	HIV related deaths annually	3,579	Kenya HIV Estimates Report, 2014
	Receiving ART (CD4 Count <500)	111,482	DHIS,2015
	Need for ART	117,991	NASCOP Program Data,2015
	ART Coverage	**87%**	DHIS,2015
Children	Living with HIV	11,104	NASCOP Program Data,2015
	New HIV infections annually	316	Kenya HIV Estimates Report, 2014
	HIV related deaths annually	448	Kenya HIV Estimates Report, 2014
	Receiving ART	6,479	DHIS, 2015
	Need for ART	8,095	NASCOP Program Data,2015
	ART Coverage	**84%**	DHIS, 2015

			Data source
PMTCT	Need for PMTCT	4,982	Kenya HIV Estimates Report, 2014
	Maternal Prophylaxis	6,916 **(79%)**	DHIS, 2015
	Infant Prophylaxis	6,745 **(77%)**	DHIS, 2015
	ANC attendance (4 visits)	82,052 **(74%)**	DHIS, 2015
	HIV positive women who deliver in a health facility	**67%**	DHIS, 2015
Orphans and Vulnerable children beneficiaries	Households with an orphan	69,730	UNICEF, 2012
	Poor households with an orphan	34,168	UNICEF, 2012
	Cash transfer beneficiary household	2,534	UNICEF, 2012
Life Expectancy	Life Expectancy at birth for females (years)	**	KNBS,2009
	Life Expectancy at birth for males (years)	51	KNBS,2009
TB Incidence	TB incidence per 100,000 persons	514	MoH Fact Sheet, 2012

Figure 2: Adult HIV Care Cascade 2015

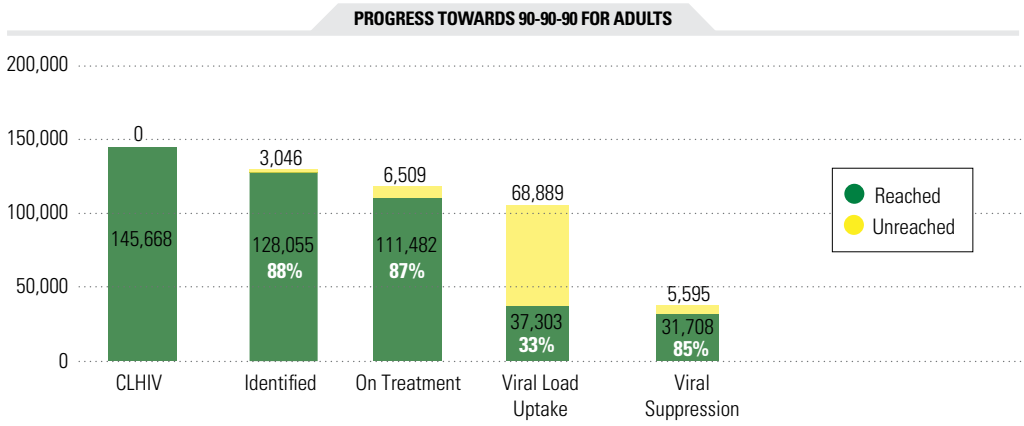
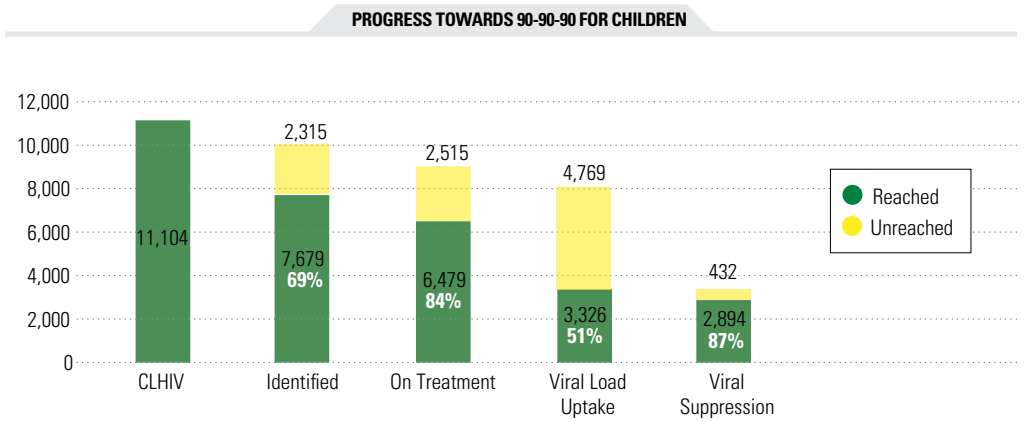


Figure 3: Children HIV Care Cascade 2015



NB: Viral Load Uptake refers to the proportion or number of the HIV+ people who have had their viral load tested.

Figure 4: ANC Cascade 2015

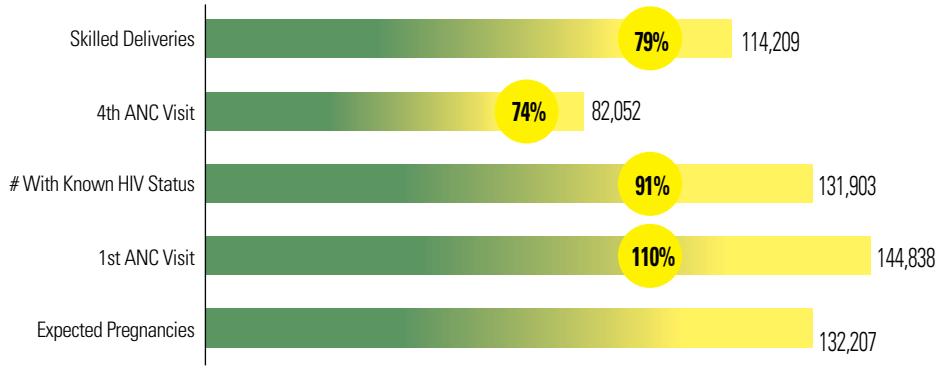


Table 3: Status of key interventions and gaps to be addressed during implementation

PROGRAMS	CURRENT STATUS	GAPS
BIOMEDICAL INTERVENTIONS		
HIV Testing and Counselling (HTC)	• 303 facilities providing services. • 83% of women and 71% of men have ever tested and received results. Out of these, 53% of women and 46% of men were tested in the last twelve months (KDHS, 2014). • From September to December 2015, testing uptake among key populations was low, with female sex workers (FSW) at 30%, PWID at 12% and MSM at 30% (NASCOP Program data). • Testing is mostly facility-based.	• Identification of new testers • Targeted community testing e.g boda boda riders, street families, people living with disability (PLWD), informal settlements, and adolescent girls and young women (AGYW) • Couple counselling and testing to identify sero-discordant couples • Retesting of high-risk individuals including key populations • Missed opportunities for linkage to care • Few outreaches, especially among the key populations
Condom Promotion, Distribution and Use	• Male condoms are available; however, there is a shortage of female condoms. • 19 percent of men in Nairobi reported having 2 or more sexual partners in the past 12 months, and among those, 45.7 percent reported using a condom during last sexual intercourse (Kenya DHS 2014) • Data also shows 43% consistent condom use among men 15-24 years with a partner of discordant or unknown HIV sero-status in the past 12 months. • 14% consistent condom use among men 25-64 years with a partner of discordant or unknown HIV sero-status in the past 12 months. • 11% consistent condom use among women 15-24 years with a partner of discordant or unknown HIV sero-status in the past 12 months. • 5% consistent condom use among women 25-64 years with a partner of discordant or unknown HIV sero-status in the past 12 months (KDHS 2014).	• Low condom use • Frequent stock-outs of male condoms • Lack of knowledge/skills on condom use • Negative attitudes towards condom use • Poor negotiation skills for condom use

PROGRAMS	CURRENT STATUS	GAPS
Voluntary Medical Male Circumcision (VMMC)	• 33 facilities providing VMMC services • 92% of men who participated in KAIS 2012 reported to have been circumcised	• No mapped data for non-circumcising communities • Lack of implementation/roll out of targeted interventions in line with the nationally-set guidelines
Elimination of Mother-to-Child Transmission (EMTCT)	• 188 out of 302 (62%) service delivery points provided PMTCT services. • 8,772 (176%) against a target of 4,982 HIV-positive pregnant women identified annually (DHIS 2015). • Uptake of first PCR was 5,007 women (57%), positivity rate done for first PCR was 190(2.8 positivity rate at 6 weeks). • HIV positive infants' linkage to care was 145/190 (3.8%). • At 18 months, the retention rate for infants was at 24%. • Maternal prophylaxis was at 79% • Infant prophylaxis was at 77%; • 91% of mothers were tested at ANC • First ANC visit was 144,838(110%); fourth ANC visit was 82,052 (74%); • 27% of HIV-positive women deliver in the hospital • (DHIS Program data, 2015).	• Weak Integration of EMTCT into MNCH • Inadequate skills in HIV care for MNCH staff • Low uptake of first PCR. • Low uptake of infant and maternal prophylaxis • Erratic supplies of HIV commodities (test kits) • Low retention of mothers in ANC
ART Coverage	• 189 facilities providing ART services out of 303 testing sites (62%). • Adults (>15yrs) - ART uptake is 87%, viral load uptake is 33%, viral suppression rate is 85% (DHIS, NASCOP Program data, 2015) • Children (<15yrs) - ART uptake is 84%, viral load uptake is 51%, viral suppression rate is 87% (DHIS, NASCOP program data 2015). • Adolescents (15-24yrs) – ART uptake is 57%, viral load uptake is 42%, viral suppression rate is 59% (Fast track plan to end HIV and AIDS NACC, 2015). • 3,579 adults and 448 children died of AIDS related conditions in 2013 (Kenya HIV Estimates Report, 2014)	• HIV testing and linkage to care and treatment are weak • High number of persons in need of ART • Low access to ART for children compared to adults
STI Screening and Treatment	• 1.34% of women tested positive for syphilis in ANC (DHIS, 2015) • Sexually transmitted infections (STI) screening and treatment has been integrated into the HIV care system • HPV vaccination has been introduced in Kenya but mainly given at private facilities • New curriculum and syndromic updates on STI management and revised by the national government • STI Screening among FSWs 43%, MSM 26%, PWIDs 27%; • with positivity rates for FSWs 3%, MSM 6%, and PWIDs 3% for at least one STI (NASCOP program data, 2015)	• Low uptake to STI treatment for PLHIV and key populations • Lack of STI kit for public facilities (lack of STI treatment) • Low coverage of Human papilloma virus (HPV) vaccinations • Curriculum not yet rolled out • Low screening for STI among KPs • (Should be higher than 50%) • Inaccurate data on STI for purposes of population estimates

PROGRAMS	CURRENT STATUS	GAPS
Health Facility HIV Infection Prevention Control	• Post Exposure Prophylaxis (PEP) available in all government facilities	• Stigma associated with health care workers (HCWs) • Data on needle stick injuries to capture HIV prevention practices
BEHAVIOURAL INTERVENTIONS		
Behaviour change programmes	• Nairobi has several behaviour change programs for the youth like Healthy Choices 1 and 2 • Early sexual debut in adolescents and young people (55% of individuals had their first experience of sexual intercourse before the age of 15) (HIV County profiles, 2014) • Average sexual debut for women is 17 years of age. • Average sexual debut for men is 16 years of age • 30% of men aged 15-24 years reported having two or more sexual partners in the past 12 months (KAIS, 2012) • 37% of women aged 15-19 years and 44% of men aged 15-19 have been sexually active; 86% of women aged 20-24 and 88% of men aged 20-24 years have been sexually active • Eleven per cent of women aged 15-24 and 22% of men aged 15-24 years have had sexual intercourse before age 15 • Forty seven per cent (47%) of women aged 18-24 and 58% of men 18-24 had sexual intercourse before age 18 • 13% of women 15-19 and 1% of men 15-19 have ever been married; 62% of women of 20-24 years and 17% of men aged 20-24 have at some point been married • Young women: Median age at first sexual intercourse: 18.3; median age at first marriage: 20.2; Gap between first sexual intercourse and first marriage: 1.9 • Young men: Median age at first intercourse: 17.4; median age at first marriage: 24.8; gap between first sexual intercourse and first marriage: 7.4 (Anderson R, Panchaud C, Singh S, and Watson K. "Demystifying Data: A Guide to Using Evidence to Improve Young People's Sexual Health and Rights." New York: Guttmacher Institute, 2013)	• Lack of coordinated approach towards targeted behavioural interventions (Adolescent Girls and Young Women (AGYW), KPs, informal settlements) • Lack of diversification in terms of geographical coverage
Interpersonal communication including peer-to-peer education in schools and workplaces	• All public schools have a school health programme	• Informal schools do not have school health programs
	• The Nairobi County education sector has a HIV workplace policy	• Inadequate mainstreaming of HIV prevention care and support in the workplace
STRUCTURAL INTERVENTIONS		
Social Protection, Cash Transfers for orphans and vulnerable children (CT-OVC), the elderly and the disabled	• Coverage of OVC households is 9% (69,730 households) • Only 2,534 out of 34,168 of households with a poor orphan benefited from a cash transfer program in 2013	• Low coverage of cash transfer beneficiaries

