Republic of Kenya

MOMBASA COUNTY
HIV & AIDS
STRATEGIC PLAN
2016/2020

"My County,
My Responsibility"

Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

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NATIONAL AIDS CONTROL COUNCIL

MOMBASA COUNTY
UTANGAMANO KWA MAENDELEO

MOMBASA COUNTY

HIV & AIDS

STRATEGIC PLAN

MCASP 2016 – 2020

Map of Mombasa County

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Acronyms and Abbreviations

AHF	AIDS Healthcare Foundation
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
CASCO	County AIDS and STI Coordinator
CASM	County AIDS Sectoral Mainstreaming
CDH	County Director of Health
CEC	County Executive Committee
CHMT	County Health Management Team
CHRIO	County Health Records Information Officer
CHS	Community Health Strategy
CHVs	Community Health Volunteers
CBOs	Community Based Organizations
CSOs	Civil Society Organizations
CUs	Community Units
DHIS	District Health Information System
DSW	Deutsche StiftungWeltbevoelkerung
eMTCT	Elimination of Mother to Child Transmission
FHOK	Family Health Options of Kenya
FY	Financial Year
GBV	Gender Based Violence
HCBC	Home and Community Based Care
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
IBBS	Integrated Biological and Behavioural Surveillance
IPR	Institute for Primate Research
KAADM	Kenya Adolescents Assessment and Decision Makers tool
KAIS	Kenya AIDS Indicator Survey
KASF	Kenya AIDS Strategic Framework
KDHS	Kenya Demographic Health Survey
KETAM	Kenya Treatment Access Movement
KEMSA	Kenya Medical Supplies Authority
KHSSP	Kenya Health Sector Strategic Plan
KMOT	Kenya Modes of Transmission
KNASP	Kenya National AIDS Strategy Plan
KNBS	Kenya National Bureau of Statistics
KPs	Key Populations
KRCS	Kenya Red Cross Society
MARAs	Most At Risk Adolescents
MARPs	Most at Risk Populations
MAT	Medically Assisted Therapy
MCASP	Mombasa County AIDS Strategic Plan
MNCH	Maternal Newborn Child Health
MoEST	Ministry of Education, Science and Technology
MOT	Modes of Transmission
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
NACC	National AIDS Control Council
NACOSTI:	National Council for Science and Technology
NASCOP	National AIDS and STI Control Programme
NCDs	Non Communicable Diseases
NSP	Needles and Syringe exchange Program
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
PHC	Primary Health Care
PHDP	Positive Health, Dignity and Prevention
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PWD	People With Disabilities
PWID	People Who Inject Drugs
SCACC	Sub-County AIDS Community Coordination
SRH	Sexual and Reproductive Health
SW	Sex Workers
TB	Tuberculosis
TBP	To Be Provided
TOTs	Trainers of Trainers
TWGs	Technical Working Groups
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
WOFAK	Women Fighting AIDS in Kenya
WHO	World Health Organization
YFS	Youth Friendly Services

Mombasa County AIDS Strategic Plan 2016 – 2020

Foreword

HIV and AIDS remains among the greatest public health concerns not only for Mombasa County but also in Kenya. The epidemic has continued to cause deaths and suffering among residents, tearing the social and community fabric and decimating the workforce. Its effects are experienced in the entire spectrum of our County. HIV and AIDS is among the leading causes of deaths in Mombasa County. Mombasa County has reduced the HIV prevalence from 11.1% (KAIS 2012) to the current estimated 7.4% in 2014. This has been through scaling up of HIV prevention education, provision of HIV testing services and also ensured adult treatment coverage of over 60% for those in need of ARVs in accordance with the new treatment guidelines by the World Health Organization (WHO).

More work still needs to be done. The County HIV prevalence currently stands at 7.4%. This is higher than the national prevalence of 6%. With annual new infections of 1,609 persons, Mombasa is among the top counties burdened by HIV. We have a Constitutional obligation of attending to and ensuring that the 54,600 people living with HIV are granted quality care, treatment and support. Furthermore, we must scale up paediatric treatment and ensure that the current HIV incidence is reduced. There are children orphaned by HIV and households ravaged by AIDS that we must put into the county social safety nets. Persons living with HIV should also be given a higher priority within our county set-up.

Mombasa County HIV epidemic brings forth varying dynamics in respect of the modes of transmission and population demographics. The County's HIV trends exhibit both characteristics of general and concentrated epidemic. Identified groups of key and priority populations continue to be vulnerable to acquisition and transmission of HIV. This strategic plan underscores the need to address health service delivery amongst the various populations with emphasis towards reversing the annual incidence. MCASP 2016 – 2020 envisages strong leadership based on the principle of participation, involvement and multi-sectorality. It provides guidance on how the County will scale up interventions which are geared towards achieving the County's set objectives, in line with Kenya's development blue-print, Kenya Vision 2030.

We, as the County Government of Mombasa therefore reiterate our commitment to the implementation of all provisions of the Mombasa County HIV and AIDS Strategic Plan (MCASP 2016 – 2020) and also urge all actors in this field including the Development Partners in Mombasa County to align their HIV programming and funding to the Plan.

H.E. ALI HASSAN JOHO
THE GOVERNOR - MOMBASA COUNTY

Preface

The Mombasa County AIDS Strategic Plan (MCASP 2016 – 2020) marks a great turning point for the County's HIV response. It provides an opportunity for county owned and driven interventions that take into consideration the geographical and population diversities of Mombasa County. MCASP seeks a prudent utilization of resources and collaborative platforms to increase synergy and efficiency in HIV programming. In developing the MCASP, the County Health Department and our implementing partners have taken into account the social, political, cultural and development dynamics of the County thus creating an opportunity for a multi-sectoral response. In addition, MCASP seeks a paradigm shift in HIV and AIDS response that will see a closer attention to behavioural and structural interventions to compliment the biomedical component. Through an elaborate results framework and designed evidence gathering mechanisms spelt out in this Strategic Plan, all players will therefore be required to prioritize their programmatic activities in accordance to this plan. The objectives of the MCASP 2016 – 2020 will results in a reduction of new infections, scaling up of treatment and care, and will mitigate the negative social and economic impacts of HIV and AIDS. To achieve this and more, MCASP has four Strategic Objectives which are aligned to the Kenya AIDS Strategic Framework (KASF) and other relevant policies and guidelines that guide health as well as HIV and AIDS response nationally and globally. The four Strategic Objectives of the MCASP are:

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

To attain these objectives, MCASP spells out eight Strategic Directions which include reduction of new HIV infections and improving health outcomes of persons living with HIV and other priority populations. The County Health Department will continue providing strong leadership and fostering partnerships in order to achieve the set MCASP objectives.

HON. MOHAMED ABDI
COUNTY EXECUTIVE FOR HEALTH
MOMBASA COUNTY

Acknowledgements

It is our joy to present the Mombasa County AIDS Strategic Plan 2016 – 2020 which provides the foundation for the County's HIV response. This Strategic Plan will provide a mechanism for HIV programming among all stakeholders in the County. It provides guidance and seeks to outline key areas of investment in HIV prevention.

This plan has been developed through the efforts of bold individuals. Hence, we would like to extend our appreciation to the leadership of the County Government of Mombasa for being instrumental in steering this noble process. We thank the Mombasa County Department of Health and County Health Management Team (CHMT) for taking the lead in the entire process. Thanks to the national and regional offices of National AIDS Control Council (NACC) and National AIDS and STI Control Programme (NASCOP) for providing both technical and resource support that saw the process come to fruition. To the members of MCASP working groups, who tirelessly worked towards the completion of this document, we say thank you very much for your sacrifice.

There are those key stakeholders, implementers and partners too, either from the County and Regional (Coast) or National levels. To the networks of Persons Living with HIV (PLHIVs), Persons Living with Disability (PLDs), representatives from all priority populations, members of the public and private sector, thank you for your valuable input and contribution that enriched the entire process.

We are also grateful for the contribution, commitment and efforts of various partners during the development of the process of this Strategic Plan. Our sincere gratitude goes to Family Health Options Kenya (FHOK) and Women Fighting AIDS in Kenya (WOFAK), Pathfinder International, and Trace Kenya, AIDS Health Foundation-Kenya (AHF-K), for their technical, financial and logistical support in the course of the development of this Strategic Plan. As a County, we are committed to the implementation of this plan.

DR. KHADIJA SOOD SHIKELY
CHIEF OFFICER OF HEALTH
MOMBASA COUNTY

Comments from NACC Director

The National AIDS Control Council (NACC) is proud to be associated with Mombasa County in the development of its first HIV and AIDS Strategic Plan (MCASP 2016 – 2020). The plan underscores the principle of multi-sectoral approach in responding to the HIV and AIDS epidemic in the County. Further, through well set objectives, clearly defined strategic interventions that are guided by the Kenya AIDS Strategic Framework (KASF 2016 – 2020), MCASP seeks to strengthen coordination structures, streamline service delivery systems towards attainment of the targets.

With a HIV prevalence of 7.4%, a HIV burden of 54,600 persons, an annual HIV incident of 1,609 persons (National HIV and AIDS Estimates, 2014), Mombasa is ranked among the high HIV epidemic counties. Notably, Mombasa County is also critical to the national HIV response. With HIV and AIDS exhibiting a marked dynamics in terms of geography and population; especially with the existence of population of priority, gains made by the county in responding to the epidemic are expected to be translated to the national gains. It is for that reason that the county has currently been identified for piloting the HIV combination prevention strategies (COMBO).

The National AIDS Control Council will continue working closely with Mombasa County during the period of the MCASP implementation, tracking and measurement of the results and strengthening the institutions that respond to HIV and AIDS. Our gratitude to the County Government of Mombasa, key partners and stakeholders whose valuable contribution made the MCASP development process possible.

DR. NDUKU KILONZO
DIRECTOR- NATIONAL AIDS CONTROL COUNCIL (NACC)

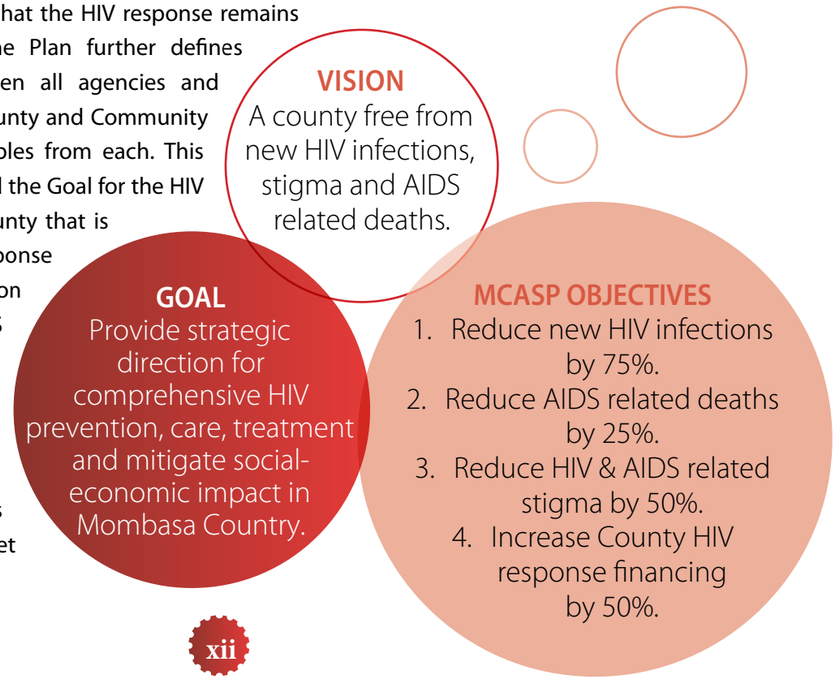
Executive Summary

With approximately 54,600 persons living with HIV in the county (National HIV Estimates, 2014), Mombasa County is ranked amongst the ten highest burdened in the country. The County exhibits characteristics of both general and concentrated epidemic in terms of population and geography. Whereas the County Prevalence stands at 7.4%, against the national prevalence of 6%, HIV prevalence in the identified populations such as women, adolescents and youth remains comparatively high with prevalence among Key Populations (such as Persons Who Inject Drugs, Men who have Sex with other Men, and Sex Workers) being as high as 18-20%. The County's annual new HIV infection among adults is 1,609 persons. Notably, 44% of new infections occur among Key Populations. Despite gains made on ANC and PMTCT, 171 new born infants are infected with HIV annually. This number is significant considering the global push toward elimination of mother to child HIV transmission.

Home delivery among pregnant women still remains high. In the year 2013, 71% of pregnant women living with HIV did not deliver in a health facility while only 52% of pregnant women attended the recommended four antenatal visits in the same period. Paediatric ART coverage remains low at 42% (National HIV Estimates 2014). The County's sectoral advantages in tourism and transport (port, ferry-docks, standard gauge railway and other nation's mega infrastructure) bear adverse effects to the population. These tend to increase vulnerability to HIV and risky sexual behaviours associated with sex work and abuse of drugs. Mombasa AIDS Strategic Plan 2016 – 2020 is a guide to coordination and implementation of the HIV response. In addition, it further serves as a resource mobilization and accountability tool for all players in the County.

