NAROK COUNTY

HIV & AIDS

STRATEGIC PLAN

2014/15 – 2018/19

maisha!
National AIDS Control Council

My County My Responsibility

COUNTY HIV & AIDS STRATEGIC PLAN

2014/15 – 2018/19

Table of Contents

List of Tables and Figures

Abbreviations and Acronyms

ACUs	AIDS Control Units
ACK	Anglican Church of Kenya
AGC	African Gospel Church
AIDS	Acquired Immunodeficiency Syndrome
APOC	Adolescent Package of Care
ART	Antiretroviral Therapy
BCC	Behaviour Change Communication
CASCO	County AIDS & STI Coordinator
CASP	County AIDS Str ategic Plan
CBHTC	Community Based HIV Testing &Counseling
CCO	County Clinical Officer
CD4	Cluster of differentiation 4
CDOH	County Director of Health
CEC	County Executive Committee member
CHAC	County HIV and AIDS Coordinator
CHCs	Community Health Committees
CHEWs	Community Health Extension Workers
CHVs	Community Health Volunteers
CPHO	County Public Health Officer
CHVs	Community Health Volunteers
CSOs	Civil Society Organizations
CSR	Cooperate Social Responsibility
CUs	Community Units
CWC	Child Welfare Clinic
DHIS	District Health Information System
DOHS	Department of Health and Sanitation
DQA	Data Quality Audit
EID	Early Infant Diagnosis
EMR	Electronic Medical Records
EMTCT	Elimination of Mother-To-Child Transmission
ENOCOW	Enaitoti Coalition for Women
ENSDA	Ewaso Ng'iro South Development Authority
FBOs	Faith Based Organizations
FGM	Female Genital Mutilation
FSWs	Female Sex Workers
GBV	Gender Based Violence
GIS	Geographical Information Systems
HAART	Highly Active Antiretroviral Therapy
HBC	Home Based Care
HCWs	Health Care Workers
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
IDU	Injecting Drug Users
IEC	Information Education and Communication
IGAs	Income Generating Activities
IPC	Infection Prevention and Control
IPD	In-Patient Department
IPs	Implementing Partners

ISO	International Standards Organization
KASF	Kenya Aids Strategic Framework
KEMSA	Kenya Medical Supplies Authority
KEPH	Kenya Essential Package of Health
KEMRI	Kenya Medical Research Institute
KHQIF	Kenya HIV Quality Implementation Framework
KNASP	Kenya National Aids Strategic Plan
KNBTS	Kenya National Blood Transfusion Services
M&E	Monitoring and Evaluation
MCH	Maternal Child Health
MEDS	Mission for Essential Drug Supplies
MMU	Maasai Mara University
MNCH	Maternal Newborn and Child Health
MoE	Ministry of Education
MoH	Ministry of Health
MSM	Men who have Sex with Men
NACC	National Aids Control Council
NCASP	Narok County AIDS Strategic Plan
NASCOP	National AIDS & STD Control Programme
NIDP	Narok Integrated Development Programme
NPHLS	National Public Health Laboratory Services
ODSS	Organizational Development Systems Strengthening
OIs	Opportunistic Infections
OPD	Out-Patient Department
OVC	Orphaned and Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PHDP	Positive Health and Dignity Prevention
PITC	Provider Initiated Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
PWP	Prevention with Positives
QA	Quality Assurance
SCAC	Sub-County AIDS Coordinators
SCASCO	Sub-County AIDS and STI Coordinator
SCMOH	Sub-County Medical Officer of Health
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SOPs	Standard Operating Procedures
SRH	Sexual Reproductive Health
TB	Tuberculosis
TBAs	Traditional Birth Attendants
TTIs	Transfusion Transmissible Infections
TWG	Technical Working Group
VCT	Voluntary Counseling and Testing
VL	Viral Load

Foreword

The Narok County AIDS Strategic Plan (NCASP) 2014/15-2018/19, is a strategic guide for the County's response to HIV and AIDS. It is the first 5-year plan for the County that addresses the drivers of the HIV epidemic and guides the response to HIV and AIDS. NCASP development is in line with the Kenya AIDS Strategic Framework (KASF), which is aligned to the Kenya Vision 2030 and the Constitution of Kenya 2010. It aims to provide universal access to comprehensive HIV prevention, care and treatment for all people infected and affected by HIV and AIDS.

With the expiry of the Kenya National AIDS Strategic Plan (KNASP III) in 2013/2014, the need arose to come up with the KASF to give direction in HIV multi-sectoral response. Devolution of health services in 2010 necessitated the development of NCASP 2014/2015-2018/2019 to guide HIV response in the County.

The development of this document started with stakeholder involvement in 2014 at Maasai Mara University and a series of activities have taken place to culminate in the development of the final document. This plan is instrumental towards achieving Vision 2030 Sustainable Development Goals (SDGs) and County performance contract obligations.

The NCASP will ensure that home-grown innovative interventions are implemented to give direction in HIV response in the County. This will bring together all sectors within the County for better coordination, governance and synergy which will translate into improved responsiveness.

To this end, the County Government through the Department of Health and Sanitation is committed to implement the interventions spelt out in this document. Furthermore, the County Government commits itself to increase domestic funding for HIV prevention, care and treatment in order to decrease the morbidity and mortality related to the epidemic.

H. E. SAMUEL KUNTAI OLE TUNAI

Governor,

Narok County

Acknowledgement

We wish to express our sincere gratitude for all the efforts and resources from various stakeholders and partners towards realization of this plan. This NCASP will provide direction in the HIV response within the County by all actors. The development of this plan could not have been possible without the technical and financial contributions from the following stakeholders:

- The Narok County Government
- The Committee of Health, Narok County Assembly
- Chief Officer, Medical Services
- Chief Officer, Public Health and Sanitation
- County Director of Health
- National AIDS Control Council
- The Beyond Zero Secretariat
- The Narok County First Lady
- US Government through PEPFAR, its agencies USAID, CDC and DOD and its implementing partners KEMRI/WRP, APHIA plus, NADINEF, ENOCOW
- Population Services Kenya
- Christian Aid through its implementing partners NIDP, CHP & TRDP
- Maasai Mara University
- PLHIV including Ambassadors of Hope and KENEPOTE
- The County Drafting Team
- The Technical Review Team
- Ewaso Ng'iro South Development Authority among others.

Finally a full list of contributors towards this plan is provided in the Annex section.

To everyone we say a "Big Thank You".

HON. VIVIAN SERETI MPETI

CEC. Health and Sanitation,

Narok County

Executive Summary

It is now over 30 years since the first case of HIV was reported in Kenya. With approximately 1.6 million people living with HIV and annual total new infections of 101 563, the burden of the epidemic has had devastating effects in all sectors of the economy.

According to the County HIV Estimates 2013, Narok County is ranked position 28th in the country in terms of the HIV and AIDS burden. The overall HIV adult prevalence stands at 5% with 25,700 adults living with HIV. Annually, there are 2,025 adults and 82 children who get infected with the virus. The number of children living with HIV is 3,456 with new mother-to-child transmission standing at 316.

This County AIDS Strategic Plan (NCASP) 2014/15-2018/19, is the first plan to be developed by the County. The plan adopts a multi-sectoral and decentralized approach in the coordination and management of County HIV response. Given the urgency to stop new infections and the need to provide comprehensive and quality care and support, this plan is evidence and results based.

The plan presents four major results or objectives to be achieved at the end of five years namely;

1) Reducing the number of new infections by 60%.
2) Reducing AIDS mortality by 25%.
3) Reducing HIV and AIDS stigma and discrimination by 50%.
4) Increasing domestic financing for HIV by 50%.

These objectives will be achieved through the implementation of prioritized interventions that contribute to specific output results. To accomplish these goals, this strategic plan outlines a more coordinated County response to the HIV epidemic. The Strategy is intended to be a concise plan that will identify a set of priorities and strategic action steps tied to measurable outcomes. Accompanying the Strategy is a Monitoring and Evaluation Plan that outlines the specific indicators to be measured routinely and at the end of the implementation period.

The plan outlines the various gaps in the HIV and AIDS response and proposes actions to achieve the desired results. Among the gaps identified in the plan include; inadequate implementation of interventions targeting key or most at risk populations, insufficient coverage, intensity and duration of interventions targeting young people and in particular those out of school, high levels of stigma and discrimination which prevents the utilization of HIV Testing and Services (HTS), Antiretroviral Therapy (ART), and Elimination of Mother-to-Child Transmission (EMTCT) among other services.

The Strategy remains a steady foundation on which to build future HIV and AIDS response efforts. As such, it is a living document, designed to be reviewed to respond to the emerging issues.

CHAPTER 1

Background Information on the County

Narok County is located in the Southern part of Kenya. It lies between latitudes 0° 50´ North and 0° 50´ South and longitude 350° 28´ West and 360° 25´ East. It borders the Republic of Tanzania to the South, Kisii, Migori, Nyamira and Bomet counties to the West, Nakuru County to the North, and Kajiado County to the East (see Figure 1.1 below) The county headquarters is in Narok Town. Narok County is the 11th largest county covering an area of 17, 933.1 km2 representing 3.1% of the total area of Kenya. It has a projected population of 1, 002, 968 with a male to female ration of 1:1. Table 1.1 below is a summary of the population projections per cohort and gender for 2015.