PROGRAMS	CURRENT STATUS	GAPS
Girls enrolled in secondary school	• Lower secondary school enrolment for girls (48%) and boys (51%), thus lower economic empowerment and gravitation of some youth to sex work	• Low transition rates from primary to secondary school
Building the resilience of women and girls	• Small-scale implementation of projects that combine on-going behavioural and structural interventions	• Low number of projects addressing empowerment of women and girls

Strength, Weakness, Opportunity and Threat (SWOT) Analysis

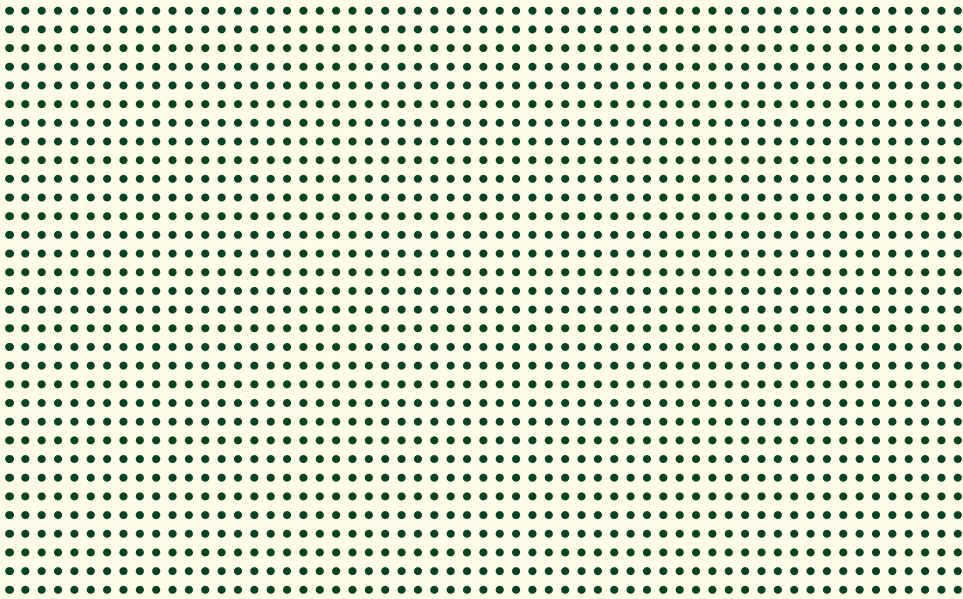
In developing this strategy the team identified a need to ensure that the proposed interventions are well-targeted and are improving the HIV response in the county. The SWOT analysis summary below highlights the achievements that can be built on, as well the challenges that need to be addressed.

Table 4: SWOT ANALYSIS

STRENGTHS	WEAKNESSES
• OVC programs are running well • Well-trained staff • High number of health centres with integrated HIV and AIDS services (189 with CCCs) • High rate of HIV and AIDS awareness - over 98% • Programs to address stigma in place • Active NACC decentralised structures for coordination • Establishment of 7 youth friendly clinics and services in the county • Mentor mother initiatives • Strengthened programs that focus on key populations and established drop-in centres	• High HIV and AIDS incidence especially among the adolescents and key populations • Resistance to behaviour change • Inadequate number of staff • High cost of trainings • Low level of funding • Erratic commodity supplies (both HIV test kits and drugs) • Data quality and research gaps • Inadequate Infrastructure
OPPORTUNITIES	**THREATS**
• Development partners supporting HIV and AIDS activities such as USAID, Global Fund, AMREF, and UNICEF • A rapidly growing and vibrant private sector comprised of financial institutions, small industries, horticulture, hotel industries, etc. with untapped resources, offering an opportunity for PPPs in funding HIV programs • Committed Civil Society Organisations (CSOs) • Supportive clients who seek treatment • Devolution offers a perfect opportunity for HIV prevention and treatment as it brings the control of resources closer to the community and shortens lengthy decision-making processes • Improved PPPs with partners and some private facilities	• Poverty • Food shortages • High level of unemployment • Increase in opportunistic ailments • Internally displaced persons exposed to risks of contracting HIV • Some NGOs not utilising funds to give the required services • Embezzlement of funds • Lack of harmonisation of stakeholders

03.

RATIONALE, STRATEGIC DEVELOPMENT PROCESS AND GUIDING PRINCIPLES



3.1 Purpose of the HIV & AIDS Strategic Plan

The Nairobi City County HIV & AIDS Strategic Plan seeks to provide direction in the overall coordination and delivery of the county's HIV response to effectively and efficiently deliver HIV programming. It focuses on cost effective and socially inclusive interventions towards prevention, treatment and management of HIV and AIDS.

3.2 Process of developing the plan

The development of the Nairobi City County HIV & AIDS Strategic Plan (NCCHASP) was initiated after the National AIDS Control Council (NACC) held a meeting for dissemination of the framework in August 2015. During this meeting, guidelines for developing the NCCHASP were disseminated and a technical working group (TWG) formed to spearhead the development of the strategic plan.

Further meetings were convened during the first week of April 2016 to review the draft and make final corrections on the NCCHASP. The validation process for the NCCHASP was completed in June 2016, before the launch of the strategic plan in August 2016.

The NCCHASP was developed through an in-depth analysis of available data and a highly participatory process involving a wide range of stakeholders from the Nairobi City County government, civil society, non-governmental organisations (NGOs), faith-based organisations (FBOs), networks of People Living with HIV (PLHIV), Key Populations, the private sector and various development partners.

After a situation analysis, the following were the guiding statements that were to be considered as they had a direct impact on developing the strategic plan:

1. **Implement a multi-faceted HIV & AIDS control program:** The program should take into account the fact that Nairobi City County is unique, given that it has a high population of almost four million people and has a high number of people living with HIV and AIDS (approximately 160,000). Additionally, due to urbanisation, NCC has a large number of key populations and adolescents who required tailored programs.

2. **Target the informal settlements:** The program should concentrate its efforts on the informal settlements, where over 60% of Nairobi's population reside. These areas are characterised by poverty and limited access to health services. Poverty results in activities that expose the population to HIV &AIDS, e.g. sex work and using drugs.

3. **Conduct more in-depth research:**
   a) Key population dynamics.
   b) Treatment regimens: Resistance patterns and drug effects.

4. **Scale-up best practices in HIV and AIDS control:**
   a) Kenya Mentor Mothers Program and Drop-In Centres.
   b) Beyond Zero Clinics in the slums to improve maternal and child health outcomes in relation to HIV and AIDS.
   c) OVC care to discourage early sex engagement, especially among adolescents.
   d) Focus on PLWD and the elderly.
   e) Test and Treat all diagnosed with HIV.

5. **Strengthen the coordination of HIV and AIDS control activities:** With the devolution of health services to the county level, it is necessary to re-orient and structure HIV and AIDS control activities and also strengthen the coordination of partners' efforts. The governor's office and other coordinating structures need to understand and provide a leadership role in HIV control within the county.

6. **Strengthen community strategy:** Through strengthening of the community strategy, ensure proper

follow-up and linkage of people living with HIV and AIDS with community support groups to improve adherence and reduction in viral load.

7. **Strengthen School health programmes:** To include testing for HIV, support for adherence to ART and linkage to support groups.

3.3 Guiding Principles

These will be the guiding principles for the NCCHASP.

- **Results-based planning and delivery:** HIV programming shall be linked to and demonstrate contribution towards the results of the KASF, 2014-2018 and the Nairobi City County Health Sector Strategic and Investment Plan, 2013-2018. During the planning process, the results achieved will be used to guide the allocation of resources and guide prioritisation of key areas of service delivery.

- **Scaling-up of quality improvement models for enhanced service delivery:** The County will focus on scaling-up quality improvement based on the Kenya Quality Model of Health by establishing and/or strengthening quality and work improvement teams.

- **Multi-faceted HIV and AIDS response approach:** Nairobi City County has populations with diverse economic, cultural, social and religious backgrounds that require a targeted approach. There is also a need to specifically handle the influx of workers during the day and frequent rural-to-urban and urban-to-rural migration that affects HIV transmission, care and treatment. There is a large number of key and vulnerable populations in NCC who need targeted interventions to reduce new HIV infections, stigma and discrimination and access to comprehensive care.

- **Prioritisation of informal settlements:** Sixty percent (60%) of people in Nairobi live in informal settlements and bear a large burden of HIV and AIDS due to their low social economic status and inability to access HIV care and treatment. There's a need to bring HIV interventions closer to the people, for example through the formation of more community units and outreaches for testing and linkage to care for these communities. There is also need to have economic empowerment programs to uplift their socio economic status.

- **Use of sound evidence base:** Use of resources, planning and implementation will be based on evidence with high value, high impact and scalable initiatives.

- **Resource mobilisation and allocation:** The County will mobilise funds and ensure adequate resources are provided for implementation of the plan.

- **Multi-sectoral partnership and networking:** The NCC government will spearhead the HIV and AIDS programs through a multi-sectoral approach, working with the national government and its agencies, other implementing partners, the private sector, faith-based organisations/ NGOs and the broader community.

- **Leadership and accountability:** The NCC government will provide oversight in the implementation of the NCCHASP and ensure that the HIV and AIDS programs are included as a measurable indicator in the performance contract signed with the county public service board.

- Based on the strategic direction, different stakeholders who will be implementing specific components will need to demonstrate a quality of service that is in line with the NCCHASP. To accelerate results and increase resources, an accountability mechanism will be established by the county health office through the partnership coordination unit.

- **Gender-sensitive approach and human rights advocacy:** The County will ensure gender equality and empowerment activities are integrated in all HIV programming activities. This includes addressing sexual and gender-based violence (SGBV) and increasing male involvement in health-related activities. Protecting and promoting the rights of the socially excluded, marginalised and vulnerable will contribute to the results of this plan.

- **Efficiency, effectiveness and innovation:** There will be efforts to explore and operationalize sustainable domestic funding options through improved efficiency in service delivery and innovative approaches aimed at achieving more reduced costs without compromising quality. One example is the use of Electronic Medical Records (EMR) in health facilities, mobile phone reporting by the community health workers and Point of Care testing.

3.4 Alignment with other national and international strategic frameworks.

The Nairobi City County HIV Strategic Plan is aligned with Kenya's Vision 2030, Kenya AIDS Strategic Framework (2014-2018), Nairobi County Integrated Development Plan (2014), National Health Sector Strategic Plan (2012-2017), Nairobi County Strategic Plan (2015-2025) and the Fast Track Cities: Ending the AIDS Epidemic.

1. **Vision 2030** defines health as a key building block for the transformation of Kenya into a successful middle-income country. HIV contributes significantly to the county's burden and needs to be addressed to achieve the desired health outcomes.

2. **KASF (2014-2018)** – The Nairobi County HIV Strategic Plan will be aligned with the vision, goal and objectives of KASF. KASF is the strategic guide for Kenya's response to HIV and it contributes to achievement of Vision 2030 through universal access to comprehensive HIV prevention, treatment and care.

3. **Nairobi County Strategic Plan (2015-2025)** provides a common understanding of Nairobi City County's priorities. It focuses on embracing strategic planning in order to strengthen operations, improving service delivery by realigning its priorities to the current situation and tracking progress.

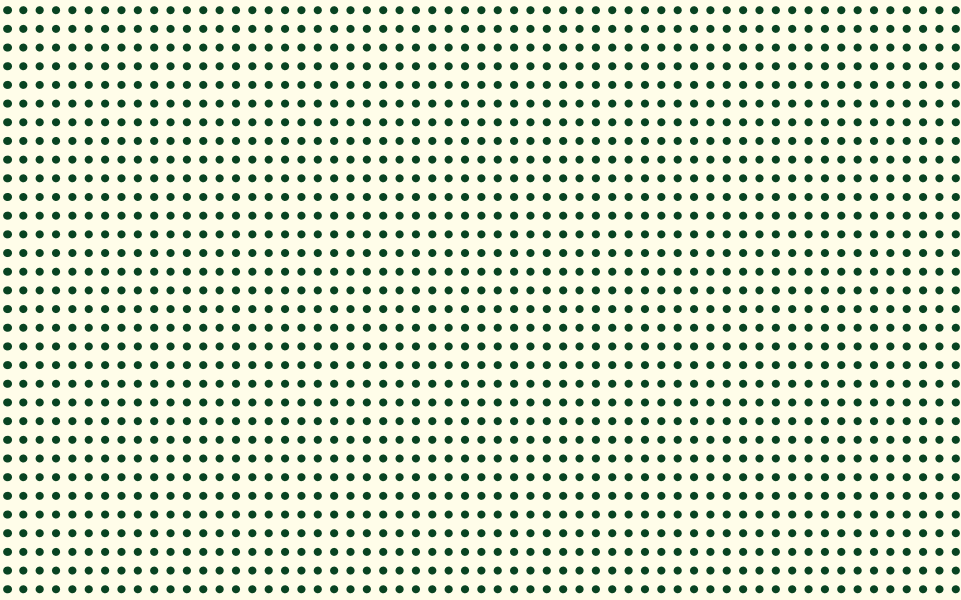
4. **Nairobi County Integrated Development Plan (2014)** outlines development plans that would guide county expenditure for effective planning and implementation of public programmes.