MCASP 2016 – 2020 ensures that the HIV response remains a multi-sectoral function. The Plan further defines working relationships between all agencies and organs at the County, Sub-County and Community levels and expected deliverables from each. This plan sets out a clear Vision and the Goal for the HIV and AIDS response in the County that is hinged on the nation's HIV response as spelt out by KASF. Reduction of new HIV infections, AIDS related mortality, and stigma are among the expected results of this Plan.

MCASP 2016 – 2020 envisages eight Strategic Directions as vehicles of achieving the set objectives while each Strategic Direction is backed by a set of identified and priority interventions, expected results, targets and recommended activities/actions for achieving the targets. In addition, MCASP 2016 – 2020 spells out a clear four-year work plan and assigns responsibility to various entities both at the county and national governments and agencies. In addition, MCASP 2016 – 2020 seeks to leverage the existing sectoral advantages such as tourism, transport and private sectors in Mombasa County in the attainment of the objectives.



Mombasa County AIDS Strategic Plan 2016 – 2020

Chapter 1

Mombasa County Background Information

Mombasa County lies between latitudes 3056' and 4010' south of the Equator and between longitudes 39034' and 39046' east of Greenwich Meridian. The County borders Kilifi County to the North and North-West, Kwale County to the South and South-West, and Indian Ocean to the East. It has a land mass area of 229.9 sq. km and a water mass area of 65 sq. km which extends to 200 nautical miles into the Indian Ocean. The population of Mombasa County is projected to be 1,179, 929 (KNBS, 2015). Mombasa County is strategically placed owing to its advantage as the gate-port to east and central Africa and also its role in tourist attraction.

The County is divided into six administrative and legislative sub-counties. These are Changamwe, Jomvu, Mvita, Likoni, Nyali and Kisauni. Mvita Sub-County constitutes the main island of the County. Kisauni Sub-County/Constituency has the highest population representing 20.7% of the County population. The productive population (25-59 years) for Mombasa County in 2015 was estimated to be 358,693 while the dependent population was 734, 884. More than one third of the population is under 15 years old.

Table 1.1: Demographic indicators for Mombasa County

Population by age group	Value
Estimated total population (all ages)	1,179,929
Estimated population of women of reproductive age (ages 15-49)	290,263
Estimated population of adolescents (ages 10-19)	202,688
Estimated population of adolescents (ages 10-14)	99,302
Estimated population of adolescents (ages 15-19)	103,386
Estimated population of young people (ages 20-24)	144,228
Estimated population of adolescent girls (ages 10-19)	105,251
Estimated population of adolescent girls (ages 10-14)	50,386

Estimated population of adolescent girls (ages 15-19)	54,865
Estimated population of adolescent girls (ages 20-24)	72,885
Estimated population of adolescent boys (ages 10-19)	97,437
Estimated population of adolescent boys (ages 10-14)	48,916
Estimated population of adolescent boys (ages 15-19)	48,521
Estimated population of adolescent boys (ages 20-24)	71,343
Percent of the estimated population that is adolescents (aged 10-19)	17%

Source: KNBS (2015)

Mombasa County has made several gains in HIV and AIDS response. A combination of interventions undertaken has resulted in a decrease in prevalence from the estimated 11% in 2012 to the current 7.4% (Kenya HIV Estimates, 2014). HIV treatment coverage for adults stands at 60% while PMTCT coverage is at 78% (National HIV Estimates, 2014). The County has strengthened support structures for persons living with HIV through robust grass root organizations that are linked to the Community Health Strategy. The County Government, through the Mombasa County Health and Investment Plan, continues to strengthen the entire spectrum of health service delivery through equipping health facilities and addressing human resource gaps. Despite the mentioned gains, the HIV and AIDS epidemic remains a challenge for the County. With approximately 54,600 persons living with HIV (National HIV Estimates Report, 2014), the County ranks amongst the highest burdened in the country. New adult annual HIV infection rate remains unacceptably high at 1,609 people. Similarly, despite gains made on ANC and PMTCT service delivery, 171 new born infants acquire HIV annually with home deliveries among mothers still remaining high.

In the year 2014, 71% of pregnant women living with HIV did not deliver in a health facility while in 2013; only 52% of pregnant women attended the recommended four antenatal visits in the same period. Paediatric ART coverage remains low in Mombasa at 42%. Further, addressing HIV and AIDS transmission and acquisition in the County continues to be a challenge due to the existence of identified Key Populations such as men who have sex with men, sex workers, and persons who inject drugs. These are estimated to contribute 44% of new HIV infections annually in the region. HIV remains the lead cause of deaths in Mombasa County.

The productive population (25-59 yrs) of Mombasa County was estimated to be 358,693 while the dependent population was 734,884 in 2015. More than 30% of the population is below 15 years while adolescents (10-19yrs) constitute 17% .

In 2014, 71% of pregnant women living with HIV in Mombasa County did not deliver in a health facility

(County HIV Profiles, 2015)

Chapter 2

Situational Analysis

Mombasa County, like most parts of the country, has made several gains in HIV and AIDS response. The biomedical, structural and behavioural interventions undertaken have resulted in a decrease in HIV prevalence from an estimated 11.1% to the current 7.4% (Kenya HIV Estimates, 2014). Other gains include scaling up of ART coverage, HIV zero status awareness to 70% and PMTCT coverage to 78% (National HIV Estimates, 2014). Support structures for persons infected and affected by HIV and AIDS have been established and community response strengthened through funding of grassroot organizations and establishment of community units. The County Government, through the Mombasa County Health and Investment Plan, continues to strengthen the entire spectrum of health service delivery through equipping health facilities and addressing human resource gaps. Despite the mentioned gains, HIV and AIDS epidemic remains a challenge for the County.

With approximately 54,000 persons living with HIV (Kenya HIV Estimates 2014), the County ranks among the highest burdened in the country. New adult annual HIV infection rate remains unacceptably high at 1,609 people in the County. Similarly, despite gains made on ANC and PMTCT, 171 new born infants acquire HIV annually. In the year 2014, 71% of pregnant women living with HIV did not deliver in a health facility while in 2013, only 52% of pregnant women attended the recommended four antenatal visits in the same period. Paediatric ART coverage remains low in Mombasa County at 42%. Despite the huge importance of HIV testing as a way of increasing prevention and treatment, about 73% of people in Mombasa County had never tested for HIV by 2009 (Kenya HIV County Profiles, 2014).

Table 2.1 : Summary of key HIV&AIDS indicators

INDICATOR	MOMBASA
Total Population (2013)	1,179,929
HIV adult prevalence (overall)	7.4%
HIV prevalence among women	10.5%
HIV prevalence among men	4.5%

Number of adults living with HIV		47,800
Number of children living with HIV		6,870
Total number of people living with HIV		54,670
% of people never tested for HIV by 2009		73%
% of HIV Positive pregnant women who do not deliver in a health facility		71%
New adult HIV infections annually	County	1,609
	National Estimate	88,620

(HIV Estimates 2014)

Table 2.2: Ranking of top 10 causes of morbidity & mortality in Mombasa County

Major conditions causing death	Rank
HIV/TB co-infections	1
Pneumonia	2
Malaria	3
Cancer	4
Diarrhea diseases	5
Tuberculosis	6
Hypertension	7
Anaemia	8
Diabetes	9
Neonatal sepsis	10

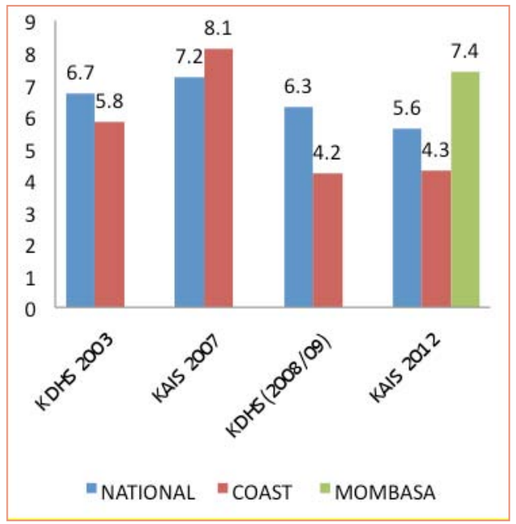
(Source: Annual Performance Report on Implementation of Health Services; CHD; 2015)

2.1 HIV Epidemic Analysis

2.1.1 HIV Prevalence Trends

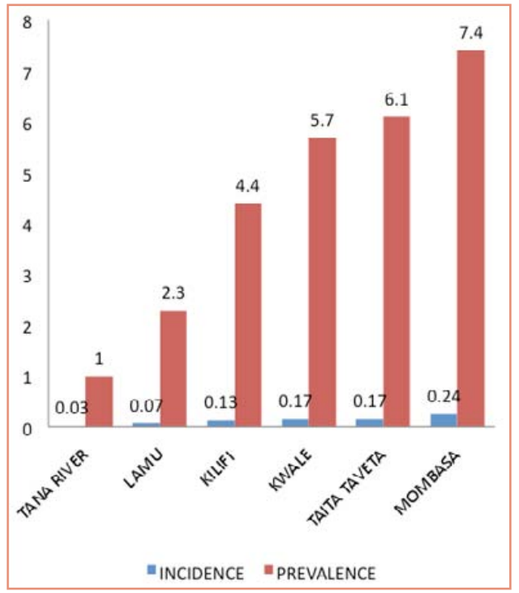
At a prevalence of 7.4 % (National HIV Estimates, 2014), Mombasa County has the highest prevalence in the entire Coast region, higher than the Coast Region HIV prevalence of 4.2% (KAIS 2012). The County HIV prevalence is also higher than the national prevalence of 5.6 % (KAIS 2012). HIV prevalence in Mombasa County declined from 11.1% in 2009 to the current 7.4%. This was attributed to sustained biomedical, behavioural and structural interventions by both the national and the county governments and the partners. Conducive HIV programming environment has seen an improved program focus to key and priority populations. Much needs to be done to reduce HIV prevalence in Mombasa County.

Figure 2.1: Comparison of National, Regional and County HIV Prevalence



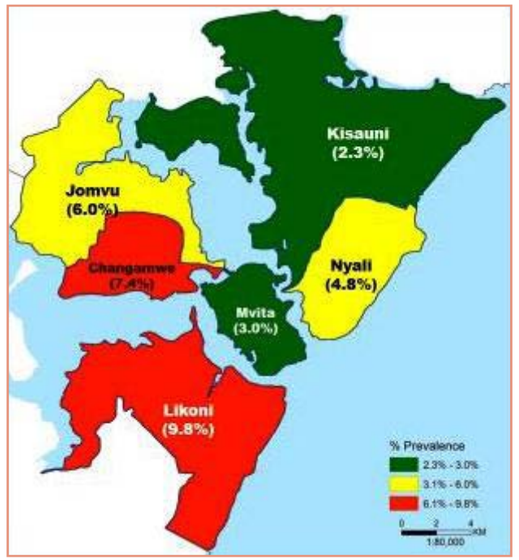
(Kenya Demographic Health Survey 2003, 2008/9, Kenya AIDS Indicator Survey 2007, 2012)

Figure 2.2: HIV Prevalence and Incidence in Coast Region counties



2.1.2 HIV Prevalence by Sub-County

Figure 2.3: Mombasa Sub-County HIV Prevalence



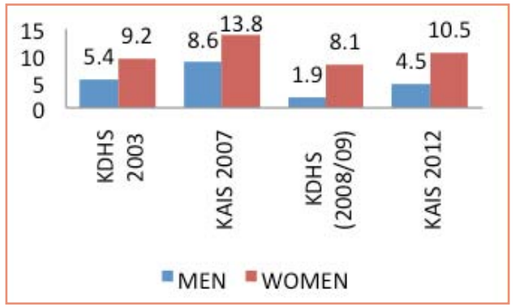
Source: PEPFAR Funded Global Health Project 2014

HIV prevalence is higher in Likoni, Changamwe and Jomvu sub-counties; a factor attributed not only to larger populations in these sub-counties, but also increased infrastructure activities occasioned by highways and main connecting roads.

2.1.3 HIV Prevalence by Sex

Women continue to bear disproportionate impacts of HIV epidemic in Mombasa. Data shows that the HIV prevalence is two times higher among women than men.

Figure 2.4: HIV Prevalence by Sex



Source: (Kenya Demographic Health Survey 2003, 2008/9, Kenya AIDS Indicator Survey 2007, 2012)

2.1.4 The Key Population Factor

Key Populations remain the largest contributor of new HIV infections in Mombasa County. Kenya Modes of Transmission Study (KMOT, 2009) estimated that 44% of new infections in the Coast Region result from four sub-populations; Men who have Sex with Men (MSM), Prison Populations, People Who Inject Drugs (PWIDs), Sex Workers (SWs) and their clients. Reports indicate that HIV Prevalence among these groups is two to three times the national HIV Prevalence.