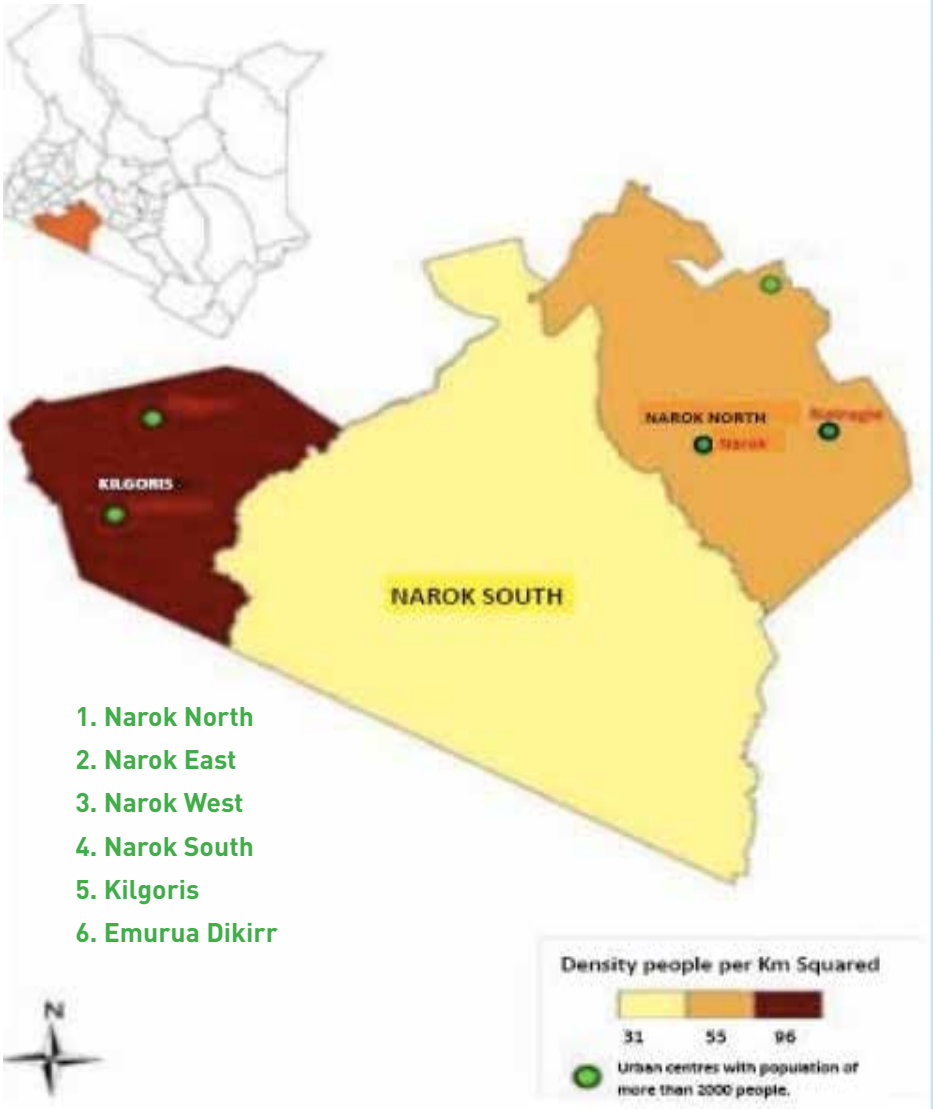


Figure 1.1: Map of Narok County

Table 1.1:
Projected Population Age and Gender Cohort

Age Cohort	Male	Female	Total
0-4	112,901	109,260	222,161
5-14	176,485	169,304	345,789
15-24	109,631	113,059	322,688
25-49	133,546	130,903	264,449
50-59	18,095	16,102	34,197
60 +	20,136	20,712	40,848

The county lies in the Great Rift Valley. It is home to a number of major rivers, arid and rugged landscapes and volcanic landforms with areas of prominent geothermal activities. The highland areas of the Mau Escarpments, rising to an attitude of 3,100 m above sea level provides fertile ground for farming. Production of wheat and barley has made the county acquire the name tag "The Bread Basket" of the country.

The county is divided into six administrative sub-counties, namely Transmara West, Transmara East, Narok North, Narok South, Narok West and Narok East. The sub-counties are further sub-divided into 16 divisions, 92 locations and 182 sub-locations with 169,220 households (CIDP, 2014).

The county has five agro-climatic zones namely; humid, sub-humid, semi-humid arid and semi-arid. Two-thirds of the county is classified as semi-arid. Temperatures range from 18°C to 28°C. This climatic characteristic has been influencing the migration of wildebeest into Kenya from the Serengeti in Tanzania. The wildebeest migration, which is the 8th Wonder of the World, in the Maasai Mara Game Reserve is a major tourist attraction in the county; making tourism a major economic activity. Agriculture and livestock production are other economic activities in this county with the main crops grown being wheat, barley and maize.

Narok County is made up of mainly the Maasai community that value keeping of cattle, sheep and goats. The urban centres in the county are cosmopolitan. The Maasai are a patriarchal society; men typically speak for women and make decisions in the family. The community practices polygamy and encourages early marriages for young girls.

The county has approximately 689 ECDE centres with over 52,384 children enrolled. The ratio of teachers to pupils is 1:46. Out of the total enrolment in the ECDE centres, 82% proceed to join the lower primary school. There are 624 primary schools in the county. The teacher to pupil ratio is 1:51 on average. Dropout rate is 8% which is a serious concern and is mainly due to the nomadic pastoralist way of life. Twenty one percent of pupils who complete primary school education do not proceed to secondary school. The total number of secondary schools in the county is 77. The ratio of teachers to students is 1:62. The average age of attendance is 14 years. Completion rate at this level is 72% . The county has only one institution of higher learning, Maasai Mara University (MMU) which was formerly Narok University College. There are eight youth polytechnics, one institute of science and technology and one private accredited private college. The literacy level in the county is about 63%. The women literacy level is 31% compared to men at 69%.

The top ten causes of morbidity in the county are: diseases of the respiratory system, malaria, pneumonia, diarrhea, diseases of the skin, eye conditions, intestinal worms, injuries and joint pains, typhoid fever, and urinary tract infections. The Department of Health and Sanitation is mandated to offer curative, preventive, promotive and rehabilitative health services to the catchment population.

The county has four referral health facilities comprising three sub-county hospitals located at the sub-county headquarters, namely Narok town, Kilgoris and Ololulunga. The fourth facility is a missionary hospital located in Kilgoris. In addition, there are 30 health centres, 84 dispensaries and 40 private clinics in the county.

Despite the presence of a substantial number of health facilities in the county, access to health services is still low. A large proportion of the population (70%) travel for more than 5 kilometres to access the nearest health facility. Furthermore, some patients face insurmountable challenges in accessing health facilities due to poverty and poor impassable roads. Some of the health facilities have inadequate infrastructure, drugs and trained personnel to attend to some of the medical needs of the patients.

The County Department of Health and Sanitation together with partners are implementing various HTC strategies such as Provider Initiated Testing and Counseling (PITC), Voluntary Counseling and Testing (VCT), Diagnostic Testing and Counseling (DTC), eMTCT and community based HTC. The county has trained 24 medical social workers to offer HTC services. In addition 64 counselors have been enrolled for Proficiency Testing (PT).

CHAPTER 2

Situational Analysis

According to the last census of 2009, Narok County had a population of 850,920; with a projected population of 1,002,968 by 2015 (KNBS, 2015) and a ratio of men to women of almost 1:1. The overall HIV prevalence is 5% which makes the county to be ranked 28th in Kenya. The HIV burden is more among women whose prevalence is 7.1% compared to 4.3% among men – Figure 2.1 (KAIS, 2012). Women and girls are more vulnerable to HIV infection and this is attributed to lack of access to information and education services necessary in ensuring sexual and reproductive health, human rights violation due to societal conditions such as sexual and gender-based violence are mitigated(KDHS, 2014).

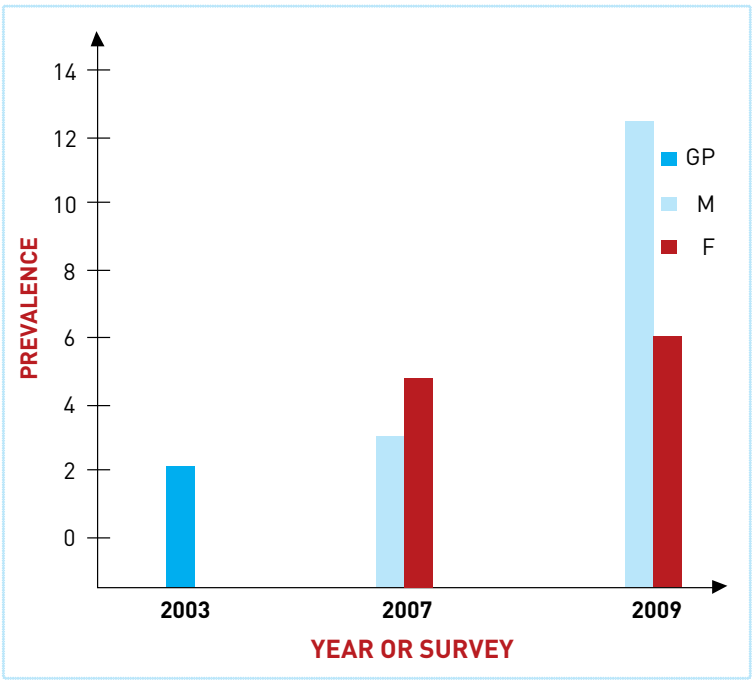
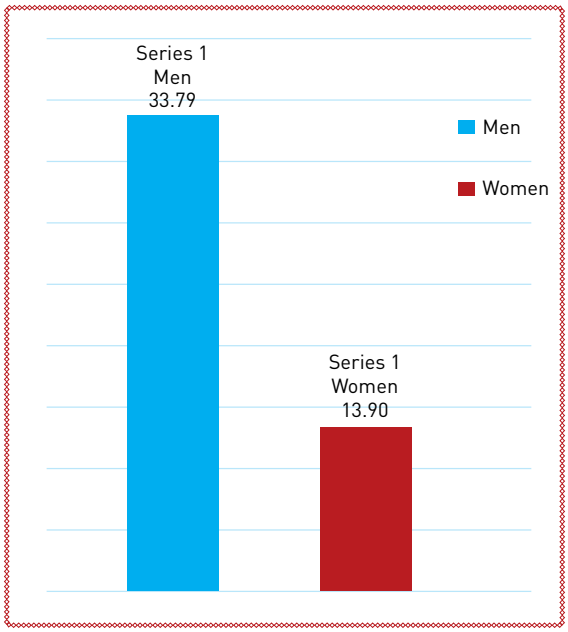


Figure 2.1: Prevalence of HIV by Gender in Narok County
Source: Narok County Profile 2014

The number of adults living with HIV is 25,700 while the number of children living with HIV in the county is 3,325 (NASCOP, 2014). Pregnant mothers living with HIV is 1,462 while the ones enrolled in care are 699 (NASCOP, 2014).In terms of new HIV cases, Narok County is categorized among the medium burden counties with estimated annual new infections of 2,025 and 82 among adults and children respectively (NASCOP, 2014). The number of people who had never been tested for HIV has declined from 73% in 2009 to 48% in 2014 (KAIS, 2012) as illustrated in Figure 2.2 below.