5. **Kenya Health Sector Strategic Plan (2012-2017)**, which outlines the health and community systems development priorities to ensure effective health service delivery. It also provides policy guidance on human resources for health (HRH), procurement and supply of pharmaceuticals and other medical products and health information systems, which impact the delivery of services for the HIV response.
In addition, the health sector leads the implementation of a large proportion of the HIV response.

6. **Fast Track Cities:** Ending the AIDS Epidemic is an initiative that focuses on fast tracking the HIV response in cities to achieve 90:90:90 targets by 2020 – 90% of people living with HIV knowing their status, 90% of people who are diagnosed HIV positive placed on treatment, and 90% of people on HIV treatment achieving viral suppression. Success will depend on cities frontloading investments and accelerating the pace of delivering.

04.

VISION, MISSION, GOAL, OBJECTIVES AND STRATEGIC DIRECTIONS



4.1 Vision

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

4.2 Goal

Contribute to achieving Vision 2030 through universal access to comprehensive HIV prevention, care and treatment services.

4.3 Mission

To provide quality, comprehensive HIV services that are equitable, accessible and sustainable to the population of Nairobi City County and beyond.

4.4 Objectives

The following objectives contribute to and are adapted from the strategic objectives in the KASF. These objectives will form the basis for the specific actions and activities that will contribute to the achievement of the Nairobi City County HIV& AIDS Strategic Plan.

1. Reduce new HIV infections by 75%.
   a) Reduce mother-to -child transmission of HIV from 8.1% to less than 3%.
   b) Increase testing amongst eligible clients at all health facilities from 40% to 80%.
   c) Reach and provide HIV testing and prevention services to 80% of all key and vulnerable populations.
   d) Scale-up targeted community-based interventions.

2. Reduce AIDS-related mortality by 25%.
   a) Enhance linkage to HIV care and treatment for 90% of all eligible children, adolescents, pregnant women, adults and key populations.
   b) Ensure provision of ART to 90% of all eligible children, adolescents, pregnant women, adults and key populations.
   c) Promote retention in HIV care and treatment for 90% of all eligible children, adolescents, pregnant women, adults and key populations.
   d) Provide access to viral load testing and ensure viral suppression for 90% of all HIV patients on ART.
   e) Ensure screening and treatment for opportunistic infections (OIs) and STIs for 100% of all HIV positive patients.
   f) Strengthen quality improvement.

3. Reduce HIV-related stigma and discrimination by 50%.
   a) Reduce incidents of reported stigma from 40% to 20%.
   b) Reduce levels of SGBV experienced by priority populations by 20%.
   c) Increased protection of human rights and improved access to justice for PLHIV and other priority groups.

4. Increase domestic financing of the HIV response to 50%.
   a) Maximise efficiency of existing delivery options for increased value and results within existing resources.
   b) Promote innovative and sustainable domestic HIV financing options in the county.
   c) Develop an HIV investment criteria for resource allocation in the county to align resource to needs.
   d) Implement a partnership accountability framework to ensure alignment of resources to NCCHASP priorities.

As articulated in the KASF, the Nairobi City County Strategic Plan will adopt the following strategic directions:

Table 5: Strategic directions to be adopted by Nairobi City County

SDA 1: Reducing new HIV infections	**SDA 2:** Improving health outcomes and well-being of all people living with HIV	**SDA 3:** Using a human rights-based approach to facilitate services for PLHIV, key populations and other priority groups	SDA 4: Strengthening integration of health services and community systems
SDA 5: Strengthen research innovation and information management to meet the Nairobi City County HIV Strategy goals	**SDA 6:** Promoting the utilisation of strategic information for research, monitoring and evaluation to enhance programming	**SDA 7:** Increasing domestic financing for a sustainable HIV response	**SDA 8:** Promoting accountable leadership for delivery of the NCCHASP results by all sectors

4.5 Strategic Directions

4.5.1 Strategic Direction 1: Reducing New HIV infections

Nairobi is one of the nine counties that contribute 65% of new HIV infections in Kenya annually. The main modes of HIV transmission in Nairobi are through heterosexual sex within unions, between regular partners and through casual sex, and among MSM/prison populations and between sex workers and their clients.

The county also has a high number of key populations (MSM, SW and PWID) who contribute nearly 30% of new HIV infections annually. It is estimated that there are a total of 50,000 MSMs, SW and IDUs in Nairobi City County.

Two thirds of the population of Nairobi live in the informal settlements, where drivers of HIV infection including poverty dominate and the population is mobile. Overall, Nairobi is clustered as a medium incidence county with annual infections of 1,000-4,999. Prevalence of HIV among pregnant women is 8%, and with a high number of pregnant women, this translates to a high number of HIV-infected pregnant women annually.

Table 6: SD 1: Reducing New HIV Infections

KASF Objective	NCCHASP Sub-objective	Key Activity	Sub-Activity/ Intervention
			Biomedical
Reduce New HIV infections by 75%	a. Reduce mother-to child-transmission of HIV from 8.1% to less than 3%	All pregnant and breastfeeding mothers access PMTCT services	• Test 95% of all pregnant/breastfeeding women. • Immediate initiation onto ART for all HIV-positive pregnant and breastfeeding mothers • 90% have optimum viral suppression. • All HIV-exposed infants (HEIs) are put on prophylaxis • Optimum follow- up of HEI for up to 2 years • Minimize/ eliminate mother to child transmission of HIV during labour and delivery
	b. Increase testing among eligible clients at all health facilities to 80%	Increase HIV testing in all service delivery points in health facilities	• Engage more HIV testing and services (HTS) providers in health facilities • Train/sensitise HCWs on HTS • Offer HTS to all patients visiting health facilities
	c. Reach and provide HIV testing and prevention services to 80% of all vulnerable and key populations	Increase access to HTS for KPs and vulnerable populations	• Conduct integrated outreaches and in-reaches • Quarterly re-testing for KPs • Provision of key commodities, including lubricants and condoms. • Implement medication-assisted therapy (MAT) program • Screen for alcohol and provide addiction support • Screening and management of HPV among the FSW/MSM and Hepatitis B&C for PWIDs • Scale-up STI management • Establish youth friendly clinical services
	d. Scale-up targeted community-based interventions	Increased access to HIV services by target populations	• Targeted HTS outreaches for target populations in the general population Provide door-to- door services to populations such as domestic workers and house wives. • Provide VMMC services

	Behavioural	Structural	Target Population	Geographic areas by County/ Sub-county	Responsibility
	• Implement the Kenya Mentor Mothers program • Conduct in-reach activities: e.g. evening and weekend services	Engage CHVs to strengthen linkages between the facilities and community and train them on their role on HIV prevention and EMTCT/ PMTCT	All HIV-positive pregnant and breastfeeding mothers, their babies, and their partners	Entire county	County Department of Health, sub-counties, facilities and partners
	• Utilize IEC materials to create demand for services. • Encourage couples/ partner testing	• Ensure national guidelines on stigma reduction are utilised. • Encourage and provide opportunities for family testing. • Deliver the integrated HTS package, including screening for TB, STIs and cervical cancer screening • Dissemination of HTS guidelines • HIV testing introduced in the Non communicable disease (NCD) clinics/treatment points	General population	Entire County	County Department of Health, sub counties, facilities and partners
	• Promote correct and consistent condom use • Regular contact through peer education and treatment support • Offer harm reduction interventions • Stigma reduction • Offer peer-to- peer outreaches in and outside of schools • Implement evidence based interventions such as Sister to Sister, Respect K and Shuga • Use of pre-exposure prophylaxis (PrEP) & PEP to eligible clients	• Map hotspots • Scale-up Drop–in centres • Implement cash transfer programs • Strengthen protection of rights of KPs to deliver non-discriminatory services	MSM, FSWs, PWIDs, OVCs, PWDs, prisoners and AGYW	• Hotspots in entire County • Informal settlements • Children's homes. • Correctional facilities • Schools and colleges	County Department of Health, sub counties, facilities and partners
	• Implement evidence-based behavioural interventions • Targeted health promotion messages and materials such as T-shirts, caps, etc. • Conduct support groups • Peer-to-peer outreaches	• Economic empowerment	Boda boda riders, construction workers, matatu sector, street families	Entire County	County Department of Health, sub counties, facilities and partners

4.5.2 Strategic Direction 2: Improving Health Outcomes and Wellness of People Living with HIV (PLHIV)

Nairobi City County has the highest population in Kenya compared to the other counties, translating to a high number of HIV-infected individuals. Its HIV prevalence remains below the national average. The county is home to the highest numbers of KPs and vulnerable populations who have high HIV prevalence. Due to the high percentage of mobile populations and a high number of people working in Nairobi City County but residing outside the city, the need for HIV care and treatment could be higher than estimated. For example, access to HIV care and treatment for KPs has remained low.

Priority Interventions:

NCC identifies the following as the key gaps to improving health outcomes and wellness of PLHIV:

1. **Health systems-related barriers:** Health systems-related barriers exacerbate the gaps in the cascade of care, including identification, linkage, retention, and viral suppression. These barriers include limited access to and unequal geographical distribution of services, human resource inadequacies, poor referral and tracking mechanisms, commodity and supply-related challenges and limited infrastructure for information management systems.

2. **Diagnosis and linkage to care:** Late provision or lack of HIV diagnosis and suboptimal linkage to care is a challenge. For key populations, legal barriers, stigma and negative provider attitudes reduce access to care.

3. **Care and treatment coverage:** There is disproportionately lower coverage of ART in children and adolescents. Sub-optimal integration of screening, prophylaxis and management of co-infections and co-morbidities result in high attrition of those enrolled. PLHIV experience stigma, impacting their decisions related to disclosure and adherence, particularly among priority and key populations.

4. **Gaps related to quality of care and treatment services and viral suppression:** Quality of care, use of EMR and evidence-informed interventions at the facility level and viral load monitoring all need improvement. In addition, there is limited coordination and support to quality of care by other sectors, such as learning institutions, nutrition, legal and social services.

This strategic plan aims to ensure prompt linkage and retention in HIV care services of those diagnosed with HIV; timely initiation into treatment for those eligible to achieve optimal viral suppression; and improved quality of care and treatment outcomes. The focus of this strategic plan is to put NCC on the path to achieving the 90-90-90 targets by 2020.

It also aims to fast track the Paris Declaration to end the HIV epidemic in the cities signed by the County in December 2014.

- **Improve timely identification, linkage and retention in care for persons diagnosed with HIV:** Targeted HTC strategies will be utilised to increase the detection rate for HIV positive cases. Identifying each individual on treatment for tracking and follow-up will be essential to reduce losses in the treatment cascade, especially with the influx of patients expected during scale-up. The interventions recommended for linkage to care for those diagnosed with HIV are both population-specific and general

strategies. Priority strategies to improving linkage to care include developing the county's capacity to track and link points of testing and points of treatment. These will include:

a) **Increasing coverage of care and treatment and reducing those lost to follow up in the cascade of care** - Retention in care and treatment in the short and long-term requires clear identification of points where patients are lost within the cascade of care and addressing these at service delivery points and county levels. This also requires recognising the need to focus on different populations (by age, sex and sexual activity) depending on their situation, challenges in the cascade of care and treatment and reasons for attrition.

b) **Improving quality of care and treatment outcomes** - Improvement of quality of care and health outcomes involves routine analysis, use of health and program data and strengthening systems to meet patient and program needs.

