MINISTRY OF HEALTH
KENYA

National Plan for **Accelerating HIV Care** and **Treatment**

2015-2017

National AIDS & STI Control Programme

November 2015

The National Plan for Accelerating HIV Care and Treatment in Kenya 2015-2017 defines the key strategies and actions that need to be undertaken by the national and county governments to contribute to meeting the 90-90-90 targets articulated in the Kenya AIDS Strategic framework by 2019. All reasonable precautions have been taken by NASCOP to verify the information contained in this plan.

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Foreword

Over the last two decades Kenya has made significant strides in the war against HIV & AIDS. The HIV prevalence has reduced from 10% to 6% with 1.6 million people living with HIV. Further, mortality has also reduced from 167,000 in 2003 to about 58,000 AIDS related deaths in 2013, largely due to increased access to antiretroviral therapy.

Despite the gains made, only half of all eligible adults and about a third of children are accessing treatment by end 2014. This is largely due to stigma, suboptimal identification of PLHIV, linkage to care and other health systems related barriers. There is need to increase momentum and reduce HIV morbidity and mortality by accelerating care and treatment. This will in turn contribute to achieving Kenya's Vision 2030, which seeks to ensure a healthy workforce that will transform Kenya into a middle-income rapidly industrializing country by 2030, that offers all its citizens a high quality of life.

The National Plan for Accelerating HIV Care and Treatment Plan (2015-2017) seeks to contribute to achieving goals outlined in the Kenya AIDS Strategic Framework (KASF) and Kenya Health Sector Strategic and Investment plan (KHSSP). The Kenya AIDS Strategic Framework sets ambitious targets of identifying 90% of HIV infected children, adolescents and adults, providing treatment to 90% of those identified and achieving at least 90% viral suppression among those on antiretroviral therapy by 2019.

The Plan focuses on strengthening the health systems building blocks to ensure accelerated implementation of care and treatment services while sustaining achievements.

In line with the Constitution, the role of the National Government's Ministry of Health will be to bridge policy gaps, set standards and provide technical assistance to Counties to set targets and implement service delivery. The County Health Departments will provide health services and leadership in their respective areas. They will be expected to mobilize county level stakeholders for multi-sectoral response to achieve results.

The Ministry of Health is grateful to all the staff, partners and stakeholders that contributed in various ways in shaping the content and structure of this plan. The Ministry is committed to fully implement this plan. The plan has robust results and performance monitoring matrices that will serve as accountability tools. Further, they will support evidenced-based decision making with the goal of attaining set targets.

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Acknowledgements

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Sincere appreciation goes to the NASCOP Care and Treatment team for spearheading this process and working tirelessly to ensure the plan was developed and completed as desired.

I take this opportunity to pay special compliments to Dr Irene Mukui of NASCOP for her role in coordinating and providing guidance in the development of the plan, Dr Irene Inwani and Dr Mary Wangai; the consultants who synthesized all inputs and compiled the plan and the key members who took their time to review and provide technical inputs into this plan.

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Head of National AIDS & STI Control Program
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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral Drug
CASCO	County AIDS and STI Coordinator
CLHIV	Children Living with HIV
CDC	Centers for Disease Prevention and Control
CD4	CD4+ T-cell
CHV	Community Health Volunteers
CS	Cabinet Secretary
CQI	Continuous Quality Improvement
DOD	Department of Defense
DMS	Director of Medical Services
DQA	Data Quality Audit
EID	Early Infant Diagnosis
EMR	Electronic Medical Records
FDC	Fixed Drug Combinations
GOK	Government of Kenya
HAART	Highly Active Antiretroviral Therapy
HBTC	Home-Based Testing and Counseling
HCW	Health Care Workers
HEI	HIV Exposed Infant
HIT	HIV Infected infant tracking
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HTC	HIV Testing and Counseling
IEC	Information Education Communication
IPT	Isoniazid Preventive Therapy
KAIS	Kenya AIDS Indicator Survey
KEPH	Kenya Essential Package for Health
KHQIF	Kenya HIV Quality Implementation Framework
KHSSP	Kenya Health Sector Strategic & Investment Plan
KNASP	Kenya National AIDS Strategic Plan
KP	Key Populations
KQMH	Kenya Quality Model for Health
LTFU	Lost to Follow Up
MCH	Maternal Child Health
MIPA	Meaningful Involvement of PLHIV
MNCH	Maternal Newborn and Child Health
MER	Monitoring Evaluation and Reporting
MOH	Ministry of Health
MSM	Men who have Sex with Men
NACC	National AIDS Control Council