2.2: Women and men who were never tested for HIV in the past 12 months in 2014 (Source: KDHS, 2014)

Consistent and proper use of condoms can reduce the risk of HIV and other sexually transmitted infections by more than 90%. In the county, low condom use may pose a significant risk of HIV infection to the population. Male circumcision reduces the risk of female-to-male transmission of HIV infection by approximately 60%. Most communities in the county traditionally circumcise men, with over 91% of men who participated in a national survey in 2009 reporting that they had been circumcised. Even in traditionally circumcising communities, the practice should be carried out under safe and hygienic conditions and encouraged before sexual debut. In the county, approximately 55% of individuals had their first experience of sexual intercourse before the age of 15, an indication of early sexual debut (KAIS, 2012).

According to DHIS 2, the county is among the counties with the highest mother-to-child transmission rates currently at 10%. The county has operationalized the Beyond Zero Mobile Clinic, which is used to carry out integrated outreaches in hard to reach and underserved populations with the aim of reducing maternal and child mortality.

The county has a total of 60 ART sites whereby 5,426 adults and 658 children are receiving ARVs with 7,707 adults and 808 children currently on care and treatment. Poor linkages have contributed to an estimated 75% of those testing HIV positive in the county delaying to join care and treatment as per the DHIS 2.

The county retention rate for clients on care and treatment stands at 65% (Figure 2.2). This is attributable to poor adherence due to stigma, food insecurity, transfer out, poor adherence to counseling and client preparation, poor infrastructure and distance affecting access, provider-client attitude, nomadism, lack of disclosure, lack of resources for support supervision and mentorship, inadequate/ inconsistent supply of commodities among many others.

Stigma and discrimination related to HIV and AIDS is a persistent problem in our community. This is exacerbated by lack of knowledge, fear of disclosure and community perception. The Kenya Stigma Index Survey (2014) reported stigma and discrimination in the county at 46%. Although there is no documented survey for the county, the national figure is a good indicator of the situation in the county.

HIV and AIDS is one of the greatest threats to socio-economic development in Kenya, Narok County included. The number of households with an orphan in the county is 18,021, while poor households with orphans stand at 8,830. The number of households benefiting from cash transfer program is 3,058 with only 34.6% of households with an orphan benefiting from the cash transfer.

Table 2.1 below shows the Strength Weaknesses Opportunities and Threats analysis of the HIV epidemic in the county. It includes the factors that have led to the maintenance of a low HIV prevalence in the county (Strengths); the factors

that can contribute to HIV incidence (Weaknesses); the enabling environmental aspects in the county that continue to ensure the prevalence remains low (Opportunities); and the factors that if not addressed will contribute to HIV incidence (Threats).

Table 2.1: Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis of the HIV situation in Narok County

Strengths

- Availability of health structures which can support the care and treatment of PLHIV.
- Ability of the county to mobilize stakeholders and partners in support of the elimination of new HIV infections by funding activities geared towards achievement of national objectives.
- Political goodwill from the county leaders to involve stakeholders in developing policies that promote the access and dissemination of HIV information to its people.
- Support by the NACC in providing a strategic framework in the fight against HIV and AIDS.
- Availability of a quality control and standards team
- Ongoing mentorship activities supported by partners.
- Availability of 2 GeneXpert machines for diagnosis of TB and co-infection.
- Availability of policy and research documents that can guide in identifying the gaps that need quick interventions and what resources are needed in order to address the gaps.
- Operationalized Beyond Zero mobile clinics

Weaknesses

- Low partner/male testing.
- Inadequate human resources for health & poor deployment of trained persons.
- Inconsistent supplies of commodities especially test kits and condoms.
- Challenges in disclosure.
- Stigma and discrimination.
- Few ART sites.
- Low male engagement.
- Inadequate supportive supervision.
- Sub-optimal use of the GeneXpert machines,
- Erratic supply of commodities and drugs.
- Inadequate reporting tools & late reporting.
- Irregular data quality audits & poor utilization of data.
- Poor knowledge of certain indicators and tools among HCWs.
- Inconsistent support for supervision and mentorship.
- Lack of data review meetings with the health facility in-charges.
- Poor linkages between those who test HIV positive and the care and treatment program
- Early sexual debut before 15 years.
- Low percentage of people on the cash transfer program. Inadequate number of community units.

Opportunities

- Ability to partner with other state actors and stakeholders in financial support of HIV activities in the county.
- Availability of legal frameworks that protect the rights of People Living with HIV (PLHIV).
- Availability of county political goodwill in participating and championing HIV & AIDS response.
- Availability of willing partners in funding and ensuring the success of the HIV program activities.
- Availability of a county HIV committee that oversees the success and implementation of the NCASP.
- NCASP towards elimination of new HIV infections and care and support of PLHIV.
- Established community support structures.
- Congregate settings like churches, schools and cultural ceremonies.

Threats

- Cultural practices; early marriages, Female Genital Mutilation(FGM), polygamy, Traditional Birth Attendants (TBAs), unsafe traditional male circumcision, moranism.
- Poverty.
- High illiteracy levels.
- Alcoholism and drug abuse.
- Influx of priority populations during tourism and wheat harvesting seasons, e.g. Female Sex Workers (FSWs), brokers, truck drivers, charcoal traders, gold miners and migrant workers.
- Service women for cattle drivers along trading routes.
- Multiple sexual partners outside marriage.
- Vulnerability of women and girls to HIV infection due to lack of access to information, lack of education and services necessary in ensuring sexual and reproductive health, human rights violation due to societal conditions such as sexual and gender-based violence.
- Adherence due to stigma, leading to low retention rate for clients on care and treatment .
- Nomadism.

CHAPTER 3

Rationale and Strategic Plan Development Process

Purpose of the NCASP

The expiry of the **Kenya National AIDS Strategic Plan (KNASP) III** in 2013/2014 created the need to come up with the KASF to give direction to the national and county HIV multi-sectoral response. The devolution of health services in 2010 called for the development of NCASP 2014/2015 - 2018/2019 to guide HIV response in the county in line with the national strategy KASF.

The purpose of the NCASP is to provide a comprehensive guiding document that will be used by all stakeholders under the leadership of the county government towards the successful elimination of any new HIV infections and promote the effective uptake and utilization of HIV care and treatment services for all PLHIV in the county through the mobilization of resources in and by the county.

The NCASP addresses the rights enshrined within the constitution of Kenya. In the constitution, the Bill of Rights is an integral part of the county's democratic state and a framework for socio-economic and cultural policies. Article 27 of the constitution outlaws discrimination on the basis of one's health status, provides for equality between men and women, and allows use of affirmative action to redress past discrimination. Article 43 sub section 1 (a) states that every person has the right to the highest attainable standard of health which includes the right to health and care services including reproductive health care. The Fourth Schedule of the Kenya Constitution 2010 provides for the distribution of functions between the national government and the county governments. Part 2 (2) of the Fourth Schedule provides for the devolution of county health services.

Process of Developing the NCASP

The development of NCASP commenced after the dissemination of the KASF in the counties. In Narok County, a Sub-Committee was selected to formulate the County Plan. The Sub-Committee came up with a zero draft that was later presented to stakeholders for their input. The select committee then incorporated the views adduced from the stakeholders to come up with the first draft.

An expanded county team later reviewed this first draft and submitted it to NACC for approval. Following NACCs review, a technical review team was set up in the county to edit and develop the final plan. This plan was then submitted for stakeholder validation prior to its launch.

Guiding principles of the NCASP

The guiding principles of this plan are:

- **Governance and Leadership:** The successful implementation of this NCASP is premised on good leadership and governance structures in the county. This will ensure an effective health system that supports the implementation of the HIV policy frameworks.

- **Human Rights and Gender Transformativenes:** NCASP is expected to mainstream gender and human rights in all aspects of the response planning and service delivery. The promotion and protection of human rights therefore forms the centre of all aspects of an effective response to the epidemic.

- **Stakeholder involvement:** This document emphasizes the principle of stakeholder involvement in HIV activities considering county priorities. The relationship between various stakeholders in the county will ensure the successful implementation of this NCASP. These partnerships improve the financial mobilization, monitoring, delivery, utilization of HIV health services and resources in the county.

- **Efficiency, effectiveness and innovation:** Kenya being a Low Middle Income country, donor resources may decline thus exacerbating the HIV funding situation. The NCASP explores sustainable county funding options through improved efficiency in service delivery and innovative approaches aimed at achieving more at reduced cost without compromising quality.

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

- **County ownership and partnership:** All HIV stakeholders including the county government, development partners, private sector, faith-based organizations and communities of PLHIV shall align their efforts towards the results envisioned.

CHAPTER 4

Vision, Mission, Objectives and Strategic Directions

VISION

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

MISSION

To provide leadership in HIV prevention, care and treatment and mitigate its socio-cultural and economic impact in Narok County.

OBJECTIVES

The overriding strategic objectives, in line with the national ones, will include;

1. Reduce new county infections by 60%
2. Reduce AIDS related mortality by 25%
3. Reduce HIV related stigma and discrimination by 50%
4. Increase domestic HIV program financing by 50%

STRATEGIC DIRECTIONS

The above objectives will be achieved through the implementation of the 8 Strategic Directions as indicated in the matrices that follow.