Table 7: SD 2: Improving Health Outcomes and Wellness of PLHIV

KASF Objective	NCCHASP Sub-objective	Key Activity	Sub-Activity/ Intervention
			Biomedical
Reduce AIDS-related mortality by 25%.	a. Increase linkage to HIV care and treatment to 90% of all eligible children, adolescents, pregnant women, adults and key populations	• Introduce family testing of HIV positive patients • Run campaigns on self-testing • Link all people who tested HIV positive to care and treatment services and document	• Conduct same-day enrolment • Integrate distribution of ART into other service delivery points (e.g. TB clinics and MNCH clinics) • Increase number of ART sites to ease access
	b. Ensure provision of ART to 90% of all eligible children, adolescents, pregnant women, adults and key populations	Start all HIV-positive patients on ART treatment in line with national guidelines	• Sensitisation of HCWs on current ART guidelines • Conduct CD4 testing to all HIV positive clients not on ART, as per national guidelines
Reduce AIDS-related mortality by 25%	c. Promote retention in HIV care and treatment for 90% of all eligible children, adolescents, pregnant women, adults and key populations	Enhance adherence counselling and defaulter tracing	• Fast-tracking the patients at triage sites • Capacity building of HCWs on counselling patients for retention on care and treatment for different populations • Use of appointment and defaulter tracing diaries • Use of mentor mothers and peer educators to enhance adherence
Reduce AIDS-related mortality by 25%	d. Provide access to viral testing and ensure viral suppression for 90% of all HIV patients on ART	Ensure access to viral load testing to all patients in care	• Establish sample networking in the county • Improve laboratory monitoring for all patients • Establish facility-based multidisciplinary teams • Establish systems in various facilities to review switching of patients to second/third line treatment • Establish a viral load review system
Reduce AIDS-related mortality by 25%	e. Ensure screening and treatment for OIs and STIs for 100% of all HIV positive patients	Early diagnosis and management of OIs and STIs	• Screen for TB using ICF tool during all visits • Conduct GeneXpert testing for all presumptive TB cases • Sample networking for GeneXpert • IPT initiation for all eligible HIV positive clients • Screening and treatments for other OIs and STIs • Conduct CMEs for capacity building for OIs and STIs to CHVs, CHAs and patients • OIs and STIs treatment commodities supply chain strengthened

	Behavioural	Structural	Target Population	Geographic areas by County/Sub-county	Responsibility
	• Enhance pre- and post-test counselling to create an understanding for the importance of enrolment	• Utilise linkage registers at all testing sites. • CHVs and linkage counsellors to escort patients to care clinics • Conduct follow-up through peer educators, mentor mothers, CHWs, and phone calls	All HIV-positive clients	Entire County	County Department of Health, sub-counties, partners and networks of PLHIV
		• Strengthen commodities security (reporting, forecasting/ projections) • Establish more central and stand-alone ART sites	All eligible clients.	All comprehensive care clinics in the county.	County Department of Health, sub counties, facilities and partners
	• Establish and enrol clients in psychosocial support groups (PSSGs) • Utilise technology (e.g. bulk SMS) to send reminders for appointments and drug adherence • Long period appointments for stable clients and use of decentralised ART models as per national guidelines • Use of CHVs and CHAs at the community level for ART adherence and retention in care	• Provide supported disclosure • Provide friendly services to targeted groups • Implement school-based programs to address stigma	All eligible clients Treatment literacy materials for patients and caregivers, especially in schools (house mothers, matrons, school heads), religious leaders and herbalists/ alternative medicine	All comprehensive care clinics in the county	County Department of Health, sub counties and partners
	• Conduct patient literacy. • Conduct adherence counselling	• Establish county viral load testing centres	All eligible clients	All CCCs in the county	County Department of Health, sub-counties and partners
	• Conduct health talks to sensitise clients on OI prevention • Provide IEC materials with targeted information for CCC clients	• Establish facility-based IPC committees	All clients enrolled in care	All facilities in the county	County Department of Health, sub counties and partners

4.5.3 Strategic Direction 3: Using Human Rights-based Approach to Facilitate Access to Services

The Constitution of Kenya (2010) outlines gender equality, in Article 27, as one of its key principles and prohibits discrimination on the basis of sex, pregnancy and marital status. It states: (4) The State shall not discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth.

Kenya's HIV and AIDS Prevention and Control Act, 2006 provides the legal framework to address HIV providing for protection and promotion of public health, the appropriate treatment, counselling, support and care of persons infected or at risk of HIV infection. Access to justice is embedded in the establishment of the HIV and AIDS Tribunal.

Stigma and discrimination have been identified as barriers to HIV prevention and uptake of care and treatment services, making it challenging for the socially excluded, poor and vulnerable people who are living with HIV to take up services. The Kenya Stigma Index Survey (2013) reported stigma and discrimination at over 40%. An estimated 15% of PLHIV reported discrimination by a health professional through disclosure of their sero-status without their consent.

Gay, bisexual and other men who have sex with men; transgender people; people who inject drugs; and sex workers are socially marginalised, often criminalised and face a range of human rights abuses that increase their risk of HIV infection. This contributes to significantly lower access to uptake of relevant services for these populations than for other groups.

The stigma associated with HIV and TB infection in many settings means that often those who have been diagnosed with one of these illnesses experiences additional risks for co-infection, marginalisation and/or human rights abuses. Similarly, women and girls, including transgender women, experience an increased biological vulnerability to HIV and are disproportionately exposed to violence and other forms of gender oppression that increase the risk of HIV. Young people from key populations face increased marginalisation as age-related laws and policies can hinder their ability to access HIV-related and other health services.

Priority Interventions:

- **Remove barriers to access of HIV, sexual reproductive health (SRH) and right information and services in public and private entities.**
  Barriers to accessing information are individual, community and structural. At the community level, stigma and discrimination, gender inequalities, social norms and cultural practices dictate who has easier access to different services. Adolescents and young people, especially women, are more likely to be negatively impacted by these barriers to access services. Uptake by women of maternal health services, including EMTCT services, is also impacted. Structural exclusion includes poor dissemination of information, poor uptake and implementation of policy guidelines, insufficient financial resource allocation and discriminatory services at facilities and other service delivery points.

- **Improve county legal policy environment for protection and promotion of the rights of priority and key populations and PLHIV**.
  The need to have an enabling legal and policy environment has been identified by the Global Commission on Law and HIV as a key intervention in the reduction of new infections. This, in addition to ensuring access to justice for PLHIV

and key populations when violated, is key to ensuring HIV interventions are responsive to the human rights needs of these groups. An enabling legal and policy environment is necessary for a robust HIV response at the county level to ensure access to services by PLHIV and priority and key populations.

Table 8: SD 3: Using a Human Rights based approach to facilitate access to services

KASF Objective	NCCHASP Sub-objective	Key Activity	Sub-Activity/ Intervention	
Reduce HIV related stigma and discrimination by 50%.	Reducing incidences of reported stigma by 50% Reduce levels of SGBV by 20%	• Increase equitable access to HIV services • Increase the number of facilities offering integrated HIV/SGBV services. • Increase the number of HCWs and CHVs trained from 220 to 600.	• Increase the number of drop-in centres (DICE) from 13 to 20 • Increase facilities offering KP-friendly services from 4 to 7 • Integrate KP services into public facilities • Establish 12 youth friendly facilities • Integrate SGBV/HIV services in the 10 sub-counties • Sensitisation of HCWs on KPs, adolescents, and SGBV survivors • OJT and mentorship in KP friendly HIV service delivery • Advocacy and awareness-raising on KP and SGBV programs to law enforcement officers and the political arm (policy makers) of the county • Sensitisation of the religious groups on KPs, adolescents, and SGBV survivors • Formation of a county crisis response team • Ensure that staff trained in KP/SGBV are posted to facilities in areas serving high populations of KPs and SGBV survivors	
		Training of HCWs	• Training 320 HCW on KPs programming and HIV updates • Develop innovative approaches for providing PLWD with HIV services and programs, including access to IEC materials	
		Advocacy	• Develop protocols on advocacy for KP programming • Train county teams on advocacy skills • Establish M&E framework • Develop a crisis response team	
	Increased protection of human rights and improved access to justice for PLHIV, priority groups, and key populations	• Enact guidelines on human rights protection for all • Influence county lawmakers to accommodate HIV programming when enacting by laws	• Responsive budgeting for HIV programming • Awareness creation among county policy makers on HIV programming particularly among KPs and SGBV programming • Domesticate and disseminate national policies and legal frameworks into county-specific policies and laws • Create awareness on the HIV and AIDS tribunal to county teams, policy makers and partners	

	Target Population	Geographic areas by County/Sub-county	Responsibility
	PLHIV, MSM, FSW,PWID Adolescents Survivors of SGBV County Government	All sub counties	County government, sub counties and partners
	HCW, CHVs, CHMT, and peer educators		County government and partners
	Policy makers, local leaders, law enforcement agencies, opinion leaders, PLHIV		County officials, CBOs, law enforcement, religious groups, and human rights groups
	Policy makers, local leaders, law enforcement agencies, opinion leaders, PLHIV, KPs and general public		

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

One of the key development commitments of the Government of Kenya is the provision of universal health coverage to its citizens by 2030, as articulated in the 2010 Constitution and further reaffirmed in Sessional Paper No. 7 of 2012 on Universal Health Care.

In Kenya, the government health systems have limited resources and are supplemented by non-governmental providers such as FBOs, CBOs and/or NGOs working in collaboration with government systems or in parallel systems that may or may not be linked with national/county health systems. Community systems thus have a role in linking health systems to people in communities, and in providing community inputs into health systems. At the same time, health systems are just one part of a wider set of social support systems that are relevant to people's health and well-being.

Priority Interventions

- **Provision of a competent, motivated and adequately staffed health workforce for the county to deliver integrated HIV services into the essential health package**.

  The Kenya healthcare system experiences an acute shortage of qualified and competent Human Resources for Health (HRH).

  Other identified challenges to HRH include: Skewed distribution of HCWs geographically; high levels of attrition; unfavourable working conditions; lack of adequate functional structures to support performance; weak staff performance appraisals; lack of a mechanism to link training institutions involved in pre-service training with the services and updates needed at the facility level; and inadequate policy guidelines on competencies and skills required for specific cadres, coupled with inadequate facilities for in-service training.

- **Strengthen the health service delivery system at the county level for the provision of integrated HIV services into the essential health package.**

  The general service readiness index for provision of HIV and AIDS services stands at 67%, implying that only 67% of facilities are ready to provide Kenya essential package for health (KEPH) defined HIV and AIDS services. With continued scale-up of HIV interventions, and in the absence of corresponding strengthening of other service delivery structures, the quality of HIV services is compromised. Out of the 495 registered health facilities in Nairobi, only around189 currently offer comprehensive HIV services that include treatment.

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

  Health products and technologies are key components of a strong health system. In the context of the HIV program, health products that support HIV services delivery are generally called HIV commodities. These HIV commodities include antiretroviral medicine (ARV) and medicine to manage opportunistic infections (OIs), HIV test kits, CD4, viral load and other diagnostic test reagents, condoms and nutritional supplemental and therapeutic feeds.

  Periodic stock outs and poor distribution of HIV commodities due to transport challenges, limited storage space and poor storage conditions in medical stores at the county and health facility

level are other challenges in the system. There are also issues with weak and parallel HIV commodities Logistics Management Information Systems (LMIS), weak community involvement in these processes and weak capacity to generate, manage and utilise strategic information for effective and efficient commodity management ,especially at the sub county and health facility levels.

- **Strengthen the community and workplace service delivery systems at the county level for the provision of HIV prevention, treatment and care services.**

  Community systems are complementary to and closely connected with health systems and services. Both community and workplace systems engage in delivery of health services and, to a greater or lesser degree, in supporting communities' access to and effective use of those services.

  In addition, community systems have unique advantages to engaging in community mobilisation, demand creation and linkage of communities to services. They also have key roles in health promotion and delivery of community health services, and in monitoring health systems for equity and quality of services. Community actors are also able to play a systematic, organised role in advocacy, policy and decision-making, and in creating and maintaining an enabling environment that supports people's health and reduces the effects on people vulnerable to poverty, discrimination, marginalisation, criminalisation or exploitation and harmful socio cultural practices.

  Community-based organisations (including FBOs/NGOs/CSOs), workplaces and local community leadership play a critical role not only in promoting the ownership of addressing the HIV epidemic, but also in addressing the root causes of vulnerability to HIV, including skewed gender relations, harmful cultural practices, pervasiveness of stigma and discrimination and commonality of violence against key populations.

  Some of the key challenges facing community and workplace-based HIV programs include weak leadership and governance structures, inadequate financial, human and material resources, lack of capacity for planning and monitoring their programs, poor quality data, lack of capacity to use strategic information, poor community linkages with formal health systems and lack of M & E tools for evaluations.

Table 9: SD 4: Strengthening Integration of Community and Health Systems

KASF Objective	NCCHASP Sub-objective	Key Activity	Sub-Activity/ Intervention
1. Reduce new HIV infections by 75% 2. Reduce AIDS-related mortality by 25% 3. Reduce HIV-related stigma and discrimination by 50%	HIV services integrated in community health units	Strengthen the integration of community and health systems	• Scale-up the provision of home-based care for HIV through community health units • Targeted training of CHAs, CHVs, HCWs on HIV • Strengthen the referral and linkage system from community to facility • Develop innovative approaches for increasing access to HIV care and treatment services and maternal child health services
	Increase in the number of persons reached using targeted interventions and messages	Integrated approach to community outreach	• Conduct regular targeted outreach for HIV services to target groups, including key populations • Link support groups to health care workers for mentorship • Economic empowerment for support groups
	50% of the schools have HIV school health programs	Integrate HIV into school health programs	• HIV prevention, adherence and retention of children • Sensitisation of teachers on HIV and Aids in both formal and informal schools (15 per sub-county) • Integrate HIV information and education as part of the school health program
	Strengthen quality improvement	Establish quality and work improvement teams (QIT/WIT)	• Strengthen departmental WITs • Operationalize QITs • Build capacity of HCWs on quality improvement • Establish quality improvement (QI) County and Sub-county TWGs

4.5.5 Strategic Direction 5: Strengthen Research, Innovation and Information Management to Meet the Nairobi City County HIV Strategy Goals.

