# COUNTY GOVERNMENT OF NYAMIRA

DEPARTMENT OF HEALTH SERVICES

## COUNTY HIV & AIDS STRATEGIC PLAN

(2014/15-2018/19)

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National AIDS Control Council

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# Acronyms and abbreviations

| | |
|---|---|
| **AIDS** | Acquired ImmunoDeficiency Syndrome |
| **ANC** | Antenatal Clinic |
| **ART** | Antiretroviral Treatment/Therapy |
| **ARV** | Anti-Retroviral Drugs |
| **BCC** | Behaviour Change Communication |
| **CASCO** | County AIDS & STI Coordinator |
| **CBO** | Community Based Organization |
| **CCM** | Country Coordination Mechanism |
| **CCSFP** | County Community Strategy Focal Person |
| **COAC** | County AIDS Coordinator |
| **CHC** | County HIV&AIDS Committee |
| **CHEWs** | Community Health Extension Workers |
| **CHMT** | County Health Management Team |
| **CHPO** | County Health Promotion Officer |
| **CHV** | Community Health Volunteers |
| **CMHC** | County Mental Health Coordinator |
| **CMLC** | County Medical Laboratory Coordinator |
| **CNC** | County Nutritional Coordinator |
| **CRHC** | County Reproductive Health Coordinator |
| **CSO** | Civil Society Organization |
| **CTLC** | County TB Leprosy Coordinator |
| **DICE** | Drop in Center |
| **DHIS** | District Health Information System |
| **EAC** | East African Community |
| **EBI** | Evidence Based Intervention |
| **eMTCT** | Elimination of Mother to Child Transmission |
| **FBO** | Faith Based Organization |
| **FSW** | Female Sex Worker |
| **GBV** | Gender Based Violence |
| **GoK** | Government of Kenya |
| **HBC** | Home Based Care |
| **HBTC** | Home Based Testing and Counselling |
| **HCBC** | Home and Community Based Care |
| **HCW** | Health Care Worker |
| **HIV** | Human Immunodeficiency Virus |
| **HMIS** | Health Management Information System |
| **HPV** | Human Papillomavirus |
| **HR** | Human Resources |
| **HTS** | HIV Testing and counseling Services |
| **IEC** | Information, Education, and Communication |
| **IGAD** | Intergovernmental Authority on Development |
| **IPC** | Infection Prevention and Control |
| **IRC** | Inter Religious Council |
| **KAIS** | Kenya AIDS Indicator Survey |
| **KASF** | Kenya AIDS Strategic Framework |
| **NCG** | Nyamira County Government |
| **KDHS** | Kenya Demographic and Health Survey |
| **KEPH** | Kenya Essential Package for Health |
| **KNASP** | Kenya National AIDS Strategic Plan |
| **KP** | Key Populations |
| **MDAs** | Ministries, Departments and Agencies |
| **M&E** | Monitoring and Evaluation |
| **MoH** | Ministry of Health |
| **MOT** | Modes of Transmission |
| **MSM** | Men who have Sex with Men |
| **MSW** | Male Sex Worker |
| **NACC** | National AIDS Control Council |
| **NASCOP** | National AIDS & STI Control Programme |
| **NCDs** | Non-Communicable Diseases |
| **NGO** | Non-Governmental Organizations |
| **OVC** | Orphans and Vulnerable Children |
| **PEP** | Post-Exposure Prophylaxis |
| **PITC** | Provider-initiated Testing and Counselling |
| **PLHIV** | People Living with HIV and AIDS |
| **PMTCT** | Prevention of Mother to Child Transmission |
| **PrEP** | Pre-Exposure Prophylaxis |
| **PwD** | People/Persons with Disabilities |
| **PHDP** | Positive Health, Dignity and Prevention |
| **RBM** | Results Based Management |
| **SGBV** | Sexual and Gender Based Violence |
| **SRH** | Sexual and Reproductive Health |

# Foreword

The development and subsequent launch of the Nyamira County AIDS Strategic Plan, covering the period 2014/15 to 2018/19, is the culmination of many months of preparation by the County Department of Health Services, in collaboration with development and implementing partners, to deliver a framework for a strengthened County HIV/AIDS response. This is a fulfillment of our responsibilities as provided for in Schedule 4(2) of the constitution of Kenya 2010. In particular it provides mechanism of delivering on our mandate to our people as anticipated in art 43 of the constitution particularly on HIV/AIDS.

There is a general understanding among stakeholders that combating HIV/AIDS requires multi-sectorial approach to create synergy and accelerate achievements of the desired outcomes. It is my strong conviction that the participation by individuals from all sectors, and representing a wide range of organizations, will ensure dynamic County action that yields desirable results in HIV programs in Nyamira County.

This Strategic Plan will guide our HIV interventions over the next five years. It is an expression of our commitment and determination to consolidate the gains we have made as a county while exploring new approaches to tackle emerging issues especially the key populations that previously was not adequately addressed in our county. HIV and AIDS is not only as a biomedical challenge, but also as cultural, social and economic challenge that affect all sectors of our society and economy.

This plan provides a framework for addressing the complexities of our sexuality, our relationships, our culture, beliefs and attitudes that influence the transmission of HIV. In order for us to achieve the desired goals in HIV program we have to support people living with HIV, address issues of stigma and discrimination.

This Strategic Plan is aligned to the national and global HIV framework and provides both vertical and horizontal linkages that are key in the fight against HIV/AIDS. My Government will work very closely with the community and all our partners including the national government to accelerate achievement of the objectives in this plan.

In conclusion, I would like to thank the technical working group led by our team from the Department of Health Services that spearheaded this process under the guidance of lead consultant. I sincerely thank the National Aids Control Council (NACC), National STIs Control Program (NASCOP) and all our development and implementing partners for the role they have played in developing this Strategic Plan. I know the fight against HIV/AIDS requires political support, my government is fully committed to provide the required support to achieve this. I wish everyone involved a successful implementation.

**H.E John Nyagarama**
Governor, Nyamira County

# Acknowledgement

The advent of devolution in our country created fundamental changes in health sector and with this came the challenge of developing the frameworks to deliver health services. The County Government of Nyamira appreciates that it cannot deliver on this important mandate alone. Involvement of various stakeholders in our programing therefore is the key to the achievements we have made so far. I do appreciate that to reduce the new HIV infections both in adults and children will not be an easy venture but we are prepared to achieve the desired results. This strategic plan is a reflection of what can be done if we work together focused on a common goal of achieving zero new infections, zero discrimination and zero AIDS related deaths.

On behalf of the department, I sincerely thank HE the Governor John Nyagarama for the support in the fight against HIV/AIDS in our county. In particular the department thanks him for always finding time in his political engagements to talk about HIV/AIDS. I also thank Mama Naomi Nyagarama for her involvement in issues of HIV/AIDS and particularly finding time to grace some of our consultative meetings on HIV. We owe appreciation to our technical team and other partners that worked hard to develop this plan. I also want to sincerely thank the County Chief Officer for the Department of Health Service and the Director for Health Services for providing the required leadership. To all our partners, people and organisations that contributed to the development of this Nyamira County HIV and AIDS Strategic Plan 2014/15-2018/19 (NCHASP) we thank you so much.

Special mention goes to the people living with HIV who found time to provide us with useful insights that has helped in refining our strategies. National government entities like NASCOP and NACC that provided technical support and resources to develop the plan are hereby greatly acknowledged. We are banking on the partnerships we have created and nurtured to help us in the implementation of this plan for the greater benefit of the people of Nyamira. To all the organizations, entities and people that I have not mentioned individually kindly accept our sincere appreciation

**Hon. Gladys Momanyi**
CEC Health, Nyamira County

# Executive Summary

The Nyamira County AIDS Strategic Plan (NCHASP 2014/15-2018/19) is a five-year plan developed to provide strategic guidance to inform the planning, coordination, implementation, monitoring and evaluation of the county multi-sectoral HIV and AIDS response. The county HIV prevalence stands at 6.4% with a total number of 23,493 people living with HIV. (KAIS 2012, County Estimates 2014). ART coverage in the county stands at 42% (County Estimates, 2014) The county plan aims at achieving zero new infections, zero discrimination and zero AIDS related deaths which in turn compliments the national response.

This plan was developed taking cognizance of the national values of citizen participation which involved a wide range of stakeholders in the County. The process began with the launch and dissemination of the Kenya AIDS Strategic Framework (KASF 2014/15-2018/19) which is the blue print against which this plan is developed. A county drafting team was constituted that undertook the development of the plan, a process which lasted for a period of seven (7) months. This process was further supported by the NACC and a Technical Support Team consisting of key partners.

In developing the strategic plan the county has been guided by a number of principles; human rights, evidence based planning and results based management approaches, gender dimensions and equity. The plan further promotes the principle of Greater and Meaningful involvement of PLHIV (MIPA) thereby enhancing Positive Health Dignity.

This plan is aligned to both national and international strategies, instruments and commitments such as the KASF 2014/15-2018/19, the Constitution of Kenya 2010, the Health Sector Strategic plan (HSSP), UN High Level Meeting Commitments and Regional HIV frameworks such as IGAD and EAC.

**The vision of the NCHASP is 'County population free of HIV& AIDS and its effects'.**

To achieve this, four key objectives have been outlined;

1. Reduce new HIV infections by 50 per cent
2. Reduce AIDS related mortality by 30 per cent
3. Reduce HIV related stigma and discrimination by 50 per cent
4. Increase domestic financing of HIV response to 20 per cent

The strategic plan further identifies priorities and strategies that will be put in place in order to contribute to the anticipated impact and outcome. The plan further indicates priority areas of research to be implemented this is to ensure the County has county specific data and information with regard to stigma and discriminations, key drivers of the epidemic among other priorities.

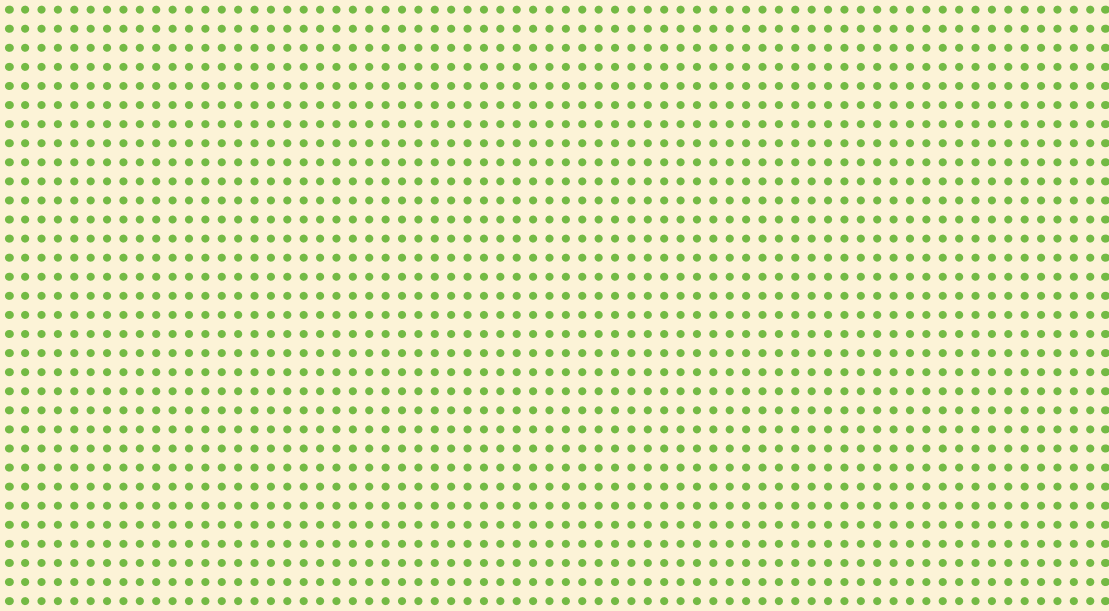
The plan also outlines the implementation framework clearly indicating the different roles by key stakeholders in order to deliver on its mandate and promote transparency and accountability. It further provides costing for the plan indicating resources needed for its implementation, the plan has with detailed a results framework that will guide monitoring of the County response. The Matrix indicates the results to be achieved in the lifespan of the plan with clear targets and outlines responsibility for each of the key areas. A risk and mitigation plan has been developed that identifies potential sources of risk and how to mitigate them in the lifespan of the strategic plan.

**Table 1: Strategic directions**

| | Strategic Direction | Expected results by 2019 |
|---|---|---|
| 1 | Reducing new HIV infections | • Reduced annual new HIV infections among adults by 50 per cent<br>• Reduced HIV transmission rates from mother to child from 14 per cent to less than 5 per cent |
| 2 | Improving health outcomes and wellness of all people living with HIV | • Increased identification and immediate linkage to care to 90 per cent for children, adolescents and adults<br>• Increased ART coverage to 90 per cent for children, adolescents and adults<br>• Increased retention on ART at 12 months to 90 per cent children, adolescents and adults<br>• Increased viral suppression to 90 per cent in children, adolescents and adults |
| 3 | Using a human rights approach to facilitate access to services for PLWHIV, key populations and other priority groups in all sector | • Reduced self-reported stigma and discrimination related to HIV and AIDS by 50 per cent<br>• Reduced incidences of sexual and gender-based violence for PLHIV, key populations, women, men, boys and girls by 50 per cent<br>• Improved protection of human rights and improved access to justice for PLHIV, key populations and other priority groups including women, boys and girls<br>• Reduced social exclusion for PLHIV, key populations, women, men, boys and girls by 50 per cent |
| 4 | Strengthening integration of health and community systems | • Increased health workforce for the HIV response at the county level by 40 per cent<br>• Increased number of health facilities ready to provide KEPH-defined HIV and AIDS services from 67 per cent to 90 per cent<br>• Strengthened HIV commodity management through effective and efficient management of medicine and medical products<br>• Strengthened community-level AIDS competency |
| 5 | Strengthening research and innovation to inform the NCHASP goals | • Increased implementation of research on the identified NCHASP-related HIV priorities by 50 per cent<br>• Increased capacity to conduct HIV research at county level by 10 per cent |
| 6 | Promoting utilization of strategic information for research and monitoring and evaluation (M&E) to enhance programming | • Increased availability of strategic information to inform HIV response county level<br>• Planned evaluations, reviews and surveys implemented and results disseminated in timely manner<br>• Enhanced existing functional county M&E systems to provide a comprehensive information package on key NCHASP Indicators for decision making |
| 7 | Increasing domestic financing for a sustainable HIV response | • Increased domestic financing for HIV response to 20 per cent |
| 8 | Promoting accountable leadership for delivery of the NCHASP results by all sectors and actors | • Good governance practices and accountable leadership entrenched for the multi-sectoral HIV and AIDS response at all levels<br>• Effective and well-functioning stakeholder co-ordination and accountability mechanisms in place and fully operationalised at county levels<br>• An enabling policy, legal and regulatory framework for the multi-sectoral HIV and AIDS response strengthened and fully aligned to the Constitution of Kenya 2010. |

# 01.

# BACKGROUND INFORMATION



Nyamira County is one of the forty seven counties in Kenya. The County borders Homa Bay County to the north, Kisii County to the west, Bomet County to the south east and Kericho County to the east. The County covers an area of 899.4km2. It lies between latitude 00 30° and 00 45° south and between longitude 340 45° and 350 00° east.

Administratively, the Nyamira County is divided into 5 sub-counties namely Nyamira, Nyamira North, Borabu, Manga and Masaba North. The county is further divided into 14 divisions with 38 locations and 90 sub locations. Borabu sub-county is the largest with an area of 248.3km2 followed by Nyamira North sub-county with an area of 219.3km2 while Manga sub-county is the smallest with an area of 111.3 km2

Politically, the county has four constituencies, namely, West Mugirango which covers administrative boundary of Nyamira sub-county; Kitutu Masaba which covers administrative boundaries of Manga and Masaba North Sub-counties; North Mugirango which covers the administrative boundary of Nyamira North sub-county except the proposed Kiabonyoru division in Nyamira North sub-county which forms part of Borabu constituency and covers the entire administrative boundary of Borabu sub-county. The county also has twenty county assembly wards.

Nyamira County has an estimated population of 632,035 in 2012 of which 303,252 are males while 328,783 are females with reference to the 2009 Population and Housing Census. The population is expected to increase to 692, 641 in 2017 respectively. The inter census population growth rate is estimated at 1.83 per cent which is below the national growth rate of 3 per cent.

Nyamira County has HIV prevalence of 6.4 per cent (Kenya HIV Estimates, 2014). It is estimated that 23,493 people are living with HIV of which 3,238 are children. The HIV prevalence in women is higher (6.8 per cent) than that of men (5.8 per cent). Annual new infections stands at 2,507 (adult: 455, Children 2052) (DHIS; Kenya HIV County Profile 2014)

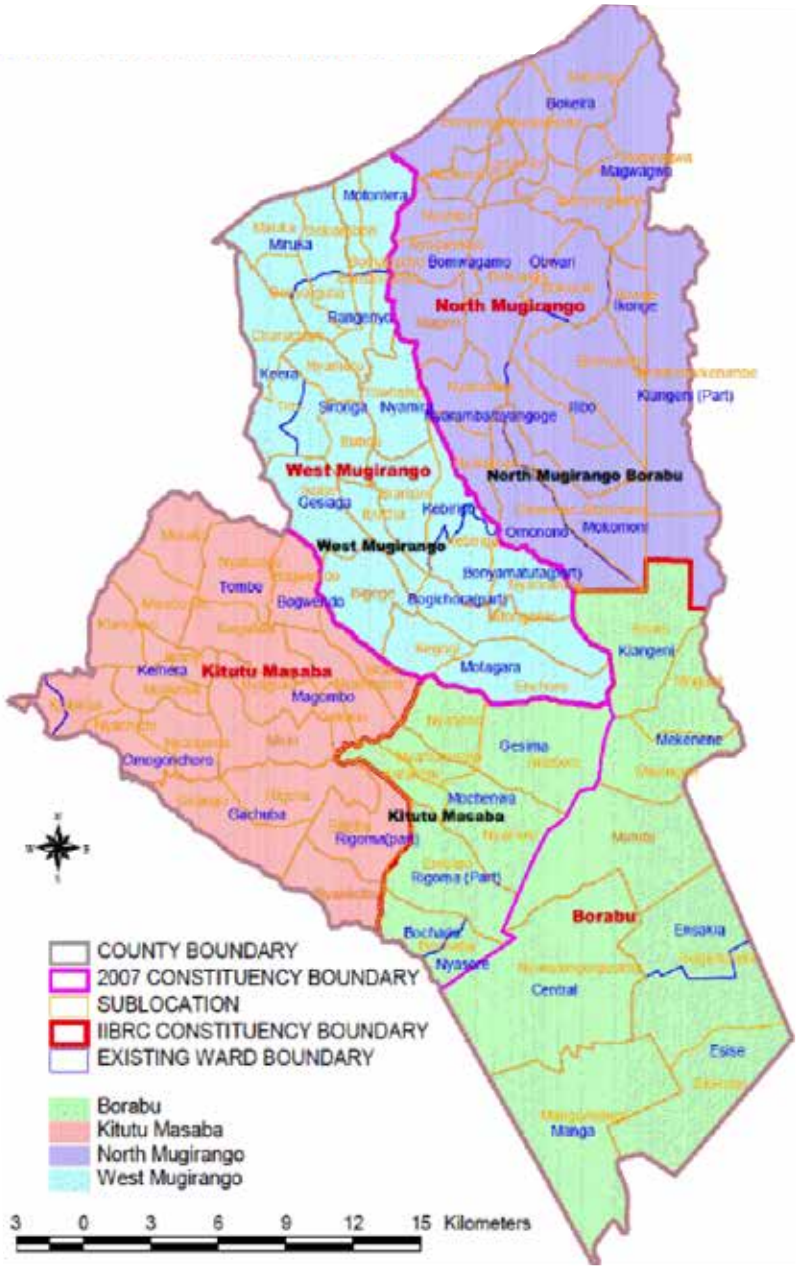
Nyamira county inhabitants are predominantly Abagusii ethnic community who traditionally practice female genital mutilation (FGM). The practice is surrounded in secrecy and often unsterilized paraphernalia is used on multiple victims. This is a contributing factor to the new infections among adolescents and young girls in the county. Consequently, this has contravened the legal rights of a girl child.