Table 2.3: National and Regional HIV Prevalence comparison by Key Population groups

GROUPS	NATIONAL	COAST
Heterosexual sex with union/regular partnership	44.1%	37.9%
Casual heterosexual sex	20.3%	14.9%
Sex workers and clients	14.1%	18.2%
MSM and prisons	15.2%	20.5%
Injecting Drug Users	3.8%	6.1%
Health Facility Related	2.5%	2.3%
Number of new infections	76,315	6,656

Source: Kenya Modes of Transmission Study 2009 (KMOT 2009)

The table below estimates there may be at least 16,000 Key Populations in Mombasa County. Although their overall population size is smaller, these sub-groups are at an increased risk of acquiring and transmitting HIV. Evidence shows that injecting with contaminated needles is the most efficient mode of HIV transmission. NASCOP has identified over 100 hotspots where KPs congregate. At least 50 hotspots are drug-using dens. While various civil society organizations are striving to deliver targeted HIV prevention interventions to reduce HIV transmission, unfortunately, the package of services as well as the geographical coverage is quite limited.

Table 2.4: Comparison of National, Regional and County Key Populations size estimates

KP	NATIONAL	COAST	MOMBASA
SWs	133,675	20,143	11,660
PWIDs	18,327	8,500	3000
MSMs	19,175	2,162	1,026

Source: (Kenya MARPs Size Estimations Consensus Report, 2013, National Guidelines for HIV/STI programming for key populations)

Figure 2. 5: Graphical comparison of National and Regional HIV Prevalence by KP

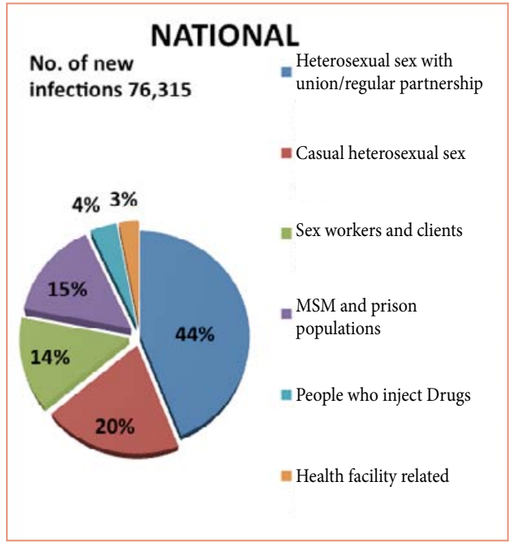


Figure 2. 6: Graphical representation of Coast Region HIV Prevalence by KP

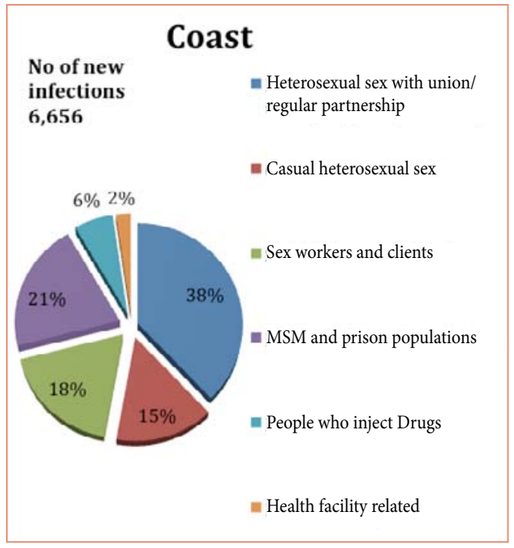


Table 2.5: PWID risk assessment

	Nairobi	Coast
Estimated number of PWID	6216	8500
% Female	9%	9%
HIV prevalence total	18	18-20
Female	40-60	49
Male	16	15
Sexual risk		
Condom use	Low	Low
Multiple partners	23	15
Transactional sex	18	20
Injection behaviour		
Daily injection	80-100	100
Any unsafe injection	80%	47%+
Shared needle	17%	17%

(Kenya Consensus Report, UNODC RSA, IBBS)

In spite of the above burden, interventions targeting key and priority populations in Mombasa and Coast have been limited or in some instances lacking. Most HIV programs for key populations are undertaken by CBOs and CSOs with minimal involvement of government at all levels.

Figure 2.7: Implementers of the County HIV response

It is however encouraging to note that the Mombasa County Government has recently taken great strides in offering medically assisted therapy (MAT) using methadone for PWIDs and also continuously supported CSOs implementing drug harm reduction programs.

- **Facts about Key Populations:**
  - HIV prevalence among key populations is twice or thrice the national prevalence, i.e. 15-20%
  - One in every two women who inject drugs is HIV positive
  - The 3 main sub-groups of key populations contribute 44% of new infections annually in Coast Region

2.1.5 Priority Populations

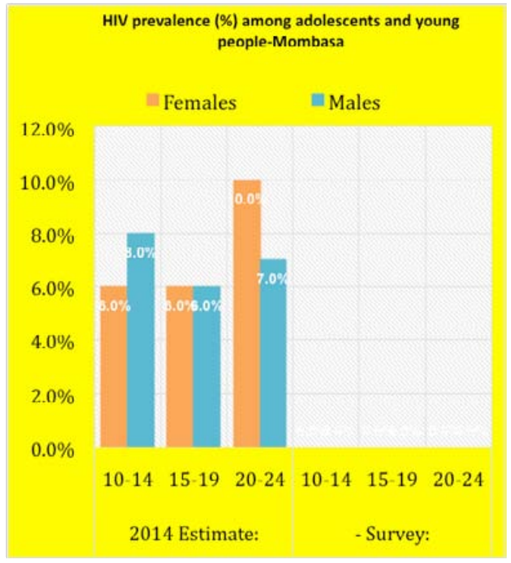
These are populations whose social contexts increase their vulnerability to HIV. In Mombasa County, priority populations include adolescents, young people and women living in informal settlements. Other identified priority populations include truck drivers, street children, persons with disabilities and mobile workers.

The Adolescents and Young People Factor

There has been a growing concern about HIV and AIDS among the adolescents and young persons in Kenya and by extension the rest of Sub-Saharan Africa. The 'All IN" campaign launched by the President of the Republic of Kenya seeks to understand HIV epidemic among adolescents, avail data and tailor interventions that conform to their needs. Data reviewed from various sources (population based, KAIS, KDHS, County Estimates (modeled data) and specific programs data) through Kenya Adolescents Assessment and

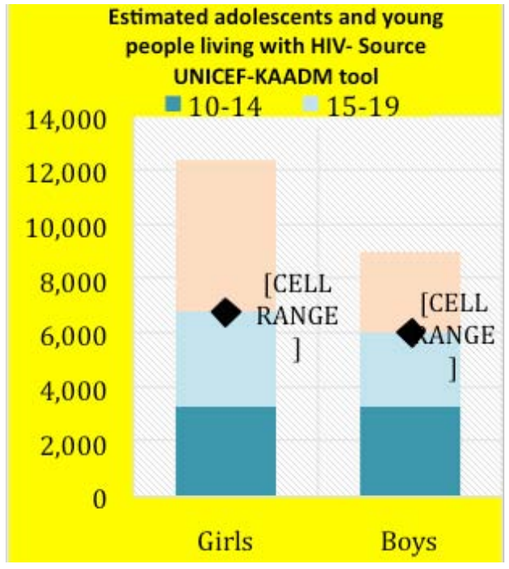
Decision Makers tool (KAADM), a tool adopted from UNICEF, revealed that 6,800 females and 6,000 males of ages between 10-24 were living with HIV in 2016 in Kenya. HIV prevalence among these ages was higher (9%) than the County's prevalence (7.4%). HIV incidence was found to be higher, especially among the Most at Risks Adolescents (MARA) while uptake of treatment was significantly lower.

Figure 2.8: HIV prevalence among adolescents and young people



AIDS is the leading cause of death among adolescents in Africa and the second highest globally - 9,720 adolescents and young people died of AIDS in Kenya in 2014

Figure 2.9: Number of adolescents and young people living with HIV



Chapter 3

Rationale, Strategic Plan Development Process and the Guiding Principles

3.1 Why the Mombasa County AIDS Strategic Plan?

The policy environment of the HIV response is defined by the Constitution of Kenya 2010. The Bill of Rights establishes the right 'to the highest attainable standard of health'. Mombasa AIDS Strategic Plan 2016 – 2020 is therefore a guide for coordination and implementation of the HIV response; a resource mobilization and accountability tool for all players in the County. MCASP ensures that the HIV response remains a multi-sectoral function. The Plan further defines working relationships between all agencies and organs at County, Sub-County and Community levels and expected deliverables from each.

3.2 Development of MCASP 2016 – 2020

This plan was developed through in-depth analysis of available data and information and a highly participatory and consultative process. The process was prompted by an end term review of the third Kenya National AIDS Strategic Plan III (KNASPIII) and the consequent development of Kenya AIDS Strategic Framework (KASF) that took into considerations the county-based governance structure. Hence, through technical assistance from the National AIDS Control Council and partners, the County Department of Health initiated the process of MCASP (2016 – 2020) development through KASF dissemination and constitution of the County working groups to guide in the plan development. MCASP is based on identified priorities and gaps on HIV activities and interventions of Mombasa County. Drafting of the MCASP was undertaken by the County Technical Teams with constant guidance and leadership from the Department of Health.

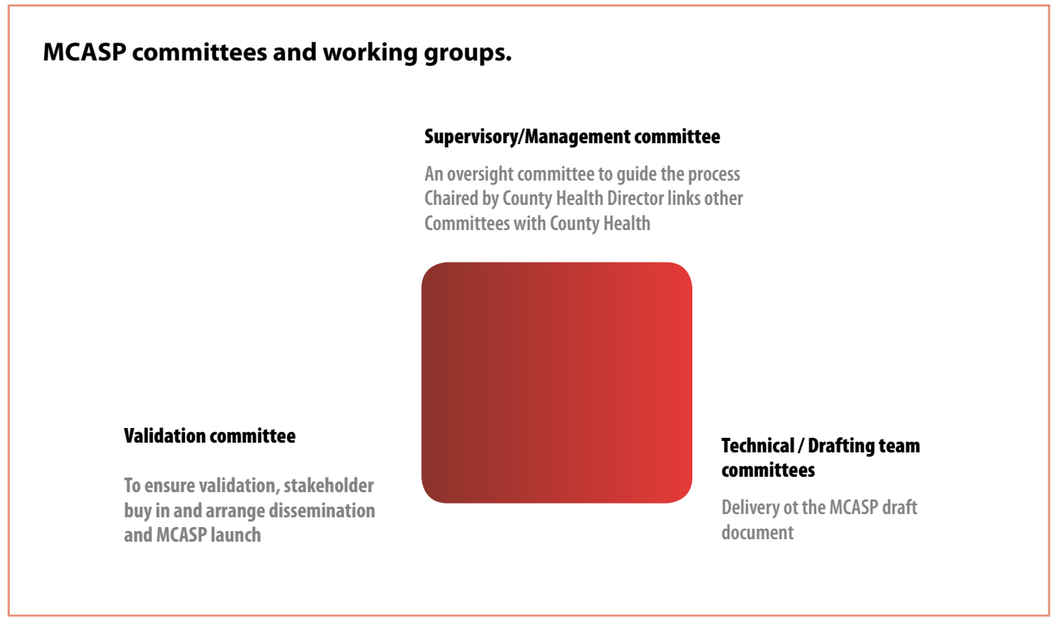
MCASP 2016 – 2020 ensures that the HIV response remains a multi-sectoral function in Mombasa County

The process of peer review and validation of the draft during various stages of development was undertaken. The process started by formulation by the various committees and TWGs domiciled at the office of the County Executive of Health; the Management Committee, the Drafting Team and Validation Team. Each committee had specific terms of reference. Thus, the process of developing MCASP entailed the following key steps:-

1. County HIV intervention gaps and priority identified during KNASP III end term review.
2. Development of KASF at national level that serves as guide to the county HIV and AIDS strategic plan development process.
3. Dissemination and training of KASF to the county teams and formation of County KASF Training of Trainers (TOTs).
4. Constitution of Mombasa County AIDS Strategic Plan development working groups andcommittees.
5. Actual drafting/writing process by the MCASP Drafting Committee.
6. Technical validation by both County and National Review Teams.
7. Stakeholder validation forums.
8. Design, layout and printing.

Several groups were involved in the MCASP validation process. These included persons living with HIV, County health teams (including CHMT), representatives from persons with disabilities, representatives from members of key populations and organizations working with key populations, youth groups, public and private sectors among others statutory agencies, and adjoining local authorities. The consultation strategy included public information and workshops and focused group discussions to encourage as much public engagement as possible. MCASP Draft was widely circulated both in hard and soft copies to various stakeholders and players of the county for their inputs. These included Persons Living with HIV and AIDS, Persons Living with Disability, County and National government agencies and implementers.

Figure 3.1: MCASP committees and working groups



3.3 Public Participation

The Kenya Constitution 2010 stipulates that one of the objectives of counties is "to encourage the involvement of communities and community organizations in the matters of County Government". Article 105(1) subsection (d) and Article 106 section (4) of the County Government Act 2012 provides for the issue of public participation in county planning.

The preparation of this plan included pre-draft consultation with communities and sectoral groups.