Strategic Direction 1: Reducing New HIV Infections								
KASF Objective	CASP Results	Key Activity	Sub-Activity/ Intervention			Target Population	Geographic Areas by County/Sub-county	Responsibility
			Structural	Biomedical	Behavioural			
Reduce new HIV infections by 75%	Reduce new HIV infections by 75%	Scale up Counseling and Testing (CT)	Establish, own and closely supervise youth/ adolescent friendly services.	PITC in youth friendly drop-in centres.	Implement healthy choices I and II.	Adolescents and young people	All sub counties	Narok County Government CASCO Department of Health and Sanitation Implement partners Opinion leaders
			Community sensitization on HIV stigma reduction. Strengthen sector planning and implementation. Increase partner demand for HTC. Male involvement initiatives in social places such as playing pool, bars, barazas, livestock markets and sensitize on FGM and SRH. Target HTC messaging among women in Table Banking groups. Establish ACUs in all sectors. Implement workplace protection and implementation policies. Implement policies on SGBV. Capacity building of CSOs and FBOs on ODSS.	Implementation of new ART guidelines. Increase partner HTC. Scale up ART sites. PITC in high yielding areas: OPD, IPD, TB Clinics, CWC, malnutrition. Improve commodity supply management	Strengthen PHDP messaging at facility and community level. Involve opinion leaders in BCC activities. BCC through use of IEC materials including local languages . Involve HIV ambassadors / PLHIV. Targeted sensitization on HTC, e.g. for religious groups, institutions such as universities and prisons. Empower CHVs to provide BCC messages. Improve distribution and consistent condom use. Strengthen stigma reduction activities. Peer to peer mobilization			

KASF Objective	CASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographic Areas by County/Sub-county	Responsibility
Reduce new HIV infections by 75%	Reduce new HIV infections by 75%	Integration and linkage of services	Enhance coordination of all stakeholders by the Department of Health and Sanitation. Capacity building of HCWs to offer integrated services. Recruit more HCWs.. Use of age appropriate support groups, peer educators, CHVs to enhance linkage to care. Setting up and strengthening the link desks. Offer integrated HIV services in the health facilities. Strengthen inter-facility, intra-facility and community-facility referral systems.. Establish EMR linkages..	General Population	All sub counties.	Department of Health and Sanitation Implementing partners Non-state actors
		Prevention of HIV in health care settings	Collaborate with KNBTC to introduce donor notification of HIV results at blood collection sites and post testing for TTIs. Train HCWs on infection prevention. Strengthen IPC committees. Strengthen PEP among HCWs for all occupational exposures. Strengthen medical waste management in health facilities and provide adequate IPC equipment and infrastructure. Put in place incident and accident registers.	Health Care workers		Department of Health and Sanitation NPHLS Implementing partners

KASF Objective	CASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographic Areas by County/Sub-county	Responsibility
Reduce new HIV infections by 75%	Reduced HIV transmission rates from mother-to-child from 14% to less than 5%	Prevention of HIV in health care settings	Strengthen EMTCT and EID services . Advocacy to increase ANC attendance. Advocacy for skilled deliveries. Advocacy on male involvement. Ensure consistent supply of RTKs and consumables. Ensuring immunization schedules are adhered to. Ensuring PCR is done at 6weeks for exposed infants. Employ adequate number of mentor mothers.	Expectant HIV positive mothers Newborns and infants	All sub counties.	Narok County Government, CASCO Implementing partners

STRATEGIC DIRECTION 2: IMPROVING HEALTH OUTCOMES AND WELLNESS OF PLHIV						
KASF Objective	**NCASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographic Areas by County/Sub-county**	**Responsibility**
Reduce AIDS related mortality by 25%	Increased linkage to care within 3 months of HIV diagnosis to 90% of children, adults and adolescents	Improve linkage and retention to care.	Strengthen the referral system through use of the linkage and referral tool, i.e. account for every HIV+ person within 3 months. Adopt a standardized patient unique identifier and defaulter tracking tool. Public education literacy for care and treatment to address stigma & discrimination.. Strengthen inter-facility, intra-facility and community-facility referral systems. Ensure identified gaps in HIV care and prevention are addressed.. Put in place male involvement initiatives. Sensitize HCWs on issues of attitude. Carry out periodic review of data. Establish ACU at healthcare settings. Integrated services, e.g. ART in MCH, ART, TB clinics etc	General population	All sub counties.	Department of Health and Sanitation Implementing partners PLHIV ambassadors
			Integrate HIV services into MCH/CWC. Conduct public and care giver education. Establish age appropriate support groups. Sensitization of schools on HIV care and treatment.	Children living with HIV		

KASF Objective	NCASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographic Areas by County/Sub-county	Responsibility
Reduce AIDS related mortality by 25%	Increased linkage to care within 3 months of HIV diagnosis to 90% of children, adults and adolescents	Improve linkage and retention to care.	Use of peer mobilizers and support groups. Initiate adolescent/youth friendly services. Sensitization of schools and tertiary institutions on HIV care and treatment. Use of technology, e.g. social media for HIV education. Implement adolescent package of care (APOC). Train HCWs on adolescent reproductive health services.	Adolescents and youth	All sub counties.	Department of Health and Sanitation Implementing partners PLHIV ambassadors
			Establish more drop-in centres to offer key pop friendly services to KPs. Build staff capacity build staff in health facilities to offer Key pop KPs friendly services. Enhance peer mobilization strategies for recruitment, enrollment and retention in care. Integration of care services in drop-in centres.	Key and vulnerable populations		
	Increase ART coverage to 90% for children, adolescents and adults	Increasing coverage to care and treatment	Capacity building of staff on integrated HIV prevention, care and treatment. Establish more ART sites. Enhance treatment literacy and & patient empowerment. Use of integrated and decentralized HIV delivery models. Ensure adequate commodity supply. Employ more HCWs.	General pre–ART and ART care		Department of Health and Sanitation Implementing partners

KASF Objective	NCASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographic Areas by County/Sub-county	Responsibility
Reduce AIDS related mortality by 25%	Increase ART coverage to 90% for children, adolescents and adults	Leveraging other sectors such as education, tourism, religious sector, agriculture, social services (prison department and children's department).	Provide care givers with HIV education and empowerment. Integrate HIV care treatment to youth friendly services. Scale up MoOE programs for HIV education & treatment literacy. Standardize methodologies for disclosure by and to adolescents living with HIV. Use of technology, e.g. social media to improve coverage. Establish paediatric ART clinics.	Children living with HIV, adolescents and youth	All sub counties.	Department of Health and Sanitation Implementing partners
	Reduced HIV transmission rates from mother-to-child from 14% to less than 5%		Scale up friendly services to key populations friendly services with peer mobilization and support. Use strategies of reducing stigma and discrimination so as to increase access to C&T.	Key and vulnerable populations		

KASF Objective	NCASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographic Areas by County/Sub-county	Responsibility
Reduce AIDS related mortality by 25%	Reduced HIV transmission rates from mother-to-child from 14% to less than 5%	Improve quality of care and treatment outcomes	Ensure proper documentation in patient files. Regular skills updates for HCWs. Monitoring and evaluation including use of data for decision making. Strengthen availability of medical supplies, e.g. ARVs, OI drugs and laboratory reagents. Improve access to laboratory tests, e.g. CD4, VL and Gene Xpert. Implement the KHQIF in full. Reduce turn-around time for results and feedback. Ensure QA for laboratory services. Propose for ISO certification for laboratories. Use innovative mobile and web-based technology to increase adherence and follow up options. Scale up use of PLHIV peer support strategies. Ensure the use of updated ART guidelines.	General population	All sub counties.	Department of Health and Sanitation Implementing partners
	Increase retention on ART at 12 months to 90% in children, adolescents and adults	Increase coverage and retention to ART	Improve documentation through the installation of EMR. IGAS to improve food security. Create awareness on the need for partner testing. Hold anti-stigma campaigns on the uptake of ART. Continuous adherence, counseling and & follow up.			Department of Health and Sanitation Implementing partners Community of PLHIV

KASF Objective	NCASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographic Areas by County/Sub-county	Responsibility
Reduce AIDS related mortality by 25%	Increase viral suppression to 90% in children, adolescents and adults	Increase coverage and retention to ART	Establish innovative approaches to enhance adherence, e.g. use of mobile technology–alert systems. Undertake client education through campaigns and outreaches as well as one to one sessions during CCC visits. Ensure regular patient viral load monitoring as per the guidelines.. Create awareness on the need for partner disclosure.	General population	All sub counties.	Department of Health and Sanitation Implementing partners Community of PLHIV

STRATEGIC DIRECTION 3: USING A HUMAN RIGHTS APPROACH TO FACILITATE ACCESS FOR PLHIV, KEY POPULATIONS AND PRIORITY GROUPS						
KASF Objective	**NCASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographic Areas by County/Sub-county**	**Responsibility**
An enabling legal and policy environment necessary for a robust HIV response at the national and county levels to ensure access to services by persons living with HIV.	Reduce self reported stigma and discrimination related to HIV and AIDS by 50%. Reduced social exclusion for PLHIV, KPs, women, men, boys and girls by 50%.	Removing barriers to access of services	Sensitize health workers to avoid use of stigmatizing language in healthcare provision. . Sensitize the police on SGBV. Develop communication messages that target the youth. Establish at least one youth friendly centres per sub-county where youth can access preventive services and integrate HIV services with thin the youth centre. Empower the youth living with HIV to reach out to the fellow youths. Empower men to disclose their status and reach out to their fellow men. Decentralize and sensitize the community to access PEP Services on SGBV	Healthcare workers KPs Police	All sub counties.	CHAC /CASCO
			Use the council of elders to give a more appropriate name for HIV and guide in selecting cultural and traditional practices that reduce protect from the spread of HIV. Integrate sports in HIV prevention activities. Sensitize the teachers who handle the children and youth living with HIV at school.	General population Teachers Council of elders		Department of Health and Sanitation Social Services

KASF Objective	NCASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographic Areas by County/Sub-county	Responsibility
An enabling legal and policy environment necessary for a robust HIV response at the national and county levels to ensure access to services by persons living with HIV.	Reduce self reported stigma and discrimination related to HIV and AIDS by 50%. Reduced social exclusion for PLHIV, KPs, women, men, boys and girls by 50%.	Removing barriers to access of services	Building the capacity of the CHVs and CHCs to reduce stigma and promote HIV competency. Education/ sensitization on rights and gender issues. Reach out to the men through barazas and men to men forums mobilized through the CHVs and CHCs. Sensitize Sub-county administrators, ward administrators, chiefs and opinion leaders to make it a priority to involve PLHIV in their speeches during barazas. Empower the age set leaders to reach to fellow age mates on HIV issues.	Community KPs	All sub counties.	Social Services County Government administrators
			Include a HIV Week within the religious institutions where religious leaders are sensitized on how to deal with issues of HIV among the congregants. Sensitize the religious leaders on the legal issues pertaining to HIV and AIDS. Reach out to the men through the churches and mosques with HIV services.	Faith Based Organizations		Department of Health and Sanitation OH KNHRC
			Use the local media to fight stigma, discrimination and promote uptake of HIV services.	Media		