HIV and AIDS continues to pose a major challenge to all sectors of the economy and is affecting the development programmes in the county. HIV prevalence rate in Nyamira County is 6.4 per cent (NASCOP, County HIV Profiles 2012). The main cause of the spread of HIV and AIDS in the county is unsafe sexual behavior and transmission of mother to child. There are approximately 900 new infections annually, and child ART coverage is 21 per cent (NASCOP HIV County Profiles 2012). Low uptake of HTC services, infrastructure inadequacies, stigma, human resource and commodity constraints remain as key challenges in the fight against HIV and AIDS in the county. According to Kenya HIV Estimate report of 2014, 26,738 people in Nyamira County are living with the HIV virus, of which 12 per cent are children. The county is expected to face various socio-economic impacts of HIV and AIDS if interventions are not enhanced. Household expenditure on health care will increase, reducing savings and investments. Pressure on health services will increase, reducing the quality of service offered; households will spend more time in caring for the sick, further affecting productive activities at the household and community levels. An increase in orphans is expected to raise dependency ratios at the household levels.

There is need therefore to upscale interventions to mitigate the socio-economic impacts of the pandemic as illustrated in the county development agenda. (Nyamira County Integrated Development Plan 2013-2017)

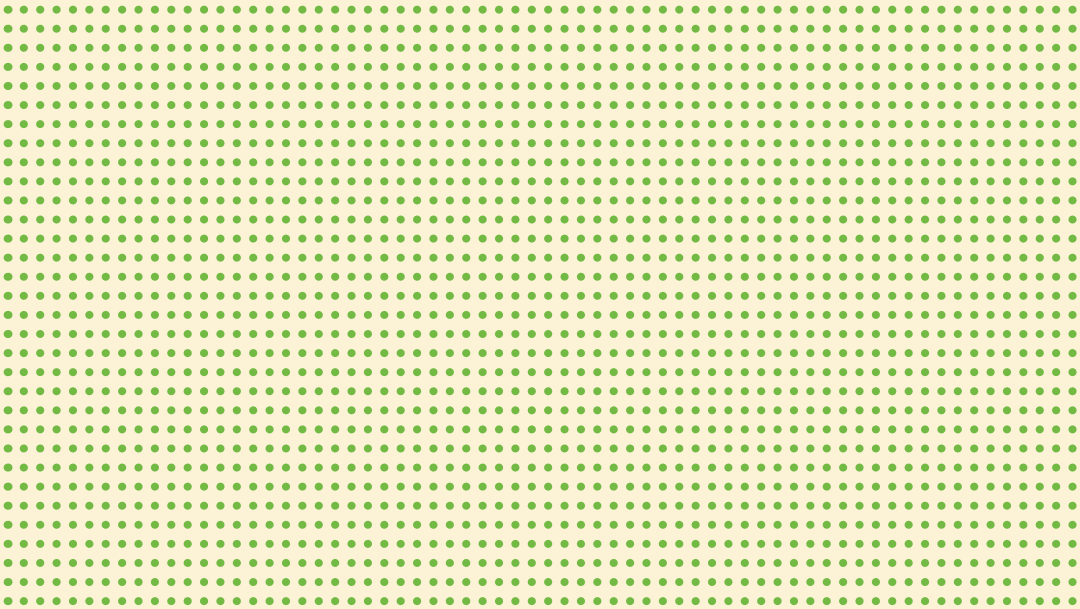
HIV and AIDS pandemic equally poses a great challenge in the attainment of healthy county citizenry hereby adversely affecting the socio-economic development of the county. Current priorities lie in the area of reducing child mortality, promoting maternal health as well as mitigating the vulnerability of HIV and AIDS and other major diseases (Nyamira County Annual Development Plan 2014/2015).

**Map 1: Map showing Nyamira County**



# 02.

# SITUATION ANALYSIS



## Population and Demographics

Nyamira County has an estimated population of 632,035 in 2012 of which 303,252 are males while 328,783 are females with reference to the 2009 Population and Housing Census. The population is expected to increase to 692, 641 in 2017 respectively. The inter census population growth rate is estimated at 1.83 per cent which is below the national growth rate of 3 per cent (County Integrated Development Plan 2013-2017).

## HIV Epidemiology of Nyamira County

Nyamira is experiencing a mixed and geographically heterogeneous HIV epidemic with characteristics of both a 'generalised' epidemic among the mainstream population.

The overall HIV prevalence among adults and children was 6.4 per cent translating to 26,738 people living with HIV in Nyamira County out of which 23,500 are adults and 3,238 are children. The HIV prevalence among women in Nyamira County is higher (6.8 per cent) than that of men (5.8 per cent). Over the years, the women living in the county have been more vulnerable to HIV infection than men. (County HIV profile 2014)

Annual new infections stands at 2507 (adult: 2052, Children 455) (DHIS; Kenya HIV County Profile 2014)

The drivers of the epidemic, (being verified through the consultation process and programming data) are generally understood to include: Commercial Sex work (female, male), boda boda riders and tea estate workers. While the geographical location sources of new HIV infections are, tea estates and market centers.

### HIV Testing, Care and Treatment

While we recognize that we have HIGH levels of stigma in our community, the PLHIV are yet to be identified.

HTS will be scaled up as a prevention strategy to have more people know their HIV status and make informed choices in adopting key prevention behaviours; and as an entry point for treatment, care and support.

The NASF promotes and supports both client-initiated counselling (commonly referred to as Voluntary Counselling and Testing – (VCT) and testing and provider-initiated counselling and testing.

The NASF approach is to strengthen existing services and expand coverage especially in the community and the workplace. To date, only 40% of residents of Nyamira county have been counselled and tested, hence the need to scale up HT services.(DHIS, 2014) Currently the demand for HTS is on the increase as programmes such as MC, PMTCT, PEP, STI, blood safety and increased outreach to most at risk populations are rolled-out. This demand can only be met through improved and intensified coverage coupled with an organised strategy of recruitment, training and retention of HIV counsellors and testers. Innovative strategies will be explored including strengthening mobile HTS facilities, establishing youth friendly HCT centres that will also offer adolescent friendly sexual and reproductive health services and complement counselling and testing services. PLHIV will be trained and participate as peer counsellors and community mobilizers. Couples counselling, including regular counselling and testing for discordant couples will be among the core activities. HTS will be carried out in conformity with relevant international human rights standards, respective of the "five Cs" (Consent, Counselling and Confidentiality, correct results and connection).

Currently Nyamira County is among the counties with high HIV prevalence with 2052 new HIV infections in adults and 451 new HIV infections in children.

According to the "Kenya Fast Track Plan to End HIV and AIDS among Adolescents and Young

People, 2015", in Nyamira County it is estimated that 7,511 adolescents aged 15-24 years are living with the virus, while approximately 6,009 do not know their HIV status and could be contributing to the new infections in this age group.

**HIV Prevention**

Prevention is the cornerstone for the county response. Prevention interventions focus on behavior change, addressing structural barriers and accelerating biomedical interventions. The general knowledge of HIV and AIDS has consistently improved and knowledge about how to prevent HIV increased

However, comprehensive knowledge of HIV has remained still low and schools were not providing enough life skills based HIV education.

Evidence has shown that Consistent and proper use of condoms can reduce the risk of HIV and other sexually transmitted infections by more than 90 per cent. In Nyamira County despite the knowledge on condom use being high at 98 per cent for both men and females (KDHS 2014), low condom use still poses a significant risk of HIV infection to the population. Therefore, there is need for interventions to increase the uptake of condoms within the county.

Male circumcision reduces the risk of heterosexual transmission of HIV infection by approximately 60 per cent. Nyamira County traditionally circumcises men, with over 91 per cent being circumcised, but it's important that the practice is carried out under safe and hygienic conditions that should be encouraged before sexual debut (below 15yrs). In Nyamira county approximately 55 per cent of individuals had their first sexual intercourse before the age of 15, an indication of early sexual debut (County HIV profile, 2014)

Erratic supply of this prevention commodities has hindered the county efforts in reducing new infections, but most important is consistent and proper use of condom even when they are available, is what we need to emphasize and invest in.

**Elimination of Mother to Child Transmission of HIV (EMTCT)**

Although voluntary counselling and testing (VCT) has been integrated in all health facilities, Not all facilities do offer comprehensive PMTCT services. Out of 125 facilities in the county only about 119 do offer PMTCT services.

About 90% of mothers visiting the antenatal clinic get to be tested before delivery of the newborn, however only 48% access these services from the expected no. of pregnancies (*NASCOP ESTIMATES 2013/2014*). There are 942 HIV positive mothers in need of ARVs, but currently the coverage is at 49 per cent (County HIV service delivery profile, 2014). Using the national EMTCT targets towards elimination of mother to child transmission of HIV the county has 51 per cent void to be met to achieve reduction of EMTCT rates. We need to reach all expectant mothers and ensure they receive these services early in pregnancy. Currently the County rates are at 8 per cent which is high above the National target of 5 per cent. This scenario is attributed to some mothers declining uptake of PMTCT services (due to stigma), lack of commitment from private health facilities in provision of the comprehensive HIV care services and low level of disclosure among partners.

**ART uptake**

The rapid roll-out of most treatment, care and support services has increased access and utilisation of services. Many patients have resumed active, productive lives with reduction in the frequency of illnesses that require in-patient care. Nyamira County currently offers ART services to 106 sites as opposed to 125 health facilities available.

In Nyamira County, adult ART coverage is at 58 per cent (8,886) while pediatric ART coverage is at 18 per cent (972). This is much lower than the

national coverage for both adults and pediatrics which is at 81 per cent and 38 per cent respectively (DHIS, Nyamira County profile, Kenya HIV estimates 2014). Using the 90:90:90 strategy eleven thousand, eight hundred and forty (11,840) adults and 2,546 children are in need of ART. The county is ranked 30 out of 47 and 24 out of 47 in ART coverage among adults and children respectively. Approximately 567 adults and 206 children died of AIDS related conditions in 2013. (Kenya HIV County profiles, 2014).

**Table 2: Gaps and challenges analysis (Biomedical, Behavioral, structural)**

The gap analysis focused on the six pillars of health system strengthening that promote the HIV service delivery.

| Area of Assessment | Description of Capacity Gap | |
|---|---|---|
| Biomedical | • Erratic and inadequate supply of HIV/STI related commodities<br>• Lack of integration of HIV services into routine health services including in GBV<br>• Weak referral and linkage system<br>• Inadequate Kenya Mentor Mothers Program<br>• Lack of consistent capacity building of service providers in HIV related updates.<br>• Limited time for implementation of available policy documents that enhance oversight of health service. | |
| Behavioral | • Inadequate targeted interventions for sexually active children and young people No targeted interventions for MARP and vulnerable groups<br>• Inadequate Evidence Based Interventions (E.B.Is) targeting different age groups and Key populations<br>• Inadequate comprehensive knowledge on HIV due to:-<br>✓ Low levels of comprehensive knowledge among the general population<br>✓ Low literacy levels among particular populations, particularly women and girls which compromise access to and utilisation of information<br>✓ Low levels of HIV and AIDS knowledge among young people aged 15-24 years<br>✓ Failure to include a programme of continuous education targeted to new entries into 15-24 year group and exit of others due to aging process<br>• Outdated social cultural beliefs and norms have negative impact on prevention strategies for example GBV including Female Genital Mutilation (FGM)<br>• Low levels of condom use among adults and young people above 15 years of age, Inconsistent and correct use of condoms as well as Female condoms are not readily available, are more expensive than male condoms, and require special training to use.<br>• Low levels of participation due to resource, knowledge and skills constraints in communities<br>• Poor parenting to the adolescents on sexual reproductive health.<br>• High attributed peer influence and misinformation. | |

The low coverage can be attributed to inadequate ART sites, inadequate knowledge on these services amongst health providers and clients, stigma and discrimination, limited access to SRH services among women and girls, early sexual debut, teenage pregnancy and early marriage and poor male involvement.

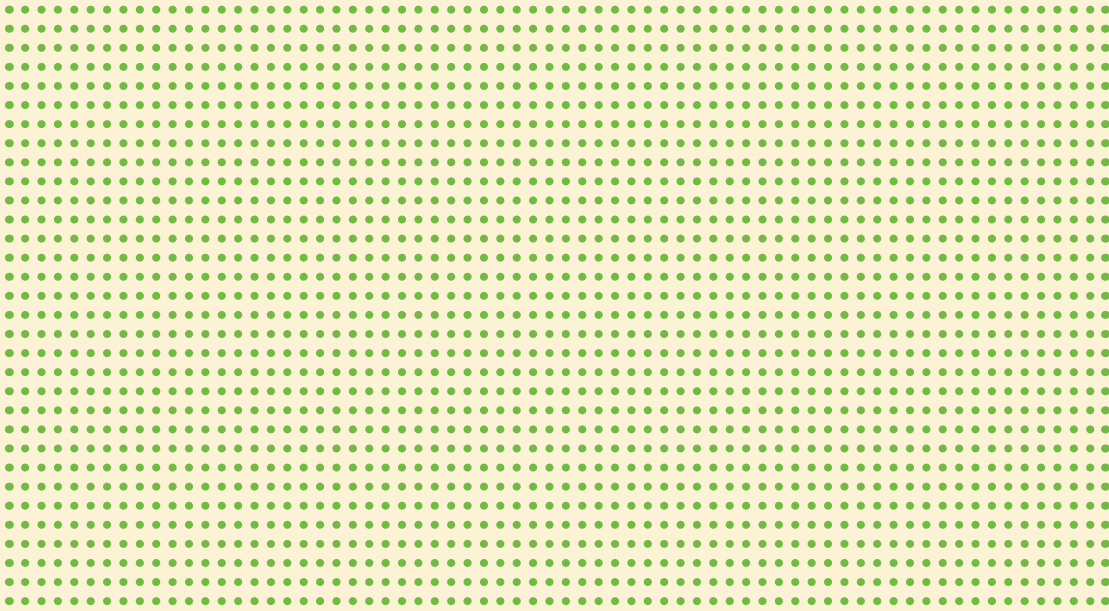
| | Suggested Strategies for Mitigation |
|---|---|
| | • Hold regular forecasting and quantification meetings with all stakeholders and frequent joint supervision and monitoring of commodities<br>• Integration of services in all service delivery points i.e TB/STI/HIV/FP//RH.<br>• Involve peer educators and community focal people/Community Health Workers, Mentor mothers in health system management.<br>• Develop and Avail Database of staff trained in various HIV trainings<br>• Mobilize resources for capacity building.<br>• Early preparation and planning as well as dissemination of these policies.<br>• Early and frequent Stakeholder engagement forum and community participation. |
| | • Accelerate the implementation of the National and county guidelines and frameworks and with priority actions on epidemic drivers and socio and structural factors that influence the spread of HIV.<br>**Improve knowledge on HIV/AIDS by:-**<br>• Intensify HIV education using innovative strategies such as combination prevention, Inter-personal communication, Communication for Behaviour Change (COMBI)<br>• Increase quality and coverage of the sexuality education in schools for young people and targeted behaviour change programmes/ campaigns for young people, particularly young women.<br>• Develop youth targeted interventions including accelerate implementation of life skills based HIV education.<br>• Develop campaigns for low literacy populations<br>• Review customary laws and practices, and strengthen the capacity of customary courts to take cognizance of negative customary laws, social norms and practices as well as Sensitise traditional leaders on effective HIV prevention strategies at community levels including MCP and Male circumcision among others.<br>• Increase distribution points, Increase availability and promote use of female condoms and Develop campaigns for young people on condom use<br>• Capacity building of service providers and community focal people on correct and consistent condom use.<br>• Intensify condom education and awareness linked the usage with other prevention interventions such as male circumcision, prevention of STI and sexual and reproductive health, and PMTCT.<br>• Develop and implement a community-based prevention and management HIV and AIDS program targeted for different sub-counties and communities.<br>• Education on parenting and adolescent and sexual health.<br>• Peer education. |

| Area of Assessment | Description of Capacity Gap | |
|---|---|---|
| Structural | • Uptake of ART remains slow in both children and adults due to Inadequate HTS, ART AND PMTCT sites<br>• Inadequate skilled and experienced human resources and High levels of attrition especially in the health sector<br>• Lack of services geared to mitigate SGBV among the vulnerable populations i.e. Orphans & SW<br>• In adequate infrastructure (Physical & information technology) to accommodate specific HIV services namely care and treatment, DICE for KP etc.<br>• Weak defaulter tracing system from the facility to the CU's within the community.<br>• Inadequate budgetary/ funding allocation towards TB HIV and AIDS activities.<br>• Inadequate programs towards eradicating HIV related stigma and discrimination<br>• Poor involvement mechanism for the religious/cultural leaders on HIV prevention within the community i.e. on condom use.<br>• Lack of political will in addressing critical determinants of the HIV pandemic in the county including the Men having Sex with Men and female sex workers<br>• Lack of research that can be used to inform the existing gaps<br>• Underutilization of the social media platforms for example the local radio stations, newsletters etc.<br>• Weak HIV commodity management and supply chain systems within the county.<br>• Weak M&E system with missing data or not documented or not reported leading to Poor data use in decision making.<br>• The National and County HIV response is largely dependent on external funding and the county does not have a comprehensive sustainability strategy. | |

| Suggested Strategies for Mitigation |
| --- |
| • Scale op of HIV services to all health facilities and availing personnel, reporting tools and commodities. |
| • Capacity building of Health Care staff |
| • Creating demand for these services |
| • Strengthening of PRE-ART interventions and lab networking |
| • Conduct a regular capacity assessment in all sectors and levels of the response. |
| • Develop a long term HIV and AIDS related capacity development framework. |
| • Recruit additional skilled and experienced staff as well as develop a staff retention strategy |
| • Strengthen capacity of ministry of health, implementing partners and structures for more effective gender response and capacity building of staff and at community level. |
| • Mobilize resources |
| • Hold Stakeholders engagement and commitment forums |
| • Sensitize CHWs and community focal people |
| • Mobilize resources |
| • Inadequate HIV and AIDS planning capacity |
| • Build capacity for evidence and results based planning across all sectors and implementing partners. |
| • Operationalize the Code on HIV and AIDS and Human Rights. |
| • Develop county guidelines articulating how stakeholders should work with the county system |
| • Stigma and discrimination in the workplace and the community |
| • Sensitize political leaders on HIV and ensure they understand the county epidemic and reason to intervene on time. |
| • Review programme interventions and apply available evidence in planning |
| • Frequent reporting. |
| • Strengthen data management systems in all sectors including the establishment of a central HIV and AIDS database that is linked with other key data banks such as DHIS. |
| • Strengthen the capacity of M&E personnel at all levels. |
| • Document and disseminate best practices. |
| • Undertake critical research studies to generate data needed for evidence based decision making, evaluation and planning. |
| • Review guidelines for financial support of implementing partners projects to include a requirement for implementing partners and county to articulate a sustainability strategy and how they will dis-engage (exit strategy) with the potential funding agencies. |
| • HIV to a priority in the County and included in the budgetary process. |
| • Mobilize resources from community, private institution, county and faith based institutions, Develop a culture of fund raising for health projects. |
| • Capacity building on healthy living and positive health lifestyles. |

# 03.

# RATIONALE AND STRATEGIC PLAN PROCESS



## Purpose

The NCHASP has been developed to:

i. Provide a strategic framework that will guide and inform the planning, coordination, implementation, monitoring and evaluation of the county multi-sectoral and decentralized HIV and AIDS response with the aim of achieving zero new infections, zero discrimination and zero AIDS related deaths.

ii. Articulate county priorities, results and targets that all stakeholders and partners will contribute to.

iii. Provide the basis for consolidating strategic partnerships and alliances especially with civil society organizations, public and private sector and development partners.

iv. Establish the basis for Nyamira to consolidate its efforts in developing sustainable financing mechanisms for HIV and AIDS response.

## The Process of developing NCHASP

The process of developing the NCHASP has been participatory involving a wide range of stakeholders from public sector institutions, private sector, and civil society organizations (NGOs, FBOs and CBOs) to organizations of PLHIV, and communities themselves. It started with development, launch and dissemination of Kenya AIDS Strategic Framework (KASF) 2014/15-2018/19. The dissemination was done at both national and regional level including the counties.

Technical working group and other consultative meetings were organized that increased stakeholders participation in the process of developing NCHASP. The process was participatory and took place between March and June 2016.

## NCHASP Guiding Principles

The NCHASP interventions are premised on the following principles and commitments:

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

**Equity:** Access to services is a basic human right. During the implementation of the NCHASP efforts will be made to ensure equitable distribution, availability and access to services by all people especially most at risk and other key populations.

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

**Integrated service delivery:** The NCHASP will support services integration as a strategy to improve synergy between interventions, complementarity and optimized use of resources.

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

**Good practices:** Stakeholders will be encouraged to replicate the practices that have proven effective.

**The "Three Ones" Principle:** Nyamira county will continue the application of the three ones principle of having one county coordinating authority, one county strategic plan and one monitoring and evaluation system.