3.4 Guiding Principles

- County ownership and partnership
- Rights based and gender transformative approach
- Multi-sectoral accountability
- Evidence and result based approach
- Efficiency, effectiveness and innovation
- Integration of services, activities and resources

Chapter

4 Vision, Goal, Objectives and Strategic Directions of the MCASP

VISION

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

GOAL

Provide strategic direction for comprehensive HIV prevention, care, treatment and mitigate social-economic impact in Mombasa country

MCASP OBJECTIVES

1. Reduce new HIV infections by 75%.
2. Reduce AIDS related deaths by 25%.
3. Reduce HIV & AIDS related stigma by 50%.
4. Increase County HIV response financing by 50%.

Strategic Directions

1 Reduce new HIV infections.	2 Increase health outcomes and wellness of all people living with HIV.	3 Using a human rights approach to facilitate access to services for PLHIV, key populations and other priority populations in all sectors.
4 Strengthening integration of health and community systems.	5 Strengthening research, innovation and information management to meet MCASP goals.	6 Utilization of strategic information for research, monitoring and evaluation (M&E) to enhance programming.
7 Increasing domestic financing for a sustainable HIV response.	8 Promoting accountable leadership for the delivery of the MCASP results by all sectors and actors.	

Strategic Direction 1: Reducing New HIV Infections

In Mombasa County, annual new HIV infections amongst adults is 1,609 whereas in children it is 171 (Kenya HIV Estimates Report 2014). The county has substantial populations who are at risk of new HIV infection including key populations (MSM, PWIDs and sex workers), priority populations (women and youths), immigrant and mobile populations working in tourism and recreation centres, mining, construction, transport and fisheries industries.

These populations engage in risky sexual and drug use behaviours including multiple sex partners, unprotected anal and vaginal sexual intercourse, alcohol and drug abuse, sharing of drug injecting equipment, group sex among others. Gender based violence and condom use are other risky behaviours.

Geographically, Likoni, Changamwe and Jomvu sub-counties have a higher HIV burden in terms of prevalence.

Expected Results:

- **Increased uptake of HIV testing services to 90%**
- **Increased access to PMTCT**
- **Reduced risky sexual behaviour**

Program Gaps:

- **Low uptake of HIV testing services especially among Key Populations, adolescents and children**
- **Low uptake of PMTCT services**
- **Sexual behaviour change has been minimal**
- **Low levels of implementation of combination prevention**

STRATEGIC DIRECTION 1: REDUCING NEW HIV INFECTIONS

KASF Objective	MCASP Results	Key Activity	Target Population	Geographic Areas by County/Sub-County	Responsibility
1. Reduce new HIV infections by 75% among adults	Increased uptake of HIV testing services to 90%	Innovative HIV testing services models.	General Population, Key Populations, Priority Populations, Bridging populations	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, MoH, Implementing partners
		Establish and strengthen integrated youth friendly comprehensive services.	Adolescents, Young people	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, MoH, Implementing partners
2. Reduce HIV transmission rates from mother to child to below 5%	Increased access to PMTCT	Strengthen ART enrolment programs for pregnant and lactating women and children living with HIV.	Pregnant women, Children living with HIV	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, MoH, Implementing partners
		Male involvement in PMTCT programs.	General Population	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, MoH, Implementing partners
		Integrate eMTCT with MNCH.	Pregnant women	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, MoH, Implementing partners
	Reduction of risky sexual behaviour	Increase access to HIV prevention education.	General Population, Key Populations, Priority Populations, Bridging Populations	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, MoH, MoEST Implementing partners
		Promote uptake of harm-reduction interventions.	Key Populations	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, MoH, MoEST. Implementing partners
		100% condom programming.	General Population, Key Populations, Priority Populations, Bridging Populations	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, MoH, MoEST. Implementing partners

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

With approximately 54,600 persons living with HIV, Mombasa County ranks among the highest burdened counties in the country. AIDS-related deaths are at 2000 persons per year with 500 children deaths (Kenya HIV County Profiles, 2014). In order to improve the health outcomes of people living with HIV, the MCASP proposes clear activities to operationalize the 90-90-90 UNAIDS Cascade Strategy. The county will strive within the period of this strategic plan to increase the number of people who have tested for HIV from 27% in 2009 to 90% by 2020. Thus, more HIV positive persons will be diagnosed, linked to care, initiated and retained in treatment with the ultimate aim of achieving permanent viral suppression. This will not only reduce mortality and morbidity among people living with HIV, but will also significantly reduce the rates of infection. In this regard, HIV testing services will be promoted in both clinical and community settings targeting discordant couples, pregnant women, and key and priority populations. Other measures will include prompt linkage to care and treatment for positive clients, defaulter tracing, treatment literacy, partner involvement in treatment and strengthened systems and structures that deal with acquiring and distribution of commodities, test kits, supplies, equipment and personnel.

Expected Results:

- Improved quality of care
- Ensure 90% retention of PLHIV in to care
- Increased ART uptake to 90%
- Increased linkage to care and treatment within 3 months of HIV diagnosis to 90%

Program Gaps:

- Delayed linkage and enrolment to care after diagnosis
- Limited capacity of patients to access services
- Low uptake of ART among the PLHIV
- Low retention rate of patients on ART
- Inadequate monitoring of patients in care
- Gaps related to quality of care and treatment services
- Disproportionately lower coverage of ART in children and adolescents

STRATEGIC DIRECTION 2: IMPROVING HEALTH OUTCOMES AND WELLNESS OF ALL PEOPLE LIVING WITH HIV AND AIDS

KASF Objective	MCASP Results	Key Activity	Target Population	Geographic Areas by County/ Sub-County	Responsibility
Reduce AIDS related mortality by 25%	Increased linkage to care and treatment within 3 months of HIV diagnosis to 90%	Improve timely linkage to care and treatment for persons diagnosed with HIV.	PLHIV	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, NASCOP, NACC, Implementing partners, community

	Increased ART uptake to 90%	Scale up access to ART.	PLHIV	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, NASCOP, NACC, Implementing partners, community
		Consistent capacity building of staff on ART.	PLHIV	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, NASCOP, NACC, Implementing partners, community
	Ensure 90% retention of PLHIV in care	Integrating community strategy to HIV treatment, care and support.	PLHIV	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, NASCOP, NACC, Implementing partners, community
	Improved quality of care and treatment	Scale up interventions to improve quality of care and improve health outcomes.	Health service providers	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	Quality Improvement Teams (QITs), County Health Department, MoH, Implementing partners

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

It is estimated that there are approximately 6,000 KPs including 11,666 FSW in Mombasa County (The National MARPs Technical Working Groups, 2013). The Kenya HIV Prevention Revolution Road Map estimates that 54,670 people are living with HIV in Mombasa County. Evidence shows that key populations, PLHIV and youth are consistently under-served, and that low service coverage remains an important driver of ongoing HIV transmission. At the core of these inequities are the social and structural barriers of stigma and social discrimination, including discrimination in healthcare settings, and the criminalization of substance use, sex work, and same sex behaviour. These social and structural realities can generate risk environments which undermine public health goals, violate human rights, and limit safe and effective provision of services. Pragmatic human rights based approaches can help develop enabling environments where inclusion in HIV services can be progressively realized. The right to health is enshrined in the Kenyan Constitution. There is need to put intervention that hinges human rights in all HIV programmes in the County. In Mombasa County there are reported cases of stigma and discrimination towards PLHIV and KPs in families, communities and in institutions in which they seek services.

The MCASP is therefore integrating human rights norms and principles in the design, implementation, monitoring and evaluation of health related policies and programmes. These include; enhancement of human dignity, principle of equality and freedom from discrimination and attention to the needs and rights of participation in decision making processes

Expected Results:

- Reduced stigma & discrimination related to HIV and AIDS by 50%
- Reduced levels of GBV by 50%
- Increased involvement and participation of KPs in decision making
- Strengthened engagement of PWDs in HIV programs

Program Gaps:

- Rampant HIV related stigma and discrimination against PLHIV and key populations
- High incidences of sexual and gender based violence against KPs, PLHIV and priority populations
- Negative provider attitudes that reduces access to care and affects disclosure and adherence
- Insufficient programs designed to increase uptake of legal services and redress by KPs and PLHIV
- Inadequate interventions to address stigma and discrimination
- Inadequate focus on gender dynamics of HIV especially GBV and male involvement

STRATEGIC DIRECTION 3: USING A HUMAN RIGHTS APPROACH TO FACILITATE ACCESS TO SERVICES FOR PLHIV, KPS AND OTHER PRIORITY GROUPS IN ALL SECTORS

KASF Objective	MCASP Results	Key Activity	Target Population	Geographic Areas by County/Sub-County	Responsibility
An enabling legal and policy environment necessary for a robust HIV response at the national and county levels to ensure access to services by persons living with HIV	Reduced stigma & discrimination related to HIV and AIDS by 50%	Implement PHDP programs.	PLHIVs	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	CHD, MoH, PLHIV networks, Implementing partners
		Build capacity of county health services providers for the provision of population specific friendly services.	County Health Service providers	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	CHD, MoH, NASCOP, NACC, Implementing partners
		Design and implement programs that educate on stigma and discrimination.	General Population, Key Populations, Priority Populations	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	CHD, MoH, NASCOP, NACC, Implementing partners
	Reduced levels of GBV by 50%	Design and implement programs that educate on GBV.	General Population, Key Populations, Priority Populations	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	CHD, MoH, NASCOP, NACC, Implementing partners
		Integration and mainstreaming of gender responsive programs.	General Population, Key Populations, Priority Populations	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	CHD, MoH, NASCOP, NACC, Implementing partners

		Strengthen referral and access to legal and health services for survivors of SGBV.	General Population, Key Populations, Priority Populations	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	CHD, MoH, NASCOP, NACC, Implementing partners
	Increased involvement and participation of KPs in decision making	Implement leadership development programs for KPs.	Key Populations, Priority populations	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	CHD, MoH, NASCOP, NACC, Implementing partners
	Strengthened engagement of PWDs in HIV programs	Develop and implement population specific programs leveraging on PWD networks.	PWDs	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	CHD, MoH, NASCOP, NACC, Implementing partners

Strategic Direction 4: Strengthening Integration of Health and Community Systems

Mombasa County has 40 community units that seek to interlink with the main health provision facilities. In 2006, the Ministry of Health through its National Health Sector Strategic Plan II 2005-2010 came up with a Community Health Strategy (CHS) to re-vitalize the PHC concept. This is implemented by both state and non-state actors. Mombasa County has found various gaps in the CHS which leads to weakened community mobilization, poor referral or linkage networks and weak specific disease follow up and supportive initiatives such as provision of psychosocial support, defaulter tracing and other community health interventions. In total, the County has the following health facilities:

- 1 Level Five facility
- 4 Level Four facilities
- 36 health centres and dispensaries
- 296 private facilities

Kenya revised its Community Strategy in 2007 as the vehicle for community interventions in collaboration with both state and non-state actors. Integration of the community and health systems is necessary towards ensuring a well functional health system. Community systems play a critical role in HIV prevention, care, treatment and support. Their roles include referrals and linkages to care and treatment services and enhancement of the treatment literacy. The County will strengthen community mobilization and Home and Community Based Care (HCBC). There is need to build the capacity of all players and other civil societies to play these roles including gender and human rights mainstreaming.

Table 4.1: Status of Community Units in Mombasa County

Description	Numbers
Number of community units	40
Fully functional units	37
Partially functional units	3
Units not established	132

Expected Results:

- Strengthened community health systems to deliver quality HIV services.
- HIV services integrated into primary health care.
- Improved management of community health workforce.

Program Gaps:

- Inadequate workforce, equipment, commodities and supplies
- Weak coordination and linkage mechanisms between different community actors
- Inadequate integration of HIV services in primary health care
- Weak community mobilization for HIV services.

STRATEGIC DIRECTION 4: STRENGTHENING INTEGRATION OF COMMUNITY AND HEALTH SYSTEMS

KASF Objective	MCASP Results	Key Activity	Target Population	Geographic Areas by County/ Sub-County	Responsibility
Build a strong and suitable system for HIV service delivery through specific health and community systems approaches, actions and interventions to support HIV response	Strengthened community health systems to deliver quality HIV services	Strengthen logistical systems to ensure timely and consistent supply of essential commodities to the community units.	County Health, Management Teams, Community Units	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	CHD, MoH, NACC, NASCOP, KEMSA
		Strengthen community to facility referral systems.	Community Units, Primary health facility heads	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	CHD, MoH, NACC, NASCOP, KEMSA
	HIV services integrated into primary health care	HIV services integrated with existing primary health care services.	Community Units, Primary health facility heads	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	CHD, MoH, NACC, NASCOP, KEMSA
	Improved management of community health workforce	Formalize engagement of community health workers including recruitment, orientation, training, supervision and reporting.	County Health Management Teams	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department

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

There is increased need for new evidences and information to guide programming in both National and County levels. However efficient translation of research findings into policies and practices remains a challenge across all counties in Kenya. There are still research gaps in understanding drivers of the epidemic by population and geography and in evaluating effectiveness and efficiency of various interventions. Data and research on social determinants on health and their impacts on incidence and mortality are scanty. Timely generation and translation of data and evidence is important in informing decision making and programming. Multiplicity of data sources, lack of qualified personnel and necessary equipment for data and evidence collection, storage and processing continues to impinge HIV response in Mombasa County.