KASF Objective	NCASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographic Areas by County/Sub-county	Responsibility
An enabling legal and policy environment necessary for a robust HIV response at the national and county levels to ensure access to services by persons living with HIV.	Increased protection of human rights and improved access to justice for PLHIV, key populations and other priority groups including women, men, boys and girls	Improving legal and policy environment	Set a County HIV and AIDS week culminating to the World AIDS Day commemoration. Develop, implement and adhere to a county policy on the bursary fund for OVC affected or infected by HIV.	County Government	All sub counties.	Department of Health and Sanitation OH and Implementing Partners County Assembly
			Engage the legal sector to review protection of partners who disclose their status and who are vulnerable to GBV. Address negative cultural practices such as FGM and early marriages that increase the level of vulnerability.	Law Makers and Law Enforcement agents		National Government County Assembly Department of Health and Sanitation OH
	Reduce self reported stigma and discrimination related to HIV and AIDS by 50% Increased protection of human rights and improved access to justice for PLHIV, key populations and other priority populations	Conduct County Stigma Index Survey Conduct a county baseline survey to document the magnitude and nature of human rights violations and gender disparities in the context of HIV including SGBV.	Conduct regular surveys on the HIV stigma situation in the county. Capacity building for health workers on GBV reporting. Provision of tools for GBV. Conduct a county baseline survey to document the magnitude and nature of human rights violations.	National and County Governments		Learning institutions /Implementing Partners /Department of Health and Sanitation OH

STRATEGIC DIRECTION 4: STRENGTHENING INTEGRATION OF COMMUNITY AND HEALTH SYSTEMS						
KASF Objective	**NCASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographic Areas by County/Sub-county**	**Responsibility**
Build a strong and suitable system for HIV service delivery through specific health and community systems approaches, actions and interventions to support HIV response	Improved health workforce for HIV response at county levels by 40%	Provision of competent motivated and adequate health workers	Capacity building of health workers on HIV. Sensitize the administration on provision of friendly working environment for the health workers. Review/implement workplace policies. Improve working conditions-basic needs (water, housing, airtime for communication and reporting). Strengthen supportive supervision through Provision of transport for CHMT and SCHMTs. Improve access to the rural health facilities(roads) in the long term. Recruitment of adequate staff.	Healthcare workers Employers	All sub counties.	Departmental of Health and Sanitation OH Implementing Partners County Government

KASF Objective	NCASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographic Areas by County/Sub-county	Responsibility
Build a strong and suitable system for HIV service delivery through specific health and community systems approaches, actions and interventions to support HIV response	Increased number of health facilities ready to provide KEPH- – defined HIV and AIDS services from 33% to 90%	Provision of competent motivated and adequate health workers	Strengthened health service delivery systems	Initiate and support sustainable CUs per location to strengthen the linkages- Bringing CHVs on board. Integration of HIV referral and linkage service into mainstream health services. Adopt legal frameworks to decriminalize key population activities to increase demand for and access for health services. Conduct supportive supervision at Level 1 health facilities. Integrate HIV messages in community dialogue and action days. Strengthen community and home-based care.	Health facilities	Department of Health and Sanitation OH National and County Governments Implementing Partners
	Strengthened HIV commodity management		Improved access to and use of essential quality health products and technologies	Standardize the supplies by procuring the right commodities (KEMSA,MEDS). Improve availability of the drugs and nutrition supplements for PLWHIV. Provide Viral Load and PCR machines for sub-counties Improve infrastructure –increase space in the health facilities.	Healthcare workers	Social Services County Government administrators

KASF Objective	NCASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographic Areas by County/Sub-county	Responsibility
Build a strong and suitable system for HIV service delivery through specific health and community systems approaches, actions and interventions to support HIV response	Strengthened community –level AIDS competency	Provision of competent motivated and adequate health workers	Strengthening community service delivery systems	Support sustainable CUs per location to strengthen the linkages. -Bringing CHVs on board. Conduct stakeholder analysis. Appoint/Avail the staff-CHEWs and focal persons per sub-county. Involve the mother companions (TBAs) in the system through training and sensitization on HIV prevention, care and support. Continuous customer care services-suggestion box, customer care desk.	Healthcare workers	Department of Health and Sanitation OH Partners County Government

STRATEGIC DIRECTION 5: STRENGTHENING RESEARCH, INNOVATION AND INFORMATION MANAGEMENT TO MEET NCASP GOALS						
KASF Objective	**NCASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographic Areas by County/Sub-county**	**Responsibility**
Identification and implementation of high impact research priorities, innovative programming and capability and capacity strengthening to conduct research	Increased evidence-based planning, programming and policy changes by 50% Increased capacity and implementation of research on the identified NCASP-related HIV priorities by 50% Increased resources to support HIV research activities at county levels by 10%	Resource and implement a HIV research agenda informed by NCASP	Conduct a county stigma index survey. Conduct a county baseline survey to document the magnitude and nature of human rights violation and gender disparities in the context of HIV including SGBV. Identify research gaps within the county using the available data. Establish a research hub to promote information management and use. Capacity building on research methodologies. Establish ethics review committees. Develop policies to attract and guide research activities. Leverage on partnerships in research. Allocate resources for health research activities.	Research TWG Research stake-holders	All sub counties.	Implementing partners CEC PEPFAR/WRP CHC

STRATEGIC DIRECTION 6: PROMOTE UTILIZATION OF STRATEGIC INFORMATION FOR RESEARCH AND MONITORING AND EVALUATION TO ENHANCE PROGRAMMING						
KASF Objective	**NCASP Results**	**Key Activity**	**Sub-Activity/ Intervention**	**Target Population**	**Geographic Areas by County/Sub-county**	**Responsibility**
To improve data quality, demand, access and use of data for decision making at the County and National levels	Increased availability of strategic information to inform HIV response in the County. Planned evaluations, reviews and surveys implemented and results disseminated in a timely manner.	Promote utilization of strategic information for research and monitoring and evaluation. Establish county data repository	Implement the M&E agenda of NCASP. Regular review of county specific HIV programmes. Timely data entry into various online data systems. Create and develop county specific reports. Strengthen existing TWGs. Utilization of county data for decision making. Establish county data repository. Allocate adequate funding for M&E activities.	Research TWG Research stakeholders	All sub counties.	Narok County Government MU Implementing partners NACC

STRATEGIC DIRECTION 7:

INCREASING DOMESTIC FINANCING FOR SUSTAINABLE HIV RESPONSE

KASF Objective	NCASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographic Areas by County/Sub-county	Responsibility
Increase domestic financing of the HIV response to 50%	Increased domestic program financing for HIV response to 50%	Promote efficiency in HIV and AIDS response at the county.	Map all partners actively involved in HIV and /AIDS programmes in the county and their respective resource envelops. Stakeholders' involvement in joint planning of HIV activities. Lobby for HIV budgetary allocation by the county government.	Lawmakers Stakeholders Governor	All sub counties.	County Government County Assembly Implementing partners
		Promote innovative and sustainable HIV financing options.	Setting up an HIV investment unit within the Department of Health and Sanitation. DOH Advocate for a vote head for HIV activities in every Annual Work Plan and budget. Engage local celebrities in fund raising for HIV activities through various activities. Lobby for funds from social corporate responsibility kitties from the tourism Department and other sectors. Dedicated tax levy modeled on the 19% as per the county bylaw on the Maasai Mara Collections.	Department of Health and Sanitation Department of Tourism Celebrities		County Executive Department of Tourism

STRATEGIC DIRECTION 8: PROMOTING ACCOUNTABLE LEADERSHIP FOR DELIVERY OF NCASP RESULTS BY ALL SECTORS AND ACTORS						
KASF Objective	NCASP Results	Key Activity	Sub-Activity/ Intervention	Target Population	Geographic Areas by County/Sub-county	Responsibility
Promote good governance practices by identifying, developing and nurturing effective and committed leaders for the HIV and AIDS response	Good governance practices and accountable leadership entrenched for the multi-sectoral HIV and AIDS response at all levels An enabling policy and legal regulatory framework for the multi-sectoral HIV and AIDS response strengthened and fully aligned to the constitution	Build and sustain high level political and technical commitment for strengthened county ownership of the HIV response.	Provide political leadership and support for the county HIV and AIDS response. Formation and oversee county HIV and AIDS programmes. Mobilize and allocate adequate resources for HIV and AIDS response. Reach out to the Council of Governors to help reduce bureaucracy in donor engagement.	County Executive	All sub counties.	County Government
	Good Governance practices and accountable leadership entrenched for the multi-sectoral HIV and AIDS response at all levels. Enabling policy and legal regulatory frameworks for the multi-sectoral HIV and AIDS response strengthened and fully aligned to the constitution.	Entrench good governance and strengthen multi-sector and partner accountability in the results delivery to NCASP.	Establish systems to oversee governance issues of the HIV response. Develop and implement resource management and accountability mechanisms.	Policy and Systems Accountability Committee		CEC, Health County HIV Coordination Committee
	Effective and well-functioning stakeholder co-ordination and accountability mechanisms in place and fully operationalized at county level.	Create Functional HIV and AIDS co-ordination mechanisms in the county	Formation of county HIV coordination committee. Structured quarterly stakeholders meetings. M & E of HIV and AIDS resource allocation and utilization. Strengthen HIV and AIDS TWG in the county.	Coordination		County Government