**Gender sensitivity and responsiveness:** NCHASP strategies will address gender inequality of county response including services uptake.

**Creating an enabling environment:** An enabling environment is premised on the existence of appropriate and effective policies, laws, operational guidelines and standards, and more importantly the respect and fulfillment of human rights. During the NCHASP period, policies and legislations will be reviewed and strengthened. Monitoring of stakeholders compliance with such policies and legislation will be intensified.

**Leadership and Stewardship of the County Response:** Strong political leadership and stewardship of the national HIV and AIDS response and commitment to transparency and prudent management of financial and other resources at all levels of the response.

**Multisectoral HIV Response:** Commitment to forge consistent and effective partnership and collaboration with development partners, the private sector, and civil society through harmonized and aligned ways of working to support the HIV and AIDS response at all levels

**Rights of PLHIV:** Protection and promotion of the rights and access of PLHIV to comprehensive prevention, treatment, care and support services as well as reduction of stigma and discrimination and ensuring meaningful involvement of PLHIV (MIPA) in the HIV and AIDS response at all levels.

**Rights of Vulnerable Groups:** Commitment to promote and protect the rights of women, children, young people, and marginalized groups and reduce their vulnerability to HIV.

**Addressing Gender factors that increase female vulnerability to HIV:** Commitment to address social, economic, and cultural factors responsible for disproportionate vulnerability of women and girls to HIV infection.

**Enhanced focus on Key Population:** Commitment to accelerate the scale up HIV prevention among KPs

**Delivery of Integrated Services:** Commitment to strengthen linkages and optimize synergies between HIV and AIDS programs and poverty alleviation initiatives to break the vicious cycle of the disease and its relationship with economic disempowerment.

**Evidence-based HIV and AIDS Programming:** Commitment to evidence-based approach to planning and implementing interventions

**Alignment with other national and international strategic frameworks**

HIV and AIDS remains the greatest development challenge for Nyamira County. Its impacts are many and complex ranging from a decline in life expectancy, productivity, investment in education, health, agriculture and human capital development. The epidemic is robbing communities of their breadwinners, leaders and the knowledge and skills necessary to sustain livelihoods.

HIV is threatening the traditional community coping mechanisms (safety nets), food security and long term development. It is creating a vicious circle that reduces the county capacity to absorb and utilize existing resources earmarked for socioeconomic development. This process contributes to deepening poverty and lack of county productivity.

As the epidemic impacts on human capital, the cost of replacing skilled manpower has increasingly becomes expensive. The epidemic is further shrinking the pool of HIV free persons

where development labour is being drawn from. In the long run, this may contribute to County's dependence on imported labour.

Available evidence indicates that the epidemic is being fuelled by behavioural, structural and biological drivers. While biological drivers are easier to address, behavioural and structural drivers of the epidemic are more complex and inter-linked with socioeconomic development issues such as poverty, gender inequality, food insecurity and urban development with special emphasis on informal settlements.

These complex challenges can only be adequately addressed when the county response to HIV and AIDS is properly anchored in the broader context of national socioeconomic development policy framework. Anchoring the HIV and AIDS response in the broader development framework has several advantages such as:

Firstly, it expands the scope of the response and increases the opportunities for sectoral participation based on their institutional mandate and comparative advantage.

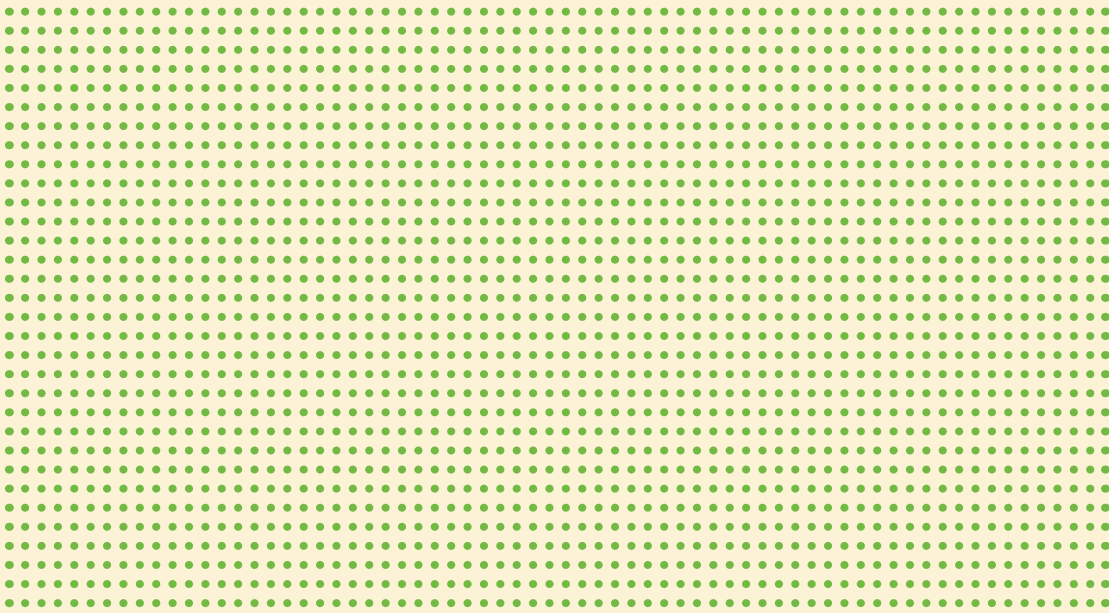
Secondly, expanding the scope of participation by more stakeholders enables additional flow of resources (financial and human) that support HIV and AIDS response, contributing towards longer term sustainability.

Thirdly, the process increases ownership, commitment and accountability.

It is on this premise that the NCHASP has been aligned to key County and national development frameworks including Vision 2030 and County Integrated Development Plan 2013-2017 , Sustainable Development Goals, the African Union Abuja declaration, and Universal Access. The NCHASP is aligned to the provisions of the Kenya Health Policy 2012-2030 and it has taken cognisance of the provisions of the Kenyan of Constitution 2010 and other international basic human rights instruments in the context of HIV and AIDS.

# 04.

# VISION, GOAL AND OBJECTIVE OF THE NCHASP AND STRATEGIC DIRECTIONS



## Vision:

County population free of HIV& AIDS and its effects

## Goal:

Achieve universal access targets for HIV&AIDS prevention, care, treatment and social support and protection by 2019

## Objectives of NCHASP

1. Reduce new HIV infections by 50 per cent
2. Reduce AIDS related mortality by 30 per cent
3. Reduced self-reported HIV related stigma and discrimination by 50 per cent
4. Increase domestic financing of HIV response by 20 per cent

## Nyamira County expected Outcomes by 2019

1. Improved utilization of health care services for HIV prevention.
2. Communities empowered to effectively respond to HIV and AIDS.
3. Improved access to quality HIV and AIDS services.
4. Partners aligned to County priorities and held accountable.
5. County response adequately resourced
6. Ethical and legal environment for HIV and AIDS improved.
7. Increased availability of quality, comprehensive and harmonized information on the response to the epidemic.
8. Improved utilization of information by partners for policy development, advocacy and programming.
9. Improved basic and operational research, monitoring and evaluation of the HIV and AIDS response.
10. Improved access to comprehensive quality treatment, care and support services

## Strategic Direction 1: Reducing new HIV infections

**Introduction**

Prevention remains the most important strategy and the most feasible approach for reversing the HIV epidemic since there are no vaccines and no medical cure. The majority of Kenyans are HIV-negative and keeping them uninfected is critical for altering the epidemic trajectory. This underscores the importance of prevention as a cornerstone of the national HIV and AIDS response. Moreover, persistent HIV-risky behavior in spite of high level of HIV awareness requires continuous and concerted focus on effective preventive interventions that will address specific needs key population segments and stimulate adoption of appropriate behavior that reduces the risk of HIV transmission.

This Strategic Direction aims to reduce annual new HIV infections among adults by 75 per cent and HIV transmission rates from mother to child from 14 per cent to less than 5 per cent in Kenya.

**County Situational Analysis.**

Nyamira County has an annual adult new HIV infections of 2507 (Children 455 and adults 2052) (HIV Prevention Revolution Road Map 2014). Despite the huge importance of HIV testing as a way to increase prevention and treatment, about 47 per cent of people in Nyamira county had never tested for HIV by 2009 (County HIV Profiles, 2014). Most communities in Nyamira County traditionally circumcise men with 100 per cent of men who participated in a national survey in 2009 reporting that they had been circumcised. The practice is mostly carried out in a safe and hygienic way before the age of sexual debut. Approximately 41 per cent of individuals in Nyamira County had their first experience of sexual intercourse before the age of 15, an indication of early sexual debut. Other

drivers of HIV epidemic in the county are stigma, disclosure, cultural practices and poverty. Professional related drivers (Boda boda riders and PSV drivers). Others include low knowledge of HIV sero-status and low condom use.

The expected results of NCHASP:

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

**Table 3: Strategic Direction One**

| **STRATEGIC DIRECTION 1:** Reducing new HIV infections | | | | | |
|---|---|---|---|---|---|
| **KASF Objective** | **NCHASP Results** | **Key Activity** | **Target Population Age/Sex** | **Biomedical strategies** | |
| | | | **General Population** | **Health facility settings** | |
| Reduce new HIV infections by 75 per cent | Reduce new HIV infections by 50 per cent | Offer innovative and evidence based HIV prevention and care activities. | 0-5 years | • Enhance Early infant diagnosis( EID)<br>• HIV testing for children<br>• Pediatric ARV for all HIV + children<br>• Ensure blood and injection safety | |
| | | Offer innovative and evidence based HIV prevention and care activities. | 5-9 years | • HTC, PEP, Post-rape care<br>• Ensure blood and injection safety.<br>• Training on GBV for HCWs | |
| Reduce new HIV infections by 75 per cent | Reduce new HIV infections by 50 per cent | Offer innovative and evidence based HIV prevention and care activities. | 10-14 years | • HTC, PEP, Post-rape care HPV vaccines.<br>• Ensure blood and injection safety. | |
| | | Offelinnovative and evidence based HIV prevention and care activities. | 15-19 y 15-19 years | • HTC, PEP, Post-rape care, Emergency contraception (EC), HPV vaccines.<br>• Screening for cervical cancer<br>• Ensure blood and injection safety. | |

The county will prioritize the following key interventions to reduce new HIV infections:

- Offer innovative and evidence-based HIV prevention and care activities
- Increasing knowledge of HIV status and linkages to other services
- Leveraging opportunities through creation of synergies with other sectors for HIV Prevention

| | | Behavioral strategies | Structural strategies | Geographical Area | Responsibility |
|---|---|---|---|---|---|
| | **Community settings** | | | | |
| | • Integration and scale up of HIV testing in PNC and immunization programmes | • Exclusive breastfeeding for up to 6 months | • Training of ECDE teachers and CHEWs as advocates for child HIV testing to Parents<br>• Social protection | Entire County | MOEST,<br>MOH<br>Implementing Partner s |
| | • HIV and Sexual Reproductive Health Education clubs in schools.<br>• Mentorship by leaders of Girl Guides and Boy Scouts | • Life skills training-stepping stones: crating futures. | • Advocacy for child rights protection<br>• GBV counselling and prevention<br>• SRH education at school.<br>• Social Protection | Entire County | MOH<br>Implementing Partners |
| | • HIV and SRH education programmes by CHEWS and school clubs.<br>• Information on HIV and STI testing prevention and referral. | • Life skills training e.g. stepping stones creating futures<br>• Stigma reduction, disclosure and enhanced access to services. | • Initiative to keep girls in school (<br>• GBV counselling and prevention<br>• SRH education at school.<br>• Community sensitization and advocacy for legal action against sex offenders. | Entire County | MOH<br>Implementing Partners |
| | • HIV and STI testing, prevention and referral<br>• SRH and HIV education,<br>• FP and condom use. | • Advocacy for healthy choices by role models<br>• Life skill training and public speaking<br>• Stigma reduction and enhanced access to services. | • Economic empowerment through micro-finance: Youth Fund<br>• Reform of legal requirement for parental. Consent for HTC.<br>• Programmes to keep girls in school.<br>• Address intergenerational sex. | Entire County | MOH<br>Implementing Partners |

| KASF Objective | NCHASP Results | Key Activity | Target Population Age/Sex | Biomedical strategies | |
|---|---|---|---|---|---|
| | | | General Population | Community settings | |
| Reduce new HIV infections by 75 per cent | Reduce new HIV infections by 50 per cent | Offer innovative and evidence based HIV prevention and care activities. | 20 years and above | • PITC, FP, PEP, Post-rape care, EC, HPV vaccines.<br>• Screening for cervical cancer<br>• Ensure blood and injection safety. | |

Focus on high risk and vulnerable Focus on high risk and vulnerable populations as an effective prevention intervention is essential in reducing new infections, a biomedical, behavioral and structural intervention approach will be appropriate.

**Table 4: HIV Prevention Efforts In vulnerable and high risk groups**

| KASF Objective | NCHASP Results | Key Activity | Target Population | Biomedical strategies | |
|---|---|---|---|---|---|
| | | | | Community settings | |
| Reduce new HIV infections by 75 per cent | Reduce new HIV infections by 50 per cent | Offer innovative and evidence based HIV prevention and care activities | Transport sector boda boda riders PSV drivers and touts | • Mobile /moonlight/door- to-door HTC.<br>• SRH services,<br>• CHTC<br>• Condom Use<br>• STI/TB screening.<br>• Treatment literacy for prevention<br>• Wellness centers in strategic sites. | |
| Reduce new HIV infections by 75 per cent | Reduce new HIV infections by 50 per cent | Offer innovative and evidence based HIV prevention and care activities. | Orphans and other vulnerable children (OVC)* | • Door-to-door /outreach HTC. | |

| | | Behavioral strategies | Structural strategies | Geographical Area | Responsibility |
|---|---|---|---|---|---|
| | **Health facilities settings** | | | | |
| | • HTC, CHTC, condom use and advocacy. | • Alcohol and drug abuse reduction campaigns<br>• Positive Health, Dignity and Prevention.<br>• Promotion of condom programming for dual protection. | • Economic empowerment – IMAGE programme.<br>• GBV prevention programmes.<br>• Advocacy and reform of socio-cultural norms and practices linked to HIV acquisition and transmission e.g. FGM, sex-based rites.<br>• Promote and sustain post-HIV test clubs/support groups.<br>• Male engagement in HIV prevention, elimination of SGBV and eMTCT. | Entire County | MOH<br>Implementing Partners |

| | Behavioral strategies | Structural strategies | Geographical Area | Responsibility |
|---|---|---|---|---|
| **Health facilities settings** | | | | |
| • ART for all HIV positives, PEP, PrEP, EMTCT.<br>• Treatment for STIs, TB. | • Peer education on HIV prevention and targeted BCC.<br>• Positive Health Dignity and Prevention.<br>• Advocacy for safer sexual practices (condom use and reduction of concurrent multiple sexual partners. | • Establish and implement sexual of ethics for riders, PSV drivers and touts<br>• Empower passengers on their sexual and economic rights<br>• Implement conditional economic support policies. | Entire County | MOH<br>Implementing Partners |
| • Targeted HTC, post-rape care, and emergency contraception. | • Peer education on HIV prevention and targeted life skills training and healthy choices.<br>• Stigma reduction and counseling. | • Targeted social protection programs<br>• Implement and enforce OVC policy<br>• Access to legal services. | Entire County | MOH<br>Implementing Partners |

| KASF Objective | NCHASP Results | Key Activity | Target Population | Biomedical strategies | |
|---|---|---|---|---|---|
| | | | | **Community settings** | |
| Reduce new HIV infections by 75 per cent | Reduce new HIV infections by 50 per cent | Offer innovative and evidence based HIV prevention and care activities. | Female sex workers | • Regular and timely screening for HIV, STIs, HPV including anal screening.<br>• Use of male and female condoms. | |
| Reduce new HIV infections by 75 per cent | Reduce new HIV infections by 50 per cent | Offer innovative and evidence based HIV prevention and care activities. | • Small and medium scale enterprises (SMEs)<br>• Jua Kali operators<br>• Chang'aa Dens<br>• Salon workers<br>• Tea Estate Workers<br>• Kinyozi operators<br>• Female members of Chamas | • HTC various models.<br>• CHTC.<br>• Condom Use.<br>• SRH. Services.<br>• FP education. | |
| Reduce new HIV infections by 75 per cent | Reduce new HIV infections by 50 per cent | Offer innovative and evidence based HIV prevention and care activities. | Elderly care givers (over 50 years) | • HTC various models.<br>• CHTC<br>• SRH services.<br>• FP education.<br>• Condom use. | |
| | | | People with disabilities (PwDs)** | • VMMC<br>• PEP<br>• Post Rape Care<br>• PITC | |
| | | | • People with unusual sexual orientation (PWUSO).<br>• MSM<br>• Lesbians. | • Use of male and female condoms<br>• Use of lubricants<br>• Periodic and regular HTC, STI, HPV screening and vaccines<br>• Anal STI screening | |

| | Health facilities settings | Behavioral strategies | Structural strategies | Geographical Area | Responsibility |
|---|---|---|---|---|---|
| | • STI treatment<br>• ART for all HIV positives.<br>• PEP, PrEP, eMTCT<br>• HPV vaccines. | • Positive Health Dignity and Prevention.<br>• Anti-alcohol and substance abuse programmes<br>• Campaigns for HIV negatives to remain negative. | • Safe spaces<br>• Conditional economic support.<br>• GBV prevention programmes.<br>• Promote human rights.<br>• 100 per cent condom use policy.<br>• Recognition of negative status since previous HIV test.<br>• Sensitivity to their rights by healthcare providers, police and judiciary. | Entire County | MOH<br>Implementing Partners |
| | • FP<br>• PITC.<br>• PEP.<br>• Post-rape care<br>• EC.<br>• HPV vaccines. | • Peer education for HIV prevention.<br>• Positive Health dignity and prevention.<br>• Condom use campaign.<br>• Risk perception training.<br>• Risk reduction programmes. | • Smart investment of disposable income.<br>• Capacity development programmes for food poverty reduction. | Entire County | MOH<br>Implementing Partners |
| | • VMMC.<br>• PEP<br>• Post-rape care.<br>• PITC. | • Peer education for HIV prevention.<br>• Positive Health dignity and Prevention.<br>• Stigma reduction programmes. | • Implement policies on OVC care.<br>• Capacity development programmes for inter-generational care giving. | Entire County | MOH<br>Implementing Partners |
| | | • Behavioural change intervention using specific interpersonal tools and techniques including those in Braille and sign-language. | • Implement policies on PWD<br>• Capacity building of PWD to advocate for their HIV issues | Entire County | MOH<br>APWD<br>Implementing Partners |
| | • ART for all HIV positive people<br>• PEP, PrEP, eMTCT.<br>• HPV vaccines.<br>• STI treatment. | • Campaign for HIV negatives to stay negative.<br>• PHDP.<br>• Reduction in number of partners.<br>• Alcohol and substance abuse programmes. | • Psychosocial support mechanisms<br>• GBV prevention programmes<br>• Sensitivity for trainings for healthcare providers and police<br>• Social support empowerment.<br>• Safe spaces/drop in Centres<br>• Human Rights Protection. | Entire County | MOH<br>Implementing Partners |

**Table 5: Strategies for increasing knowledge of HIV status and linkage to other services**

| Intervention areas | Recommended actions | Geographical Area | Responsibility |
|---|---|---|---|
| Adopt population and geography specific appropriate HTC approaches | • Scale up facility-based PIHTC and ensure linkage to care<br>• Deliver routine community-based HTC for priority and key populations<br>• Deliver door-to-door testing and community-based testing at population scale in high prevalence areas<br>• Implement high impact and effective strategies for HTC for targeted geographic areas and populations | Entire County | CASCO |
| Strengthen HIV diagnostic infrastructure and systems | • Strengthen early infant HIV diagnosis and Networking<br>• Expand innovative diagnosis strategies including point of care and self-testing<br>• Invest in adequate skilled staff, commodity security and quality assurance mechanisms | Entire County | CASCO |
| Deliver targeted and integrated HIV testing and counselling | • Offer couples/partners HTC with supported disclosure options<br>• Deliver integrated HTC packages to include TB screening, family planning services, cervical cancer screening, other health checks such as blood pressure/sugar, weight and include other risk-reduction services (counselling, condoms with lubricants, STI screening) for priority population<br>• Identify and retain high risk individuals for regular HTC and screening<br>• Contact testing of PLHIVs<br>• Scale up Positive Health Dignity and Prevention (PHDP) interventions. | Entire County | CASCO<br>CRHC<br>CTLC |
| Strengthen linkages to care and treatment | • Obligate HTC and TB services providing points to account for linkage to prevention<br>• programmes, care and treatment<br>• Utilise community health extension workers (CHEWS) and community health<br>• workers (CHW) to link diagnosed individuals with facilities and support groups<br>• Strengthen engagement and leadership of networks of people living with HIV to<br>• mobilise and facilitate HTC | Entire County | CASCO |

## Strategies of strengthening integration and linkages of services to catalyze HIV prevention outcomes

| Interventions | Recommended actions | Geographical Area | Responsibility |
|---|---|---|---|
| Integrate HIV prevention into routine health care delivery mechanisms | • Integrate comprehensive HIV prevention messages, condom distribution, pre-and post-exposure prophylaxis, GBV and fertility intention interventions into health services such as immunization, reproductive, maternal, neonatal and child healthcare as appropriate<br>• Strengthen capacity of service providers and increase demand for delivery of HIV prevention services including active engagement of private sector for EMTCT | Entire County | CASCO<br>CHPO |
| Strengthen Community and Health Facility-level Linkages | • Equip and utilise peer educators, community health and outreach workers with commodities to effectively deliver stigma free prevention and provide effective referral for services.<br>• Strengthen engagement and leadership of faith communities, people living with HIV, County/Sub-County administrators, councils of elders and political leaders for knowledge of HIV prevention and interventions | Entire County | CASCO<br>CHPO |

**Table 6: Strategies targeting prevention of HIV in health care settings**

| Interventions areas | Recommended actions | Geographical Area | Responsibility |
|---|---|---|---|
| Improve blood and injection safety | • Implement strategies to recruit and increase adult blood donors<br>• Introduce donor notification of HIV results at blood collection points and post testing for Transfusion Transmissible Infections (TTIs) | Entire County | CMLC<br>CASCO |
| | • Train health workers on infection prevention<br>• Implement quality assurance mechanisms for injection safety to eliminate HIV transmission in health care settings<br>• Institute mechanisms to report and receive PEP for all occupational exposures among health care workers. | Entire County | CDH |
| Medical waste and IPC management | • Improve disposal of medical waste in all levels of the health system to minimize risk of infection<br>• Improve the availability and accessibility of appropriate IPC equipment and infrastructure in all health care settings | Entire County | CDH |

### Leveraging opportunities through creation of synergies with other sectors for HIV Prevention

HIV prevention will leverage opportunities in other sectors at county to implement evidence based strategies. The prevention roadmap provides detailed interventions and Nyamira county will adopt the following:

Targeted sectors include: Transport, media, health department. mobile and web technology, education, tourism and hotels including bar and lodging, micro-finance, law, order and justice sectors.