NASCOP	National AIDS & STI Control Programme
NCAHU	Neonatal Child & Adolescent Health Unit
NEPHAK	Network of People living with HIV/AIDS in Kenya
NHITC	National HIV Integrated Training Curriculum
NIMART	Nurse Initiated Management of Antiretroviral Treatment
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PITC	Provider Initiated Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
POC	Point-of-Care
PPP	Public Private Partnerships
SI	Strategic Information
SQA	Service quality assurance
TAT	Turn-around-time
TB	Tuberculosis
TOT	Trainer of Trainers
TWG	Technical Working Group
QA	Quality Assurance
UMB	University of Maryland, Baltimore
UNICEF	United National Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VL	Viral Load
YFC	Youth Friendly Centers

Executive Summary

The National Plan for Accelerating Care and Treatment aims to rapidly increase identification of persons living with HIV (PLHIV), provide those eligible with antiretroviral therapy and achieve viral suppression. The Plan will be implemented over a two year period, 2015/16 and 2016/17, and serve to fast-track operationalizing the Kenya AIDS Strategic Framework's Strategic Direction 2, which guides HIV care and treatment response in Kenya for a four year period through to 2019.

The overall goal of the Plan is to *'Reduce of HIV related morbidity and mortality and contribute to preventing new infections'*. More specifically, the plan seeks to identify 80% of infected individuals, provide ART to at least 90% of those identified and achieve 90% viral suppression in those on antiretroviral therapy by the end of 2017.

The Plan defines the implementation framework of the acceleration of HIV care and treatment, thereby contribute to achieving the 90:90:90 targets set for 2019 in Kenya AIDS Strategic Framework 2014/15-2018/2019. It will also provide guidance on high impact strategies to achieve set targets based on the county HIV burden and context.

Further, the Plan seeks to recognize and build on care and treatment gains that have been made over the last two decades. Additionally it articulates the key barriers and uses them to develop an implementation plan and performance monitoring framework. It focuses on barriers that hamper identification of PLHIV, linkage to care and treatment, retention in care and access to viral load testing. The Plan addresses these barriers by strengthening health systems in a bid to sustain results.

The target audience for the Plan is drawn from actors and stakeholders at both national and county level with the aim of mounting a multi-sectoral coordinated and accelerated scale up of HIV care and treatment. Key stakeholders include persons living with HIV, civil society, other key government agencies, development partners, implementing agencies, faith based and private sector. The Plan will serve as a roadmap for implementers and stakeholders to align individual plans, resources and performance monitoring.

The Plan is founded on the strengthening health systems as articulated in seven thematic areas as follows:-

- **Thematic Area 1: Leadership and Governance:** The National level, NASCOP will work to close identified policy gaps, which are a barrier to implementation of the acceleration plan. In addition, NASCOP will give technical assistance to Counties to set targets, develop corresponding implementation plans and monitor for results. Counties will strengthen leadership and governance structures such as multi-sectoral technical working groups and periodic audits.
- **Thematic Area 2: Service Delivery:** Service delivery primarily occurs at the county level in line with the Constitution. Counties with high disease burden will utilize high yield strategies to identify the infected individuals especially children and adolescents. Further, the Counties will implement activities to link, track and retain identified PLHIV. The Plan also seeks to optimize the community strategy to support acceleration.
- **Thematic Area 3: Health Products and Technologies:** Sustained provision of commodities has continued to be a challenge. However the Plan will seek to strengthen supply chain and commodity management through enhanced quantification, procurement, distribution, periodic stock monitoring and use of data for decision making. Another key area of focus is strengthening laboratory systems to increase access and equity.

- **Thematic Area 4: Human Resource for Health (HRH):** Scale up of treatment and care can only be achieved by a well capacitated workforce. Rapid assessment of health worker numbers and training needs will be conducted to inform strengthening of this crucial resource. Improving HRH skills, competencies and appropriate deployment will be crucial to achieving desired results. Building capacity of the Education sector and other relevant agencies to support children, adolescents and institutionalized patients will also be done.
- **Thematic Area 5: Information Management and Research:** The Plan implementation will seek to ensure relevant tools are in place to capture and manage data for evidence-based decision making. The national Ministry will build capacity at the county level to scale up electronic medical record (EMR) platforms and conduct regular data quality audits. Operational research will also be institutionalized to inform practice.
- **Thematic Area 6: Communication Strategy:** A culturally appropriate communication strategy will be developed to include, age, population and region appropriate, specific messages for wider HIV services such as adherence, retention and treatment literacy. Implementation will take place at both national and county levels.
- **Thematic Area 7:** Health Financing: Strategies to increase resources for implementation of the Plan will be employed by the National and County Governments. This will involve identification of synergies and opportunities for resource mobilization, including from non-traditional sources. These resources will be aligned to county and epidemic priorities and minimize inefficiencies.