Although information exists on HIV, including information adopted from different national surveillance studies (such as KAIS and MOT) for this strategic plan, there are still research gaps in understanding drivers of the HIV epidemic, including by population. Data and research on social determinants of health and their impact on incidence and mortality are scarce, and there are limited studies on the impact of stigma, discrimination, cultural practices, and gender norms on prevention, mortality and quality of life.

There is a lack of synchronisation of research and data between the health, community, and other systems, with research and data collection from NGOs, hospitals and universities often not being fully captured in the development of national frameworks. This raises a need to have a central archive/ portal coordinated by the county to store and disseminate information and to inform evidence-based programming, policy development and research priorities at the county level. Additionally, HIV research is still largely donor-dependent and is, therefore, not always harmonised with national HIV research priorities. One solution is to strengthen the county operational research unit to effectively coordinate these activities.

	Target Population	Geographic areas by County/ Sub-county	Responsibility
	HCWs, CHAs, opinion leaders, CHVs	All sub counties	County Department of Health, All sub-counties and partners
	Establish more community health units	KPs, adolescents, youth, support groups	County Government, sub counties and partners
	Health workers, teachers, pupils and partners	All sub-counties	County Department of Health, all sub-counties and partners
	All clients enrolled in care	All facilities in the county and sub-counties	County Department of Health, all sub-counties and partners

Priority Interventions

- **Resource and implement a HIV research agenda informed by the County HIV Strategy.**

  There is need to have a unified research agenda for HIV to address emerging challenges and gaps so that there is evidence-based programming. Greater emphasis will be placed on identifying high-impact research priorities, as well as building the capacity of health care workers to conduct research.

- **Increase evidence-based planning, programming and policy changes.**

  There is a need for a stronger emphasis on research and innovation to generate timely evidence to inform the scale-up of policy, programming and interventions. The county will establish ad-hoc research committees to identify research priorities, determine policy changes from existing research, as well as establishment of a central archive/portal coordinated by the county to store and disseminate health research findings.

Table 10: SD 5: Strengthening Research Innovation and Information management to meet Nairobi County HIV Strategic goals

KASF Objective	NCCHASP Sub-objective	Key Activity
• Reduce new HIV infections by 75% • Reduce AIDS-related mortality by 25% • Reduce HIV-related stigma and discrimination from 40% to 20% • Increase domestic financing of the HIV response from less than 10% to 50%	• Ensure quality HIV data in the county is available • Ensure evidence-based programming	• Strengthen research and information management (collection, aggregation, analysis and use) • Identify and implement high-impact research priorities

4.5.6 Strategic Direction 6: Promote Utilisation of Strategic Information for Research and Monitoring and Evaluation to Enhance HIV Programming in Nairobi City County.

The HIV surveillance system in Kenya has been characterised by a set of high quality national level surveys (KAIS and KDHS) and facility-based HIV sero-prevalence surveys. The data from these sources is used to provide trends in HIV prevalence and incidence. IBBS surveys and research studies have also been conducted in a number of cities and urban centres to track HIV-related risk behaviour and the burden of HIV and AIDS among key populations.

Monitoring and evaluation (M&E) of the county's multi-sectoral response to HIV and AIDS continues to rely on a variety of systems, data sources, routine collection, periodic collection and collation systems, which are supported and maintained by various stakeholders.

The achievement in monitoring the HIV Program has, however, not been without challenges. The M&E system is faced with gaps in strategic approach on coordination, ownership and meaningful data use for decision-making and planning among various stakeholders, levels and sectors.

Another important gap is that both the programmatic data available for routine monitoring of programs and the sentinel surveillance data that facilitates modelling trend analysis are not sensitive enough to adequately detect emerging trends in the epidemic. Additionally, the analytical capacities at the county level are weak and will need to be strengthened to effectively address the strategic data needs at this level. County ownership and recognition of the importance of an effective and efficient M&E system are yet to be established.

	Sub-Activity/ Intervention	Target Population	Geographic areas by County/Sub-county	Responsibility
	• Capture relevant patient information at health facilities and community level. • Strengthen capacity of health care workers to conduct research and promote mortality and morbidity data capture • Conduct operational research on emerging issues in HIV programming • Undertake a stigma and discrimination index study • Undertake a study on socio-cultural factors that influence the spread of HIV in the county • Conduct operational research on emerging issues in HIV programming • Avail data tools/EMR at facilities • Promote data use and proper recordkeeping at health facilities • Develop a data warehouse in the county • Establish ad-hoc research committees to identify county research priorities and determine policy changes based on existing research • Advocacy for increased funding for research • Multi-level cross-sectoral collaboration to improve research funding	County and sub county managers, HCWs, community, health facilities, work places, Nairobi County HIV Coordinator	All sub-counties	County managers, sub-counties

Priority Interventions

- **Improved data quality and data use.**

  As the routine M&E systems become more accessible, a renewed focus on improving data quality, demand and use of data for decision-making at the county and health facility levels will be given priority.

- **Increased funding towards M&E activities.**

  Adequate funding for M&E activities, ownership and support for establishing and maintaining a HIV M&E system and data quality assurance at the county and sector levels will be prioritised.

Table 11: SD 6: Interventions for Promoting the Utilisation of Strategic Information for Research and Monitoring and Evaluation to Enhance HIV Programming in Nairobi City County

KASF Objective	NCCHASP Sub-objective	Key Activity	
• Reduce new HIV infections by 75% • Reduce AIDS-related mortality in adults by 25% • Reduce HIV-related stigma and discrimination from 40% to 20% • Increase domestic financing of the HIV response from less than 10% to 50%	• Strengthen HIV M&E data management • Quality of HIV services improved	Promote data demand and use of HIV strategic information to inform policy and programming	
	Data for HIV programming is available	Collection of HIV data	
	Progress report on achievement of the strategy	Review midterm progress of the strategic plan	
	Information for review of the next strategic plan is available	Review end term progress of the strategic plan	
	ICC makes informed HIV decisions	Hold quarterly M&E meetings and report to the County ICC	

4.5.7 Strategic Direction 7: Increased Domestic Financing for a Sustainable HIV Response.

Following devolution, over 90 percent of the Nairobi City County funds for health have been set aside for use in the development of infrastructure, human resources and essential medical equipment. To-date, the national government and implementing partners have been the main supporters of HIV programs and activities. Although in the last three years there has been no direct allocation in the health budget line for HIV programming from the NCC government, the government has allocated Sh4 million towards HIV programming from the direct budget, after lobbying and advocacy, in FY 2016/2017.

Although it is stipulated that HIV services will be free to all patients in Kenya, patients/clients are sometimes paying out-of-pocket for HIV services, depending on the service delivery access points.

HCWs may also incur out-of-pocket costs in the delivery of services when on official duty. Support for HIV activities has mainly been for capacity building, supportive supervision, data quality assessments and improvements and stakeholder engagement and performance reviews, among others.

	Sub-Activity/ Intervention	Target Population	Geographic areas by County/Sub-county	Responsibility
	• Conduct periodic data quality assessments/checks • Conduct M&E supervision. • Performance reviews • M&E capacity development for staff • Scale up EMR • Develop guidelines and standard operating procedures for comprehensive HIV M&E systems • Advocacy for increased financing for HIV- related M&E • HIV yearly newsletter prepared and distributed	Health facilities and sub-counties, HCWs, communities, work places	All sub-counties	County and sub county management teams (CHMT/ SCHMTS), NASCOP, NACC
	• Undertake a Nairobi City County HIV baseline survey • Print and distribute M&E tools for collection of HIV data			
	Undertake a mid-line review of the NCCHASP		All sub-counties	
	Undertake an end line review of the NCCHASP			
	Quarterly M&E review meetings			

Priority Interventions:

The county has identified promoting effective cost-saving models for HIV and AIDS service delivery as a priority area. These interventions include:

- Reduce training costs by implementing on-job training (OJT) models that utilise the national harmonised HIV training curriculum.
- Rationalise the ART collection system – this will reduce the distribution and referral costs associated with laboratory referrals.
- Integration of HIV/RH and MNCH services.
- Strengthened coordination among implementing partners to ensure alignment to County priorities, reduce duplication and double counting of results, and enhance county ownership of the HIV response.

Table 12: SD 7: Increasing Domestic Financing for a Sustainable HIV Response.

KASF objective	NCCHASP Sub-Objective	NCCHASP Results	Key Activity	
Increase domestic financing of the HIV response from less than 10% to 50%	• Promote innovative and sustainable domestic HIV financing options in the county • Maximise efficiency of existing delivery options for increased value and results within existing resources	Policy on HIV financing developed	Draft and legislate a bill on HIV financing through the County Assembly	
		Increased domestic financing for HIV response in the county	• Advocate among the County Assembly members to increase county-level financing for HIV • Resource mobilisation from local partners and the business community • Mapping of partners and their resource envelopes • Hold planning meeting and undertake activities to raise funds for HIV	
	Develop HIV investment criteria for resource allocation in the county to align resources to needs	Ensure equitable distribution of resources in the county	• Establish Public Private Partnerships • Allocate finances for HIV to respond to the HIV burden in the county	
	Implement a partnership accountability framework to ensure alignment of resources to NCCHASP priorities	Resources from partners identified and quantified for the county	Mapping of partners and their resource needs	

4.5.8 Strategic Direction 8: Promoting Accountable Leadership for Delivery of the CASP Results by all Sectors.

The first case of HIV was discovered in Kenya in 1984, and consequently HIV was declared a national disaster in 1999. In response to the situation, the NACC was created under legal notice no.170 of 1999 to coordinate a multi-sectoral response at the country level.

Under the previous constitution, the MoH and NASCOP had the responsibility of treatment and care for PLHIV, and the HIV response in the country has always been guided by the Kenya National AIDs Strategic Plan (KNASP) I, II and III. The present KASF 2014/15 – 2018/19 was developed under the new constitution. In Nairobi City County, the CASP guides the coordination and implementation of HIV programmes at the county level.

	Sub-Activity/Intervention	Target Population	Geographic areas by County/sub- county	Responsibility
	Development of a policy paper and bills on increasing domestic financing for HIV at the county level	County Assembly Health Committee, Senior CHMT, Constituency AIDS Control Coordinators (CACCs), CASCO	Nairobi City County	County government, NASCOP, NACC
	• Advocate for specific budgets for HIV activities in every Annual Work Plan and budget • Engage local celebrities in fundraising for HIV activities • Lobby for funds from social corporate responsibility from all sectors • Establish Public Private Partnerships	CACCs, CASCO, partners	Nairobi City County	County government, NASCOP, NACC
	• Stakeholders meetings • Granulation of data on the HIV burden per Sub-county for Nairobi	CACCs, CASCO, partners	Nairobi City County	County government, NASCOP, NACC
	• Carry out partner mapping exercise • Establish a county HIV partners' directory	CACCs, CASCO, partners	Nairobi City County	County government

The county will endeavour to build political commitment for ownership of the HIV response through engagements with the County Assembly. Advocacy for resource allocation for HIV response will also continue.