**Table 7: Priority sectors to leverage HIV prevention**

| Other sectors | Recommended actions |
|---|---|
| Education | • Increase knowledge on HIV and HIV status, STIs and HPV among teachers and students<br>• Address stigma reduction in schools<br>• Implement education policy, guidelines and teacher training that includes age appropriate HIV, sexual and reproductive health and rights<br>• Improve access to accurate information on sexuality through introduction of age appropriate comprehensive sexuality education in school curriculum<br>• Ensure girls stay in schools through social security programmes, conditional cash transfers, sanitary towels |
| Infrastructure and ICT sector | • Use public transport systems for prevention messages, condom distribution targeting the general and Key Populations.<br>• Promote a bold mass media HIV prevention campaign that challenges norms, attitudes and beliefs |
| Tea Buying Centers, Tea estates, Tea factories, police lines, Hotels (Including bars and Lodgings) | • Require HIV prevention messages and services in hotels, bars and lodgings |
| Religious Leaders | • Address notion of HIV healing through faith as a barrier to HIV treatment and adherence<br>• Conduct and adapt stigma-free HIV prevention campaigns |
| Justice law and order | • Promote access to social equity and justice in the context of rights violation specific to HIV response<br>• Promote the use of Internal Security as an important contributor to an integrated response to HIV and AIDS by addressing the dangerous interaction between AIDS, drug and alcohol abuse, sex and child trafficking and sexual violence<br>• Scale up prison-based HIV and AIDS programmes that look into how to respond to HIV and AIDS and misuse in prison system strengthening and provision of clinical services, prison based care, support and treatment |
| Public Service, Labour and Social Service | • Promotion of effective social inclusion with no room for stigma and discrimination<br>• Pursue "AIDS-Sensitive'" rather than "AIDS -Specific" social protection instruments including cash transfers, protection of orphans and vulnerable children (OVC] from the impoverishing effects of HIV and AIDS while potentially encouraging pro-poor growth<br>• Close the gap of the unmet need for support services for Orphans and Vulnerable Children (OVC) to ensure the protection, care, and support of at least 92,000 children*.<br>• Incorporate a transformative agenda that empowers women to access their rights and entitlements in terms of inheritance, education and labour market access both protecting and mitigating against HIV and AIDS<br>• Expand workplace programmes on HIV and AIDS in the public, private and civil society sectors through policy development, implementation and review |
| CBS | • Institutionalization of HIV information sources for effective and efficient management of the HIV response |
| Treasury | • Continuous use of economic evaluations of existing interventions to inform resource allocation decisions for the HIV programmes at national and county levels<br>• Evaluate the role of donors and other actors in informing HIV resource allocation decisions<br>• Support the operationalization of the HIV Trust Fund as primary vehicle for mobilizing and leveraging resources for health financing in the country |
| Agriculture | • Enhance the capacity and the political will of agricultural sector to respond actively to HIV and AIDS by providing empirical data to guide agricultural policy-makers in the areas of poverty reduction, food and nutrition security, use of antiretroviral drugs, and advancing gender equality. |
| Universities | • Provide resources<br>• Undertake HIV prevention activities |

| | Geographical Area | Responsibility |
|---|---|---|
| | Entire County | • MOEST, Universities and CACC<br>• County HIV TWG<br>• Health Department<br>• Partners |
| | Entire County | • Private Sector transport associations<br>• County HIV TWG |
| | Entire County | • Health Department<br>• Private sector<br>• Department of Health services |
| | Entire County | • HEALTH DEPT<br>• County HIV TWG |
| | Entire County | • Ministry in charge of justice law and order<br>• Health Department<br>• County HIV Committee |
| | Entire County | • County Public Service, Labour and Social Service<br>• Implementing Partners<br>• County Multi-sectoral AIDS Coordination Secretariat |
| | Entire County | • The KNBS<br>• HEALTH DEPT<br>• County HIV TWG |
| | Entire County | • Department of Finance<br>• Health Department<br>• County HIV TWG |
| | Entire County | • County Department in charge of agriculture<br>• NACC<br>• Health Department<br>• County HIV TWG |
| | Entire County | • All universities<br>• All MDAs<br>• NACC<br>• County HIV TWG |

## Strategic Direction 2: Improving Health Outcomes And Wellness of All People Living With HIV

**Introduction**

Kenya has embraced the UNAIDS 90-90-90 ambitious treatment target to help end the AIDS epidemic; By 2020, 90 per cent of all people living with HIV should know their HIV status, 90 per cent of all people with diagnosed HIV infection should be on ART and 90 per cent of all people receiving ART should be retained and they achieve viral suppression.

It is on this concept of triple 90 per cent which will help Nyamira County improve health outcomes and wellness of PLWHIV. Within Nyamira county the estimated number of PLHIV is at 28,617 (Adults 25,300 and children 3317) however 9795 adults and 1013 children have been put on ART which translates to 48 per cent and 38 per cent ART coverage among adults and children respectively.

Viral suppression within the population estimated to be living with HIV is low at < 20 per cent for both adults and children, there are several challenges attributing to the low identification among them being stigma, discrimination and disclosure. Retention has equally been a challenge however with engagement of facility peer educators and community units there has been improvement.

The county health systems face varied challenges in the delivery and promotion of services ranging from identification, linkages to care, retention and viral suppression. There is inadequate and unequal access to health services and human resource. Additionally, services to PLHIV are characterized by poor referral and tracking, weak commodity and supply chain as well as inadequate skills and infrastructure for information management systems.

Lower coverage of ART among children implies retention of a heavy reservoir of HIV in the general population. Improper co-ordination between health and other sectors such as education, legal and social services lowers quality of care delivered to clients.

Reduction in loss in the cascade of care and treatment require clear detection of determinants and points of loss of patients and resolve them at service delivery points and County levels by recognizing need to focus on different population based on age, sex and sexual activity including focus on their geographical location, situation and challenges in the cascade of care, treatment and reason for loss or attrition.

**Programmatic gaps**

Health systems related barriers have been reported to exacerbate the gaps in care all the way from identification, linkage, retention and viral suppression. These include limited access to and unequal geographical distribution of services, human resource inadequacies, poor referral and tracking mechanisms, commodity and supply-chain related challenges and limited infrastructure for information management systems.

a) **Patient identification and linkage to care:** Late or lack of HIV diagnosis and suboptimal linkage to care is a challenge for the general population where as legal barriers, stigma and negative provider attitudes reduce access to care for key population. However Nyamira County has demonstrated good linkage of HIV client to care over period of time.

b) **Access to care and treatment services:** There is disproportionately lower coverage of ART in children and adolescents compared to adults. Similarly sub-optimal

integration of screening, prophylaxis and management of co-infections and co-morbidities result in high attrition of those enrolled. In addition, PLHIV experience stigma impacting on disclosure and treatment adherence, particularly among key and priority populations.

C) **Quality of care, treatment services and viral suppression:** Quality of care, limited use of electronic medical records, evidence informed interventions at facility level and Emphasis on viral load monitoring need improvement. Furthermore, there is limited co-ordination and support to quality of care by other sectors such as learning institutions, nutrition, legal and social services.

This strategic direction focuses on three key intervention areas namely: improve timely linkage to care for persons diagnosed with HIV, increased coverage of care and treatment and reduce loss in the cascade of care and scale up interventions to improve quality of care and improve health outcomes.

**Table 8: Strategic Direction two**

| **STRATEGIC DIRECTION 2:** IMPROVING HEALTH OUTCOMES AND WELLNESS OF ALL PEOPLE LIVING WITH HIV | | | |
|---|---|---|---|
| **KASF objective** | **NCHASP Results** | **Key Activity** | |
| Reduce AIDS related mortality by 25 per cent | Increased enrolment to care within 3 months of HIV diagnosis to 90 per cent for children, adolescents and adults | Increase coverage to care and treatment and reduce the loss in the cascade of care | |
| | Increased ART coverage to 90 per cent for children, adolescents and adults | Increase coverage to care and treatment and reduce the loss in the cascade of care | |
| | Increased ART coverage to 90 per cent for children, adolescents and adults | | |
| Reduce AIDS related mortality by 25 per cent | Increased viral suppression to 90 per cent in children, adolescents and Adults | | |
| | | Increase coverage to care and treatment and reduce the loss in the cascade of care | |
| Reduce AIDS related mortality by 25 per cent | Increased viral suppression to 90 per cent in children, adolescents and Adults | | |
| | | Strengthen supply systems and ensure continuous availability of quality HIV commodities at the point of service delivery | |
| Reduce AIDS related mortality by 25 per cent | Increased viral suppression to 90 per cent in children, adolescents and Adults | Viral load monitoring | |

| | Sub-Activity/Intervention | Target Population | Geographic areas by County/ sub- county | Responsibility |
|---|---|---|---|---|
| | Strengthen facility and community linkages with inter- and intra- facility referral protocols and linkage strategies | PLHIV | County | CDH, CASCO<br>IMPLEMENTING PARTNERS |
| | Ensure the identified gaps in HIV prevention and treatment cascade are addressed Immediately | PLHIV | County | CDH |
| | Integrate HIV testing, care and treatment services into maternal, neonatal and child health settings and services | Expectant mothers/nursing infants | County | CDH, CASCO |
| | Scale up integrated youth friendly services | Youth(15-24) | County | CDH, CRHC |
| | Utilize peer support and networks of adolescents living with HIV | Adolescents Living with HIV | County | CRHC |
| | Conduct peer mobilization in identification , enrolment and retention in care and treatment | Children (0-9 Years) | County | CASCO<br>IMPLEMTING PARTNERS |
| | Integrate alcohol and drug dependence reduction strategies in care services | Adolescents (10- 19 yrs) | County | CDH |
| | Provide screening and diagnostic equipment for TB, NCDs, malnutrition, opportunistic infections together with those for HIV. | PLHIV | County | CDH |
| | Scale up prevention interventions for TB, OIs and other co-morbidities. | PLHIVs | County | CDH |
| | Conduct integrated HIV trainings for a skilled and competent health workforce | Relevant healthcare workers providing clinical care | County | CDH |
| | integrate and decentralize HIV delivery models that increase access to care and treatment at community and other non-ART service points | PLHIV | County | CSFP |
| | Conduct treatment literacy, patient empowerment, psychosocial and adherence support and disclosure interventions | PLHIV | County | CSFP<br>Civil Society |
| | Integrate HIV care treatment into youth friendly services | Youth | County | CRHC |
| | Integrate & Introduce treatment literacy, adherence and retention in the Ministry of Education programme for HIV education, | School going children<br>MOEST | County | CDE |
| | Introduce key population friendly HIV care and treatment services. | KPs | County | CASCO |
| | Conduct periodic stock audit for HIV Commodities | Health Facilities | County | CDH |
| | Redistribution of HIV commodities | | County | CMLC |
| | Implement periodic monitoring viral suppression | ART Sites | County | CASCO |
| | Strengthen laboratory networks to reduce turnaround time for viral load results | Health Facilities With Lab | County | CDH,CMLT |
| | Conduct QC& QA to ensure adherence to laboratory protocols | Health facilities with lab | County | CMLT |

## Strategic Direction 3: Using Human Rights Based Approach To Facilitate Access To Services

**County Situational Analysis**

Despite compelling evidence that reducing stigma, promoting and protecting human rights, promoting greater involvement of PLHIV and gender mainstreaming strengthen HIV and AIDS control; More than two decades after the identification of the first case of HIV in Kenya, violation of human rights of persons infected and affected is still rampant and stigma remains pernicious and pervasive. The National average stigma index is 45 per cent while for Nyamira county stands at 35 per cent.

This can be attributed to socio-cultural norms such as women not able to negotiate for safe sex and male dominance, gender based violence, self-discrimination and lack of legal framework for protection of the vulnerable. This situation is compounded by attitudes and practices which discriminate against widows and persons orphaned by AIDS.

**Table 9: Strategic Direction Three**

| **STRATEGIC DIRECTION 3:** USING HUMAN RIGHTS APPROACH TO FACILITATE ACCESS TO SERVICES FOR PLHIV, KPs AND OTHER PRIORITY GROUPS IN ALL SECTORS | | | | |
|---|---|---|---|---|
| **KASF objective** | **NCHASP Results** | **Key Activity** | **Sub-Activity/Intervention** | |
| Reduce HIV related stigma and discrimination by 50 per cent | Reduced HIV related stigma and discrimination by 50 per cent | • Sensitization to reduce stigmatizing attitudes | • Training on stigma reduction<br>• Support formation of psychosocial support groups | |
| | Reduce levels of sexual and gender-based violence for PLHIV and vulnerable populations | • Sensitization on SGBV reduction | • Training of PLHIV, key populations, women, men, boys and girls on life skills<br>• Implement structural interventions that empower vulnerable populations, especially women and the young girls | |
| | | | • Enroll PLHIV, OVCs, Key Populations and other priority groups into the social protection Programmes | |
| | | • Improved male engagement in HIV, SRH programs and interventions and offer them services | • Carry out Sensitization on importance of male involvement | |
| | • Improve access to legal and social justice and protection from stigma and discrimination in the public and private sector | • Execution of SGBV Offenders and protection of survivors | • Sensitization of police, health care workers, Civil Societies and legal groups on SGBV support<br>• Strengthen linkages with psychosocial support groups for SGBV survivors<br>• Advocate for decentralization of HIV tribunal to the county<br>• Link SGBV survivors to gender response units within the county<br>• Fast tracking of the SGBV legal cases | |

The Nyamira county AIDS strategic plan calls for effective and appropriate responses to stigma, discrimination and gender-based violence in order to have interventions that facilitate access to services for vulnerable and key populations. Furthermore, the approach of the county response under the NCHASP is to accentuate the differential access to information, services and participation by marginalized segments of the population and those with high vulnerability to HIV infection including women, young people, and persons who engage in transactional sex or same sex relationships.

**Key Intervention Areas**

This strategic direction focuses on four key interventions namely:

- Remove barriers to access of HIV, sexual reproductive health (S.R.H)
- Improve county legal and policy environment
- Reduce and monitor stigma and discrimination
- Improve access to legal and protection from stigma and discrimination in the public and private sector.

| | Target Population | Geographic areas by County/sub- county | Responsibility |
|---|---|---|---|
| | • Healthcare workers<br>• PLHIVs<br>• General population | County | CASCO |
| | • SGBV survivors<br>• Priority population<br>• PLHIV, key populations, women, men, school going children | County | CASCO/CACC<br>Education Sector<br>CSOs |
| | • PLHIV, OVCs, Key Populations and other priority groups | County | Social services department, CSOs, CACC |
| | • Male partners of women living with HIV and ANC clients | County | CRHC |
| | • Police, health care workers, Civil Societies and legal groups<br>• SGBV survivors<br>• HIV Tribunal<br>• SGBV survivors<br>• Judiciary | County | CSOs and Public entities<br>CRHC<br>CASCO, CAC<br>CACC<br>CACC, CSOs,<br>JUDICIARY |

| KASF objective | NCHASP Results | Key Activity | Sub-Activity/Intervention | |
|---|---|---|---|---|
| Reduce HIV related stigma and discrimination by 50 per cent | • Improve access to legal and social justice and protection from stigma and discrimination in the public and private sector | • Enhance Community Awareness on SGBV and HIV | • Educate communities on gender based and legal issues affecting HIV | |
| | • Improve county legal and policy environment for protection and promotion of the rights of priority, key populations and PLHIV | • Enactment of laws and regulations for protection of rights of PLHIV | • Conduct Sensitization of law makers on the need to enact non-discriminatory regulations and services for PLHIV | |
| | • Reduce and monitor stigma and discrimination, social exclusion, and gender based violence by 50 per cent | • Enhance Stigma monitoring strategies | • Conduct focused stigma index, social exclusion and human rights violation studies | |

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

**County Situational Analysis**

Health agenda in the Nyamira County is driven via a health and community strategy but this is yet to be rolled out to all villages. The county has 83 CUs out of the expected 135; the units are linked to 80 facilities across the county. The county has a total of 135 Health Facilities; 85 GoK, 34 Private Facilities and 16 Faith- Based Organizations facilities.

The Nyamira County health system is characterized by the following challenges;

- shortage of qualified staff and competent Human Resource
- uneven geographical distribution of health workers,
- high levels of turnover,
- inadequate functional structures to support performance,
- weak linkage mechanisms between training institutions and health facilities
- lack of proper remuneration for personnel working in the community units

| | Target Population | Geographic areas by County/sub- county | Responsibility |
|---|---|---|---|
| | • Communities | County | CDGSS |
| | • County Assembly members | County | CEC (HEALTH) |
| | • PLHIV | County | CHC,<br>NEPHAK |

During the strategic plan period 2015/16-2018/19,the county aims to review existing coordination structures at the county and sub-county levels for appropriateness and clarity of roles and responsibilities, support integrated HIV and aids plans and improve on collaboration, partnerships and networking among implementing partners at all levels.