To ensure implementation of the Plan is well monitored, specific indicators have been selected to demonstrate progress towards achieving the set targets. The results and monitoring matrices will also serve as governance tools for both the national and county levels. More specifically they include key output, outcome and program implementation indicators that will be measured and regularly reported. In addition, indicators have been included to track care and treatment for populations previously not tracked such as children, adolescents and key populations.

In summary, the National Plan for Accelerating Care and treatment aims to contribute to a Kenya free of HIV infections, morbidity and mortality.

1.0
Introduction

The National Plan for Accelerating HIV Care and Treatment aims to rapidly identify persons living with HIV (PLHIV), provide them with antiretroviral therapy and achieve viral suppression over a two year period; 2015/2016-2016/2017. This is plan is anchored on the Kenya AIDS Strategic Framework (KASF)[1] and Kenya Health Sector Strategic and Investment plan (KHSSP)[2]. These documents articulate key strategic objectives for the health sector that focus on improving health outcomes and wellness of persons living with HIV.

The Vision of the Kenya AIDS Strategic Framework (KASF) 2014/15 -2018/19 is to attain a Kenya free of new HIV infections, stigma and AIDS related deaths. The framework will contribute to the achievement of the national Vision 2030 by ensuring universal access to HIV prevention, treatment care and support. The Acceleration Plan has been developed to operationalize the first two years of the KASF's strategic direction 2 which aims to *'Improve health outcomes and wellness of People Living with HIV'*.

The Kenya Health Sector Strategic and Investment Plan (KHSSP) identifies HIV & AIDS as the leading cause of death and a key cause of ill health in the population. Providing HIV care and treatment for people living with HIV has the potential to not only reduce deaths and illness but also contribute to prevention of new HIV infections.

The Acceleration Plan seeks to provide a roadmap for rapid implementation and outcome monitoring of HIV care and treatment for the fiscal years 2015/16 and 2016/17. Further, it aims to attain universal coverage of people living with HIV (PLHIV), accelerate treatment gains and reduce mortality and morbidity across the Country. In addition, Counties with a high HIV burden will be guided to identify and implement high impact strategies.

As a roadmap, all health care managers and providers, Key Government Ministries and related Sectors (e.g. Education, Agriculture), Development Partners, implementing organizations, Private sector, Civil Society and other stakeholders at the national and counties will be able to use the Plan to determine their respective targets, mobilize resources and align activities to contribute to a Kenya free of HIV infections, morbidity and mortality.

1.1 Rationale for the plan

The Kenya AIDS Strategic Framework sets ambitious targets to identify 90% of HIV infected children, adolescents and adults, provide treatment to 90% of those identified and achieve at least 90% viral suppression among those on antiretroviral therapy over four years, by 2019. The 90-90-90 targets are aligned to the global targets set by the Joint United Nations Programme on HIV/AIDS (UNAIDS) towards ending AIDS by 2030[3]. These global and national targets recognize that ending AIDS requires providing antiretroviral treatment to all who require it. As at December 2014, of the expected coverage for ART based on the 90-90-90 targets, only 55% of adults and 53% of children were accessing HIV treatment.

The Plan to accelerate HIV care and treatment for all children, adolescents and adults living with HIV, defines the key strategies and actions that need to be undertaken by the national and county governments to contribute to meeting the 90-90-90 targets articulated in the Kenya AIDS Strategic framework by 2019. Further, the plan provides strategic policy, planning and implementation guidance and leadership for a coordinated initiative.

1 MOH, KASF, 2014.
2 MOH, KHSSP 2014
3 UNAIDS 2014.

1.2 Target Audience

The target audience for the Acceleration Plan is drawn from all actors and stakeholders at National and County level with the goal of mounting multi-sectoral coordinated and accelerated scale up of HIV care and treatment.

1. **National Government** – This plan will serve as a roadmap for the key departments and agencies of the Ministry of Health such as NASCOP, NACC and Division of Family Health (including Community Health and Development Unit).
2. **County Government** – Service delivery is the Constitutional mandate of the County governments. The plan therefore lends its self as a roadmap for coordinated and rapid implementation of HIV care and treatment at county level under the stewardship of the County Health Department.
3. **Other Key Government Sectors and Agencies** – These include Education, Devolution and Planning, Social services, Finance and Agriculture. These sectors will also be roped in to contribute to accelerated implementation of HIV care and treatment as key stakeholders at both national and county levels.
4. **Development Partners and implementing agencies** – These stakeholders will use this plan as a roadmap to align their resources, technical support and care and treatment activities.
5. **Private sector** – The private sector is a significant player in the provision of health care and resource mobilization. The Plan will provide a framework for enhancing coordinated response between the public and private sector. The private sector will be guided to align their plans and service delivery practices. Further, public private partnerships will be targeted for resource mobilization to contribute to the successful implementation of the Plan.
6. **Faith Based health sector** – The faith based organizations also significantly contribute in the provision of resources and service delivery. As such, the plan will also be a roadmap to guide the sector to work in tandem with the national program.
7. **Civil Society and community based organizations including PLHIV networks** – The civil society is a key stakeholder in achieving the goals of the acceleration plan, including identifying the barriers to care and treatment, crafting the response and being advocates for implementation of the plan and stigma reduction.