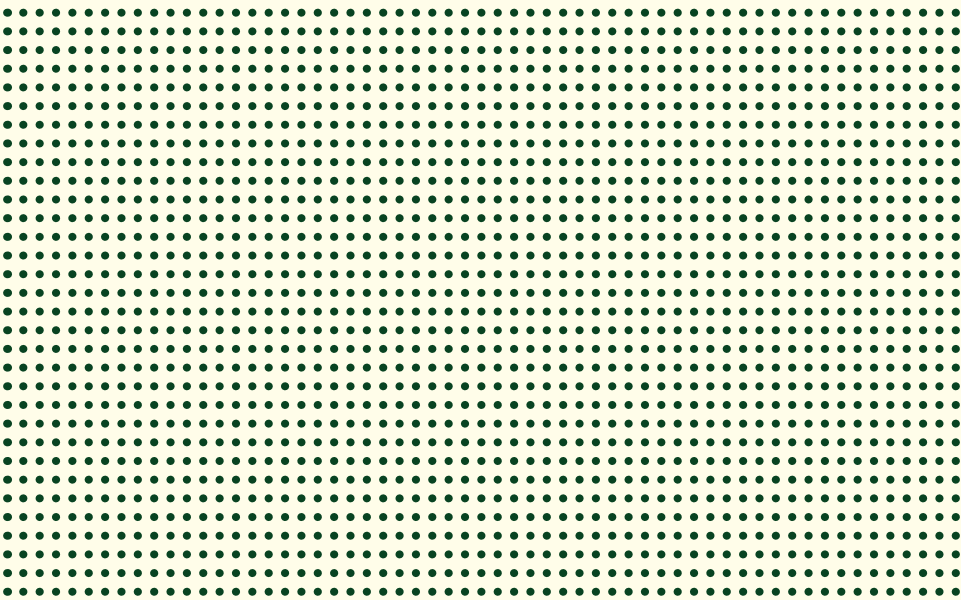
Table 13: SD 8: Promoting accountable leadership for delivery of the Nairobi City County HIV strategic plan

KASF objective	NCCHASP Results	Key Activity	Sub-Activity/Intervention
• Reduce new HIV infections by 75% • Reduce AIDS-related mortality by 25% • Reduce HIV-related stigma and discrimination by 50% • Increase domestic financing of the HIV response from less than 10% to 50%.	• Establish and implement the NCCHASP	• Disseminate and roll out the NCCHASP	Print copies and launch of the NCCHASP
			• Hold meetings to disseminate the NCCHASP to the Nairobi County Assembly Health committee, All Sub-County Facilities, FBOs, stakeholders in Nairobi County
	• County HIV Oversight committee formed and meeting quarterly	• Formation of a county HIV coordinating committee	• Form the County HIV Oversight Committee and hold quarterly meetings • Advocate for the operationalization of budget tracking for the health sector account
	• County HIV ICC formed and meeting biannually	• Conduct biannual coordination meetings for the ICC	• Form the County HIV ICC and hold biannual meetings
	• Constituency AIDS control committees strengthened	• Constituency committees meeting regularly and reporting	• Support constituency AIDS committees
	• Partnership accountability framework established/developed	• County PPP framework and MOU developed	• Implement the PPP framework, MOU as well as the partnership and accountability framework
	• HIV TWGs formed at county and sub-county levels • Marking of HIV Health Days	• TWGs meet and make informed decisions on a quarterly basis • World AIDS Day, International Condom Day events supported	• Strengthen County TWGs and establish sub-county HIV TWGs • Campaigns against HIV and AIDS

	Target Population	Geographic areas (County)	Responsibility
	County and Sub-county teams and partners	Nairobi City County	County government, national government (NASCOP, NACC), Health sector budget champions, development partners
		Nairobi City County	County government, national government (NASCOP, NACC), Health sector budget champions, development partners
	County and Sub-county teams and partners	Nairobi City County	County government, national government (NASCOP, NACC), Health sector budget champions, development partners
	County and Sub-county teams, partners	Nairobi City County	County government, national government (NASCOP, NACC), Health sector budget champions, development partners
	County and Sub-county teams, partners	Nairobi City County	County government, national government (NASCOP, NACC), Health sector budget champions, development partners
	County Health Department and partners	Nairobi City County	County government
	County Sub-county team and partner	Nairobi City County.	County government, national government (NASCOP, NACC), Health sector budget champions, development partners

05.

IMPLEMENTATION ARRANGEMENTS



5.1 Stakeholder Coordination, Leadership and Accountability

Implementation of this strategic plan will require stakeholder coordination, political leadership and accountability. The County HIV Partnership office will register all the partners, sign a memorandum of understanding (MoU) on HIV service delivery and targets and ensure partner's accountability for results and reporting.

The County Executive Committee Member for Health will chair the County HIV Committee. The County HIV Committee will provide leadership, mobilise resources, set the county HIV agenda, approve county HIV targets, approve the county HIV Plans/Strategy, present county HIV budgets to Health Sector Working Group and County Assembly. It will also receive and approve reports on county HIV plan performance and routine M&E from the county HIV Plan Monitoring Committee, receive reports from the county HIV ICC/Stakeholder forum and receive and approve work plans and reports from the Sub-County HIV committees.

5.2 Sustainability

There is a risk of reliance on external funding sources to sustain operations. Due to the changes in the funding climate and the financial challenges in the national government, Nairobi City County should begin to consider ways of sustaining its own strategic plan.

County leaders could consider beginning to seek each other out to explore potential partnerships to ensure sustainability of implementing the strategic plan. The following are some of the ways Nairobi City County can mobilise resources:

1. Establish high level partnerships with organisations that have similar strategic goals to reduce duplication of efforts.

2. Demonstrate value and accountability by continuously engaging in evaluation activities and consistently communicating the status of evaluation efforts to investors, demonstrating accountability and increasing trust, leading to more funding.

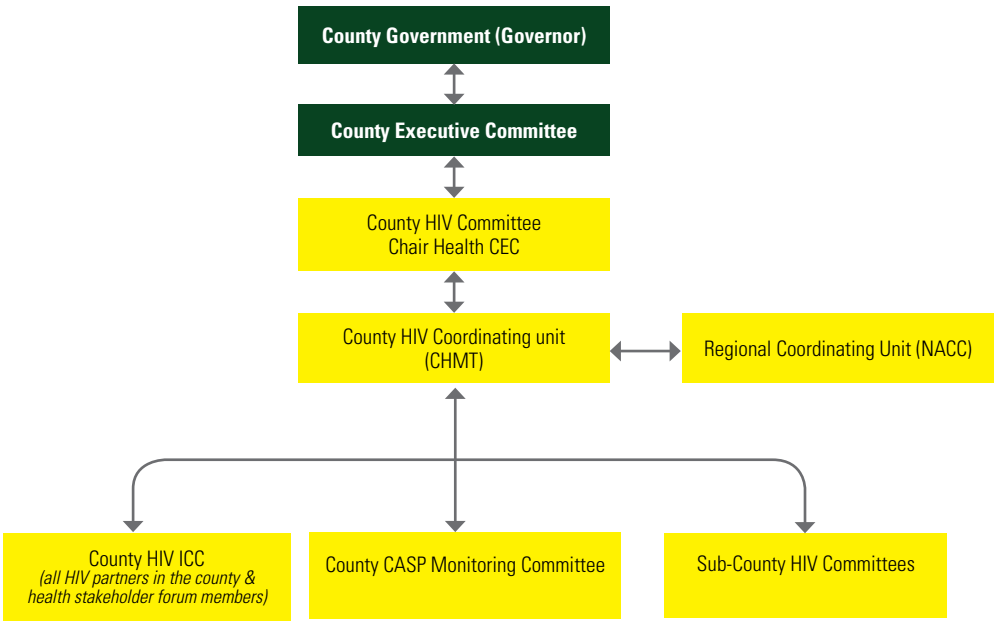
3. Engage volunteers through community outreach, which can also promote sustainability.

4. Formalise collaborations with private sector investors and private hospitals.

5. Allocate a portion of the county budget to HIV-specific activities in the county's operational plans.

6. High levels of political goodwill are required to effectively address the impact of HIV.

Figure 5: County HIV Coordination Mechanism



Roles and responsibilities

Governor

The governor shall implement national and county legislation to the extent that the legislation requires, and is responsible for the delivery of a range of services, planning and prioritisation of resource allocation to address the HIV burden in Nairobi City County.

County HIV Committee

The County HIV Committee shall be accountable to the Governor of the Nairobi City County for the performance of the functions of the County HIV Committee and the exercise of their powers on matters relating to HIV and AIDS.

Membership

The committee shall be chaired by the County Executive Committee member (CECM) for health with CASCO/NACC regional coordinator as the Secretariat. Membership of the County HIV Committee will include: Chair; Health Assembly, Partners, County Commissioner and/or a representative, Sub County Health Management Team (SCHMT) representative, private sector, FBOs, PLHIV, youth and PLWD. The committee can co-opt three members from relevant departments in the county.

Roles:

The County HIV Committee shall:

- Be the custodian of the NCCHASP.
- Hold meetings on a quarterly basis to review the implementation plan.
- Be responsible for the effective delivery of the HIV response at the county level through periodic reviews and monitoring progress against the NCCHASP.
- Guide the county HIV program targets and plan.
- Review and source for funding for the county HIV Budget.
- Set the county HIV agenda.
- Receive and review reports on NCCHASP progress from the monitoring committee.
- Receive and review reports from the County ICC and the NCCHASP monitoring committee.

County HIV Coordination Unit

This will be the responsibility of the County Director of Health's office, in partnership with NACC Regional office. The unit shall coordinate the day-to-day implementation of the strategic framework at the county level.

Roles

The County HIV Coordination Unit shall:

- Ensure quarterly county ICC HIV meetings are held and follow-through on county ICC HIV actions.
- Ensure that the HIV agenda is active in the CHMT.
- Regularly engage all state and non-state actors within the county in planning, prioritisation, implementation, monitoring, and evaluation of HIV and AIDS programmes.
- Strengthen linkages and networking among stakeholders and provide technical assistance, facilitation and support for Nairobi CASP delivery.
- Monitor county legislation to ensure that bills enacted do not discriminate against HIV positive clients.

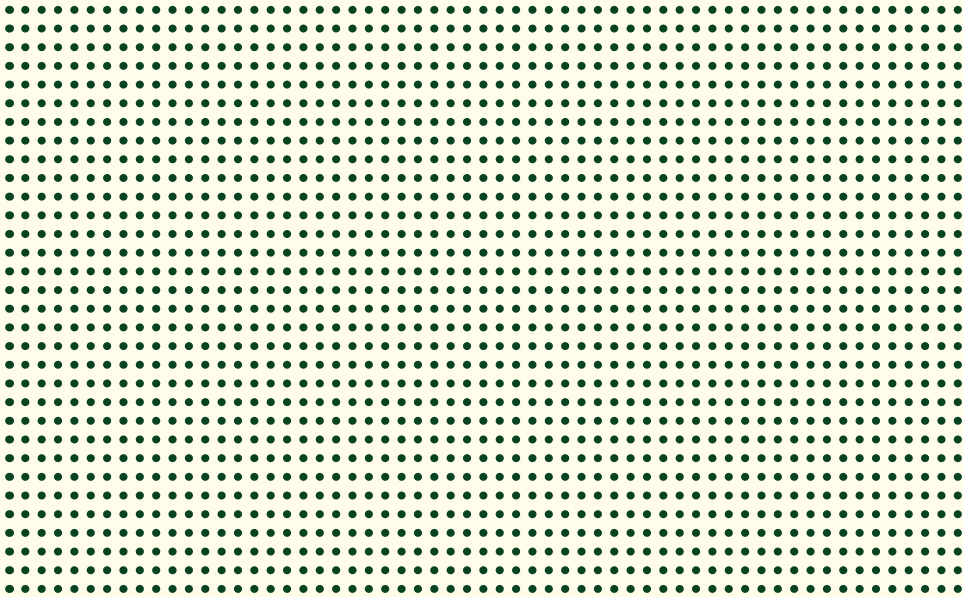
Monitoring and Evaluation Unit

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

- Ensure that all the prerequisite tools and materials for data collection are available at the points of service delivery.
- Build the capacity of HCWs on data collection and transmission.
- Ensure collection, collation, data quality, interpretation and dissemination of data.
- Ensure the preparation, publication, and dissemination of a County Department of Health newsletter on an annual basis, to include health articles, data and human interest stories, including on HIV.

06.

MONITORING AND EVALUATION PLAN



- The M&E unit of the County Department of Health is in place, with an M&E TWG representing all the programs. The TWG is inclusive of partners, inter-sectoral departments and county staff. At the sub-county level, there are established M&E units comprised of program heads who support the health facilities. Facility-based data is collected, compiled and disseminated to the sub-county offices, which is then uploaded to DHIS 2. However, facilities with information and communications technologies (ICT) infrastructure and human resources upload their data directly to DHIS2.

- M&E activities for HIV are largely supported by the county, NASCOP, partners and NACC. The main M&E activities include routine HIV data management, performance review meetings, data quality assessments, supportive supervision, rapid results initiatives and capacity building. NACC supports community-based activities through community-based activity reports (COBPAR form) which is completed by CSOs on a quarterly basis.