**Key Intervention Areas**

1. Provide a competent motivated and adequately staffed workforce at County and Sub-County levels to deliver integrated HIV services at different Tiers.
2. Strengthen health service delivery system at County and Sub-County levels to deliver integrated HIV services at different Tiers
3. Improve access to and rational use of quality essential products and technologies for HIV prevention, treatment and care services.
4. Strengthen community service delivery system at county and sub-county for the provision of HIV prevention ,treatment and care services

**Table 10: Strategic Direction four**

| **STRATEGIC DIRECTION 4:** STRENGTHENING INTEGRATION OF HEALTH AND COMMUNITY SYSTEMS | | | |
|---|---|---|---|
| **KASF objective** | **NCHASP Results** | **Key Activity** | |
| To build a strong and sustainable system for HIV service delivery at county level through specific health and community systems approaches, actions and interventions to support HIV response | • Improved health workforce for the HIV response in the county by 25% | • Provision of competent, motivated and adequately staffed health workforce | |
| | Strengthened community level AIDS competency and response | Empower the communities to effectively respond to HIV | |
| | Strengthen health service delivery system for the provision of HIV services integrated with Kenya essential health package (KEPH) | Increase number of health facilities ready to provide KEPH-defined HIV and AIDS services. | |
| | | • Adoption and implementation of Kenya HIV Quality Improved Framework (KHQIF) | |
| | | • Integration of HIV referral and linkage services into health and community referral systems | |
| | • Strengthened HIV commodity management | • Strengthen HIV commodity management and supply chain monitoring | |
| | | Promote timely forecasting and quantification for HIV commodities | |
| | | • Promote appropriate prescription practices and rational use of HIV commodities | |
| | | • Decentralization of comprehensive HIV services including laboratory networks to all health facilities | |
| | | • Provision of adequate and functional HIV diagnostic equipment | |

| | Sub-Activity/Intervention | Target Population | Geographic areas by County/sub-county | Responsibility |
|---|---|---|---|---|
| | • Staff recruitment to improve overall staff: population ratio | Health care workers | County | PSB<br>CDH |
| | • Staff redistribution to ensure availability of appropriate competent skilled personnel | Health care workers | County | CDH |
| | • Address the remuneration issues of the health personnel | Health care workers | county | CDH |
| | Continuous Capacity building of health personnel | Health Care Workers | County | CDH |
| | Implement health staff retention policy that takes into account the additional HIV burden | Health care workers | County | CDH |
| | Integration of HIV referral and linkage services into mainstream health services | Health facilities | county | CDH<br>CASCO |
| | • Develop and implement community health strategy policy | Members of County Assembly | County Assembly | CEC |
| | • Increase health facilities offering HIV services | Health facilities | County | CASCO |
| | • Carry out data quality assessments (DQAs)<br>• Carry out laboratory panel testing | Health care workers | County | CASCO<br>CMLC |
| | • Use of CHVs to facilitate referrals to and from community | CHEWs/CHWs | County | CCSFP |
| | • Carry out pharmacovigilance to ensure right drugs are ordered and supplied<br>• Hold regular commodity TWGs meetings | Health care workers | County | CPHARM |
| | • Training on quantification and forecasting | Healthcare workers | County | CPHARM |
| | • Carry out regular supportive supervision | Healthcare workers | County | CPHARM |
| | • Adequately equipping lower level laboratories | Lab personnel | County | CMLC |
| | • Regular maintenance of point of care CD4 machines, cyflow for CD4 testing and VL | Lab personnel | County | CMLC |

## Strategic direction 5: Strengthening Research, Innovation and Information Management to Meet NCHASP Goals.

**County Situational Analysis**

Research provides critical evidence on the basis of which strategic decisions and interventions are undertaken. A county research strategy is to be formulated to prioritize research projects and ensure that research undertaken is driven by demand.

Nyamira has a major gap on HIV research including but not limited to;

- lack of research oriented institutions,
- limited tertiary learning institutions,
- lack of health research TWG in the county,
- poor advocacy for medical research
- Inadequate funding to support County HIV Research & lack of Development priorities
- Uncoordinated Research Environment
- Disjointed Research for HIV Prevention
- Uncoordinated public engagement for research & Development
- Limited capacity both technical & Human Resource to Conduct comprehensive HIV Research
- Socio-cultural factors prevent the Community from Participating in HIV Research

**Table 11: Strategic Direction five**

| **STRATEGIC DIRECTION 5:** STRENGTHENING RESEARCH AND INNOVATION TO INFORM THE KCASP GOALS | | | |
|---|---|---|---|
| **KASF objective** | **CASP Results** | **Key Activity** | |
| Identification and implementation of high impact research priorities, innovative programming and capability and capacity strengthening to conduct research | Increased evidence-based planning and programming by 10% | Establish and operationalize a Research Technical Working Group | |
| | Increased capacity to conduct HIV research in the county by 10% | Develop County HIV Research Agenda | |
| | | Conduct county dissemination forum of HIV research | |
| | | Mobilize resources for the HIV research agenda | |
| | | Utilization of research findings | |

- Delayed translation of Research findings into policy& Practices
- Inadequate Dissemination of HIV Information.

There is need to strengthen research agenda in Nyamira County. The areas suggested for further research include but not limited to;

- Stigma and discrimination
- Drugs and substance abuse in relation to HIV
- The drivers of the epidemic among the key populations
- The use of technologies that pre-dispose people to HIV infection
- Determinants of socio-behavioral factors that enhance the spread of the epidemic

The research strategy shall ensure a balance between clinical and social science research in line with the multi-sectoral approach adopted by the county response. Overall research will provide in-depth analysis of key issues and information gaps that are identified through monitoring and evaluation.

**Expected Results**

1. Nyamira expects by 2019 to deliver increased evidence-based planning, programming and policy changes by 10 per cent,
2. Increased capacity to conduct HIV research at County level by 10 per cent.

| | Sub-Activity/Intervention | Target Population | Geographic areas by County/sub-county | Responsibility |
|---|---|---|---|---|
| | Expand the mandate and membership of the existing Ethics and research TWG | Research TWG | County | CEC |
| | Conduct operational research in the county on various thematic areas of HIV | Research stakeholders | County | CEC |
| | Build county HIV research capacities including epidemiological surveillance, good laboratory, clinical practice and ethics | Research stakeholders | County | CEC |
| | Establish an interactive web based county HIV research hub | Research stakeholders | County | CEC |
| | Disseminate the identified County research priority areas to mobilize resources. | Research stakeholders | County | CEC, CHC |
| | Hold annual dissemination of research findings and quarterly review meetings by different actors including publication of abstracts | Research stakeholders | County | CEC |
| | Develop policies to attract public, private partnerships in HIV research funding | Research stakeholders | County | CEC, CHC |
| | Advocate for resource allocation from the consolidated funds across the relevant sectors in the County budget | Research stakeholders | County | CEC, CHC |
| | partner with learning Institutions to prioritize HIV research needs | Research stakeholders | County | CEC, CHC |
| | Put in place a sustainable financing for HIV M&E planned activities | Research stakeholders | County | CEC, CHC |
| | utilization of research findings to inform programming and policy making | Research stakeholders | County | CEC, CHC |

## Strategic direction 6: Promote Utilization Of Strategic Information For Research And Monitoring And Evaluation To Enhance Programming

### Introduction

A functional and effective monitoring and evaluation (M&E) system serves to provide the data needed to guide the planning, coordination, and implementation of the HIV response; assess the effectiveness of the HIV response; and identify areas for program improvement. It also enables enhanced accountability to those infected or affected by HIV and AIDS, as well as the funders.

The county Government of Nyamira is geared to promotion and utilization of strategic information for research and monitoring of evaluation of HIV and AIDS programming. This plan will be informed by various data sources which will provide trends in HIV prevalence and incidences. This plan will strengthen coordination, ownership and data use for evidence based planning and decision making.

### County Situational Analysis

The county has Monitoring and Evaluation (M&E) systems and structures which are borrowed from the then national Ministry of Health.

The county uses the District Health Information System (DHIS2) which hosts the facility-based data. The system has been able to capture most of the HIV facility-based data within the county. However, the system is not designed to capture data for the specific groups of interests, such as key population data.

The community based HIV programme is being captured by the COBPAR system hosted by NACC. However, this data is not easily accessed by the interested parties.

**Table 12: Strategic Direction six**

| **STRATEGIC DIRECTION 6:** PROMOTING UTILIZATION OF STRATEGIC INFORMATION FOR RESEARCH AND MONITORING AND EVALUATION TO ENHANCE PROGRAMMING | | | |
|---|---|---|---|
| **KASF objective** | **NCHASP Outcome** | **Broad Activity** | |
| To improve data quality, demand, access and use of data for decision making at county and health facility levels | Prudent / Result Based Monitoring &Evaluation systems integrated with the County Data review & reporting tools. | Incorporate Research in strengthening M&E systems in the County. | |
| | Increased utilization of strategic information to inform HIV response at all levels | Enhance M&E Coordination | |
| | Adequate & sustainable sources of finance to conduct M&E activities | Soliciting for Funds to effectively implement M&E activities | |
| | Established and maintained vibrant M&E system in the County | evaluations, reviews and surveys implementation and results disseminated in timely manner | |

Further, development partners, NGOs and some CBOs have developed their own parallel M&E systems which are not in the spirit of the Three- Ones Principle.

The county Monitoring and Evaluation systems are characterized by the following gaps:

- Lack of a clear and defined functional monitoring and evaluation framework.
- Insufficient monitoring and evaluation tools on HIV & AIDS at the county and sub-county levels.
- Lack of monitoring and evaluation Technical Working Groups (TWGS)
- Insufficient funds for monitoring and evaluation activities in the county and sub-county.

The Nyamira County AIDS Strategic plan expects to contribute to achievement of the following results by 2019;

- Increased availability and utilization of strategic information to inform HIV response at county level
- Planned evaluations, reviews and surveys implemented and results disseminated in timely manner
- M&E Information Hubs established at County Level and providing comprehensive information package on key NCHASP Indicators for decision making
- Increase community information system

As the regular monitoring and evaluation systems in the County become more accessible, a renewed focus on improving data quality, demand and use of data for decision making will be given priority. Table 12: Strategic Direction six

| | Sub-Activity/ Intervention | Target Population | Geographic areas by County/sub- county | Responsibility |
|---|---|---|---|---|
| | Conduct Result Based M&E capacity assessment and formation of County M&E TWG | Implementing partners & Key stakeholders involved M&E system | County /Sub-County Level | CH M&EC |
| | Establish functional multi-sectorial HIV M&E co-ordination structures | The primary Beneficiaries (Community), Implementing & Development partners CHEWS, CHVs & The Medical fraternity. | County /Sub-County Level | CHC CHM&EC |
| | Advocate for allocation of funds to conduct M&E in the county | Implementing &Development Partners' Private & Government Health Facilities. | County /Sub-County Level | COH CDOF |
| | Conducting periodic data review meetings | Stakeholders | County /Sub-County Level | CHM&EC |

## Strategic Direction 7: Increasing Domestic Financing For Sustainable HIV Response

**County Situational Analysis**

Despite achievements towards control of HIV and AIDS the epidemic continues to pose significant challenges to County development. While the response has experienced inflow of resources from the county government, development partners and stakeholders, significant funding and resource gaps still exist. Also, the County response is largely donor dependent and for most part, donor driven.

According to The Kenya National AIDS Spending Assessment (KNASA) of 2014, Nyamira County had spent USD20.19 million and USD18.60 million in 2010/11and 2011/12 financial years respectively.

During the financial year 2013/14 to date, the county has been operating with limited resources in the implementation of core HIV programs, most of these core HIV programs are funded by partners, notably APHIA PLUS.

As counties devolve the health services including HIV, Nyamira county government is putting in place structures and strategies through the development and eventual launching of Nyamira County HIV and AIDS Strategic Plan to guide planning, implementation and resource mobilization to tackle the HIV pandemic in line with the KASF 2014/15-2018/19.

The overarching aim is to leverage increased political and resource commitment to the county response by all stakeholders while ensuring stewardship, transparency and accountability for all resources allocated for the county response.

**KEY INTERVENTIONS**

1. Coordination of all resources available for the HIV response in Nyamira county to avoid duplications of efforts
2. Innovative and sustainable domestic HIV financing options in the county
3. Maximize efficiency of existing HIV delivery options for increased value and results within existing resources

**Table 13: Strategic Direction Seven**

| **STRATEGIC DIRECTION 7:** INCREASING DOMESTIC FINANCING FOR A SUSTAINABLE HIV RESPONSE | | |
|---|---|---|
| **KASF objective** | **NCHASP Results** | |
| Increase domestic financing by 50 per cent<br>Increased county financing for HIV response by 20 per cent<br>Increase domestic financing by 50 per cent | Increased county finacing for HIV response by 20% | |
| | Coordination of all resources available for the HIV response in the county to avoid duplication of efforts. | |
| | Maximize efficiency of existing HIV delivery options for increased value and results within existing resources | |
| | Aligning HIV resources/ investment to strategic plan priorities | |

4. Aligning HIV resources/investment to strategic plan priorities

**EXPECTED RESULTS BY 2019**

1. Increased domestic financing for HIV response by 20 per cent

This strategic direction focuses on three key intervention areas namely: maximize efficiency of existing delivery options, promote innovative and sustainable domestic HIV financing options and align resources/ investment to strategic framework priorities.

| | Intervention/ Key Activity | Sub Activity | Geographic areas | Responsibility |
|---|---|---|---|---|
| | Innovative and sustainable domestic HIV financing options in the county | • Participation in the Annual county budgetary making cycle to ensure resource allocation<br>• Establish the County HIV kitty under MOH lobby the County Assembly to allocate separate budget vote line for HIV interventions and not as part of health budget.<br>• Lobby County Assembly to legislate levies on certain key sector<br>• Create strategic Public-Private Partnership in support of HIV programmes in the county<br>• Strengthen public private partnership engagement at all levels at the county and sub-county through regular PPP forums<br>• Initiate an annual AIDS lottery program.<br>• Organize High level Engagement with the county stakeholders to advocate for domestic financing.<br>• Build and enhance capacity of civil society organization to achieve self-financing and sustainability. | Entire County | NCG<br>Implementing Partners<br>Dev. Partners<br>Community<br>County Assembly<br>National government |
| | Coordination of all resources available for the HIV response in the county to avoid duplication of efforts. | • Creation of an information hub for the county to track resources from all partners (Grand check system)<br>• Carry out cost benefit analysis on the HIV & AIDS programs. | Entire County. | County government through the health services sector |
| | Maximize efficiency of existing HIV delivery options for increased value and results within existing resources | • Align the HIV and AIDS response within the local context<br>• Promote effective cost saving models of HIV /AIDS service delivery... | Entire County. | • NCG<br>• Partners |
| | Aligning HIV resources/ investment to strategic plan priorities | • Carry out a needs assessment on key priority interventions<br>• Consolidate and direct HIV resource allocations of different agencies.<br>• Develop a partnership accountability framework at county level to ensure alignment of resources to county HIV response priorities | Entire County. | • NCG<br>• Partners |

### Resource Needs

The resource requirement to fully implement the NCHASP is estimated at USD. 86.53 million for the five-year period. The expected implementation cost in the 2014/15 financial year is USD 15.31 million. This figure will rise annually to USD 18.47 million in the final year of the strategic plan due to scaling up of the Key HIV interventions. In estimating the resource needs, a macro-costing (down up) approach was employed. The resource needs was based on the current County's HIV burden that stands at 25,617 people. Treatment and care is expected to consume the largest share of HIV allocations followed by HIV prevention. The remaining amount is shared among the other intervention areas.

**Table 14: Resource Needs**

| Strategic Directions | Specific NCHASP Intervention Areas | |
|---|---|---|
| **SD1** | HIV Prevention | |
| **SD2** | Treatment and Care | |
| **SD3** | Social inclusion, human rights and gender | |
| **SD4** | Health systems | |
| | Community systems | |
| **SD5** | Research | |
| | Supply chain management | |
| **SD6** | Monitoring and evaluation | |
| **SD7 & SD8** | Leadership, governance and Resource Allocation | |
| | **Grand Total** | |

## Strategic direction 8: Promoting Accountable Leadership for Delivery of NCHASP Results by All Sectors and Actors

### Introduction

Good governance, accountable leadership and ownership of HIV response is a critical component for delivery of this plan. In alignment to the Kenya Constitution, a functional coordination structure is necessary to enhance multi-sectoral response at the County.

There is good evidence that an HIV epidemic can be contained with strong political will, employment of a pragmatic approach, and with an effective mobilization of resources. To succeed in dealing with HIV pandemic, the county assembly needs to have a political commitment by passing legislation and policies focusing on prevention and management of HIV and AIDS in the county. Leaders at all levels need to be encouraged to keep HIV high on the county agenda and share information about the epidemic with their wards and sub-counties. The capacity of the county structures needs to be built to manage HIV programs. There is need also to for

| | Percent of Resource Dedicated for the strategy | 2014/ 2015 | 2015/ 2016 | 2016/ 2017 | 2017/ 2018 | 2018/ 2019 | Total |
|---|---|---|---|---|---|---|---|
| | 25.99 per cent | 3.98 | 4.53 | 5.11 | 5.72 | 6.20 | 25.55 |
| | 53.37 per cent | 8.17 | 8.94 | 9.33 | 9.50 | 9.39 | 45.33 |
| | 4.00 per cent | 0.61 | 0.80 | 0.99 | 1.20 | 1.43 | 5.03 |
| | 6.35 per cent | 0.97 | 0.88 | 0.72 | 0.65 | 0.34 | 3.56 |
| | 3.65 per cent | 0.56 | 0.50 | 0.41 | 0.37 | 0.19 | 2.04 |
| | 0.49 per cent | 0.08 | 0.08 | 0.09 | 0.10 | 0.10 | 0.46 |
| | 0.37 per cent | 0.06 | 0.06 | 0.07 | 0.08 | 0.08 | 0.35 |
| | 1.84 per cent | 0.28 | 0.29 | 0.28 | 0.26 | 0.24 | 1.34 |
| | 3.94 per cent | 0.60 | 0.61 | 0.60 | 0.56 | 0.51 | 2.88 |
| | 100.00 per cent | 15.31 | 16.69 | 17.61 | 18.44 | 18.47 | 86.53 |

equitable distribution of resources within the county.

Many agencies and organization are making valuable contributions to HIV prevention and control but their work is not well coordinated.

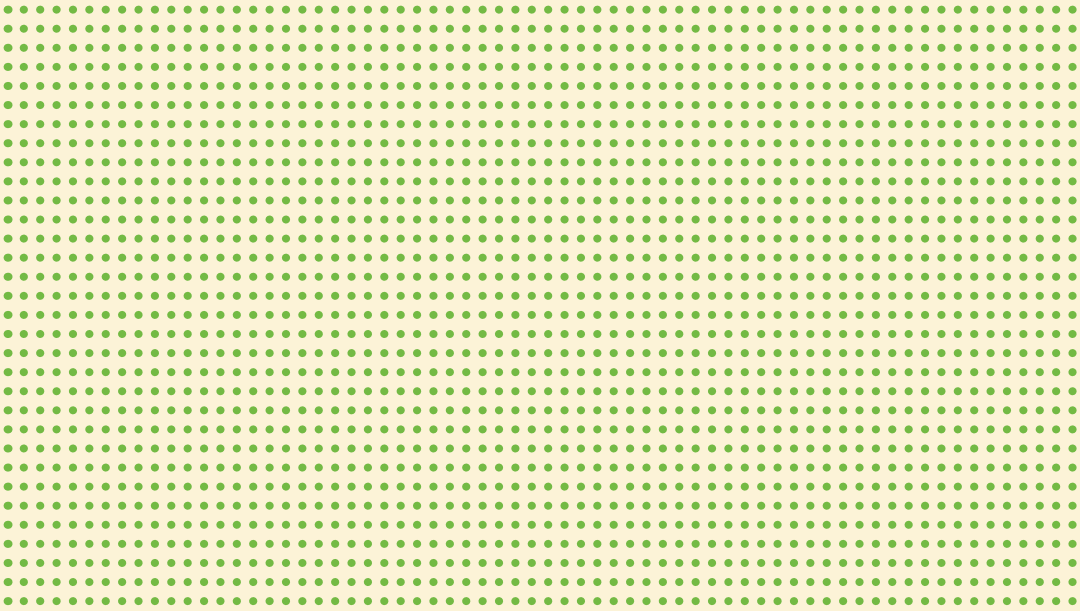
In the context of dwindling resources from donors and partners, there is increased call for ownership of the HIV response by the County. The implementation of NCHASP will require prudent governance practices that will be responsible and accountable in leadership of the multi-sectoral HIV and AIDS response. This will go a long way in ensuring effective and efficient resource allocation and subsequently create transparency and accountability. Setting HIV response as a county priority and a strategic development issue at all levels in the county, and enforcing its implementation, requires a sustained leadership, commitment and coordination from the executive and other governing bodies.