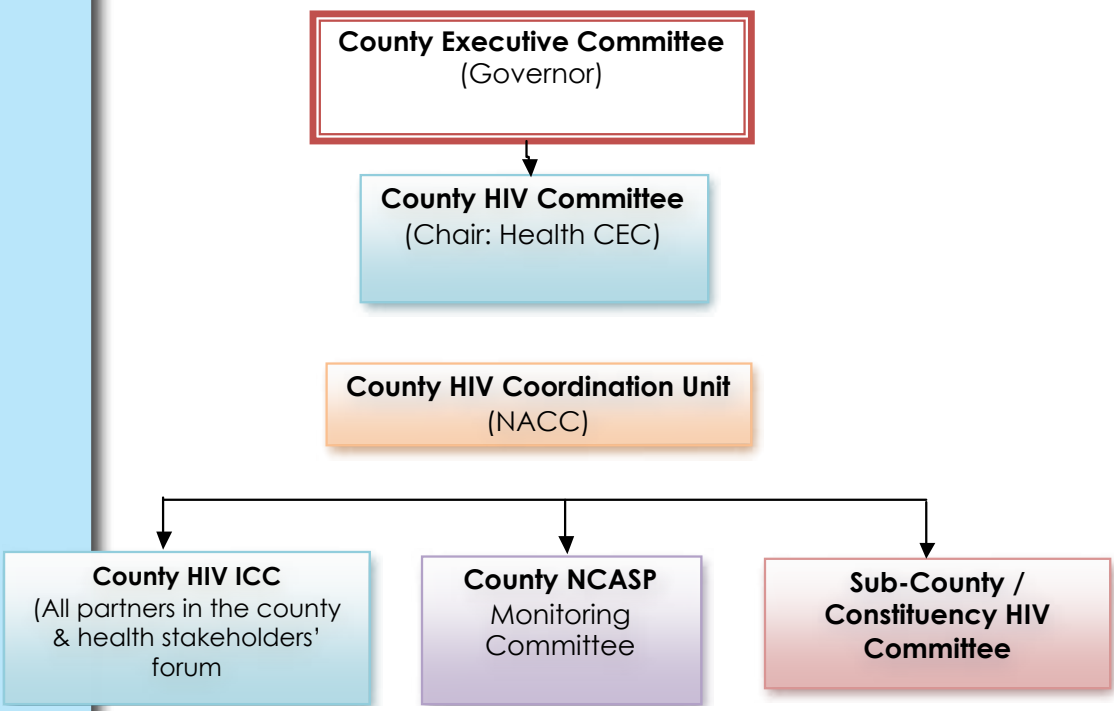
CHAPTER 5

Implementation Arrangements

HIV Coordination Mechanism

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

Figure 5.1:
Representation of the HIV county coordination mechanism



Roles and Responsibilities

Governor

The Governor, through the County Executive Committee, shall implement national and county legislation to the extent that the legislation is required and is responsible for the delivery of a range of services, planning and prioritization of resource allocation to address the HIV burden in Narok County.

NCASP County HIV Committee

The CHC is accountable to the County Governor for the performance of their functions and the exercise of their powers on matters relating to HIV. This committee is responsible for HIV response in the county. The composition of the committee is as follows:

1. Chair: Health CEC
2. Secretary to the HIV County Committee (NACC)
3. Representative of the County Assembly (1 from Health Committee)
4. Two COs – social services, planning and finance
5. A representative of PLHIV
6. A representative of the private sector
7. A representative of CACCs Sub-Counties
8. A representative of faith-based organizations
9. The County Director of Education

Roles of the County HIV Committee

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

County HIV Coordination Unit

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

Roles of the County HIV Coordination Unit

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

NCASP Monitoring Committee

This committee will be appointed and operationalized by the County HIV Committee under the leadership of the CEC.

The roles of this committee are as follows:

1. Receive reports from the County HIV ICC/ Stakeholder Forum.
2. Ensure that all the required tools and materials for data collection are available at the point of collection at all times.
3. Build the capacity of health workers on data collection and transmission.
4. Ensure HIV data collection, quality control, consolidation, interpretation and dissemination.
5. Ensure HIV issues and agenda are included in the County Department of Health newsletter.

County Inter-Coordinating Committee on HIV (County ICC- HIV)

The County ICC-HIV shall comprise various Stakeholder Working Groups representing the various constituencies. It will mirror the national ICC-HIV. The ICC-HIV is the primary forum for deliberating on AIDS issues at the county level. It has broad stakeholder membership including senior representatives from the County Government, civil society, the private sector and development partners within the county. The NACC County HIV Coordinator is the Committee's Secretary while the County CEC (Health) is the Chair.

Role of the County HIV-ICC

1. Coordinate and oversee the development of a collaborative and comprehensive strategy to roll out NCASP and subsequently monitor its implementation.
2. Ensure harmonization, coordination and resource mobilization and allocation, and tracking progress of HIV and AIDS programs within the county. .
3. Ensure coordination in information sharing within, and across partners in the county.
4. Advocate for the implementation of NCASP M&E tools, and activities into members and partners own work plans within the county.
5. Offer technical support in the implementation of NCASP.
6. Advocate for the NCASP as appropriate and as agreed with the County Government.
7. Reviewing programs and projects supporting NCASP implementation.

Meetings

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

Secretariat

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

Membership of the County ICC-HIV:

i. Representatives from the County Government
ii. Key HIV partners within the county
iii. NACC County AIDS Coordinator
iv. Representatives of PLHIV

Roles of Sub-County AIDS Coordinating Committees (SCACC)

1. Stakeholder mobilization to respond to HIV issues in the community.
2. Monitor communities' response to HIV issues and submit biannual reports to the HIV Committee.
3. Receive and disseminate appropriate National and County policies, guidelines and strategies on HIV and AIDS, in particular, NCASP and County HIV Profiles.
4. Account for any funds advanced to the SCACC.

Membership composition of SCACC

The membership is as follows:

i. The national government official at the Sub-county level – Deputy Sub-County Commissioner
ii. One person nominated from among the active Civil Society Organizations (CSOs) in the constituency
iii. A representative of PLHIV
iv. A representative of Persons with Disability (PWD)
v. One person representing women interests
vi. A representative of the youth – must be a youth at the date of appointment
vii. SCACC Coordinator – County MOH

The Chair will be appointed by the area MP in consultation with the SCACC Coordinator and the Deputy Sub-County Commissioner. The term of office of the SCACC members shall be five years irrespective of a parliamentary term and shall automatically come to an end upon the appointment of a new SCACC after a general election or a by-election.

Account signatories:

1) The Chair (alternate 1)
2) SCACC (mandatory) also the Secretary of the Committee
3) Deputy Sub-County Commissioner (alternate 2)

Stakeholder Management and Accountability

Successful implementation of the NCASP will heavily rely on the strength and effectiveness of stakeholder coordination. The process will entail joint planning, strategic partnerships, implementation, monitoring and evaluation for purposes of improving effectiveness and efficiency in HIV response. This will promote accountability and synergy among all actors to ensure optimal utilization of the scarce resources. Proper stakeholder mapping will be done. Sharing of mandates, roles and responsibilities is clearly defined in this document. As a result, there will be improved harmony to avoid duplication and conflicts between stakeholders.

As it is clearly stipulated in the objectives of this document, targets shall be discussed and agreed upon among all the stakeholders at all levels of service delivery. Performance management will be assessed through strengthened data management, quarterly TWG meetings and bi-annual general county health stakeholders meetings.

For coordination purposes, the following coordination structures will be established in the county

1. County HIV committee
2. County HIV coordination unit
3. Sub-County/ Constituency HIV committee

Sustainability

Narok County is classified as a medium HIV incidence county. This requires rapid scale up of high impact HIV investment under NCASP and a changing HIV funding landscape. In the FY 2014/2015 Narok County did not allocate sufficient funds for HIV programs.

The program will be sustained by setting up an HIV investment unit within the Department of Health and Sanitation and allocation of a percentage of the county revenues for HIV activities. The county government should also create a vote head for HIV activities in all budgetary allocations to the various sectors in their annual plans. The county is also advantaged to have celebrities who can be engaged as HIV ambassadors and to help in fund raising. The DOH will lobby for funds from social corporate responsibility kitties from tourism and other sectors.

CHAPTER 6

Research, Monitoring and Evaluation of the Plan

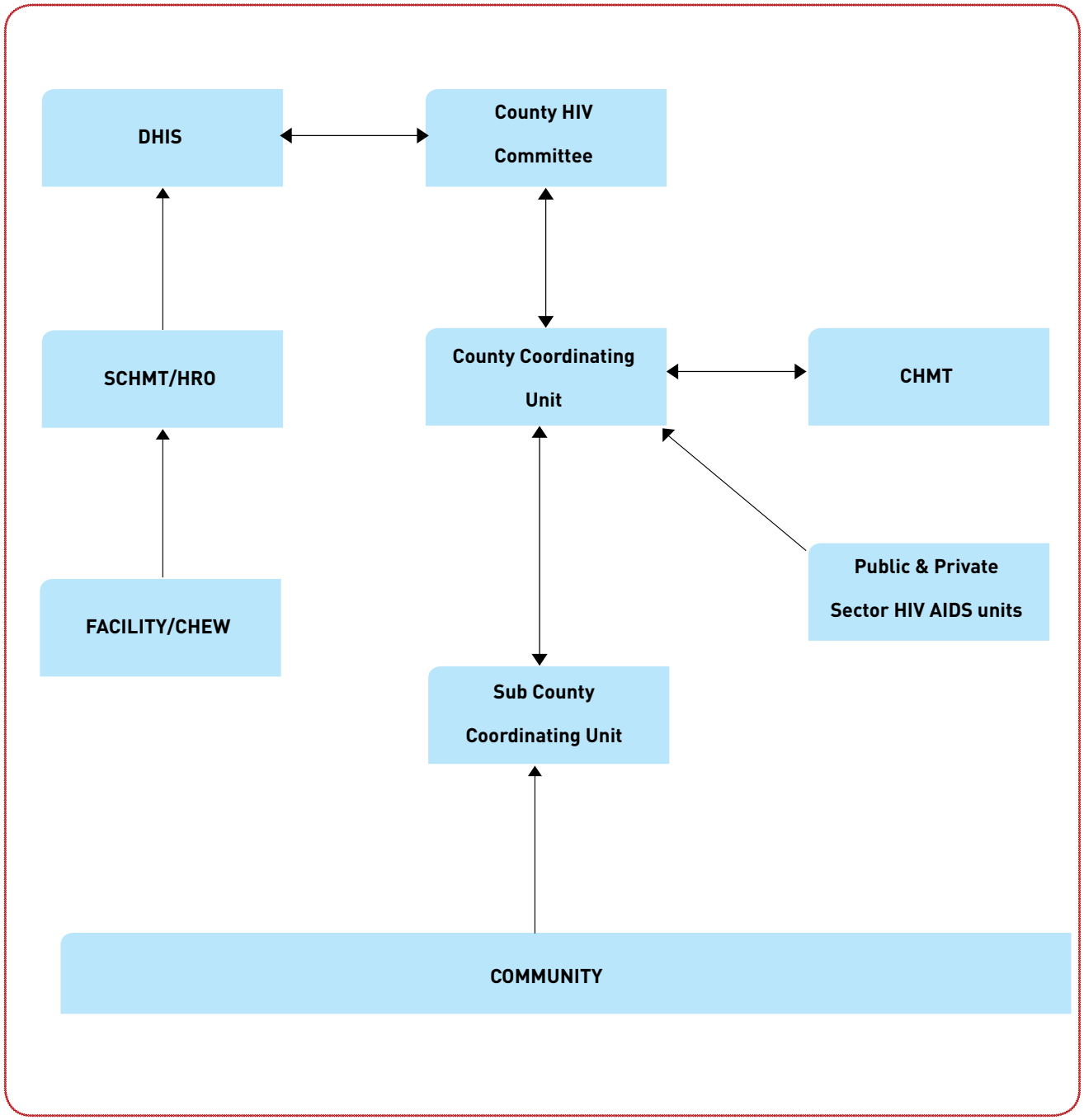
Narok County will develop an M&E plan for routine, non-routine reporting and surveillance aligned to the national framework. The existing M&E systems, guidelines, tools and SOPs will be utilized. In addition, a county data repository which will form a central information point and receive data from both public and private sector quarterly will be created to enhance information sharing. The existing county quality control system will monitor the quality delivery of systems and services through the quality control assurance team. The plan will guide the county stakeholders and implementers in the HIV response.