Figure 6: M&E DATA FLOW CHART

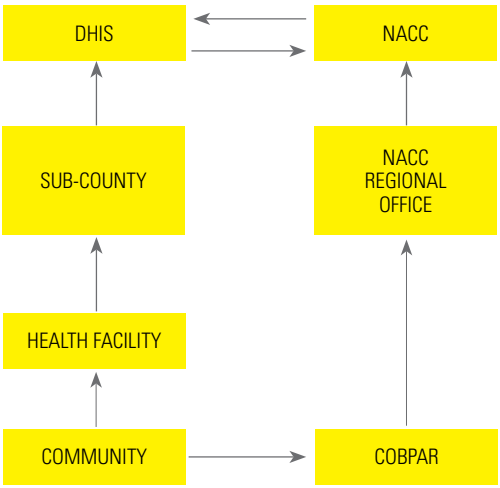
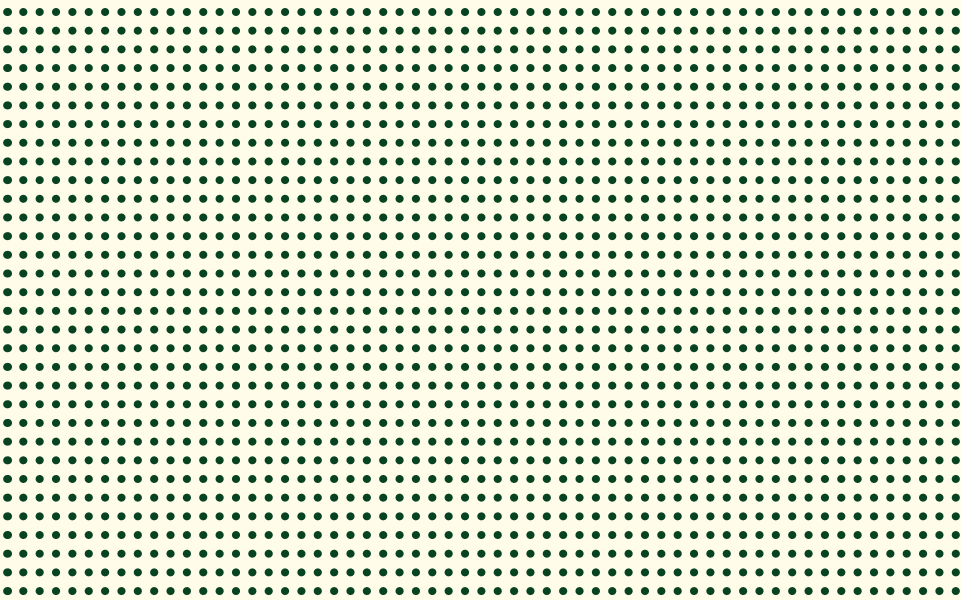


Table 14: Roles and responsibilities of Nairobi County M&E plan

Institution	Role	Frequency	Reporting Tool
Service delivery points (Health facilities)	Report HIV sector data	Monthly Quarterly Annually	DHIS IQCARE
County and sub-county health and M&E institutions	• Compile all the health-related data, including data from community health volunteers • Disseminate health information to stakeholders • Coordinate data/ performance review meetings, data quality assessments (DQAs), M&E TWG • Distribute data collection and reporting tools	Monthly/ Quarterly/ Annually	DHIS and COBPAR form Performance Appraisal tool
County AIDS &STI Coordinating Officer (CASCO)	• Provide the health sector HIV response data for use at the county level • Coordinate the Rapid Results initiative • Coordinate HIV trainings	Quarterly	DHIS
County government	• Annual evaluation surveys • Coordinate HIV partners • Implement HIV policies and guidelines • Work closely with relevant county government committees • Review sector progress against policy imperatives towards achieving the Nairobi CHIV strategic plan objectives	Annually/ quarterly	Merge DHIS and COBPAR form HIV guidelines and standards

07.

RISK AND MITIGATION PLAN



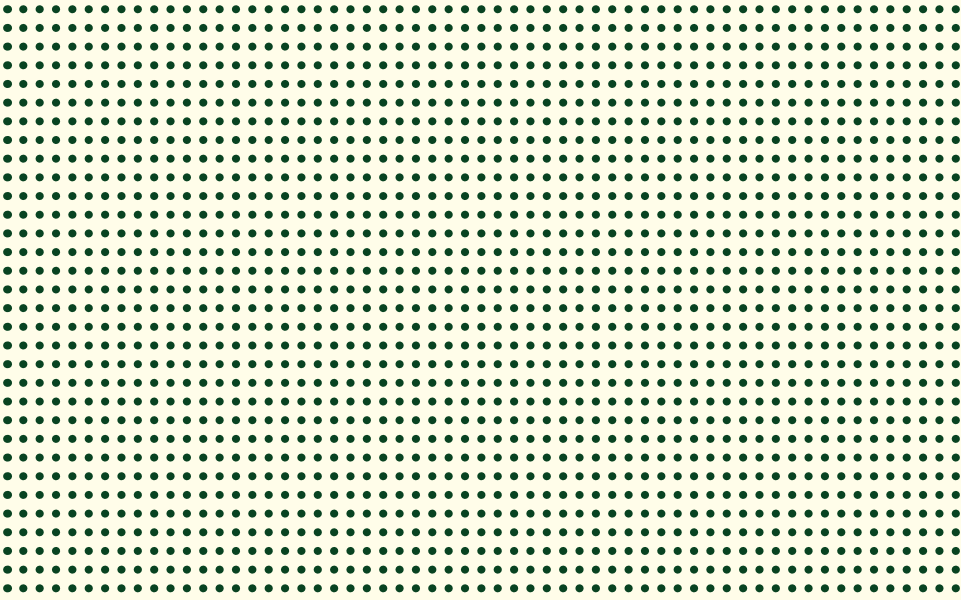
During the implementation of this strategic plan, anticipated risks will be assessed, classified and recommendations made to mitigate these risks and reduce chances of their occurrence. This will be conducted through continuous review of the plan with the leadership of the County HIV Coordinating Unit.

Risk Category	Type of Risk	Current Status	Probability	Impact	Risk Average Score
Technological	Inadequate technologies for implementation	Required key technologies have been identified and risk is actively being monitored	Medium	High	Medium
	Lengthy procurement processes.	Long bureaucratic processes in the procurement department	High	Medium	High
Political	Reduced political good will	Due to competing activities in the county, it is harder to reach the political class	Low	Medium	Low
	Disruption of County Health Structure due to change of governance	The already established structures are operational	Medium	Medium	Medium
	Delayed County government processes in approval of HIV-related bills and policies	Bills take time to be approved at the County Assembly	High	Medium	High
Operational	High staff turnover	Mostly due to transfers and other factors, such as attrition	Medium	Medium	Medium
	Weak M&E system	Continuous strengthening of M&E Systems	Low	High	Medium
	Uncoordinated implementation of HIV programs, especially among partners	There is a partnership coordination unit established at the County	Low	Medium	Medium
Financial	Low HIV budget allocation	The county government has allocated minimal funds for HIV programs	High	High	High

	Mitigation/Response	Responsible Unit
	• Budget allocation for required technologies and trainings	County government and stakeholders
	• Early quantification of required HIV commodities and technologies for the County • Prepare and submit a procurement plan in a timely manner	County Government
	• Engage champions for the County HIV agenda from the County Assembly Health Committee • Continuous advocacy on the HIV agenda among the political class	County HIV Committee and County Assembly Health Committee
	• Establish implementation plan for the NCCHASP	County HIV Committee
	• Identify and include community (citizen participation), champions among health and budget committees and in TWGS	County HIV Committee
	• Continuous capacity building of staff • Staff motivation • Retention of staff in their field of expertise	County Public Service Board Chief Officer of Health
	• Continuous DQAs • Continuous implementation and review of the M&E Plan	County M&E department and the County HIV Committee
	• Have all partners sign an MoU on HIV activities and resource packages • Allocate clear roles and responsibilities at all levels among the partners	County HIV Committee Partnership Coordination Unit
	• Advocacy at the County Assembly to increase HIV financing	County HIV Committee Partners County Assembly Health Committee

08.

RESULTS FRAMEWORK



The results framework has been developed for each strategic direction as presented below;

Strategic Direction 1: Reducing new HIV infections

KASF objective	NCCHASP Results	Key Activity	Indicators
Reduce new HIV infections by 75%	Reduce mother-to child-transmission of HIV, from 8.1% to less than 3%	All pregnant and breastfeeding mothers access PMTCT services	• Percentage of HEIs who sero-convert at 18 months
	Increase testing amongst eligible clients at all health facilities to 80%	Increase HIV testing in all service delivery points in the health facilities	• Percentage of eligible clients who tested for HIV at all health facilities
	Reach and provide HIV testing and prevention services to 80% of all key populations and vulnerable populations	Increase access to HTS for KP and vulnerable populations	• Percentage of KPs tested for HIV, disaggregated by sub-populations
			• Percentage of vulnerable populations tested for HIV, disaggregated by sub-populations
			• Percentage of KPs and vulnerable populations reached who receive prevention interventions
	Scale up targeted community-based interventions	Increased access to HIV services to targeted at-risk populations in the general population	• Number of at-risk populations in the general population reached with HIV testing and prevention services

Strategic Direction 2: Improving health outcomes and wellness of People Living with HIV

KASF objective	NCCHASP Results	Key Activity	Indicators	
Reduce AIDS mortality by 25%	Enhance linkage to HIV care and treatment to 90% of all eligible children, adolescents, pregnant women, adults and key populations	Link all persons tested HIV positive to care and treatment and document them	Percentage of newly diagnosed HIV clients linked to HIV care and treatment, disaggregated by sub-populations	
	Ensure provision of ART to 90% of all eligible children adolescents, pregnant women, adults and key populations	Start all HIV positive patients on treatment in line with national guidelines	Percentage of eligible clients on ART, disaggregated by sub-populations	
	Promote retention in HIV care and treatment for 90% of all eligible children, adolescents, pregnant women, adults and key populations	Enhance adherence counselling and defaulter tracing	Percentage of clients retained in care at 12 months of initiation, disaggregated by sub-populations	
	Provide access to viral testing and ensure viral suppression for 90% of all HIV patients on ART	Ensure access to viral load testing to all patients in care	Percentage of clients on ART with viral load done in the last 12 months, disaggregated by sub-populations	
			Percentage of clients with suppressed viral load, disaggregated by sub-populations	
	Ensure screening and treatment for OIs and STIs for 100% of all HIV positive patients	Early diagnosis and management of OIs and STIs	Percentage of clients screened for OIs especially TB	

	Baseline	Mid Term Target	End Term Target	Responsibility
	8.1%	5%	3%	County Department of Health and partners
	10%	50%	80%	County Department of Health and partners
	30%	50%	80%	County Department of Health and partners
	No disaggregated data	50%	80%	County Department of Health and partners
	50%	65%	80%	County Department of Health and partners
	50	65	80	County Department of Health and partners

	Baseline	Mid Term Target	End Term Target	Responsibility
	No disaggregated data	80%	90%	County Department of Health and partners
	No disaggregated data	80%	90%	County Department of Health and partners
	No disaggregated data	80%	90%	County Department of Health and partners
	No disaggregated data	80%	90%	County Department of Health and partners
	No disaggregated data	80%	90%	County Department of Health and partners
	No disaggregated data	80%	90%	County Department of Health and partners

Strategic Direction 3: Using a Human Rights based approach to facilitate access to services

KASF objective	NCCHASP Results	Key Activity	Indicators	
• Reduce new HIV infections by 75% • Reduce AIDS related mortality by 25% • Reduce HIV-related stigma and Discrimination by 50%	Reduce incidences of reported stigma by 50%	• Increase equitable access to HIV services • Strengthen the HIV TWGs • Build capacity of HCWs on providing KP-friendly services • Increase number of KP-friendly public facilities from 4 to 7 • Increase number of youth friendly public facilities from 7 to 12	• Percentage of incidences reported due to stigma • Number of HIV/SGBV forums • Number of HCWs trained on KP friendly services • Number of KP-friendly public facilities • Number of youth friendly public facilities	
	Reduce levels of SGBV	• Sensitization for both health care workers and CHVs • Increase number of facilities offering integrated SGBV/HIV services	• Number of HCWs and CHVs trained on SGBV from 220 to 600 • Number of facilities providing integrated HIV/SGBV from 2 to 10	
	Increase protection of human rights and increase justice to PLHIV and other priority groups	• Advocacy to law makers to accommodate HIV programming • Creating awareness and dissemination of guidelines in the HIV and AIDS tribunal	• Number of advocacy forums with law makers held • Number of dissemination meetings held	

Strategic Direction 4: Strengthening integration of health and community systems

KASF objective	NCCAHSP Results	Key Activity	Indicators	
• Reduce new HIV infections by 75% • Reduce AIDS-related mortality by 25% • Reduce HIV-related stigma and discrimination by 50% • Increase domestic financing of the HIV response to 50%	HIV services integrated into Community Health Units (CUs)	Strengthen the integration of Community and Health Systems	Number of CUs providing HIV care	
	Increased number of persons reached using targeted interventions and messages	Integrated approach to community outreaches	Number of integrated outreaches	
	50% of schools have HIV school health programs	Integrate HIV into school health programs	Number of schools with integrated school health HIV programs	

	Baseline	Mid Term Target	End Term Target	Responsibility
	40% 0 4 7	30% 6 5 10	20% 8 7 12	County Government & Partners
	220 2	395 6	600 10	County Government & Partners
	0 0	2 1	4 2	County Government & Partners

	Baseline	Mid Term Target	End Term Target	Responsibility
	272	273	274	County Government & Partners
	4	6	8	County Government & Partners
	0	2	4	County Government & Partners