**Table 15: Strategic Direction Eight**

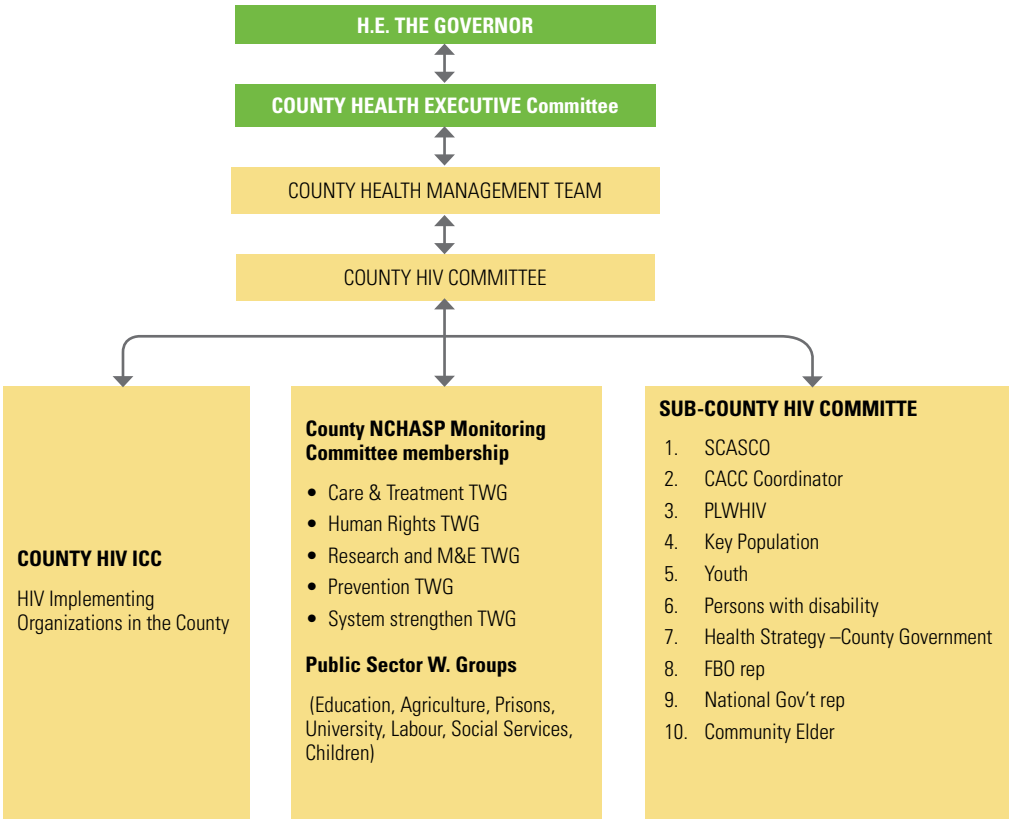
| **STRATEGIC DIRECTION 8:** PROMOTING ACCOUNTABLE LEADERSHIP FOR DELIVERY OF THE KASF RESULTS BY ALL SECTORS AND ACTORS | | | | | | |
|---|---|---|---|---|---|---|
| **KASF objective** | **NCHASP Results** | **Key Activity** | **Sub-Activity/ Intervention** | **Target Population** | **Geographic areas by County/ sub- county** | **Responsibility** |
| Promote good governance practices | Good governance practices and accountable leadership for HIV and AIDS response in the county | Provide policies and strengthen governance systems | Conduct sensitization forum for county assembly and the public to incorporate HIV activities during public participation forum during the county budget process | County Assembly<br>Public | County | CHC |
| | Effective and well-functioning stakeholder co-ordination mechanisms in the county | | Conduct advocacy meeting with the county leadership to build and sustain high-level political commitment in HIV response | County leadership | County | CHC, CSOs |
| | 80 per cent of HIV stakeholders in the county participating in quarterly stakeholder coordination forums. | | Develop policy briefs to strengthen good governance of county HIV response | County leadership | County | CHC, CSOs |
| | | | Mobilize and allocate adequate resources for HIV and AIDS response | Public<br>Private<br>Institutions | County | CHC, CSOs |
| | | | Development partners accountability | Hold the development partners HIV forum focusing on alignment to BCASP priorities. | County Assembly<br>County line departments<br>Private and informal sectors | County HIV ICC<br>Governor's office |

# 05.

# IMPLEMENTATION ARRANGEMENTS



The multisectoral county response will be managed by various structures at different levels .Each level will be mandated with diffrent tasks and roles in the delivery of the stategic plan.The coordination infrastructure of the NCHASP will be an all-inclusive one. This infrastructure will be coordinated at different levels as shown in the organogram below




The various stakeholders in the organogram shall have the following (but not limited to) roles:

**GOVERNOR:**

- Responsible for legistlation and resource allocation for financing of the NCHASP.

**CEC Health Services**

- Budgeting and resource allocation to specific annual plans for hiv interventions
- Provide strategic leadership during NCHASP implemenation period
- Accountable to the governor an all matters including performance and updating of the county HIV situation room

**COUNTY HEALTH MANAGEMENT TEAM**

- Coordination and overall management of HIV services in the county
- Quality Assurance of HIV services and commodities
- Coordination of emergency response
- HIV surveillance and control
- Logistics support and commodity security
- Resource mobilization for HIV programs in the County
- Performance monitoring and evaluation

**COUNTY HIV COMMITTEE**

The committee shall be chaired by the County Director of Health Services (CDH) and co-chaired by the County AIDS and STI Coordinator (CASCO). The secretary to the committee shall be the Regional HIV Coordinator (RHC) and assisted by the County Coordinator of Health. The sub-counties shall be represented in this committee.

**SUB-COUNTY COMMITTES**

- Technical arm of the Department of health that cordinates HIV/AIDS Program in the Sub-County.
- Shall be a member of the SCHMT and will update the team on all matters partaining the coordination of HIV activities in the Sub-County.
- Support HIV stakeholders fora at sub-county level.
- The SCASCO shall be the secretary of the sub-county HIV committee
- oversee the Implementation of the County HIV Strategic Plan along with other Policy documents and Frameworks

**CONSTITUENCY COMMITTEES**

- Cordination of HIV at the constituency level
- Shall sit in the SCASCO OFFICE and update the SCHMTon all matters partaining to cordination of hiv activities in the COMMUNITY
- Recieve and Disseminate NCHASP to the community.
- The partners, CBOs,FBOs and the private sector forms part of the structure for wholistic manangement of the HIV in communities not leaving out the PLHIV and other vulnerable population such as PWDs and the youth.

At the lowest level ,the sub-county/ constituency HIV codinating committtee is constituted and operates within the structures of ensuring devolved structures are functional

**COUNTY HIV ICC**

- Annua l Review of county achievements of the plan
- Documenting of the emerging issues during the implementation period.
- Documenting of the best practices and lessons learnt during the implementation of the NCHASP

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

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

**Sustainability**

The cost of HIV and AIDS response in the County is escalating against a backdrop of declining international financial resources for HIV and AIDS. The increase in cost is associated with the scale-up of services, adoption of the new ART treatment guidelines (Rapid Advice, June 2014) and the expansion of the county response through sector mainstreaming of HIV. The gap between resource needs and available funding continue to expand raising concerns for overall sustainability of the response. The County Government's commitment to address the issue of sustainable financing for HIV is demonstrated by the development of the Nyamira County HIV and AIDS Strategic Plan.

The decline in resources has serious implications on the sustainability of strategic HIV and AIDS interventions including prevention of new infections and sustained provision of ART. The growing resource gap means that Nyamira County will continue to face difficulties in financing the County response from donor resources. The consequence is the likelihood of compromising the health outcomes in prevention of new infections, ART, eMTCT and treatment of TB/HIV co-infections through services interruptions. During the implementation of NCHASP, efforts to introduce and strengthen sustainable financing mechanisms will be accelerated and new strategies developed.

In developing a sustainable financing strategy, Nyamira will adopt a multi-pronged approach premised on the New Investment Framework for HIV proposed by UNAIDS. The strategy will focus on;

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 services delivery.

**Capacity development plan**

The capacity development process will identify and outline the priorities to develop capacity for county program and resource management for HIV, to ensure quality implementation of the program. The purpose of the capacity development process is to enhance the skills and resources of the county government and civil society organizations to fully manage and efficiently the HIV program.

**Strategic level capacities**

A mapping exercise will be conducted at a senior level in the county and key CSOs to identify the key capacities for county disease management for HIV. These are likely to consist of high level strategic capacities including; Policy; Strategy; Sustainable Financing; Coordination; County Government / CSO relationships; and Communication.

The strategic level capacities will require clear policies and strategies to be in place at the county government level. These in turn will lead to effective county HIV response structures, clear roles and responsibilities,

procedures, plans and resources to allow implementation. The capacity development plan will include strengthening the strategic capacities identified together with the advice and guidance to adapt best practice to the county context together with support and mentoring to put these in place.

**Functional capacities**

At the implementation level there are implementation /or functional capacities required to ensure the continuity of services. The functional capacities consist of; Program Management; Financial Management; Procurement and Supply Chain Management; and Monitoring and Evaluation.

The functional capacities require the county government and key CSO systems to be strengthened to a level where the entities can manage the implementation of county and national disease programs for HIV.

The main focus of the capacity development plan is on strengthening the entities implementation systems. The systems will be reviewed and reformed drawing on best practices taking into account the context to result in 'best fit'. This organizational development will result in appropriate integrated structures being in place, with clear roles, responsibilities and utilizing standard operating procedures, to deliver accessible and responsive services in a cost efficient and effective manner. The systems will need adequate oversight put in place to increase accountability and mitigate risk.

# 06.

# RESEARCH, MONITORING AND EVALUATION OF THE PLAN

Existing Health Information systems are highly fragmented with no linkages with other healthcare providers at various levels. The design and implementation of these systems do not facilitate integration of different sources of health information within the health system. There is poor integration of vertical programs and administrative information into the routine Health Information System. Consequently, there is no clear sharing of information among health care providers in the health system.

When reporting on HIV programs, the Team will use the nationally approved Ministry of Health (MOH) standard tool to capture the required data. The following tools will be used to collect the information relevant to the Research.

| Institution | Role | Frequency | Reporting tool |
|---|---|---|---|
| Service Delivery Points(Health Facilities) | Report health Sector data | Monthly | MOH 731 |
| Sub-County Health Records &Information Officers | Collate Health Sector HIV Response data | Monthly | MOH731-DHIS |
| County Health Records &Information Officer | Collate Health Sector HIV Response data | Monthly | MOH731-DHIS |
| County HIV Coordination unity& County AIDS & STI Coordinating Officer | Provide Health Sector HIV Response data for use at the County level | Quarterly | DHIS |
| National AIDS Control Council (NACC) | Ensuring Community based Data on HIV programs have been captured | Quarterly | COBAPR |
| MOH (NASCOP) | Review DHIS data& liaise with NACC to improve data quality | Quarterly | KASF data collation tool |

## DATA REPORTING

Before final data reporting to the relevant authorities , the County HIV Monitoring &Evaluation Committee (CHM&EC) will perform the DQA procedures to ensure that the data is realistic. Once data is collected, it will be screened, analyzed, documented & reported through the DHIS. Dissemination at the County level will be during the County Stakeholders' HIV forums. This reporting system will report mainly on Behavioural &structural Indicators.

## M&E DATA USE

M&E data and Information products generated will be used at various levels:

1. County Department of health
2. County HIV Committee
3. Implementing Organization
4. Sub- County control HIV Committees.
5. Constituency HIV Committee.

## FEEDBACK MECHANISMS

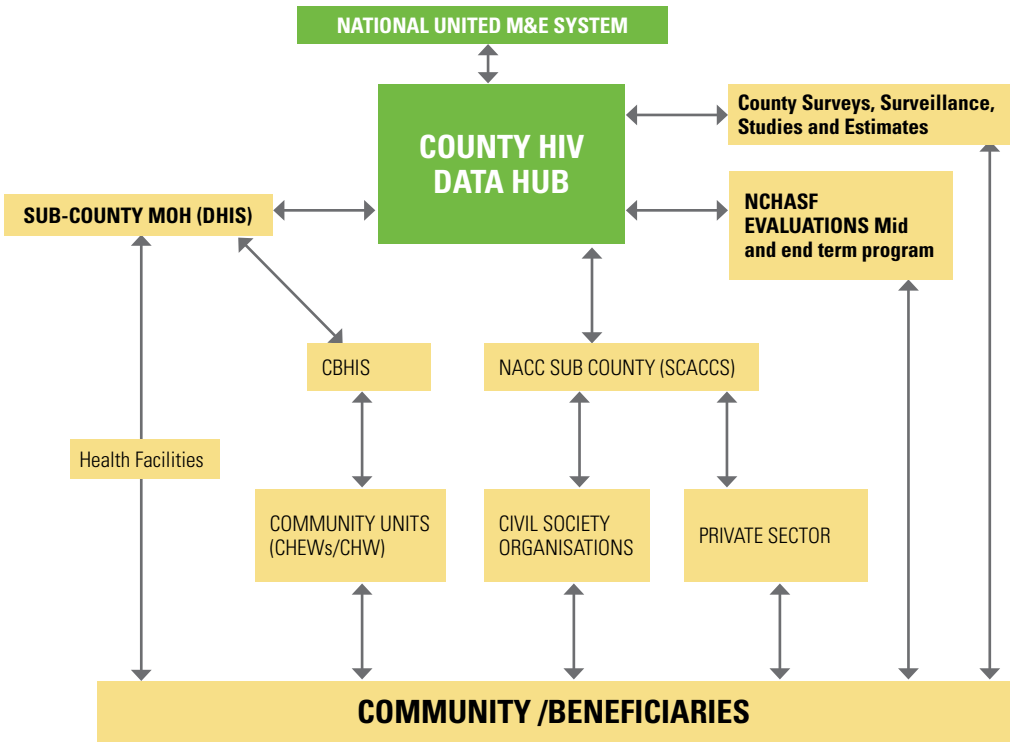
Feedback will be provided to various levels of NCHASP coordination & Implementation to improve service delivery of HIV Programs. The platforms and processes for providing feedback will be provided through;

1. CHMT
2. County HIV Committee
3. Sub-County HIV ICCs
4. County HIV ICCs

Support Supervision visits by Sub –County & County Health Management Team

| LEVELS | ROLES & RESPONSIBILITIES |
|---|---|
| Health Facilities | Health facilities will provide the routine service delivery data through the DHIS, this information will be feed to the county HIV hub |
| Community Units | The Community Health workers will provide the routine service delivery & programming data through the CBHIS, this information will be feed to the county HIV hub |
| Civil Society Organizations/ Private Sector | The Civil Society organizations/Private Sector will provide the routine service delivery & programming data to their respective sub counties, who will intern feed this information to the county HIV hub. |
| Non-Routine Data(Surveys, Surveillances, Studies & Estimates) | The non-routine date sources; surveys, surveillances, estimates and studies, the findings will be feed into the county HIV hub directly after the finding are officially published. |

## DATA FLOW CHART



# 07.

# RISKS AND MITIGATION PLAN

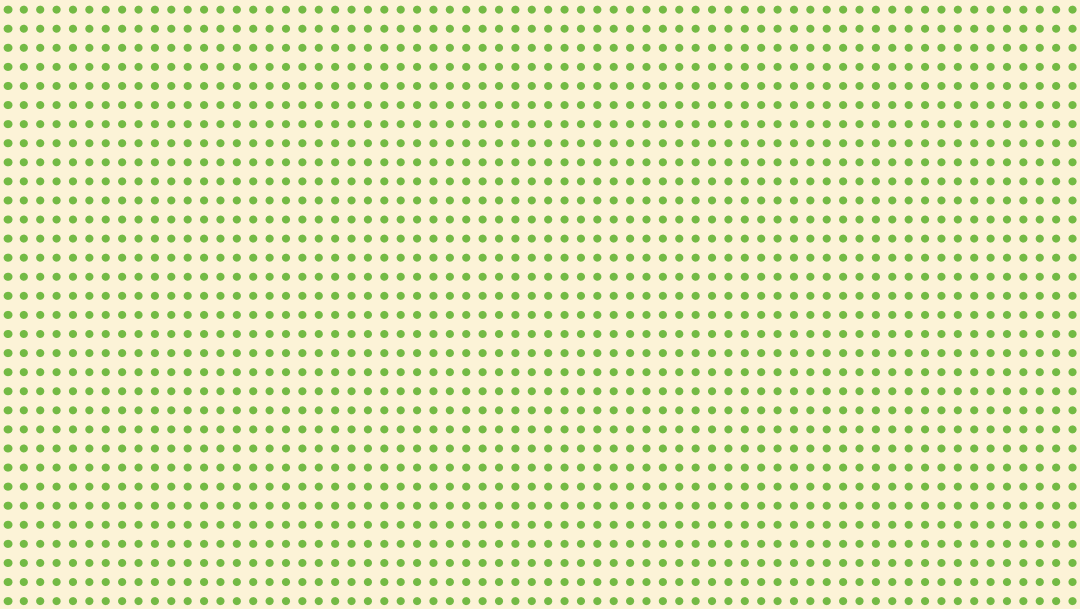


**Table 16: Risk and Mitigation Plan**

| Risk Category | Risk Name | Status | Probability (1-5) | Impact (1-5) | Risk Average score | Response | Responsibility | When |
|---|---|---|---|---|---|---|---|---|
| Technological | Partners lack Capacity | Active- risk is being actively monitored | 3/5 | 4/5 | 3.5/5 | Mitigate- budget moneys for training | CEC health | Y1 |
| Political | Inconsistent and insufficient political good will. | Passive risk, its being actively monitored. | 2/5 | 3/5 | 2.5/5 | Reduce-by Constantly engaging the political class. | CEC health | continuous |
| Operational | Inconsistent and inadequate supply of HIV commodities. | Active-<br>Being monitored. | 3/5 | 5/5 | 4/5 | Reduce-<br>Implementing the pull system of commodity and have emergency funds to replenish the supplies | CMLC/ CASCO | continuous |
| Legislation | Inadequate legislation to support (KP and vulnerable groups. | Active | 3/5 | 3/5 | 3/5 | Lobby (legislation )support from the | County Assembly and CEC Health | continuous |
| Environmental | Change in weather patterns-rain | Passive | 2/5 | 2/5 | 2/5 | Mitigate-Procuring vehicle that can manage the terrain | County Assembly and CEC Health | continuous |
| Social | Stigma | Active | 3/5 | 3/5 | 3/5 | Mitigate- | Heath County Assembly and CEC Health | continuous |
| Economical | Inflation | Active | 3/5 | 3/5 | 3/5 | Adopt – no action | County Assembly and CEC Health | continuous |
| | Competing priorities for same resources | Active | 2/5 | 3/5 | 2.5/5 | Prioritize | CEC health | |
| Organizational /human factors | Limited Capacity , | Active | 2/5 | 4/5 | 3/5 | Capacity building | County Director of health | continuous |
| | Human resource capital. | Passive | 3/5 | 3/5 | 3/5 | Reduce- staff rationalization and trainings | County Director of health | continuous |
| | Poor leadership | Active | 2/5 | 4/5 | 3/5 | Reduce- promoting good governance and leadership through accountability | County Director of health | |
| | Lack of cohesion at community level. | Active | 2/5 | 2.5/5 | 2.25/5 | Support establishment of CSO,CBOs | County Director of health | |
| | Lack of Clarity over roles and responsibilities. | Active | 2/5 | 3/5 | 2.5/5 | Design job description and performance contract | Human resource personnel | |
| Strategic/ commercial | Terrorism and insecurity | Active | 1/5 | 3/5 | 2/5 | Transfer- Insurance scheme and/or hire security services<br>Undertake security and risk assessment put appropriate measures in place (maximize opportunity to work remotely) | Security agencies | continuous |

# 08.

# ANNEXES

## Annex 1: Results Framework

The Logical Framework for the plan is based on a prioritized list of strategic options that would ensure the attainment of the stated targets. It attempts to indicate the time relationship between the various strategic options and objectives and attempts to harmonize activities to harness synergy between different interventions. The logical framework assumes that there will be adequate resources to implement the proposed interventions in a timely manner.