Expected Results:

- Increase funding and resources for HIV-relevant research and evidence generation.
- Promote/Conduct targeted implementation research in priority areas.
- Increase capacity for conducting quality HIV-related research.
- Strengthen usage of research findings and evidence in service delivery.
- Increase capacity for data demand and information use in HIV-related programming.
- Increase production of knowledge products and information.

Program Gaps:

- Increase capacity for conducting quality HIV-related research
- Promote/Conduct targeted implementation research in priority areas
- Increase capacity to monitor and regulate research in the county
- Strengthen usage of research findings and evidence in service delivery

STRATEGIC DIRECTION 5: STRENGTHENING RESEARCH, INNOVATION AND INFORMATION MANAGEMENT TO MEET MCASP GOALS

KASF Objective	MCASP Results	Key Activity	Target Population	Geographic Areas by County/Sub-County	Responsibility
Identification and implementation of high impact research priorities, innovative programming and capability and capacity strengthening to conduct research	Increased capacity to conduct HIV research in the County by 50%	Research capacity building through training and recruitment.	County, Internal implementers & Implementing partners	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, Universities and Colleges, Private institutions, NACC, NASCOP, Partners
	Promote/ Conduct targeted implementation research in priority areas	Identify and prioritize research themes and areas.	County, Internal implementers & Implementing partners	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Government, NCPWD, NACC, NASCOP, MoH
		Resource and implement a Mombasa County HIV research agenda.			
	Increase funding and resources for HIV-relevant research and evidence generation	Develop a county HIV research financing strategy.	County Government	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	
		Increased evidence-based planning and programming by 20%.			
	Increase capacity to monitor and regulate research in the county	Establish research approval procedures and structures in the county.	County Government	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, Universities and Colleges, Youth Dept., NACC, NACADA, NASCOP, Partners
	Strengthen usage of research findings and evidence in service delivery	Increase evidence-based programming/ interventions and activities.	County Government, Internal Implementers, Partners	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, Networks and Support Groups, NACC, NASCOP, Partners
	Increase capacity for data demand and information use in HIV-related programming	Strengthen data analysis and management capacity.	County Government, internal Implementers, Partners	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, Universities, Youth Dept., and Colleges, UNODC, NACC, NACADA, NASCOP, Implementers, Partners

	Increase production of knowledge products and information	Establish a multi-sectorial and interactive web-based County HIV research hub / platform.	County Government	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, Networks and Support Groups, NACC, NASCOP, Partners
		Develop and disseminate regular review of papers on key research findings and local innovations.	County Government, Internal implementers, Partners	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, Networks and Support Groups, NACC, NASCOP, Partners

Strategic Direction 6: Promoting Utilization of Strategic Information for Research, Monitoring and Evaluation (M&E) to Enhance Programming

A functional, integrated monitoring and evaluation system for HIV is vital for effective evidence-informed decision making at national and county levels. The Constitution demands for transparency, accountability, participation of people in order to assure good governance and stewardship of the HIV response. Over the past decade, the country has relied on quality national surveys (KAIS and KDHS); facility based HIV sero-prevalence surveys as well as bio-behavioural surveys to provide trends in HIV prevalence and incidence as well as HIV-related risk behaviours. Majority of these data sources are supported and maintained by various stakeholders. Both routine and non-routine M&E sub-systems are in place with reasonable infrastructure and personnel. The Kenya AIDS Strategic Framework has a detailed M&E framework in place to guide and inform M&E activities. The achievement of HIV M&E however, has not been without challenges.

Expected Results:

- **Planned evaluations, reviews, surveys and implementation science on HIV response for general and key populations implemented and results disseminated in a timely manner**
- **Increased availability of quality and timely strategic information to inform HIV response at county level**
- **Improved data use for decision making**
- **Established HIV information hub at the county level**

Program Gaps:

- **Lack of county HIV information hub.**
- **Inadequate data use for decision making in the county**
- **Parallel data collection and reporting systems that are not inter-operable**
- **Over-dependence on external funding for M&E activities at county level**

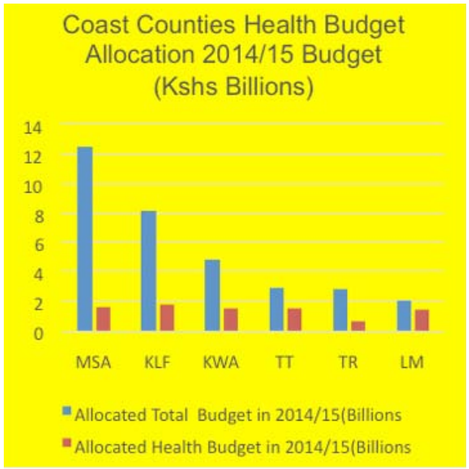
STRATEGIC DIRECTION 6: PROMOTE UTILIZATION OF STRATEGIC INFORMATION FOR RESEARCH, MONITORING AND EVALUATION TO ENHANCE PROGRAMMING

KASF Objective	MCASP Results	Key Activity	Target Population	Geographic Areas by County/ Sub-County	Responsibility
To improve data quality, demand, access and use of data for decision making at the County and National levels	Established HIV information hub at the county level	Establish a multi-sectoral and integrated real time HIV platform to provide update on HIV epidemic response accountability.	County Health Department	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, MoH, NACC, NASCOP, Implementing partners
	Improved data use for decision making	Strengthening M&E capacity to effectively monitor the KASF performance and HIV epidemics at all levels.	County Health Department, ADM, Implementers	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, MoH, NACC, NASCOP, Implementing partners
	Increased availability of quality and timely strategic information to inform HIV response at county level	Ensure harmonized, timely and comprehensive routine monitoring systems to provide quality HIV data as per national, county and sector priority information needs.	HCWs, County Health Management	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, MoH, NACC, NASCOP, Implementing partners
	Planned evaluations, reviews, surveys and implementation science on HIV response for general and key populations implemented and results disseminated in a timely manner	Strengthen county M&E capacity to effectively track MCASP performance and HIV dynamics at county and decentralized levels.	HCWs, County Health Management	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, MoH, NACC, NASCOP, Implementing partners

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

The health sector is disproportionately underfunded across all counties in Kenya. HIV and AIDS, being a sub-sector in health, is highly affected. In 2015, Mombasa County allocated approximately Kshs 1.6 Billion to the health sector, an allocation considerably low owing to the massive needs of the sector. The budget component for HIV and AIDS went to biomedical intervention, HR and commodity supplies. Little, if any, was allocated for behavioural and structural components such as stigma reduction.

Figure 4.1: Coast Counties Health Budget, 2014/15



Expected Results:

- **15% of the County health budget allocated to the HIV programs annually**
- **Involvement and inclusion of the private sector in the HIV response**
- **Efficient utilization of HIV program resources**

Program Gaps:

- **Low budgetary allocation to HIV interventions by the County**
- **Inadequate funding for behavioural and structural interventions in favour of biomedical interventions**
- **Inefficient use of existing HIV/Health resources at facility and community levels.**
- **Inadequate alignment of HIV/Health resources by County partners and implementers due to poor coordination**
- **Inadequate County mechanisms to tap resources from private and other key sectors**

STRATEGIC DIRECTION 7: INCREASING DOMESTIC FINANCING FOR A SUSTAINABLE HIV RESPONSE					
KASF Objective	**MCASP Results**	**Key Activity**	**Target Population**	**Geographic Areas by County/ sub-County**	**Responsibility**
Increasing domestic financing to 50%	15% of the County health budget allocated to HIV programs annually.	Develop and implement a county HIV response funding advocacy strategy.	County Government	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, MoH, NACC, NASCOP, Implementing partners

	Involvement and inclusion of the private sector in the HIV response	Establish and operationalize a county HIV response Public- Private Partnership.	County Government	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, MoH, NACC, NASCOP, Implementing partners
		County private partners to formulate and implement workplace HIV policies and programs.	County Government	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, MoH, NACC, NASCOP, Implementing partners, FKE, KEPSA
	Efficient utilization of HIV program resources	Develop systems to track the HIV county investment.	County Government	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, MoH, NACC, NASCOP, Implementing partners
		Integrate HIV programs into other health programs including TB, malaria, non-communicable diseases.	County Government	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department, MoH, NACC, NASCOP, NTLP, Implementing partners

Strategic Direction 8: Promoting Accountable Leadership for Delivery of MCASP Results by all Sectors and Actors

The Constitution of Kenya 2010 guarantees every Kenyan a right to the highest attainable standard of health (Article 43). Health is a devolved function and therefore all counties are obligated to ensure all residents access quality health care services. Like in all other health service delivery, the Constitution has provided for a new legal and policy environment upon which the HIV response will be implemented. Articles 10(2) and 73 outline key defining elements of good governance and leadership while Article 21(3) bestows on all State organs and all public officers the duty to address the needs of vulnerable groups within society. In cognizance of the above Constitutional and other mandatory provisions, and indeed for the good of all Mombasa County residents, all Kenyans and the visitors, the County Government of Mombasa continues to put in place responsive regulatory and service delivery policies and guidelines of ensuring efficient and effective delivery of quality health care. This also applies to the HIV and AIDS sub-sector. Delivery of quality HIV and AIDS care, prevention and mitigation of social-economic impacts of the epidemic is provided for in the Mombasa County development policies including the Mombasa County Strategic Plan and Mombasa County Health Investment Plan. Responding to HIV and AIDS will continue being a part of the County's planning and budgeting process through the County Integrated Planning (CIDP) and the related County Medium Term Expenditure Framework (MTEF) budgeting process. The County Government will

continue promoting responsive leadership, ensure mainstreaming of HIV and AIDs across all sectors through a multi-sectoral approach, involvement of Persons Living with HIV and AIDS, civil society and other key stakeholders. The existing community, religious, social and cultural structures will provide leverage in the leadership to war on HIV and AIDS.

In the context of a shrinking HIV and AIDS resource basket, Mombasa County Government will strength accountability within all systems and units responding to HIV and AIDs and also encourage Public-Private Partnerships (PPP) investments on the HIV sector.

Expected Results:

- Leadership that seeks to leverage on the County public and private sectors through PPP promoted
- County HIV multi-sectoral coordination structure established
- Effective leadership mechanisms that ensure quality service delivery

Program Gaps:

- Inadequate leadership to ensure effective delivery and quality of care.
- Gaps in implementation and adherence to County HIV coordination structures.
- Weak mechanisms to leverage existing county strengths especially in public and private sectors
- Weak mechanisms to ensure accountability in mainstreaming and other sectoral response (outside the health sector)
- Weak coordination and supervision of partners and implementers
- Inadequate political will to drive HIV agenda at the County policy bodies (County Assembly)
- Inadequate will to allocate resources to HIV structural and behavioural interventions

STRATEGIC DIRECTION 8: PROMOTING ACCOUNTABLE LEADERSHIP FOR DELIVERY OF MCASP RESULTS BY ALL SECTORS AND ACTORS

KASF Objective	MCASP Results	Key Activity	Target Population	Geographic Areas by County/Sub-County	Responsibility
Promote good governance practices by identifying, developing and nurturing effective and committed leaders for the HIV and AIDS response	Effective leadership mechanisms that ensure quality service delivery	Institute and adhere to responsive results measurement mechanisms, supervision and controls to ensure efficient and effective quality service delivery.	County Assembly County Health Executive	Kisauni, Jomvu, Changamwe, Mvita, Nyali and Likoni	County Health Department , NASCOP, NACC
	County HIV multi-sectoral coordination structure established	Establish and strengthen functional and competent HIV coordination mechanism.			

Leadership for Leveraging Other Sectors in the County HIV Response

Mombasa County boasts of many sectors that aid the HIV and AIDS response. From well-developed tourism, transport, hotel, and cultural sectors, the county leadership is committed to tapping on these and other sectoral advantages in addressing the HIV and AIDS epidemic. Under the principle of multi-sectorality, the MCASP will create mechanisms of leveraging these sectors, especially in bridging the resource gap. Some of the actions the County intends to take include:

1. Establishment of a robust Mombasa County HIV and AIDs workplace policy.
2. County sectoral and departmental HIV advocacy and communication strategy.
3. Leverage hotel, entertainment, tourism, transport and industry (factories) sectors by ensuring they develop and implement the HIV and AIDS workp lace policy and programs.
4. Develop and implement HIV programs for the informal sectors, e.g. matatus, Boda boda and Tuk Tuk businesses .
5. Leverage the strong religious and community leadership structures by recommending appropriately designed and monitored HIV awareness messages.