Strategic Direction 5: Strengthening research and innovation to inform on the NCCHASP

KASF objective	NCCHASP Results	Key Activity	Indicators
• Reduce new HIV infections by 75% • Reduce AIDS-related mortality by 25% • Reduce HIV-related stigma and discrimination by 50% • Increase domestic financing of the HIV response to 50%	Vital data on HIV in Nairobi is available	Strengthen County Operational Research Monitoring Unit (ORMU) to coordinate research, monitoring and evaluation activities	Key recommendations from the ORMU used to inform the NCCHASP
		Conduct operational research on available data from facilities and partners and sub county	Report of operational research available and used to inform the HIV program
		Undertake a stigma index study	Report on stigma index available and used for stigma reduction and non-discrimination interventions
		Undertake a study on cultural factors that influence the spread of HIV in the County	Report on cultural factors influencing the spread of HIV available and used to inform HIV programming

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

KASF objective	NCCHASP Results	Key Activity	Indicators
• Reduce new HIV infections by 75% • Reduce AIDS-related mortality by 25% • Reduce HIV-related stigma and discrimination by 50% • Increase domestic financing of the HIV response to 50%	Data is available for programming and resources are well utilised	Undertake quarterly supervision and monitoring	Reports of the supervision and monitoring visits used to inform the program
	Percentage of health facilities providing quality data on HIV	Print and distribute M&E tools for collection of HIV data	Percentage of health facilities submitting timely quality HIV data on a regular basis
	Baseline data for HIV programming is available	Undertake a Nairobi HIV baseline survey	Baseline data on NCCHASP used to plan the program
	Progress report on achievement of the strategy	Undertake a mid-line review of the NCCHASP	Results of the mid-line review used to inform the implementation of the NCCHSP
	Information for review of the next strategic plan is available	Undertake an end line review of the NCCHASP	Results of the end line review use to inform program achievement
	ICC makes informed HIV decisions	Hold quarterly M&E meetings and report to the County ICC	Number of meeting held and key decisions made to inform NCCHSP progress
	Information of health widely disseminated	Prepare and publish a County Department of Health Newsletter	Number of articles on HIV activities disseminated through the newsletter

	Baseline	Mid Term Target	End Term Target	Responsibility
	-	-	1	County Sub-county & Partners
	-	1	1	County Sub-county & Partners
	-	-	1	County Sub-county & Partners
	-	-	1	County Sub-county & Partners

	Baseline	Mid Term Target	End Term Target	Responsibility
	4	8	12	County /sub-county and & Partners
	80%	80%	90%	County / sub-county & Partners
	1	0	0	County / sub-county & Partners
	0	1	0	County / sub-county & Partners
	0	0	1	County / sub-county & Partners
	0	6	12	County / sub-county & Partners
	0	6	12	County / sub-county & Partners

Strategic Direction 7: Increased domestic financing for sustainable HIV response

KASF objective	NCCHASP Results	Key Activity	Indicators	
Increase domestic financing of the HIV response to 50%	Policy on HIV financing developed	• Draft and legislate bills on HIV financing through the County Assembly	Bill passed on HIV financing	
	Increased domestic financing for HIV response in the county	• Advocacy among the County Assembly Members • Resource mobilisation from local partners and the business community • Public Private Partnerships • Mapping of partners and their resource envelopes • Hold planning meeting and undertake activities to raise funds for HIV	• Number of meetings held with the County Assembly Members • Increased money mobilised for HIV activities from partners and the business community • PPP TWG formed and meetings held • County HIV partners directory developed • Number of meetings and fund raising activities held	
	Ensure equitable distribution of resources in the county	• Public Private Partnerships • Allocation of HIV finances, as per the HIV burden in the county	• PPP TWG Formed and meetings held • Granulation of data per Sub-county and finances allocated on the same	
	Resources from partners identified and quantified for the county	Mapping of partners and their resource envelopes	County HIV partners directory developed	

Strategic Direction 8: Promoting accountable leadership for delivery of the Nairobi City County HIV and AIDS strategic plan

KASF objective	NCCHASP Results	Key Activity	Indicators	
• Reduce new HIV infections by 75% • Reduce AIDS-related mortality by 25% • Reduce HIV-related stigma and discrimination by 50% • Increase domestic financing of the HIV response to 50%	NCChASP in place and being implemented	Disseminate and roll out the NCCHASP	NCCHASP disseminated in 10 Sub-counties	
	County HIV Oversight Committee formed and meeting regularly	Formation of a County HIV coordinating committee	County HIV coordinating committee in place	
	County HIV ICC is in place and meets biannually	Conduct biannual coordination meetings of the ICC	Meetings conducted	
	Constituency AIDS control committees strengthened	Constituency committee meet regularly and report	Number of meetings held and reports submitted	
	• TWGs in place at county and sub-county levels • Marking of HIV health days	• TWGs meet and make informed decisions • World AIDS Day, International Condom Day	• TWGs in place • Commemoration of World AIDS Day and International Condom day	

	Baseline	Mid-term Target	End Term Target	Responsibility
	0	0	1	County government, NASCOP, NACC
	1 - 0 0 0	3 - 2 1 2	6 - 4 1 2	County government, NASCOP, NACC
	0 0	2 0	4 1	County government, NASCOP, NACC
	0	1	1	County government, NASCOP, NACC

	Baseline	Medium Target	End Term Target	Responsibility
	0	10	10	County government, NASCOP, NACC
	0	1	1	County government, NASCOP, NACC, partners
	0	3	6	County government, NASCOP, NACC, partners
	0	6	12	County government, NASCOP, NACC, partners
	0 2	11 4	11 8	MOH-NASCOP &NACC County government

Budget Plan/costing

Note: Costing done in Kenya Shillings (in Millions)

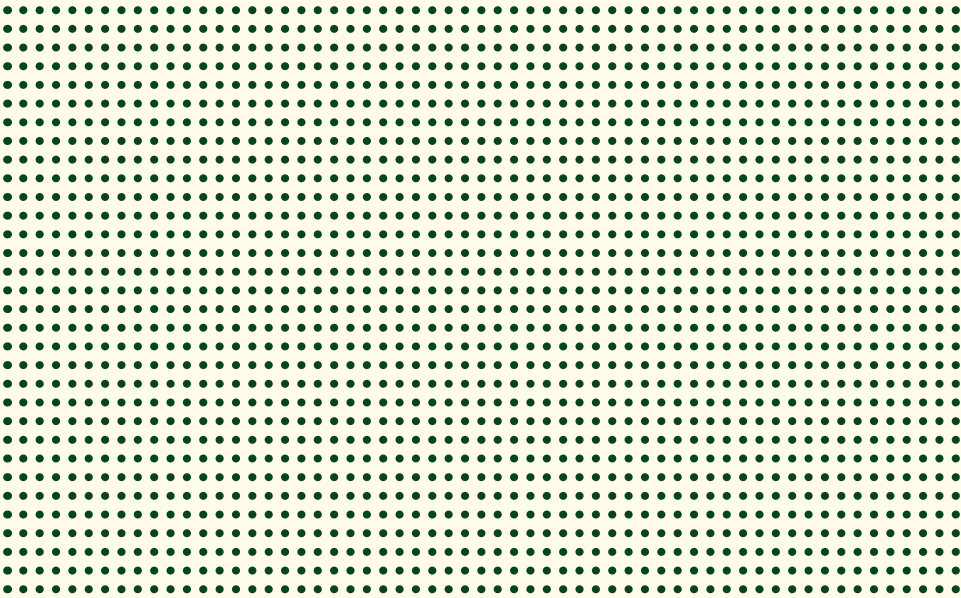
Strategic Directions	Specific NCCGHSP Intervention Area	Country Estimates	% of Resource Dedicated for the Strategy	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019	Total
SD1	HIV Prevention	210.3	25%	23.26	26.49	29.89	33.44	36.23	149.31
SD2	Treatment & Care	461.2	50%	46.52	50.86	53.13	54.10	53.42	258.03
SD3	Social inclusion, human rights and gender	87.4	4.5%	4.19	5.44	6.77	8.21	9.76	34.35
SD4	Health systems	60.7	5.72%	5.32	4.81	3.94	3.45	1.86	19.48
	Community systems	30.4	3.65%	3.40	3.06	2.51	2.26	1.18	12.41
SD5	Research	7.6	3.29%	3.06	3.46	3.79	4.07	4.27	18.65
	Supply chain management	7.6	1%	0.93	1.05	1.15	1.24	1.30	5.67
SD 6	Monitoring and evaluation	15.2	2.84%	2.64	2.68	2.61	2.45	2.21	12.58
SD7&SD8	Leadership, governance and resource allocation	75.9	4%	3.72	3.78	3.68	3.47	3.12	17.77
	Gand total		100%	93.04	101.63	107.48	112.69	113.35	528.25

NB: This is item based costing for annual finance needs from KASF 2014 country estimation

- *Costing as per international price (Sources: NACP III)*
- *PLWHIV in Kenya 1,600,000 (2015) was the costing baseline for country estimates of which Nairobi had 160,000 PLWHIV which translates to 0.1of national disease burden*

09.

IMPLEMENTATION PLAN



Strategic Area	Activities	
Strengthen program coordination, monitoring and evaluation	Lobby for recruitment of more staff	
	Continuous procurement of STI and HIV supplies	
	Lobby for the construction and equipping of more health facilities	
	Construction and expansion of storage for health commodities including ART supplies	
SDA 1: Reducing new HIV infections	Continue offering HIV services to the general population at the facility level	
	Establish 3 more DICs to offer HIV services to the key populations in urban centres	
	Increase outreach for the hard-to-reach populations for HTS, including use of the Beyond Zero Campaign	
	Implement EMTCT at health facilities	
	Develop innovative approaches for targeting vulnerable populations with HIV services (truckers, prisoners, boda boda operators, sand harvester)	
	Hold a consultative meeting with implementing partners to ensure that there is coordination in HIV programming	
SDA 2: Improving health outcomes and wellness of PLHIV	Increase the number of health facilities offering ART centres	
	Sensitise the CCI network on HIV care and management among OVC	
	Train social workers of CCI on HIV management among the OVC	
	Improvement of the existing CCI to make them child friendly	
	Build the capacity of HCWs on paediatric HIV management	
	Rationalise the ART collection systems to reduce distribution and referral costs associated with laboratory referrals	
	Develop innovative approaches for integrating HIV with other services like RH and MNCAH	
	Support partners to implement the minimum package for PWP activities[1]	
SDA 3: Using a human rights-based approach to facilitate access to services	Hold a consultative meeting to strengthen the medico-legal structures to address SGBV cases in the county	
	Train HCWs on HRBA to HIV services	
	Train/sensitise HCWs in the provision of HIV services to key populations and adolescents	
	Develop innovative approaches for increasing access to youth friendly HIV services, including integrating HIV services to youth empowerment centres	
SDA 4: Strengthening integration of community and health systems	Train/sensitise the CHAs and CHVs to enhance uptake of HIV services and retention in treatment	
	Develop and share reporting tools for CHVs to enhance reporting, as well as follow-up	
	Assess the existing community units, identify the bottlenecks and provide the needed support e.g. airtime for communication, social economic empowerment	
	Integrate HIV information, testing, treatment and support groups as part of the school health program	
SDA 5: Strengthening research, innovation and information management to meet the KCASP	Form the County Monitoring Unit to coordinate research, monitoring and evaluation activities	
	Undertake a survey/assessment on EMTCT	
	Mid-term review of the county HIV strategy	
	Final evaluation of the achievement of the County HIV strategy and development of next SP for the period 2019 – 2021	
SDA 6: Promoting utilisation of strategic information for research monitoring and evaluation	Undertake quarterly supervision and monitoring	
	Print and distribute M&E tools for collection of HIV data	
	Hold quarterly M&E meetings	
	Publish HIV research in the county in reputable journals	
	Prepare and publish a County Department of Health Newsletter	
SDA 7: Increasing domestic financing for sustainable HIV response	Prepare a session paper on increasing domestic funding of HIV activities to the County Executive Committee	
	Organise annual fundraising events towards HIV initiatives	
	Coordination meetings/forums for HIV implementing partners to ensure that available funds are well-utilised	
SDA 8: Promote accountable leadership for delivery of the CASP results by all sectors	Print and disseminate the CASP to all stakeholders in HIV implementation	
	Disseminate CASP to the County Assembly through the County Assembly Health Committee	
	Support sub-county/constituency HIV committees	

1 Minimum package for PWP includes: Nutrition, support groups, economic empowerment, social support (cash transfer, OVC funds), psychosocial support, HBC, training of CHWs, prevention and stigma reduction campaigns.

	2016				2017				2018			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X
			X									
	X	X	X	X	X	X	X	X	X	X	X	X
			X			X				X		
	X	X	X	X	X	X	X	X	X	X	X	X
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	X				X				X			
	X											
	X											
	X	X	X	X	X	X	X	X	X	X	X	X

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