| KASF objective | NCHASP Results | Key Activity | Sub activity | |
|---|---|---|---|---|
| | | | **Biomedical Interventions** | |
| Reduce new HIV infections by 50 per cent | Reduce new HIV infections by 50 per cent | Offer innovative and evidence based HIV prevention and care activities. | • Innovative HIV testing and counseling (HTC) models | |
| | | | • Linkage of those testing HIV positive to care and early ART initiation. | |
| | | | • Prevention and management of co infections and co morbidities (TB & Cryptococcal) | |
| | | | • Offer gender based violence care services including post exposure prophylaxis (PEP) for survivors. | |
| | | Roll out package of care for Key Populations and Vulnerable groups | • Provision of key commodities including lubricants and condoms | |
| | | | • Screening and management of HPV among FSW/MSM and Hepatitis B and C | |
| | | | • Scale up STI management in all health facilities | |
| Reduce new HIV infections by 75 per cent | Reduce new HIV infections by 50 per cent | Offer innovative and evidence based HIV prevention and care activities. | • Innovative HIV testing and counseling (HTC) models | |
| | | | • Linkage of those testing HIV positive to care and early ART initiation. | |
| | | | • Prevention and management of co infections and co morbidities (TB & Cryptococcal) | |
| | | | • Offer gender based violence care services including post exposure prophylaxis (PEP) for survivors. | |
| | | Roll out package of care for Key Populations and Vulnerable groups | • Provision of key commodities including lubricants and condoms | |
| | | | • Scale up STI management in all health facilities | |

| | Indicator | Baseline and source | Mid Term Target | End Term Target | Responsibility |
|---|---|---|---|---|---|
| | | | | | |
| | Percentage of people accessing HTS within the County | KDHIS | 25 per cent of new OPD clients and 90 per cent IP tested | 50 per cent of new OPD clients and 100 per cent IP tested | CHMT<br>Implementing partners |
| | Percentage Of HIV tested Positive linked into care and treatment. | KDHIS | 90 per cent Linkage | 100 per cent Linkage | |
| | Percentage Of patients treated of OI infections | KDHIS | 90 per cent Co-infected cases screened and treated | 95 per cent Co-infected cases screened and treated | |
| | Percentage of GBV cases offered PEP | KDHIS | 50 per cent of the victims who report at the health facility | 100 per cent of the victims who report at the health facility | |
| | Number of people accessing condoms and lubricants | KDHIS | Number of eligible people within the population | Number of eligible people within the population | MOH<br>Implementing Partners |
| | Percentage FSW/MSM screened of Hepatitis B and C | KDHIS | | | |
| | Percentage health facilities providing STI care package | KDHIS | 100 per cent of health facilities offering STI services | 100 per cent of health facilities offering STI services | |
| | Percentage of people accessing HTS within the County | KDHIS | 25 per cent of new OPD clients and 90 per cent IP tested | 50 per cent of new OPD clients and 100 per cent IP tested | CHMT<br>Implementing partners |
| | Percentage Of HIV tested Positive linked into care and treatment. | KDHIS | 90 per cent Linkage | 100 per cent Linkage | |
| | Percentage Of patients treated of OI infections | KDHIS | 90 per cent Co-infected cases screened and treated | 95 per cent Co-infected cases screened and treated | |
| | Percentage of GBV cases offered PEP | KDHIS | 50 per cent of the victims who report at the health facility | 100 per cent of the victims who report at the health facility | |
| | Number of people accessing condoms and lubricants | KDHIS | Number of eligible people within the population | Number of eligible people within the population | MOH<br>Implementing Partners |
| | Percentage of health facilities providing STI care package | KDHIS | 100 per cent of health facilities offering STI services | 100 per cent of health facilities offering STI services | |

| KASF objective | NCHASP Results | Key Activity | Sub activity | |
|---|---|---|---|---|
| | | | **Biomedical Interventions** | |
| Reduce new HIV infections by 75 per cent | Reduce new HIV infections by 50 per cent | Implement package of services for Adolescents and Young Women | Innovative HIV and STI testing | |
| | | | Establish youth friendly clinical services | |
| | | | Offer age appropriate contraceptives, condoms, and microbicides. | |
| | | | Increase access to sexual and reproductive health services. | |
| | | Offer package of services for sero discordant couples | Offer regular scheduled HTC to partners and families of all HIV positive clients | |
| | | | Provide ART to the infected partner and adherence support | |
| | | Implement strategies to identify and retain HIV pregnant and lactating women and their infants<br>Adopt new national and WHO guidelines on eMTCT | Integrate Early infant diagnosis of HIV with immunization services with MNCH | |
| | | | Deliver all 4 prongs of eMTCT at 100 per cent of health facilities. | |
| | | | Ensure all pregnant and lactating women are initiated on ART and all HIV positive children are offered ART | |
| | | | Offer GBV services including services for post-rape and incest among children | |
| | | | **Behavioral Interventions** | |
| Reduce new HIV infections by 75 per cent | Reduce new HIV infections by 50 per cent | • Implement strategies to address HIV related stigma<br>• Promote life skill programs among vulnerable populations | Stigma reduction campaigns | |
| | | | Risk reduction counseling and skill building | |
| | | | Male and female condom demonstration, distribution and skill building | |
| | | • Behavior change intervention using specific interpersonal tools and techniques including those in Braille | Regular outreach and contact with Key Population through peer based education, treatment and support | |
| | | | Drug and Substance screening and addiction support | |

| | Indicator | Baseline and source | Mid Term Target | End Term Target | Responsibility |
|---|---|---|---|---|---|
| | | | | | |
| | Percentage of health facilities providing STI care package | KDHIS | 100 per cent of health facilities offering STI services | 100 per cent of health facilities offering STI services | Nyamira county Government-MOH<br>Implementing partners |
| | Number of Youth friendly spaces established at the health services within the county | KDHIS | 2 facilities established | 4 facilities established | |
| | Percentage of women and men of reproductive age accessing FP services within the county | KDHIS | 30 per cent of the total population eligible accessed with FP service | 30 per cent of the total population eligible accessed with FP service | |
| | Percentage of APOC sessions rolled out within the health service delivery points within the county | NASCOP | At least one person trained per facility on APOC | 30 per cent of health workers trained on APOC | |
| | Percentage of discordant couples families accessing HTC at the health facilities within the county | DHIS | 100 per cent | 100 per cent | Nyamira County Government-MOH<br>Implementing Partners |
| | Percentage Of HIV Positive patients accessing HAART treatment in all health care facilities within the county | DHIS | 100 per cent | 100 per cent | |
| | Percentage of facilities within integrated MCH services as one stop shop within the county | CHIS | 75 per cent | 100 per cent | Nyamira county Government-MOH<br>Implementing Partners |
| | Percentage of health facilities proving PMTCT services and basic HIV care package | CHIS | 80 per cent | 90 per cent | |
| | Percentage of pregnant and lactating women are initiated on ART and all HIV positive children are offered ART | KDHIS | 90 per cent of all pregnant and lactating women initiated on ART | 100 per cent of all pregnant and lactating women initiated on ART | |
| | Percentage of GBV cases offered PEP | KDHIS | 50 per cent of the victims who report at the health facility | 100 per cent of the victims who report at the health facility | |
| | | | | | |
| | Number of stigma reduction campaign held | 35 per cent National HIV and AIDS stigma & Discrimination Index | 10 per cent | 20 per cent | Nyamira County Government- |
| | Number of skill building sessions held within the county | Not Available | 15,000 sessions | TBD 30,000 sessions | MOH<br>Implementing Partners<br>FBOs ,CBOs |
| | Number of condoms distributed within the county health facilities | KDHIS | 50 per cent of the eligible population | 80 per cent of the eligible population | |
| | Percentage of KP reached out with key messages, treatment and supported within the county | CHIS | 75 per cent | 100 per cent | Nyamira County Government-MOH<br>Implementing partners |
| | Percentage of DSA addicts reached and enrolled for support. (rehabilitated) | Implementing Partners reports. ( Impact research for development Organization and International Medical Corps) | 75 per cent | 100 per cent | MOH<br>Implementing Partners |

| KASF objective | NCHASP Results | Key Activity | Sub activity | |
|---|---|---|---|---|
| | | | **Biomedical Interventions** | |
| Reduce new HIV infections by 75 per cent | Reduce new HIV infections by 50 per cent | Implement evidence-based interventions (EBI) for adolescents and young women and provide HIV and RH related education in schools | Offer peer-to-peer outreach in school or outside school | |
| | | | HIV and RH related education in school or in the community | |
| | | | Implement life skills programs for youth in school and out of school | |
| | | Implement appropriate evidence-based behavioral interventions. | Support the formation of PSSGs to enhance adherence | |
| | | | Implement Positive Health dignity and Prevention (PHDP) | |
| | | Implement Kenya Mentor Mother Program | Offer Psycho-social and peer support services for pregnant women within the health facilities | |
| | | | Infant and Young child feeding strategies | |
| | | | **Structural Interventions** | |
| Reduce new HIV infections by 75 per cent | Reduce new HIV infections by 50 per cent | Provide an enabling environment for programming | Implement gender based violence prevention and response programs | |
| | | | Implement programs to keep girls in school and social protection of vulnerable families | |
| | | | Engage private sector to formalize a system to compliment the service delivery system and reporting requirements | |
| | | | Protection from cultural issues/practices that are directly linked to HIV e.g. FGM | |
| | | Implement package of services for Adolescents and Young Women | Innovative HIV and STI testing | |
| | | | Establish youth friendly clinical services | |
| | | | Offer age appropriate contraceptives, and condoms | |
| | | | Increase access to sexual and reproductive health services. | |

| | Indicator | Baseline and source | Mid Term Target | End Term Target | Responsibility |
|---|---|---|---|---|---|
| | | | | | |
| | Number of peer –to –peer outreaches conducted in and outside school within the county | CHIS | 4320 sessions held | 8640 sessions held | Nyamira county Government-MOH<br>Implementing Partners |
| | Number of HIV/RH sessions held | MOE | 4320 sessions held | 8640 sessions held | |
| | Number of schools with life skill programs within the county | MoE | 10 schools with every Sub-County has a life skill program | 20 schools with every Sub-County has a life skill program | |
| | Number of PSSGs formed | MoE | 264 | 528 | Ministry of Social Services<br>MOH |
| | Percentage of health facilities offering PHDP within the county | KDHIS/CHIS | 50 per cent of health facilities offering PHDP services | 90 per cent of health facilities offering PHDP services | |
| | Percentage of facilities offering Psycho-social services within the county | CHIS | 50 per cent Offering psycho-social services | 90 per cent Offering psycho-social services | Nyamira County Government-MOH<br>Implementing Partners |
| | per centage of HIV exposed infants exclusively breast feeding in the first 6 months | DHIS | 80 per cent | 90 per cent | |
| | | | | | |
| | Number of GBV prevention and response program being conducted | not Available | 90,( 2 )Sessions per ward | 180, (4) Sessions per ward | Nyamira county government-MOH<br>Implementing partners |
| | Number of programs initiated and being implemented | MOE | 45<br>1 per ward in the 45 per ward | 45 | |
| | Number of sessions the private public partnerships stakeholder forums conducted within the county | Not Available | 18 forums held | 39 forums | |
| | Number of campaigns conducted against traditional practices fueling HIV i.e. FGM within every sub-county | Not Available | 180 Sessions | 360 Sessions | |
| | Number of campaigns conducted against traditional practices fueling HIV i.e. FGM within every sub-county | Not Available | 180 Sessions | 360 Sessions | Nyamira county Government-MOH<br>Implementing partners |
| | Number of Youth friendly spaces established at the health services within the county | KDHIS | 10 facilities established | 20 facilities established | |
| | Percentage of women and men of reproductive age accessing FP services within the county | KDHIS | 30 per cent of the total population eligible accessed with FB service | 30 per cent of the total population eligible accessed with FB service | |
| | Number, Percentage of APOC sessions rolled out within the health service delivery points within the county | NASCOP | At least one person trained per facility on APOC | 50 per cent of health workers trained on APOC | |

| KASF objective | NCHASP Results | Key Activity | Sub activity | |
|---|---|---|---|---|
| | | | **Structural Interventions** | |
| Reduce new HIV infections by 75 per cent | Reduce new HIV infections by 50 per cent | Offer package of services for sero discordant couples | Offer regular scheduled HTC to partners and families of all HIV positive clients | |
| | | | Provide ART to the infected partner and adherence support | |
| | | • Implement strategies to identify and retain HIV pregnant and lactating women and their infants<br>• Adopt new national and WHO guidelines on eMTCT | Integrate Early infant diagnosis of HIV with immunization services with MNCH | |
| | | | Deliver all 4 prongs of eMTCT at 100 per cent of health facilities. | |
| | | | Ensure all pregnant and lactating women are initiated on ART and all HIV positive children are offered ART | |
| | | | Offer GBV services including services for post-rape and incest among children | |

| **STRATEGIC DIRECTION 2:** IMPROVING HEALTH OUTCOMES AND WELLNESS OF ALL PLHIV | | | | |
|---|---|---|---|---|
| **KASF objective** | **NCHASP Results** | **Key Activity** | **Sub Activities** | |
| Reduce AIDS related Mortality by 25 per cent | Increased linkage to care and treatment up to 90 per cent within 3 months of HIV diagnosis | Intensify identification and retention in care of children Living with HIV | Intensifying EID at MNCH | |
| | | | Adherence counseling to the care givers | |
| | | | Community follow up and defaulter tracing | |
| | | | Establish child friendly spaces | |
| | | | Intensified case finding by testing children in MCH, outpatient, special clinic and wards with unknown status | |
| | | | Improved identification follow-up of HEI such as in maternity wards, immunization clinics etc. | |
| | | Roll out adolescent's package of care | Provide youth friendly services, psychosocial and peer support. | |
| | | | Sensitization of APOC to Health care providers | |
| | | | Utilise technology including social media for education, recruitment and retention in care | |

| | Indicator | Baseline and source | Mid Term Target | End Term Target | Responsibility |
|---|---|---|---|---|---|
| | | | | | |
| | Number, Percentage discordant couples families accessing HTC at the health facilities within the county | DHIS | 100 per cent | 100 per cent | Nyamira County Government-MOH<br>Implementing Partners |
| | Percentage of HIV Positive patients accessing HAART treatment in all health care facilities within the county | DHIS | 100 per cent | 100 per cent | |
| | Percentage of facilities within integrated MCH services as one stop shop within the county | CHIS | 75 per cent | 100 per cent | Nyamira county Government-MOH<br>Implementing Partners |
| | Percentage of health facilities proving PMTCT services and basic HIV care package | CHIS | 90 per cent | 98 per cent | |
| | Percentage of pregnant and lactating women are initiated on ART and all HIV positive children are offered ART | KDHIS | 90 per cent of all pregnant and lactating women initiated on ART | 100 per cent of all pregnant and lactating women initiated on ART | |
| | Percentage of GBV cases offered PEP | KDHIS | 90 per cent of the victims who report at the health facility | 100 per cent of the victims who report at the health facility | |

| | Indicators | Baseline & Source | Mid Term Target | End Term Target | Responsibility |
|---|---|---|---|---|---|
| | Percentage of HIV positive Children identified and linked to care. | 70 per cent DHIS | 100 per cent | 100 per cent | Nyamira County Government-MOH<br>Implementing partners |
| | Adherence rate | Patient Blue Card | 100 per cent | 100 per cent | |
| | Percentage of defaulters traced and brought back to care. | 85 per cent, Facility defaulter registers | 100 per cent | 100 per cent | |
| | Number of health facilities with child friendly spaces | 11 Health Facilities (DHIS) | 20 Health Facilities | 30 health facilities | |
| | Proportion of children of unknown HIV status tested. | 37 per cent (KDHIS) | 64 per cent | 90 per cent | |
| | Proportion of HEIs followed up on care up to 18months | 70 per cent | 80 per cent | 90 per cent | |
| | Number of ART site that offer adolescents support group | TBD | TBD | TBD | |
| | Percentage of health care workers sensitized | 5 per cent Health care workers | 50 per cent | 75 per cent | |
| | Number of social media platforms created for education, recruitment and retention in care | Nil | 61 | 122 | |

| KASF objective | NCHASP Results | Key Activity | Sub Activities | |
|---|---|---|---|---|
| Reduce AIDS related Mortality by 25 per cent | Increased linkage to care and treatment up to 90 per cent within 3 months of HIV diagnosis | Roll out adolescent's package of care | Utilise technology including social media for education, recruitment and retention in care | |
| | | | • Mainstream KP programming in health facilities<br>• Integrate care services in drop-off centers<br>• Targeted HIV testing models.<br>• Improve referral and patient management system and infrastructure.<br>• Implement patient retention strategies (treatment literacy sessions, peer and psychosocial support)<br>• Strengthen facility and community linkages with inter- and intra- facility referral protocols and linkage strategies<br>• Establish effective tracking system of the clients<br>• Strengthened male engagement for PMTCT outcomes<br>• Roll out KMMP. | |
| | | Intensify identification and retention in care for adults living with HIV | Proportion HIV+ linked to care within the facility with CCC No indicated | |
| | | Implement PMTCT guidelines on testing. | Proportion of site implementing PMTCT guidelines | |
| Key Intervention 2: Increase Coverage to care and treatment and reduce the loss in the cascade of care | | | | |
| Reduce AIDS related Mortality by 25 per cent | Increased linkage to care and treatment up to 90 per cent within 3 months of HIV diagnosis | Decentralize HIV services for children to all health facilities including private and faith based facilities | Proportion of facilities providing HIV services for children | |
| | | Roll out package of services for adolescents and youth. | Proportion of facilities providing adolescent package of services | |
| | | Decentralization of ART services and ensure commodity security | Proportion of facilities offering ART services | |
| | | Decentralization of PMTCT services to all health facilities | Proportion of facilities offering PMTCT services | |
| Key Intervention 3: Improve quality of care and treatment outcomes | | | | |
| Reduce AIDS related Mortality by 25 per cent | Increased linkage to care and treatment up to 90 per cent within 3 months of HIV diagnosis | To improve quality of care and monitoring treatment outcomes | Proportion of facilities observing standards of care | |
| | | To improve laboratory capacity and infrastructure | Proportion of facilities with improved laboratory capacity | |

| | Indicators | Baseline & Source | Mid Term Target | End Term Target | Responsibility |
|---|---|---|---|---|---|
| | Number of health facilities mainstream KP programming | Nil | 61 | 122 | Nyamira County Government-MOH<br>Implementing partners |
| | Number of health facilities mainstream KP programming | 1 | 4 | 9 | Nyamira County Government-MOH<br>Implementing partners |
| | Percentage of PLHIV linked for follow up and treatment | 80 per cent | 90 per cent | 100 per cent | Nyamira County Government-MOH<br>Implementing Partners |
| | Percentage of sites with ART integrated in MCH | 90 per cent | 100 per cent | 100 per cent | Nyamira county Government-MOH<br>Implementing Partners |
| | | | | | |
| | Percentage Coverage of HIV services for children | 98 per cent | 100 per cent | 100 per cent | Nyamira County Government-MOH<br>Implementing Partners<br>FBOs ,CBOs |
| | Percentage Coverage of adolescent package of services for children | 50 per cent | 80 per cent | 100 per cent | Nyamira County Government-MOH<br>Implementing partners |
| | Percentage Coverage of ART sites | 99 per cent | 100 per cent | 100 per cent | Nyamira County Government-MOH<br>Implementing Partners |
| | Percentage Coverage of PMTCT sites | 100 per cent | 100 per cent | 100 per cent | Nyamira County Government-MOH<br>Implementing Partners |
| | | | | | |
| | Percentage of facilities observing standards of care | 98 per cent | 100 per cent | 100 per cent | County Government<br>Implementing Partners |
| | Percentage of facilities with improved laboratory capacity | 30 per cent | 60 per cent | 80 per cent | County Government<br>Implementing Partners |

| **STRATEGIC DIRECTION 3:** USING A HUMAN RIGHTS APPROACH TO FACILITATE ACCESS TO SERVICES FOR PLHIV, KEY POPULATIONS AND OTHER PRIORITY GROUPS IN ALL SECTORS | | | | |
|---|---|---|---|---|
| **KASF objective Strategic Direction** | **NCHASP Results** | **Key Activity** | **Indicators** | |
| Reduce HIV related stigma and discrimination by 50 per cent | Reduced HIV related stigma and discrimination by 50 per cent | Training on stigma reduction | Stigma index | |
| | | • Support formation of psychosocial support groups<br>• Integrate HIV information uptake in religious settings | • Number of psychosocial groups formed<br>• Number of religious groups sensitized | |
| | Reduced levels of sexual and gender-based violence for PLHIV, key populations, women, men, boys and girls by 50 per cent | Male engagement in HIV, SRH programs and interventions and offer them services | Number of male partners of women living with HIV and ANC clients | |
| | | Sensitize community on importance of uptake of HIV post-exposure prophylaxis among survivors of sexual violence and priority population | Number of community sensitization forums held | |
| | | Training of PLHIV, key populations, women, men, boys and girls on life skills | per cent persons trained on life skills | |
| | | Implement structural interventions that empower vulnerable populations, especially women and the young girls | Number of income generating activities (IGAs) initiated | |
| | | Sensitization of police, health care workers, Civil Societies and legal groups on SGBV support | Number of sensitization meetings held | |
| | | Strengthen linkages with psychosocial support groups for SGBV survivors | Number of referrals to psychosocial groups | |
| | Improve access to legal and social justice and protection from stigma and discrimination in the public and private sector by 50 per cent | Link SGBV survivors to gender response units within the county | Number of survivors linked to gender response units | |
| | | Educate communities on gender and legal issues affecting HIV | Number of community meetings | |
| | Improve county legal and policy environment for protection and promotion of the rights of priority, key populations and PLHIV | Sensitize law makers on the need to enact non-discriminatory regulations and services | Number of sensitization meetings held | |
| | Reduce and monitor stigma and discrimination, social exclusion, and gender based violence by 50 per cent | Conduct focused stigma index, social exclusion and human rights violation studies | Number of studies carried out | |
| | | Enroll vulnerable population into social protection Programmes | Percentage of persons enrolled in social protection programme | |