M&E data management will be strengthened at community, facility, sub-county and county levels. NCASP will promote utilization of data for decision making at all levels, best practices documented and disseminated through the existing county health stakeholders' forum. A HIV bulletin will be produced and shared annually.

There will be a feedback mechanism established among data users. Community units and CSOs will report to the health facilities to which they are linked each month and the reports will be submitted to Sub-County AIDS Coordinators. Reports from the community will be submitted to the sub-county health management teams each month and thereafter forwarded to the county health management team and the County HIV Coordination Unit through the county HIV database. This data is used to continually inform HIV programming and service delivery in the county. Dissemination of HIV data is done to the county stakeholders in public forums biannually.

The county research on HIV emerging and current issues as well as gaps is ongoing and will continue to inform HIV programming and service delivery.

Figure 6.1: M & E County Reporting Structure



CHAPTER 7

Risk & Mitigation Plan

The following are the possible risks that have been identified that may hinder the successful implementation of the NCASP and proposed recommendations or risk mitigation measures to minimize on the chances of the risk happening.

i. Increasing domestic funding.

ii. Strengthening effectiveness and efficiency in the use of financial resources, and in service delivery.

iii. Prioritization of the National/County response strategies.

iv. Cost reduction in service delivery.

Risk Category	Risk Name	Status	Probability (High, Medium, Low)	Impact (High, Medium, and Low)	Risk Average Score (High, Medium, Low)	Response and Mitigation	Responsibility
Technological	Partners lack capacity	Active- risk is being actively monitored	Medium	High	Medium	Allocation of a budget for partner capacity building	All stakeholders
Political and Legislation	Lack of political goodwill		Low	High	Medium	Identify champions among them for the county HIV agenda. Sensitization of politicians on the county HIV agenda.	County HIV Committee County Secretary
	Political uncertainty including change of senior health officers		High	High	High	Engage as many officers across all other sectors on the county HIV agenda.	County HIV Committee
	Slow government processes in approval of HIV related Bills and policies; procurement processes etc		High	High	High	Identify champions among the health and budget committees	County HIV Committee
	Lack of Ownership		High	High	High	Involvement of policy makers in the development of the county HIV policies, plans and guidelines Sensitization of policy makers on the plan	County HIV Committee
Operational	High staff turnover due to transfers and other factors		Medium	High	High	Provide staff motivation including financial, and others like training, medical covers, promotions, recognition etc.	County Public Service Board County Secretary

Risk Category	Risk Name	Status	Probability (High, Medium, Low)	Impact (High, Medium, and Low)	Risk Average Score (High, Medium, Low)	Response and Mitigation	Responsibility
Operational	Poor reports and lack of reports	Active- risk is being actively monitored	Low	High	Medium	Support the implementation of the M & E frameworks	Quality Assurance Team
	Slow implementation of financially supported activities		Low	High	Medium	Assignment of clear roles and responsibilities towards the implementation of the work plan	County HIV Committee
	Poor coordination and harmonization of implementation of HIV programs		Low	High	Medium	Forecasting Allocation of clear roles and responsibilities at all levels	County HIV Committee
Financial	Lack of specific HIV budget allocation		High	High	High	Advocating with the health and budget committees	County HIV Committee Implementing Partners
	Corruption		High	High	High	Putting in place checks and balances including financial and social audits	County Government
	Financial sustainability		High	High	High	Planning and forecasting ahead	County HIV Committee

STRATEGIC DIRECTION 1: REDUCING NEW HIV INFECTION						
KASF Objective	NCASP Results	Key Activity	Indicators	Baseline and Source as at 2015	Midterm Targets	End Term Targets
Reduce new HIV infections by 75%	Reduce new adult infections by 60%	Scale up CT	Number of people counseled and Tested	160,056	230,481	331,892
		Integration and linkage of services	Percentage of sexual and gender-based violence survivors provided with post-exposure prophylaxis (PEP)	TBD	100%	-
			Percentage of schools that provide life skills based HIV education	TBD	50%	100%
		Prevention of HIV in healthcare settings	Percentage of trained healthcare workers on prevention of HIV in healthcare settings	33%	70%	100%
			Percentage of health facilities providing PEP services	TBD	100%	100%
		Leveraging other sectors	Percentage of county government MDA reporting against targets set in their HIV plans	TBD	50%	100%
	Reduced HIV transmission rates from mother-to-child from 14% to less than 5%	Strengthen EMTCT and EID services	Percentage of HIV positive pregnant mothers put on care and treatment	87%	95%	100%
			Percentage of health facilities providing early infant diagnosis	TBD	TBD	TBD

STRATEGIC DIRECTION 2: IMPROVING HEALTH OUTCOMES AND WELLNESS OF PLHIV						
KASF Objective	**NCASP Results**	**Key Activity**	**Indicators**	**Baseline and Source as at 2015**	**Midterm Targets**	**End Term Targets**
Reduced AIDS related mortality by 25%	Increase linkage to care within 3 months of HIV diagnosis to90% of children, adults and adolescents	Improving ed linkage and retention to care	Percentage and number of newly diagnosed HIV infected persons linked to care within 3 months	31%	230,481	331,892
	Increase ART coverage to 90% for children, adolescents and adultS	Increasing coverage to care and treatment	Percentage of children 0 – 15 years on ART	26%	50%	90%
			Percentage of adults on ART	26%	50%	90%
			Percentage of identified HIV infected pregnant women started on HAART	95%	100%	90%
	Increase retention on ART at 12 months to 90% in children, adolescents and adults	Increasing ed retention to ART	Percentage of adults and children with HIV known to be on treatment 12 months after initiation	65%	90%	90%
	Increase viral suppression to 90% in children, adolescents and adults	Monitoring of viral load	Percentage of adults on ART tested for viral load who have a suppressed viral load at 12 months	34%	100%	100%
			Percentage of children on ART tested for viral load who have a suppressed viral load at 12 months	63%	90%	90%

STRATEGIC DIRECTION 3: HUMAN RIGHTS APPROACH TO FACILITATE ACCESS TO SERVICES FOR PLHIV, KEY POPULATIONS AND PRIORITY GROUPS						
KASF Objective	**NCASP Results**	**Key Activity**	**Indicators**	**Baseline and Source as at 2015**	**Midterm Targets**	**End Term Targets**
Reduce HIV related stigma and discrimination by 50%	Reduce self reported stigma and discrimination related to HIV and AIDS by 50%	Removing barriers to access of services Improving the legal and policy environment	Percentage of SGBV survivors who access PEP services	90%	100%	90%
	Increased protection of human rights and improved access to justice for PLHIV, key populations and other priority groups including women, men, boys and girls		Percentage of women and men aged 15 – 49 years expressing accepting attitudes towards people living with HIV	45%	60%	100%
			Number of laws, regulations and policies reviewed or enacted integrating HIV in the county	No baseline information available	50%	100%

STRATEGIC DIRECTION 4: STRENGTHENING INTEGRATION OF HEALTH AND COMMUNITY SYSTEMS						
KASF Objective	**NCASP Results**	**Key Activity**	**Indicators**	**Baseline and Source as at 2015**	**Midterm Targets**	**End Term Targets**
Build a strong and suitable system for HIV service delivery through specific health and community systems approaches, actions and interventions to support HIV response	Improved Health workforce for HIV workforce at county levels by 40%	Provision of competent motivated and adequate health workers	Number of adequately skilled healthcare workers to the population	125	140	177
	Strengthened community level AIDS competence	Strengthening community service delivery systems	Percentage of health facilities providing KEPH–defined HIV and AIDS services	0%	32%	64%
	Increased number of health facilities ready to provide KEPH defined HIV and AIDS services from 33% to 90%	Improve access to and use of essential quality health products and technologies	Percentage of community units implementing AIDS-– competency guidelines	60%	80%	100%
	Strengthened HIV commodity management	Strengthening community service delivery system	Percentage of community based organizations that submit timely and accurate reports according to guidelines	75%	100%	100%

STRATEGIC DIRECTION 5: STRENGTHENING RESEARCH, INNOVATION AND INFORMATION MANAGEMENT TO MEET NCASP GOALS						
KASF Objective	**NCASP Results**	**Key Activity**	**Indicators**	**Baseline and Source as at 2015**	**Midterm Targets**	**End Term Targets**
Identification and implementation of high impact research priorities, innovative programming and capability and capacity strengthening to conduct research	Increased evidence-based planning, programming and policy changes by 50%	Resource and implement a HIV research agenda informed by NCASP	Percentage of centralised data repository for sharing findings established	0%	1%	1%
	Increased capacity and implementation of research on the identified NCASP-related HIV priorities by 50%		Percentage of funds allocated to the HIV research agenda	0%	5%	5%
	Increased resource to implement HIV research at county levels by 10%					

STRATEGIC DIRECTION 6: PROMOTE UTILIZATION OF STRATEGIC INFORMATION FOR RESEARCH AND MONITORING AND EVALUATION TO ENHANCE PROGRAMMING						
KASF Objective	**NCASP Results**	**Key Activity**	**Indicators**	**Baseline and Source as at 2015**	**Midterm Targets**	**End Term Targets**
To improve data quality, demand, access and use of data for decision making at the County and National level	Increased availability of strategic information to inform HIV response at in the County.	Promote utilization of strategic information for research and monitoring and evaluation	Percentage of County HIV M & E system developed and operationalised Percentage of timely, complete and accurate reports submitted	0%	1%	1%
	Planned evaluations, reviews and surveys implemented and results disseminated in timely manner.	Establishment of a county data repository	Percentage of M&E data repository established	75%	100%	100%
	M&E information hubs established in the county and providing comprehensive information package on key KASF indicators for decision-making.			0%	1%	1%