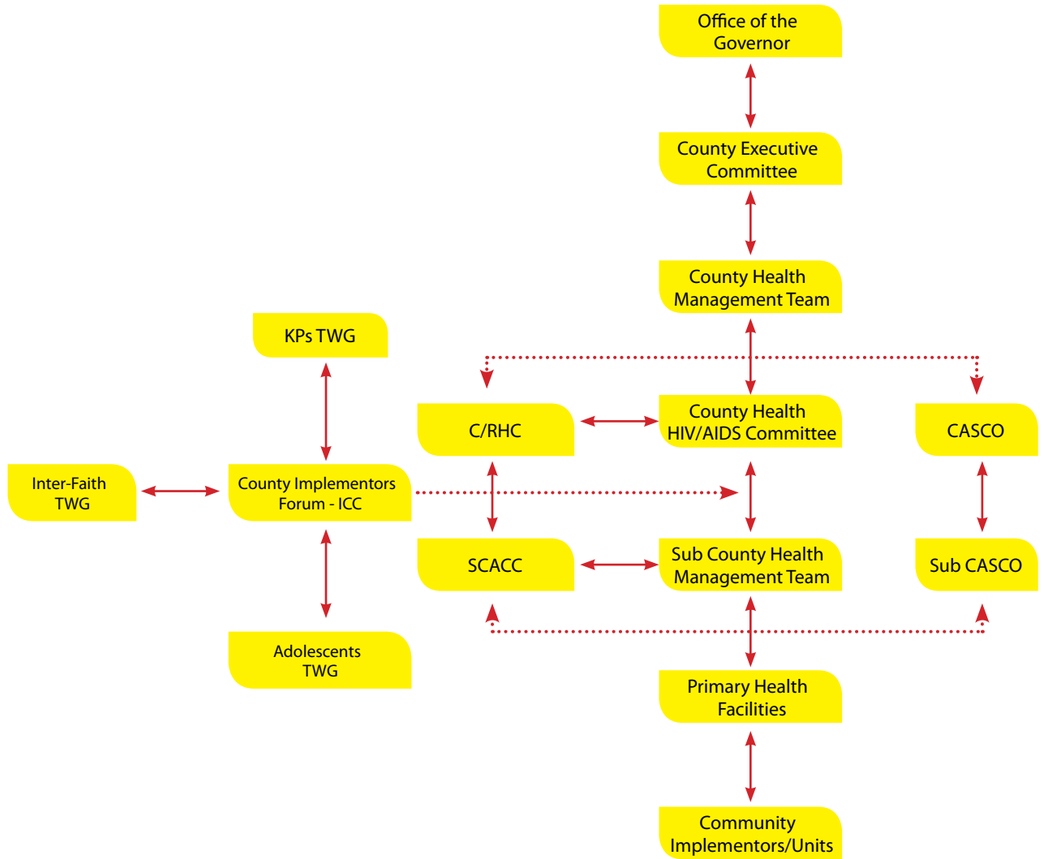
Chapter 5

Implementation Arrangements

In order to attain the set objectives, responsive coordination mechanisms and structures are necessary. The Mombasa County HIV and AIDS Strategic Plan (MCASP 2016 – 2020) has clearly defined the County and Sub-County structures that will work together, in a system model, to deliver on the plan. The following are the County and Sub- County structures:

1. **Office of the Governor** - This is the supreme office in the County. Headed by the Mombasa County Governor, this office will be responsible for provision of high level leadership, promotion of engagement with the national government, inter-county or bilateral or even multi-lateral negotiations and relationship in HIV response. This office will be responsible for the overall MCASP results.
2. **County Executive Committee** - This committee is made up of all the County executive officers and other senior County officers. The committee will provide a crucial link between HIV programs coordination and implementation with the Governor's office. The Executive Officer in charge of HIV or health matters will be the focal person. Further, this committee will be a liaison point between HIV programs with other arms of the County Government such as the County Assembly, County Service Board among others.
3. **County Health Management Team (CHMT)** – This team oversees direct implementation of HIV and health programs. The team consists of health officials, the Health CEC, Chief Officer of Health and the County Health Director. The team is in charge of all HIV activities in the County.
4. **County HIV and AIDS Committee (CHC)** – This committee advises the CHMT and the County Executive on HIV matters. The unit advocates for HIV and AIDS issues and has strong representation of persons living with HIV. CHC reflects multi-sectoral coordination in the County.
5. **County AIDS/STI Coordinating Office (CASCO-NASCOP)** - A member of CHMT and is in charge of HIV related activities in the County.
6. **County/Regional HIV Coordinating Office - C/RHC (NACC)** – This office coordinates community and sectoral-based interventions (structural and behavioural interventions), mainstreaming and fosters demand creation for health services.
7. **Sub-County AIDS/STI Coordinating Unit (CASCO)** – A member of SCHMT and is in charge of HIV related activities in the Sub-County.
8. **Sub-County AIDS Community and Sectoral and Mainstreaming Coordinating Unit SCACC)** – Coordinates community and sectoral-based interventions (structural and behavioural interventions), mainstreaming and fosters demand creation for health services at the Sub-County level.
9. **Community Units** – These units ensure the smooth coordination of activities and results delivery at community level. The units are headed by a CHEW in line with the County Community Strategy.

Figure 5.1: MCASP 2016 – 2020 delivery structure



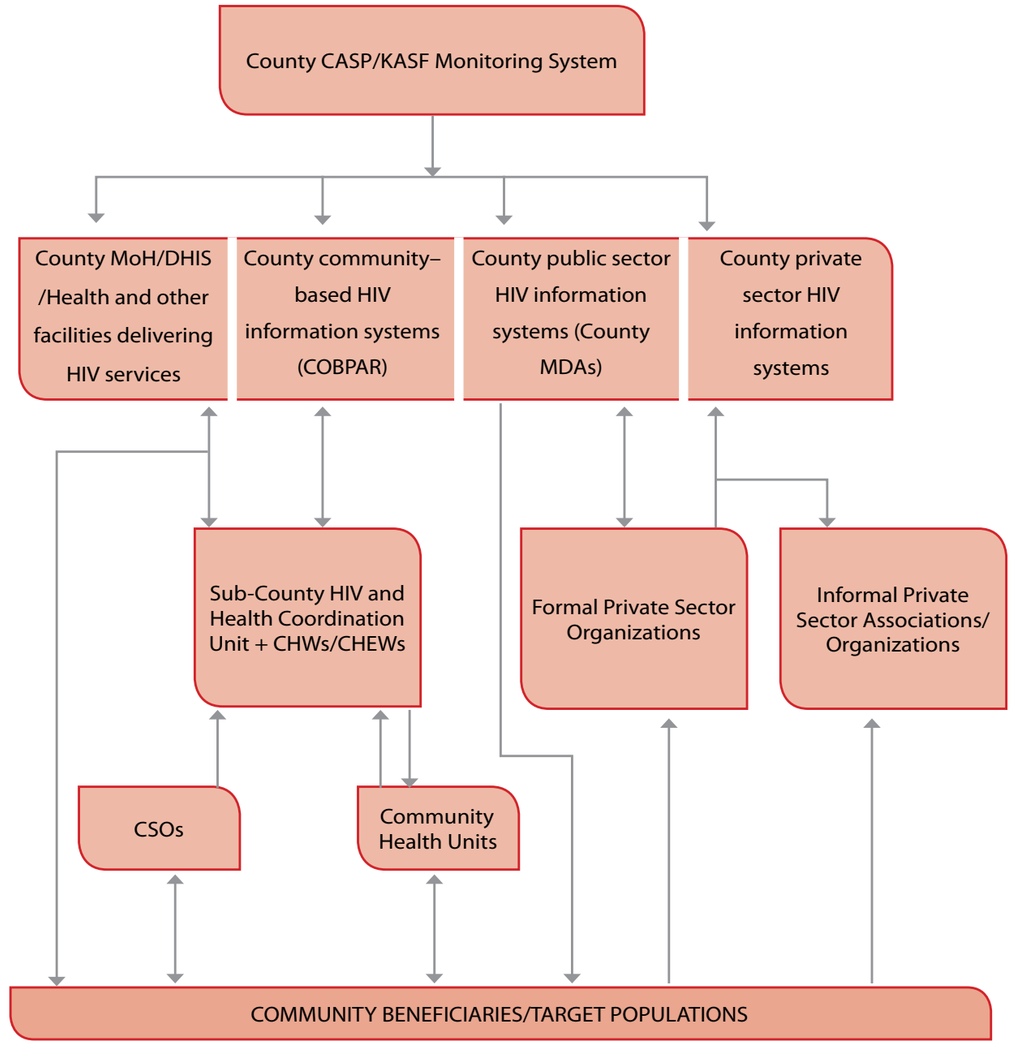
Chapter

6

Research, Monitoring & Evaluation of the Plan

County response to the evolving HIV epidemic is largely influenced by a strong commitment to availing quality quantitative data in a timely manner for effective evidence–informed decision making and documentation of best practice. The County reporting and coordination of HIV and AIDS activities will include all activities from planning, implementation, monitoring and evaluation for proper documentation in all programmatic activities, data from the community health units, health facilities, private and public sectors, state and non-state actors, and faith-based institutions and organizations. Health system delivery indicators will be captured through DHIS from the facility level. The County will build the capacity of DHIS across the entire spectrum, including providing the needed technology and building the capacity of the HRIOs. More personnel will be employed to bridge the existing gaps. Community based indicators will be reported through COBPAR.

Figure 6.1: M & E information flow and coordination



Chapter 7

Risk and Mitigation Plan

An assumption has been made that implementation of MCASP 2016 – 2020 will proceed without hitches. However, anticipated risks will be assessed and mitigated through in a continuous process. The County HIV Committee (CHC) will be expected to report to the County Department of Health, NACC, NASCOP and the other partners on the status of the identified risks and the necessary mitigation.

Risk Category	Risks	Status	Mitigation	Responsibility	When
Social Cultural	Affects programming HIV environment for PLHIV, KPs and other vulnerable populations due to high society/ culture/religious stigma and intolerance.	High	Enhanced community education and continuous engagement of community and religious leaders using the NACC interfaith and other committees.	County Government, NACC, National Government, Implementing partners	Continuous
Systems	Weak systems to address commodity stock outs and guarantee inter- and intra-county redistribution.	High	Work with KEMSA, NASCOP, NACC and County Health to strengthen HIV and health commodity forecasting, supply and distribution to avert stock outs.	KEMSA, County Government, MoH, NASCO, NACC	Y1
	Weak service delivery supervision systems to guarantee quality, efficiency and effectiveness.	Medium	Strengthened routine, non-routine and ad hoc supervision to all service delivery facilities.	County Health Department, NASCOP, MoH	Continuous
	Weak, uncoordinated and irregularly updated M&E, data systems that lead to poor quality or lack of data/strategic information.	High	Strengthen data/ M&E systems.	County Health Department, MoH, NACC, NASCOP	Continuous
Human resource and staffing	Inadequate staffing at all cadres of HIV and health service delivery.	High	Undertake staffing assessment and initiate process of ensuring minimum staffing at all cadres of health and HIV service delivery .	County Health Department, MoH, NASCOP, NACC, Implementing partners	Y1
Financial	Inadequate prudent utilization of available resources.	Medium	Initiate resource utilization transparency and accountability mechanisms and enforce corruption eradication processes.	County Government, National Government.	Y1
	Low resources allocation to the HIV sub-sector especially for key structural and behavioural interventions such as stigma reduction.	High	Lobby for an increased resource allocation to support implementation of targets set under MCASP 2016 – 2020.	County Government, County Assembly, NACC, NASCOP, CSOs	FY1
			Initiate local resource mobilization strategies through an elaborate PPP strategy, among others	County Government, County Assembly, NACC, NASCOP, Private sector, CSOs	FY1
Legislation	A legal, policy environment of HIV programming and MCASP implementation that is not conducive.	High	Flag out, amend or repeal laws, clauses that impinge MCASP implementation and initiate supportive laws and policies.	County Government, County Assembly, Law Reform, NACC, CSOs	FY1

Political	Less prioritization of health and HIV delivery due to political campaigns.	High	Lobby for a commitment by all politicians for a policy of non-interference and continued prioritization of health and HIV service delivery during the entire post and pre campaign period.	County Health, CSOs, MoH, NACC, NASCOP	FYI 2& 3
Security	Disruption of HIV service delivery and MCASP implementation by insecurity cases.	Medium	Work with national and county government security apparatus to promote security at all levels.	National & County Governments, Police, Inspectorate	Continuous

ANNEX 1

M&E Indicators and Targets

STRATEGIC DIRECTION 1: REDUCING NEW HIV INFECTIONS							
KASF Objective	**MCASP Results**	**Key Activity**	**Indicator**	**Baseline**	**Mid-term Targets**	**End -term Targets**	**Responsibility**
1. Reduce new HIV infections by 75% among adults	Increased uptake of HIV testing services to 90%	Innovative HIV testing services models.	Percentage of people accessing HIV testing services.	40%	75%	90%	County Health Department, NASCOP, NACC, Beyond Zero Secretariat, Implementing partners
2. Reduce HIV transmission rates from mother to child to below 5%		Establish and strengthen integrated adolescent and youth friendly comprehensive services.	Percentage of adolescents and young people accessing SRH-HIV services and information.	TBP	50%	70%	County Health Department, MoEST, MoH, NASCOP, NACC, Beyond Zero Secretariat, Implementing partners
			Percentage of health facilities offering comprehensive YFS.	TBP	40%	60%	County Health Department, MoEST, MoH, NASCOP, NACC, Beyond Zero Secretariat, Implementing partners