| | Baseline & Source | Mid Term Target | End Term Target | Responsibility |
|---|---|---|---|---|
| | 35 per cent - HIV stigma Index Report | 25 per cent | 18 per cent | CASCO |
| | 55- facility support groups register<br>0- Minutes of meeting | 60 (1 in each sub county)1 | 65<br>(2 in each sub county)<br>2 | CASCO |
| | 0- Minutes of meeting | 150 | 250 | CASCO |
| | TBD- minutes of meeting | 12 | 25 | CCSFP |
| | 17 per cent -School health reports | 25 per cent | 50 per cent | CSHC |
| | TBD-Social services report | 4 | 6 | Social Services |
| | 0- Minutes of meeting | 5 | 10 | CSOs/CASCO |
| | TBD- Referral reports | TBD | TBD | CASCO |
| | TBD-Gender response unit reports | TBD | TBD | CSOs |
| | 2-Community meetings report | 2 | 4 | CCSFP |
| | 0-sensitization meeting reports | 2 | 4 | CEC Health |
| | 0- HIV stigma index report | 1 | 2 | CCAC |
| | TBD- Social services reports | 25 per cent | 50 per cent | Social services |

| **STRATEGIC DIRECTION 4:** STRENGTHENING INTEGRATION OF HEALTH AND COMMUNITY SYSTEMS | | | | |
|---|---|---|---|---|
| **KASF objective Strategic Direction** | **NCHASP Results** | **Key Activity** | **Indicators** | |
| Build a strong and sustainable system for HIV service delivery at both national and county level through specific health and community systems approaches, actions and interventions to support the HIV response | Improved health workforce for the HIV response in the county | Training staffs on HIV management | Percentage of health workforce trained on HIV management | |
| | | Staff recruitment to improve overall staff: population ratio | Percentage of staffs recruited for HIV management | |
| | | Staff redistribution to ensure availability of appropriate competent skilled clinical personnel | Percentage of staffs on HIV management | |
| | Strengthened HIV commodity management | • Hold regular commodity TWGs meetings<br>• Carry out support supervision | Number of commodity TWG meetingsNumber of supervisory visits | |
| | | Develop & implement health staff retention policy that takes into account the additional HIV burden | Implementation of HR retention policy | |
| | | Empower communities and workplaces to ensure improved capacity and capability to take charge of their health | Number of community advocacy, information and education meetings | |
| | | Training of additional Community Units on HIV response | Number of C.Us trained on HIV response | |
| | | Conduct an inventory of all policies and statutory instruments likely to impact on the HIV/ AIDS response. | Policy document | |
| | | Increase health facilities offering HIV services | Number of health facilities offering HIV services | |
| | | Carry out data quality assessments (DQAs) | Number of DQAs | |
| | | Carry out laboratory panel testing | Number of people enrolled in PT | |
| | | Carry out pharmacovigilance | Number of pharmacovigilance reports | |
| | | Hold regular commodity TWGs meetings | Number of commodity TWG meetings | |
| | | Training on quantification and forecasting | • Number of staffs trained on quantification and forecasting<br>• Number of months with HIV commodity stock outs per year | |
| | | Strengthen supportive supervision | Number commodity support supervision visits | |
| | | Adequately equipping lower level laboratories | Number of lower level laboratories with pimaCD4 machines | |
| | | Procure biochemistry and haematology auto analyser | Number of health facilities with biochemistry and haematology auto analysers | |
| | | Regular maintenance of point of care CD4 machines, cyflow for CD4 testing and VL | Number of machines maintained | |
| | | Procurement of assorted laboratory reagents | Number of facilities reporting stock out | |

| | Baseline & Source | Mid Term Target | End Term Target | Responsibility |
|---|---|---|---|---|
| | County training data base | 15per cent | 25 per cent | CASCO |
| | 15 per cent- County human resource data | 20 per cent | 25 per cent | COH |
| | TBD-County human resource data | 20 per cent | 40 per cent | CHR |
| | 4- County TWG meeting minutes4- | 10 | 20 | CPHARM |
| | County HR | 1 | 1 | CHR |
| | CHP reports | 1 | 2 | CHPO |
| | TBD | 6 | 6 | CCSFP |
| | Inventory report | 1 | 1 | RHC NACC |
| | CASCO reports | 2 | 4 | CASCO |
| | DQA reports | 2 | 4 | CHRIO |
| | County PT data base | 100 | 200 | CMLT |
| | Pharmacovigilance report forms | 60 | 60 | CPHARM |
| | Minutes of meeting | 10 | 20 | CPHARM |
| | TBD<br>Facilities reporting HIV commodity stock out | 0 | 0 | CPHARM |
| | 4-Supervision reports | 10 | 20 | CPHARM |
| | 5- CMLT reports | 6 | 8 | CMLT |
| | 3- CMLT reports | 4 | 5 | CMLT |
| | Maintenance reports | 1 | 1 | CMLT |
| | 5-Laboratory report | 0 | 0 | CMLT |

| **STRATEGIC DIRECTION 5:** STRENGTHENING RESEARCH AND INNOVATION TO INFORM THE NYAMIRA COUNTY AIDS STRATEGIC PLAN GOALS | | | |
|---|---|---|---|
| **KASF objective Strategic Direction** | **NCHASP Results** | **Key Activity** | |
| 1. Reduce new HIV infections by 50 per cent | Increased evidence-based planning and programming by 20 per cent | Determine impact of alcohol &drug use on HIV prevention | |
| 2. Reduce AIDS related mortality by 25 per cent | Improve timely linkage to care for persons diagnosed for HIV | Determine HIV Transmission rate among adolescents an aware of status. | |
| 3. Reduce HIV related stigma and discrimination by 50 per cent | implementation of research on the identified NCHASP related HIV priorities | Conduct a focused stigma index, social exclusion & human rights violations. | |
| 4. Increase domestic financing of HIV response to 50 per cent | Increased capacity to conduct HIV research in the county by 10 per cent | Conduct integration research on HIV care & treatment into health insurance schemes | |
| | | Conduct county HIV research dissemination forums | |
| | | Strengthen county HIV research capacities including epidemiological surveillance, good laboratory, clinical practice and ethics | |

| **STRATEGIC DIRECTION 6:** PROMOTING UTILIZATION OF STRATEGIC INFORMATION FOR RESEARCH MONITORING AND EVALUATION TO ENHANCE PROGRAMMING | | | |
|---|---|---|---|
| **KASF objective Strategic Direction** | **NCHASP Results** | **Key Activity** | |
| Reduce new HIV infections by 50 per cent | Prudent / Result Based Monitoring &Evaluation systems integrated with the County Data review & reporting in place | Conduct Result Based M&E capacity assessment and development forums in the county | |
| 2.Reduce AIDS related mortality by 25 per cent | Increased utilization of strategic information to inform HIV response. | Establish functional multi-sectorial HIV M&E co-ordination structure | |
| 3.Reduce HIV related stigma and discrimination by 50 per cent | Research on Factors contributing to increased levels of stigma & discrimination of PLHIV | Conduct periodic data quality audits, by both Internal & external M & E Evaluators' data verification and supportive supervision | |
| 4.Increase domestic financing of HIV response to 50 per cent | Adequate & sustainable sources of finance to conduct Research on HIV response | Private partnership in HIV& AIDS Research | |

| | Indicators | Baseline & Source | Mid Term Target | End Term Target | Responsibility |
|---|---|---|---|---|---|
| | Number of Impact on alcohol &drug use HIV research conducted | 0 per cent | 1 | 2 | CASCO |
| | Number of Researches to Determine HIV Transmission rate among adolescents conducted | 0 per cent | TBD | TBD | CEC HEALTH |
| | Number of Researches conducted on focused stigma index ,social exclusion & human rights violations | 0 per cent | TBD | TBD | CASCO<br>CEC HEALTH |
| | Number of integration researches conducted on HIV care & treatment into health insurance schemes | 0 per cent | TBD | TBD | County Department of Finance<br>NACC<br>Implementing & Development partners |
| | Number of County HIV Research dissemination forums conducted | 0 per cent | TBD | TBD | CASCO<br>CEC HEALTH |
| | Number of County HIV Research capacity building meeting held | 0 per cent | TBD | TBD | CASCO<br>CEC HEALTH |
| | Number of epidemiological surveillance conducted | 0 per cent | TBD | TBD | CASCO<br>CEC HEALTH |

| | Indicators | Baseline & Source | Mid Term Target | End Term Target | Responsibility |
|---|---|---|---|---|---|
| | Number of M&E capacity assessment &development forums conducted in the County. | 0 per cent | TBD | TBD | CASCO<br>CHM&EC<br>CHRT |
| | Number of functional multi-sectorial HIV M&E co-ordination structure established | 0 per cent | TBD | TBD | CEC HEALTH |
| | Number of periodic data quality audits, by both Internal & external M& E Evaluators conducted | 0 per cent | TBD | TBD | CASCO<br>CEC HEALTH |
| | Number of HIV & AIDS meeting conducted in partnership with private sector. | 0 per cent | TBD | TBD | County Department of Finance<br>NACC<br>Implementing & Development partners |

| **STRATEGIC DIRECTION 7**: INCREASING DOMESTIC FINANCING FOR A SUSTAINABLE HIV RESPONSE | | | | |
|---|---|---|---|---|
| **KASF objective** | **CASP Results** | **Intervention** | **Key Activity** | |
| Increase domestic financing by 50% | Increased county financing for HIV response by 20 percent<br>Coordination of all resources available for the HIV response in the county to avoid duplication of efforts.<br>Maximize efficiency of existing HIV delivery options for increased value and results within existing resources<br>Aligning HIV resources/ investment to strategic plan priorities | Innovative and sustainable domestic HIV financing options in the county | Participation in the Annual county budgetary making cycle to ensure resource lobby. | |
| | | Strengthen public private partnership engagement at all levels at the county and sub-county through regular PPP forums | Number of PPP forums organised | |
| | | Initiate an annual AIDS lottery program. | No .of lottery programs initiated | |
| | | Organize High level Engagement with the county stakeholders to advocate for domestic financing. | no. of high level meetings held with the stakeholders | |
| | | Build and enhance capacity of civil society organization to achieve self financing and sustainability. | %.of CSOs trained on self sustainability concepts | |
| | | Creation of an information hub for the county to track resources from all partners | functional information hub developed | |
| | | Carry out cost benefit analysis on the HIV/ AIDS programs. | report on cost benefit analysis | |
| | | Align the HIV and AIDS response within the local context | county HIV strategic plan developed and disseminated | |
| | | Carry out a needs assessment on key priority interventions | assessment report | |

| **STRATEGIC DIRECTION 8:** PROMOTING ACCOUNTABLE LEADERSHIP FOR DELIVERY OF KASF RESULTS BY ALL SECTORS | | | | |
|---|---|---|---|---|
| **KASF objective** | **NCHASP Results** | **Intervention** | **Key Activity** | |
| 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 county ownership of the HIV response | High level engagement with the office of the governor and members of the county assembly to obtain Political will and commitment in the implementation of the strategic plan | |
| | | | High level engagement of MCAs and the county assembly executive to create awareness on the county HIV responses | |
| | | | Enact legislation that are HIV county specific based on the priorities | |
| | | | Institutional coordination and ownership of the county HIV strategic plan | |
| | Effective and well-functioning stakeholder co-ordination and accountability mechanisms in place and fully operational zed at county and sub-county levels | Entrench good governance and strengthen multi-sector and multi-partner accountability to delivery of NCHASP results | Joint NCHASP annual implementation review meetings with the stakeholders ,implementers and partners involved in the HIV/AIDS response within the county | |
| | | | Regular update meetings to Ensure accountability for performance and results by all implementing partners at the county | |
| | An enabling policy, legal and regulatory framework for the multi-sectoral HIV and AIDS response strengthened and fully aligned to the Constitution of Kenya 2010. | Establish functional HIV co-ordination mechanism at county and sub-county levels | Hold regular county and sub-county stakeholders Fora to create awareness on key HIV interventions envisaged in the strategic plan | |
| | | | Tracking and monitoring of the resources during the strategic plan implementation, monitoring and evaluation | |
| | | | Annual Joint HIV /AIDS program review at the county LEVEL | |

| | Indicator | Baseline | Mid Term Targets(2017) | End Term Targets (2019) | RESPONSIBILTY |
|---|---|---|---|---|---|
| | Number of public participations attended | NONE | 2 | 4 | NCG |
| | TBD | 8 | 16 | Implementing Partners | |
| | none | 2 | 4 | Dev. Partners | |
| | TBD | 4 | 8 | Community | |
| | TBD | 50% | 100% | County Assembly | |
| | None | 1 | 1 | County government through the health services sector | |
| | TBD | 100% | 100% | | |
| | None | 100% | 100% | NCG | |
| | TBD | 100% | 100% | NCG | |

| | Indicator | Baseline & Source | Mid Term Targets | End Term Targets | RESPONSIBILTY |
|---|---|---|---|---|---|
| | No of the high level engagement done | TBD | 2 high level engagement held (2 sessions per year) | 4 high level engagement Held | Office of the Governor |
| | # of high level engagement with MCAs held | TBD | 4 sessions held | 8 sessions held | County executive for Health |
| | No. of legislation enacted on HIV/ AIDS | TBD | 10 legislation enacted on HIV and AIDS | 15 legislation enacted on HIV county response | Members of the county assembly |
| | no.of functional coordination units throughout the strategic implementation cycle | None | 4 CASP coordination structures constituted | 4 CASP Coordination structures constituted | NACC |
| | no.of annual casp implementation review meetings held | none | 2 | 4 | NASCOP |
| | no.of performance and accountability meetings held | none | 8 | 16 | County Government |
| | no.of stakeholders fora conducted | None | 8 | 16 | NACC |
| | No. of M&E reports compiled and submitted | none | 2 | 4 | NASCOP |
| | annual HIV/AIDS program review report | None | 2 | 4 | |

## Annex 2: REFFERENCES


1. NASCOP (2013), Kenya AIDS indicator Survey 2012. Nairobi: NASCOP (NASCOP, 2009)
2. NACC, NASCOP, UNAIDS (2013), Kenya HIV Prevention Revolution Roadmap: Count Down to 2030, Nairobi, Kenya.
3. NACC, NASCOP (2014). Kenya HIV Estimates report. Nairobi, Kenya;
4. NACC, NASCOP (2012), Kenya AIDS Epidemic Update Report 2012. Nairobi, Kenya
5. NASCOP (2014), Kenya AIDS Preliminary Report Cohort analysis. Nairobi, Kenya
6. Kaiser, R., R. Bunnell, A. Hightower, A. A. Kim, and P. Cherutich, (2011) Factors Associated with HIV Infection in Married or Cohabitating Couples in Kenya.
7. NACC; 2009, Kenya National Aids Strategic Plan, 2009-2013-Delivering on universal access to services. NACC, Nairobi, Kenya
8. NACC (2014), End Term Review: Kenya National AIDS Strategic Plan 2009 – 2013. NACC, Nairobi, Kenya
9. Kenya constitution 2010
10. NACC, UNAIDS (2014), Kenya HIV County Profiles, HIV and AIDS response in my County-My Responsibility. Nairobi, Kenya; 2014.
11. NASCOP and NACC. (2012). Geographic Mapping of Most at Risk Populations for HIV (MARPs) in Kenya. Nairobi.
12. NASCOP (2012), Guidelines for Prevention of Mother to Child Transmission (PMTCT) of HIV and AIDS in Kenya, 4th edition.
13. UNAIDS (2014), 90-90-90 An Ambitious Treatment Target to help end the AIDS epidemic, UNAIDS, Geneva
14. NACC (2014), Kenya National AIDS Spending Assessment for financial years 2009/10 – 2011/12. NACC: Nairobi
15. NACC (2014), Establishing a Trust Fund to Ensure Sustainable Financing of HIV and AIDS in Kenya. NACC: Nairobi
16. NACC (2014). Cost requirements for Kenya AIDS Strategic Framework 2014/14 – 2018/19. NACC: Nairobi
17. Government of Kenya (2014), The Costs and Returns to Investment of Kenya's Response to HIV and AIDS: a HIV investment case technical paper. NACC: Nairobi
18. NACC, UNAIDS and OPM (2012), Sustainable financing for HIV and AIDS in Kenya: Oxford Policy Management: Oxford
19. Korongo, A, D Mwai, A Chen, N Judice and T Oneko (2014). Analysis of the social feasibility of HIV and AIDS programs in Kenya: Sociocultural barrier, facilitators, and the impact of devolution. Washington, DC: Futures Group, Health Policy Project.

20. Anderson, et al., (2014) Enhancing the Efficiency and the Effectiveness of the AIDS Response with Priority Areas for Prevention, The Lancet, Vol. 384 (July 19, 2014), pp. 249-56.

21. Wang'ombe, et al., (2013) Optimizing the Response of Prevention: HIV Efficiency in Africa (ORPHEA) – Presentation of Results, presented at HIV Efficiency & Effectiveness (E2) Meeting, November 11, 2013, Panafric Hotel, Nairobi

22. UNAIDS (2013), Smart investments. UNAIDS, Geneva

23. Dutta, Arin, I Mukui, P Iyer, and D Mwai. 2012. Training and mentoring clinical health workers in Kenya: Efficiency gained from the proposed harmonized HIV Curriculum. Washington, DC: Futures Group, Health Policy Project.

24. Mbote, David K, Kip Beardsley and Ryan Ubuntu Olson. 2014. Policy Analysis and Advocacy DecisionnModel for Services for Key Populations in Kenya. Washington, DC: Futures Group, Health Policy Project].

25. Mugoya, GC and Emst, K. (2014) Gender Differences in HIV-Related Stigma in Kenya. Aids Care: Psychological and Socio-Medical Aspects of AIDS/HIV. Volume 26, Issue 2.

26. KNBS (Kenya) 2008-2009 Kenya Demographic and Health Survey 2008-09 Preliminary report.Calverton, Maryland, KNBS, NACC, NASCOP, NPHLS, KMRI, ICF Macro September 2009

27. KDHS, K. N. B. S., (2009) Projections from Kenya 2009 Population and Housing Census, Nairobi: KNBS.

28. Study on Human Rights violations against people living with HIV and AIDS in Kenya by KELIN, KANCO UNAIDS, NACC, UNDP (2012) retrieved from http://kelinkenya.org/wp-content/uploads/2010/10/Human-Violation-book-final.pdf

29. KPMG (2011) The People living with HIV Stigma Index http://www.kpmg.com/eastafrica/en/IssuesAndInsights/ArticlesPublications/Documents/People%20Living%20with%20HIV%20Stigma%20 Index%20in%20Kenya.pdf

30. NACC (2009). Kenya HIV Prevention Response and Modes of Transmission Analysis. Nairobi: National AIDS Control Council.

31. Barker C., Mulaki A., Mwai, D., Dutta A. (2014) 'Assessing County Health System Readiness in Kenya: A Review of Selected Health Inputs'. Washington, DC: Futures Group, Health Policy Project.

32. The National HIV and AIDS Monitoring and Evaluation Research Framework 2009-2013

33. The Constitution of Kenya, 2010

34. The Public Finance Management Act, No. 18 of 2012

35. The County Government Act, No. 17 of 2012

36. The National Government Coordination Act, No. 1 of 2013

37. The Urban Areas and Cities Act, No. 13 of 2011

38. The Intergovernmental Relations Act, 2012

## Annex 3: LIST OF COUNTY DRAFTING AND TECHNICAL REVIEWING TEAMS

### DRAFTING TEAM

| | | |
|---|---|---|
| 1. | Moses Omayio | Civil Society Organizations Representative |
| 2. | Akoum Richard | NASCOP |
| 3. | Rosemary Otiende | MOH |
| 4. | Jairus Ongaga | MOH |
| 5. | John Kamundia | CACC |
| 6. | Abel Omao | MOH |
| 7. | Barlynz Kanyango | APHIA PLUS |
| 8. | Nathan Onduma | Ministry of Planning |
| 9. | Irene Omwenga | CASCO |
| 10. | David Gekara | MOH |
| 11. | Dennis Marwanga | NACC |

### REVIEWING TEAM

| | | |
|---|---|---|
| 1. | Elly Assurah | KEMRI Search |


maisha!
National AIDS Control Council


The Global Fund
To Fight AIDS, Tuberculosis and Malaria


COUNTY GOVERNMENT OF NYAMIRA
County of Possibilities