STRATEGIC DIRECTION 7: INCREASING DOMESTIC FINANCING FOR A SUSTAINABLE HIV RESPONSE						
KASF Objective	**NCASP Results**	**Key Activity**	**Indicators**	**Baseline and Source as at 2015**	**Midterm Targets**	**End Term Targets**
Increase domestic financing of the HIV response to 50%	Increased domestic program financing for HIV response to 50%.	Promote efficiency in HIV and AIDS response at in the county	Percentage of HIV stakeholder database developed and active	0%	1%	1%
		Promote innovative and sustainable HIV financing options	Establish a county HIV kitty	0%	1%	1%

STRATEGIC DIRECTION 8: PROMOTING ACCOUNTABLE LEADERSHIP FOR DELIVERY OF NCASP RESULTS BY ALL SECTORS AND ACTOR						
KASF Objective	**NCASP Results**	**Key Activity**	**Indicators**	**Baseline and Source as at 2015**	**Midterm Targets**	**End Term Targets**
Promote good governance practices by identifying, developing and nurturing effective and committed leaders for the HIV and AIDS response	Good governance practices and accountable leadership entrenched for the multi-sectoral HIV and AIDS response at all levels	Build and sustain high level political commitment for strengthened community ownership of the HIV response	Percentage of Functional Joint HIV coordination committee	0%	1%	1%
	An enabling policy and legal regulatory framework for the multi-sectoral HIV and AIDS response strengthened and fully aligned to the constitution	Entrenched multi-sector and partner accountability to delivery of the NCASP results	HIV and AIDS County Plan adopted and implemented by the County Assembly	0%	1%	1%

Annex II NCASP Resource Needs,

Ref No.	Activities	Resource Requirement	
		Annual Estimate (Ksh)	NCASP Period Estimate
1 .	Scale up CT People in need of testing = 496,636 annually Unit cost of testing = 513/=(496,636*513*3yrs)	254,774,268	764,322,804
2.	Prevention of HIV in healthcare setting Unit cost of training each HW = 2,400/= Health Care Workers = 918 (2,400*918*3yrs)	2,203,200	6,609,600
3.	Strengthen eMTCT and EID services (207 4 Review meetings @ 90,000/= * 5 years = 1,800,000 EID sample collection and transportation 40,000/= per month * 12 months * 3 yrs Beyond Zero campaign initiative 500,000*4*3yrs	 360,000 480,000 2,000,000	 1,080,000 1,440,000 6,000,000
4.	Improved linkage and retention to care (2075*5200*90%*3yrs)	9,711,000	29,133,000
5.	Increasing coverage to care and treatment (51,612*26752*3yrs)	1,380,724,224	4,142,172,672.
6.Refer to 5	Increased retention to ART	-	-
7.	Monitoring of viral load (Ksh.2,500*7760*3yrs)	19,400,000	58,200,000
SD3			
8. Refer to 2	Sensitize health workers to avoid use of stigmatizing language	-	-
9.	Sensitize police and health workers on SGBV (330*2400*3yrs)	792,000	2,376,000
10.	Develop communication messages that target youth	62,500,000	62,500,000
11.	Establish youth friendly centre (2000000*6)	12,000,000	12,000,000
12. Refer to 11	Empower youth living with HIV to reach out to other youth	-	-
13.	Empower men to disclose their status and reach out to other men (1183*744*3yrs)	880,152	2,640,456
14. Refer to 10	Sensitize community to access PEP services	-	-
15.	Sensitize council of elders to guide on cultural practices that promote healthy behaviour (50*2400*3yrs)	120,000	360,000

		Annual Estimate (Ksh)	NCASP Period Estimate
16.	Integrate sports in HIV prevention (1,000,000*30*3yrs)	30,000,000	90,000,000
17.	Sensitize teachers who handle children and youth living with HIV (701*2*2400*3yrs)	3,364,800	10,094,400
18.	Build capacity of CHVs and CHC on HIV competency (1876*2400)	4,502,400	4,502,400
19. Refer to 13	Carry out men-to-men forums through CHVs and CHCs	-	-
20.	Sensitize sub-county administrators, ward administrators, chief and opinion leaders to prioritize PLHIV involvement in forums (experience sharing)	312,000	936,000
21. Refer to 15	Empower age-set leaders to reach out to fellow age-mates on HIV issues	-	-
22.	Include a HIV week within religious institutions to sensitize leaders on HIV issues (60pax* Ksh.2400*3yrs)	144,000	432,000
23.Refer to 22	Sensitize religious leaders on legal issues relating to HIV	-	-
24. Refer to 22	Reach out to men through churches and mosques	-	-
25.	Use the local media to fight stigma/discrimination and uptake of HIV services (62,500,000)	62,500,000	62,500,000
26.	County and sub-county HIV week prior to World AIDS Day (500,000 *6*3yrs)	3,000,000	9,000,000
27.	Develop county policy on OVC support (3,000,000)	3,000,000	3,000,000
28.Refer to 15	Address negative cultural practices such as FGM, early marriages that increase vulnerability	-	-
29. Refer to 9	Capacity build HWs on SGBV reporting tools	-	-

SD4			
30.	Sensitize sectors on work place policies (30pax* Ksh.2,400)	720,000	720,000
31.	Strengthen support supervision (5pax*6000*6 sub-counties*-5days*4)*3yrs	3,600,000	10,800,000
	5pax*Ksh 1000*5days*4*6 sub-counties)*3yrs	600,000	1,800,000
32.	Recruitment of staff (60*60,000)*3yrs	3,500,000	17,500,000
33.	Sustain 67 community units (1206*2,000*)3yrs	2,412,000	7,236,000
34. Refer to 31	Integration of HIV referral and linkage services	-	-
35. Refer to 31	Supportive supervision at level 1	-	-
36.	Integration of HIV messages in community dialogue days	-	-

		Annual Estimate (Ksh)	NCASP Period Estimate
37.	Strengthen community and home-based care (1000*500*4)*3yrs	12,000,000	36,000,000
38. Refer to 4	Nutrition supplements	-	-
39.	Procure VL and PCR machines	-	-
40.	Integrate mother companions (TBAs) in prevention care and support (200*2400)*3yrs	480,000	1,440,000
SD5			
41.	Biennial forum to promote research findings	10,000,000	10,000,000
42.	Establish a centralized data repository for data sharing findings	-	-
44.	Establish an ethics review committee	-	-
45.	Allocate resources for health research activities	5% of county annual budget	-
SD6			
46.	Localize NCASP M&E (500*1000)	500,000	500,000
47.	Regular review of county HIV programmes (300,000*2)	600,000	600,000
48.	Develop county reports (reporting tools)- 1,560,000*3yrs	1560 000	4,680,000
49.	Strengthen existing TWG (100,000*4)*3yrs	400,000	1,200,000
50.	Provide adequate funds for M&E	-	-
SD7			
51.	Map county partners actively involved in HIV activities	-	-
52.	Involve stakeholders in joint planning (50*3000)*3yrs	150,000	450,000
53.	Lobby for HIV budgetary allocation by the county government	-	-
54.	Setting up an HIV investment unit	-	-
55.	Support advocacy forum for county leaders (100pax *10,000)	1,000,000	1,000,000
56.	Engage HIV and AIDS champions	-	-
57. Refer to 55	Lobby for funds from corporate to support HIV programmes	-	1,000,000
SD8			
59. Refer to55	Provide political leadership and support for the county HIV and AIDS response	1,000,000	1,000,000
60.	Form and oversee county HIV programmes	7.4% of direct program cost	-

		Annual Estimate (Ksh)	NCASP Period Estimate
61. Refer to 55	Develop county HIV legislative agenda	1,000,000	1,000,000
62.	Develop and implement resource management and accountability mechanism	-	-
63.	County HIV committee (13*4*2500*6)*3yrs	780,000	2,340,000
	TOTAL		**5,365,997,332**

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List of Drafting and Technical Review Team

NCASP Development Task Force

1.	H.E. Sarah Tunai	County First Lady
2.	Hon. Ezekiel Rono	CEC Health
3.	Hon. John Marindany	CEC Education and Social Services
4.	Hon. Birir	CEC Agriculture
5.	David Kimojino	CCO
6.	Kenneth Passiany	CHAC
7.	Dickson Kigwenai	SCMOH
8.	Allan Partalala	Technical Officer, APHIA PLUS
9.	Magdalene	Key Populations
10.	Grace Orina	Maasai Mara University
11.	Rosemary Lempaka	KENAPOTE
12.	Mary Naikumi	ACK-NIDP
13.	Rev. Peter Sinti	AGC Narok Region
14.	Jane Cheptarus Kiok	CACC Coordinator Narok South
15.	Dominic Sankei	CACC Coordinator Narok East
16.	Rose Naanyu	CACC Coordinator Narok West
17.	Peter Sanare	CACC Coordinator Transmara West
18.	Lily Chepkurui	CACC Coordinator Transmara East
19.	Philip Kool	NADINEF
20.	Richard Kolua	ENOCOW

Technical Review Team

1.	Dr. Francis Kiio	County Director of Health
2.	David Kimojino	CCO
3.	Daniel Sironka	CPHO
4.	Lemeria Leposo	County Nursing Officer
5.	James Yiaile	CASCO
6.	Micah Cheburet	County TB and Leprosy Coordinator
7.	Paul Rissa	County Laboratory Technologist
8.	Keneth Passiany	County HIV and AIDS Coordinator
9.	Dr. JemutaiTarus	KEMRI/ WRP
10.	Dickson Kigwenai	SCMOH Narok West
11.	Grace Orina	Maasai Mara University
12.	Jane Cheptarus	CACC Coordinator Narok South
13.	Abigael Chemutai	Community Strategy Focal Person, Narok North
14.	Donald Nyambane	SCHRIO Narok West
15.	Allan Partalala	Technical Officer, APHIA PLUS
16.	Hillary Chepsiror	Regional HIV and AIDS Coordinator, NACC
17.	Kenneth Mosoti	Legal Officer, NACC
18.	Evelyn M. Kiswii	The Jomo Kenyatta Foundation
19.	Kavutha Mutuvi	Gender and HIV Expert
20.	Kibe Ranji	NACC
21	Bryan Okiya	Program Officer- Strategy and Planning

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