	Increased access to PMTCT	Strengthen ART enrolment programs for pregnant and lactating women and children living with HIV.	Percentage of HIV positive pregnant and breast feeding women receiving HAART.	75%	80%	90%	County Health Department, NASCOP, NACC, Beyond Zero Secretariat, Implementing partners
3. Reduce new HIV infections by 75% among adults		Increase partner involvement in PMTCT programs.	Percentage of partners accessing HIV testing services in ANC, maternity & pre-natal departments.	TBP	70%	90%	County Health Department, NASCOP, NACC, Beyond Zero Campaign, Implementing partners
		Integrate eMTCT with MNCH.	Number or percentage of policies and guidelines developed/ improved institutionali-zing eMTCT in MNCH.	TBP	TBP	TBP	County Health Department, NASCOP, NACC, Beyond Zero Campaign, Implementing partners
4. Reduce HIV transmission rates from mother to child to below 5%	Reduction of risky sexual behaviour	Increase access to HIV prevention education.	Percentage of people accessing SRH-HIV education.	20%	45%	70%	County Health Department, MoEST, MoH, NASCOP, NACC, Beyond Zero Campaign, Implementing partners
		Promote uptake of harm- reduction interventions.	Number or percentage of PWIDs accessing harm- reduction services.	500	1000	2000	County Health Department, NASCOP, NACC, Beyond Zero Campaign, Implementing partners
		100% condom programming.	Number of condoms distributed	TBP	TBP	TBP	County Health Department, NASCOP, NACC, Beyond Zero Campaign, Implementing partners

STRATEGIC DIRECTION 2: IMPROVING HEALTH OUTCOMES AND WELLNESS OF ALL PEOPLE LIVING WITH HIV AND AIDS

KASF Objective	MCASP Results	Key Activity	Indicator	Baseline	Mid-term Targets	End -term Targets	Responsibility
Reduce AIDS-related mortality by 25%	Increased linkage to care and treatment within 3 months of HIV diagnosis to 90%	Improve timely linkage to care and treatment for persons diagnosed with HIV.	Percentage of people diagnosed HIV positive linked to care within 3 months.	30%	70%	90%	CDH, NASCOP, NACC, PLHIV networks, Partners
	Increased ART uptake to 90%	Scale up access to ART.	Percentage of PLHIV initiated on ART.	TBP		90%	CDH, NASCOP, NACC, PLHIV networks, Partners
		Consistent capacity building of staff on ART.	Percentage of health service providers capacity built on ART.	TBP		100%	CDH, NASCOP, NACC, PLHIV networks, Partners
	Ensure 90% retention of PLHIV in care	Integrating community strategy to HIV treatment, care and support.	Percentage of PLHIV initiated on ART retained in care.	TBP		90%	CDH, NASCOP, NACC, PLHIV networks, Partners
	Improved quality of care and health outcomes	Scale up interventions to improve quality of care and improve health outcomes.	Percentage of clients enrolled and retained in care.	TBP		90%	CDH, NASCOP, NACC, PLHIV networks, Partners

STRATEGIC DIRECTION 3: USING A HUMAN RIGHTS APPROACH TO FACILITATE ACCESS TO SERVICES FOR PLHIV, KPs AND OTHER PRIORITY GROUPS IN ALL SECTORS

KASF Objective	MCASP Results	Key Activity	Indicator	Baseline	Mid-term	End -term Targets	Responsibility
Reduce HIV related stigma and discrimination by 50%	Reduced stigma and discrimination related to HIV and AIDS by 50%	Implement PHDP programs.	Percentage of PLHIV reached with PHDP programs.	TBP	70%	90%	CDH, NASCOP, NACC, PLHIV networks, Partners
		Build capacity of county health services providers for the provision of population specific friendly services.	Percentage of county health service capacity built for population specific friendly services.	TBP	50%	80%	CDH, NASCOP, NACC, PLHIV networks, Partners
		Design and implement programs that educate on stigma and discrimination.	Number or percentage of programs addressing stigma and discrimination developed and institutionalised under the Ministry of Education.	TBP	40%	60%	CDH, NASCOP, NACC, PLHIV networks, Partners, CDE, MoEST
	Reduced levels of GBV by 50%	Design and implement programs that educate on GBV.	Number or percentage of GBV population specific programs developed and disseminated.	TBP	TBP	TBP	CDH, NASCOP, NACC, PLHIV networks, Partners
		Integration and mainstreaming of gender responsive programs.	Percentage of implementers integrating gender responsive programs.	TBP	60%	100%	CDH, NASCOP, NACC, PLHIV networks, Partners

	Reduced levels of GBV by 50%	Strengthen referral and access to legal and health services for survivors of SGBV.	Percentage of GBV survivors linked to care and legal aid.	TBP	70%	100%	CDH, NASCOP, NACC, PLHIV networks, Partners
	Increased involvement and participation of KPs in decision making	Implement leadership development programs for KPs.	Percentage of KPs led and driven programs.	TBP	50%	70%	CDH, NASCOP, NACC, PLHIV networks, Partners
	Strengthened engagement of PWDs in HIV programs	Develop and implement population specific programs leveraging on PWD networks.	Percentage of programs that are PWD friendly.	TBP	TBP	TBP	

STRATEGIC DIRECTION 4: STRENGTHENING INTEGRATION OF COMMUNITY AND HEALTH SYSTEMS

KASF Objective	MCASP Results	Key Activity	Indicator	Baseline	Mid-term Targets	End -term Targets	Responsibility
Build a strong and suitable system for HIV service delivery through specific health and community systems approaches, actions and interventions to support HIV response	Strengthened community health systems to deliver quality HIV services.	Strengthen logistical systems to ensure timely and consistent supply of essential commodities to the community units.	Percentage of health facilities experiencing commodity stock outs.	TBP	30%	5%	CDH, NACC, KEMSA, NASCOP, Partners
		Strengthen community to facility referral systems.	Percentage health facilities with appropriate community referral systems.	TBP	TBP	TBP	CDH, NACC, NASCOP, Partners

	HIV services integrated into primary health care	HIV services integrated with existing primary health care services.	Percentage of health care facilities with integrated health care services..	TBP	50%	80%	CDH, NACC, NASCOP, Partners
	Improved management of community health workforce	Formalize engagement of community health workers including recruitment, orientation, training, supervision and reporting.	Percentage of health care facilities with appropriate number of health care workers at all cadres	TBP	50%	80%	CDH, NACC, NASCOP, Partners

STRATEGIC DIRECTION 5: STRENGTHENING RESEARCH, INNOVATION AND INFORMATION MANAGEMENT TO MEET MCASP GOALS

KASF Objective	MCASP Results	Key Activity	Indicator	Baseline	Mid-term Targets	End -term Targets	Responsibility
Identification and implementation of high impact research priorities, innovative programming and capability and capacity strengthening to conduct research	Increase capacity for conducting quality HIV-related research	Research capacity building through training and recruitment.	Number or percentage of county personnel including health workers trained on research methods.	TBP	TBP	TBP	CDH, NACC, Higher learning institutions, KEMRI, NACOSTI, NASCOP, Partners
	Promote/ Conduct targeted implementation research in priority areas	Identify and prioritize research themes and areas.	Number or percentage of research themes based on MCASP conducted annually.	TBP	TBP	TBP	CDH, NACC, NASCOP, Partners, Higher learning institutions, KEMRI, NACOSTI

	Increase funding and resources for HIV relevant research and evidence generation	Develop the county HIV research financing strategy.	Proportion of HIV funds utilized on county research.	TBP	TBP	TBP	CDH, NACC, NASCOP, Partners, Higher learning institutions, KEMRI, NACOSTI
	Increase capacity to monitor and regulate research in the county	Establish research approval procedures and structures in the county	Percentage of research topics/themes approved by the County Approval Authority.	TBP	TBP	TBP	CDH, NACC, NASCOP, Partners, Higher learning institutions, KEMRI, NACOSTI
	Strengthen usage of research findings and evidence in service delivery	Increase evidence-based programming/ interventions and activities.	Number or percentage of programs/ interventions informed by the county own research.	TBP	TBP	TBP	CDH, NACC, NASCOP, Partners
	Increase capacity for data demand and information use in HIV-related programming	Strengthen data analysis and management capacity.	Number or percentage of programs informed by the county data.	TBP	TBP	TBP	CDH, NACC, NASCOP, Partners, Higher learning institutions, KEMRI, NACOSTI
	Increase production of knowledge products and information	Establish a multi-sectorial and interactive web-based County HIV research hub/ platforms.	Number or percentage of researches available on the County research hub.	TBP	TBP	TBP	CDH, NACC, NASCOP, Partners, Higher learning institutions, KEMRI, NACOSTI
		Develop and disseminate regular review of papers on key research findings and local innovations.	Number or percentage of county based research papers/ products disseminated in various forums.	TBP	TBP	TBP	CDH, NACC, NASCOP, Partners

STRATEGIC DIRECTION 6: PROMOTE UTILIZATION OF STRATEGIC INFORMATION FOR RESEARCH, MONITORING AND EVALUATION TO ENHANCE PROGRAMMING

KASF Objective	MCASP Results	Key Activity	Indicator	Baseline	Mid-term Targets	End -term Targets	Responsibility
To improve data quality, demand, access and use of data for decision making at the County and National levels	Established HIV information hub at the county level	Establish a multi-sectoral and integrated real time HIV platform to provide update on HIV epidemic response accountability.	Percentage of planned M&E products generated at county/sub-county levels.	TBP	TBP	TBP	CDH, NACC, NASCOP, Partners
	Improved data use for decision making	Strengthening M&E capacity to effectively monitor the MCASP performance and HIV epidemic.	Percentage of M&E performance reports generated by the system.	TBP	TBP	TBP	CDH, NACC, NASCOP, Partners
	Increased availability of quality and timely strategic information to inform HIV response at county level	Ensure harmonized, timely and comprehensive routine monitoring systems to provide quality HIV data as per national, county and sector priority information needs.	Percentage of planned M&E products generated and disseminated at county/ sub-county levels.	TBP	TBP	TBP	CDH, NACC, NASCOP, Partners
	Planned evaluations, reviews, surveys and implementation science on HIV response for general and key populations implemented and results disseminated in a timely manner	Strengthen county M&E capacity to effectively track MCASP performance and HIV dynamics at county and decentralized levels.	Percentage evaluations undertaken based on MCASP.	TBP	TBP	TBP	CDH, NACC, NASCOP, Partners

STRATEGIC DIRECTION 7: INCREASING DOMESTIC FINANCING FOR A SUSTAINABLE HIV RESPONSE

KASF Objective	MCASP Results	Key Activity	Indicator	Baseline	Mid-term Targets	End -term Targets	Responsibility
Increasing domestic financing to 50%	15% of the county health budget allocated to the HIV programs annually.	Develop and implement a county HIV response funding advocacy strategy.	Proportion of county health budget allocated to HIV sub-sector including structural and behavioural interventions.	TBP	30%	50%	CDH, NACC, NASCOP, KEPSA, FKE, Partners
	Involvement and inclusion of the private sector in the HIV response.	Establish and operationalize a county HIV response Public-Private Partnership.	Proportion of HIV funding coming from the public and private sectors.	TBP	TBP	TBP	CDH, NACC, NASCOP, Partners
		County private partners to formulate and implement workplace HIV policies and programs.	Proportion of county sectors that have developed and implemented HIV work-place policies.	TBP	TBP	TBP	CDH, NACC, NASCOP, Partners
	Efficient utilization of HIV program resources	Develop systems to track the HIV county investment.	Total county funds invested on HIV from various sources.	TBP	TBP	TBP	CDH, NACC, NASCOP, Partners
		Integrate HIV programs into other health programs including TB, malaria, non-communicable diseases.	Percentage of health and non-heath programs integrating HIV and AIDS in the county.	TBP	TBP	TBP	CDH, NACC, NASCOP, Partners

STRATEGIC DIRECTION 8: PROMOTING ACCOUNTABLE LEADERSHIP FOR DELIVERY OF MCASP RESULTS BY ALL SECTORS AND ACTORS							
KASF Objective	**MCASP Results**	**Key Activity**	**Indicator**	**Baseline**	**Mid-term Targets**	**End -term Targets**	**Responsibility**
Promote good governance practices by identifying, developing and nurturing effective and committed leaders for the HIV and AIDS response	Effective leadership mechanisms that ensure quality service delivery.	Institute and adhere to responsive results measurement mechanisms, supervision and controls to ensure efficient and effective quality service delivery.	Proportion of HIV related indicators included and rated within the county performance contracting system.	TBP	TBP	TBP	CDH, County Public Service NACC, NASCOP, Partners
	County HIV multi-sectoral coordination structure established.	Establish and strengthen functional and competent HIV coordination mechanism.	Number of HIV coordination meetings held and documented at county/sub-county and community levels annually.	TBP	TBP	TBP	CDH, NACC, NASCOP, Partners

ANNEX 2

Costing Plan

Note: Costing model based on MoH costing			
STRATEGIC DIRECTION 1- REDUCTION OF NEW INFECTIONS			
Recommended Actions	**Target Population**	**Total Cost (Ksh Millions)**	**By when**
Innovative HIV testing and counseling (HTC) models.	All populations	605.7	2020
Establish youth friendly HTC services.	Youth/Adolescents	2.5	2020
Initiate community stigma reduction strategies in order to create service demand for HTC.	All populations	162.8	2020
Offer HTC to partners and families of all HIV positive clients.	PLHIV	28	2020
Regular outreach and contact with KPs through peer based education, treatment and support.	KPs	193.2	2020
Offer harm- reduction interventions to PWIDS and PWUDs.	KPs	144	2020
100% proper condom use among sexual active groups.	KPs	4.14	2020
	Sub Totals	**1140.34**	
STRATEGIC DIRECTION 2: IMPROVING HEALTH OUTCOMES AND WELLNESS OF ALL PEOPLE LIVING WITH HIV AND AIDS			
Recommended Actions	**Target Population**	**Total Cost (KshMillions)**	**By when**
Improve timely linkage to care for persons diagnosed with HIV.	PLHIVs	248	2020
Strengthen facility and community linkages with inter- and intra- facility referral protocols and linkage strategies.	HCW	2	2020

Integrate HIV testing, care and treatment services into maternal, neonatal and child health settings and services.	Health facilities	125	2017
Utilize peer support and networks of adolescents living with HIV.	Youth/Adolescents	0.5	2019
Integrate alcohol and drug dependence reduction strategies in care services.	PWUDS, Health facilities	2	2019
Scale up key population friendly HIV care and treatment services with peer mobilization and support.	KPs Health facilities	100	2019
Purchase and installation of CD4 machines-Pima machine and viral load machine.	Health facilities	2.3	2019
	Sub Total	**479.8**	

STRATEGIC DIRECTION 3: USING A HUMAN RIGHTS APPROACH TO FACILITATE ACCESS TO SERVICES FOR PLHIV, KPS AND OTHER PRIORITY GROUPS IN ALL SECTORS

Recommended Actions	Target Population	Total Cost (Ksh Millions)	By when
Remove barriers to access of HIV, SRH and rights information and services to all populations.	All populations	25	2020
Reduce levels of sexual and gender based violence for PLWH, KPs , women, men, boys and girls.	Indicated populations	7.5	2020
Promote uptake of HIV pre- and post-exposure prophylaxis among survivors of sexual violence and priority population.	Indicated populations	50	2020
Leverage on religious and cultural institutions to address HIV related stigma among PLHIVs and violence among KPs.	Religious, Faith-based communities	100	2020
Develop and disseminate population specific and user friendly information including Braille.	PWDs, PLHIVs	100	2020
Develop policies to protect priority populations when accessing HIV and health services.	PWDs, vulnerable and marginalized populations	25	2020
Monitoring stigma and discrimination among health workers.	Health facilities	4	2020
Initiating heath-setting stigma reduction campaigns.	Health facilities	4	2020

Increased protection of human rights and access to justice for PLHIV, KPs , women, boys and girls.	PWDs, vulnerable and marginalized populations	7.5	2020
Improving access to legal and social justice and protection from stigma and discrimination in the public and private sectors.	All populations	162.8	2020
	Sub Total	**485.8**	

STRATEGIC DIRECTION 4: STRENGTHENING INTEGRATION OF COMMUNITY AND HEALTH SYSTEMS

Recommended Actions	Target Population	Total Cost (Ksh Millions)	By when
Increased number of functional community units in the county.	Communities	50	2017
Improve community and facility referral system.	Communities	10	2018
Scale up Community Health High Impact Interventions through integration, use of peer support networks and technology including socio media.	Communities, Youth, Adolescents	5	2018
Improve procurement and management of medical products and technologies, with emphasis being placed on ensuring the commodities are	HCW	3	2020
Provide an adequate and competent workforce to deliver integrated HIV services in the county.	County	20	2020
Revitalize the Community Health Strategy (CHS) to realize its implementation with regard to establishment of CUs and the remuneration of CHVs.	County Department of Health	5	2020
Ensure firm leadership by the county to guide the delivery of the health sector priorities.	County Department of Health	3	2019
Improve community and facility referral system.	All facilities	10	2019
Establish minimal package/standards for guiding community and workplace health implementation and practice.	Communities and facilities	2	2017
	Sub Total	**108**	

STRATEGIC DIRECTION 5: STRENGTHENING RESEARCH, INNOVATION AND INFORMATION MANAGEMENT TO MEET MCASP GOALS			
Recommended Actions	**Target Population**	**Total Cost (KshMillions)**	**By when**
Identify barriers to testing and access to interventions services by populations in the county.	All populations	10	2016
Barriers to access among PWDs and other populations of priority identified and addressed.	PWDs, Other priority populations	10	2016
Determine impact of alcohol and drug use on HIV prevention by KPs and their geographical distribution.	General and specific populations, PLHIVs	20	2016
Evaluate Opiate Substitution Therapy/ Medically Assisted Therapy programme and Needle and Syringe Exchange Programme.	PWIDs	25	2016
Identify and test interventions that address determinants and barriers to linkage into care for PLHIV.	PLHIVs	12.5	2016
Determine outcomes and causes of loss to follow up among PLHIV on care and treatment.	PLHIVs	12	2017
Single out, amend or repeal all health access disenabling laws at national and county assemblies.	General population	1.5	2016
	Sub Total	**91**	

STRATEGIC DIRECTION 6: PROMOTE UTILIZATION OF STRATEGIC INFORMATION FOR RESEARCH, MONITORING AND EVALUATION TO ENHANCE PROGRAMMING			
Recommended Actions	**Target Population**	**Total Cost (Ksh Millions)**	**By when**
Establish a multi-sectoral HIV programming web-based data	County health system	2	2016
Establish and strengthen functional multi-sectoral HIV M&E coordination structure and partnership at county level.	Facilities, CUs	5	2016
Put in place sustainable financing for HIV M&E planning activities.	County	2	2016
Strengthen routine HIV information management at county level.	CHIMS, HMIS, Situation Room, HIPSOR	2	2016
Conduct regular M&E supervision, data quality audits and verification.	County health	2.5	2020
	Sub Total	**13.5**	

STRATEGIC DIRECTION 7: INCREASING DOMESTIC FINANCING FOR SUSTAINABLE HIV RESPONSE			
Recommended Actions	**Target Population**	**Total Cost (Ksh Millions)**	**By when**
Developing and implementing a county HIV financing lobbying strategy.	County Health Department	5	2017
Ensure participation of PLHIVs and other interested stakeholders in budget forums (citizen participation).	PLHIVs, Stakeholders, Wananchi	3	2016
Establish a framework for HIV Combination Prevention Strategy.	County Health Department	5	2016
Institute a corruption eradication strategy for health/HIV programmes at all levels.	County	2	2016
Establish, operationalize a County HIV funding PPP.	Privates	2	2017
	Sub Total	**17**	

STRATEGIC DIRECTION 8: PROMOTING ACCOUNTABLE LEADERSHIP FOR THE DELIVERY OF THE MCASP RESULTS BY ALL SECTORS AND ACTORS			
Recommended Actions	**Target Population**	**Total Cost (Ksh Millions)**	**By when**
Regular support and supervision for healthcare givers.	County Health Department	**2.5**	**2015**
Establish and strengthen a functional and competent HIV coordination mechanism at the county and sub-county levels.	County Health Department	**3**	**2015**
Establish and operationalize a HIV multi-sectoral committee to oversee HIV mainstreaming at the ounty level.	County Government	**1**	**2016**
Roll out a Partner-Coordination online reporting platform.	County Government	**2**	**2016**
	Sub Totals	**8.5**	

Summary	
Strategic Direction 1 sub-total	1,140,340,000
Strategic Direction 2 sub-total	479,800,000
Strategic Direction 3 sub-total	485,800,000
Strategic Direction 4 sub-total	108,000,000
Strategic Direction 5 sub-total	91,000,000
Strategic Direction 6 sub-total	13,500,000
Strategic Direction 7 sub-total	17,000,000
Strategic Direction 8 sub-total	8,500,000
Total	**2,343,940,000**

Costing standards based on the KNASPIII Framework & 2013 Population Estimates (not exhaustive)

Table 7: KNASP III Costing Model

Intervention	Unit Cost	Source
BASIC PROGRAMMES		
ART	$561 per patient per year	NACP III
Care and support	$52 per patient per year	NACP III
PMTCT	$19 per mother-baby pair	NACP III
Condoms	$0.06 per condom distributed	NACP III
Male circumcision	$38.70 per circumcision	Kioko, 2010 [2]
Prevention for sex workers and clients	$70 per person per year	NACP III
Prevention for MSM	$42 per person per year	NACP III
Harm reduction counseling for PWID	$48 per person per year	NACP III
Special populations	$55 per person reached	NACP III
ENABLING ENVIRONMENT		
Provider initiated testing and counseling	$5.58 per person	Obdure, 2012 [1]
Workplace prevention	$24 per covered employee	International averages

Community mobilization	$1.50 per population	NACP III
Mass media	$625,000 per campaign	NACP III
School-based programs	$120 per teacher trained	NACP III
Out-of-school youth	$7.44 per youth reached	NACP III
Program management	7.4% of direct costs	NACP III

Obure CD, Vassall A, Michaels C, Terris-Prestholdt F, Mayhew S, Stackpool-Moore L, Warren C, The Integra Research Team, Watts C. Optimizing the cost and delivery of HIV counseling and testing services in Kenya and Swaziland. Sexually Transmitted Infections. 2012; 88: 498-503.

Kioko U. Estimating the costs and impacts of male circumcision in Kenya, 2010, unpublished.

NACP III. Kenya National AIDS Strategic Plan, 2009/10 – 2012/13. Supporting Documents for the Plan, NACC. Unit costs calculated from number reached and total costs.

ANNEX 3

References and Operational Documents

1. The Kenya AIDS Strategic Framework (KASF) 2014/2015- 2018/2019 that seeks to reduce new HIV infections by 75% come 2019.
2. DHIS-MOH/CHD
3. COBPAR- NACC
4. The Kenya HIV Prevention Revolution Road Map: Count Down to 2030 – that set out to reduce HIV incidence by 50% in 2015, by 75% by 2020 and zero new HIV infections by 2030.
5. The Kenya HIV County profiles 2014 – that analyzed each county profile, established baseline programme data and made county-specific priority programme interventions.
6. The Monitoring and Evaluating Framework for KASF 2014/2015-2018/2019 – providing indicators for KASF strategic Direction's.
7. The Annual Kenya HIV Estimates – that provides an annual progress in HIV programming.
8. The Strategic Framework towards Elimination of Mother to Child Transmission of HIV and keeping Mothers Alive 2012-2015 – that aims to reduce MTCT rate to less than 5% and HIV-related maternal mortality by 50%.
9. A Strategic Framework for Engagement of the First Lady in HIV control and promotion of maternal, newborn and child health in Kenya 2013-2017- which seeks to provide guidance for the engagement of the First Lady on political championship towards elimination of new HIV infections among children and promoting maternal and child birth.
10. The National Guidelines for HIV Testing and Counseling, Couples and Prevention with Positives (Positive Health, Dignity and Prevention).
11. Policy Analysis and Advocacy Decision Model for services for Kenya populations in Kenya.
12. Kenya's Fast – track Plan to End HIV and AIDS Among Adolescent and Young People 2015-2017 – which seeks to reduce among adolescents and young people HIV incidence, AIDS-related mortality and stigma and discrimination by 40%, 15% and 25% respectively by 2017.
13. The Constitution of Kenya (2010).
14. The Kenya Vision 2030.
15. The Adolescents and Youth Sexual Reproductive Health and Development Policy (2003) and its Plan for Action (2007).
16. Education Sector Work Plan Policy on HIV and AIDS Second Edition (2013).
17. Eastern and Southern Africa Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People.
18. The Kenya Guidelines for conducting HIV and Sexual Reproductive Health Research with adolescents.
19. The Kenya National Reproductive Health Policy (2007) and Strategy (1997 – 2010).
20. The Kenya National Maternal and Newborn Health (MNH) Road Map (2010).
21. Obure CD, Vassall A, Michaels C, Terris-Prestholdt F, Mayhew S, Stackpool-Moore L, Warren C, The Integra Research Team, Watts C. Optimising the cost and delivery of HIV counseling and testing services in Kenya and Swaziland. Sexually Transmitted Infections. 2012; 88: 498-503.
22. Kioko U. Estimating the costs and impacts of male circumcision in Kenya, 2010, unpublished.
23. NACP III. Kenya National AIDS Strategic Plan, 2009/10 – 2012/13. Supporting Documents for the Plan, NACC. Unit costs calculated from number reached and total costs.

Mombasa County AIDS Strategic Plan 2016 – 2020

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ANNEX 4

MCASP Developing Teams

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