Target Audience for the Plan:

1. National Government
2. County Government
3. Key Government Sectors and Agencies e.g. Education, Social Services, and Agriculture
4. Development Partners and Implementing Agencies
5. Private Sector
6. FBO Sector
7. Civil Society and CBOs

1.3 Purpose of the document

1. Define the implementation framework for the acceleration of HIV care and treatment to contribute towards meeting the 90:90:90 targets by 2019.
2. Provide guidance on high impact strategies to achieve acceleration targets based on the county burden and context.
3. Provide guidance to both National and County Governments for target setting, monitoring and evaluation of the acceleration initiative.
4. Serve as a guide to determine resource needs and mobilize the required resources.

1.4 Goal

Reduce HIV related morbidity and mortality and contribute to preventing new HIV infections.

1.5 Objective

By the end of 2017, identify 80% of infected individuals, provide ART to at least 90% of those identified and achieve 90% viral suppression for those on antiretroviral therapy.

These targets are planned to be achieved by 2017. The overall plan is to contribute to meeting the 90-90-90 targets by 2019.

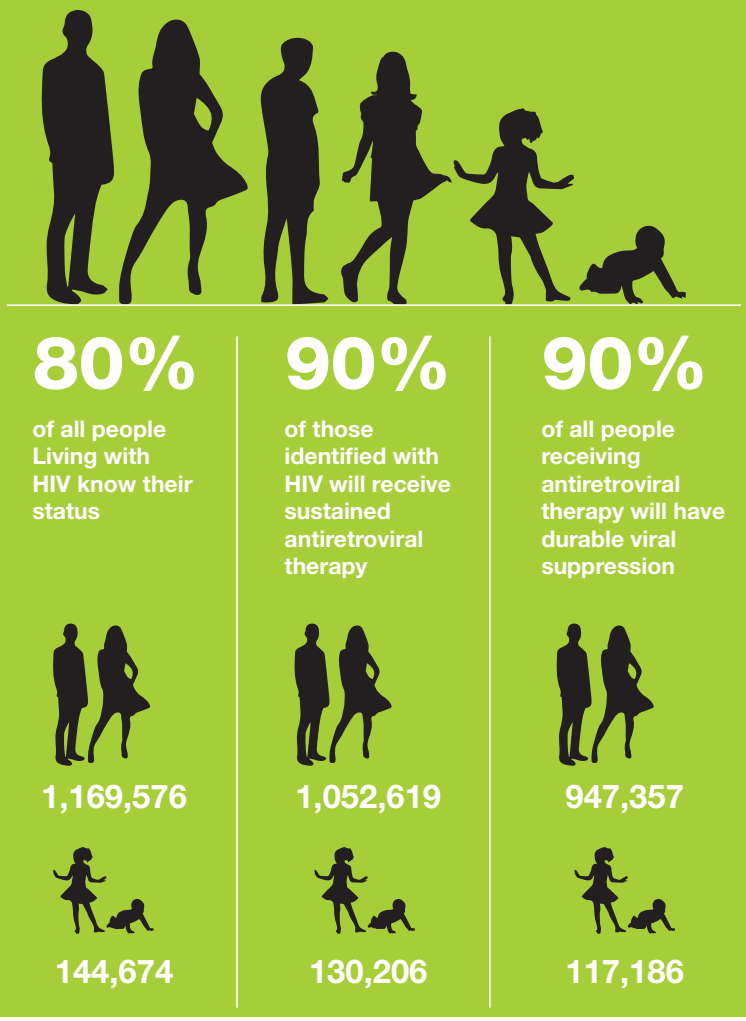


Figure 1: Summary of Key Objectives and Expected Results by end of 2017

2.0
Situational Analysis

2.1 Epidemic Analysis

Prevalence: The HIV prevalence in Kenya is estimated at 6% with 1.6 million people living with HIV in Kenya, of which 179,894 are children aged 0-14 years.[4] This prevalence represents a decline from a high of 10.5% in the 1990s. Traditionally, HIV prevalence surveys have not provided estimates in children, until KAIS 2012. In this latter survey, the prevalence in children aged 18 months to 14 years was estimated at 0.9%[5].

Incidence: The 2014 Kenya HIV estimates indicated that a total of 101,560 new infections occurred. About 13,000 of the new infections occurred in children, majority of which were through mother to child transmission. The MTCT rates remain high, with estimates of 14%[6].

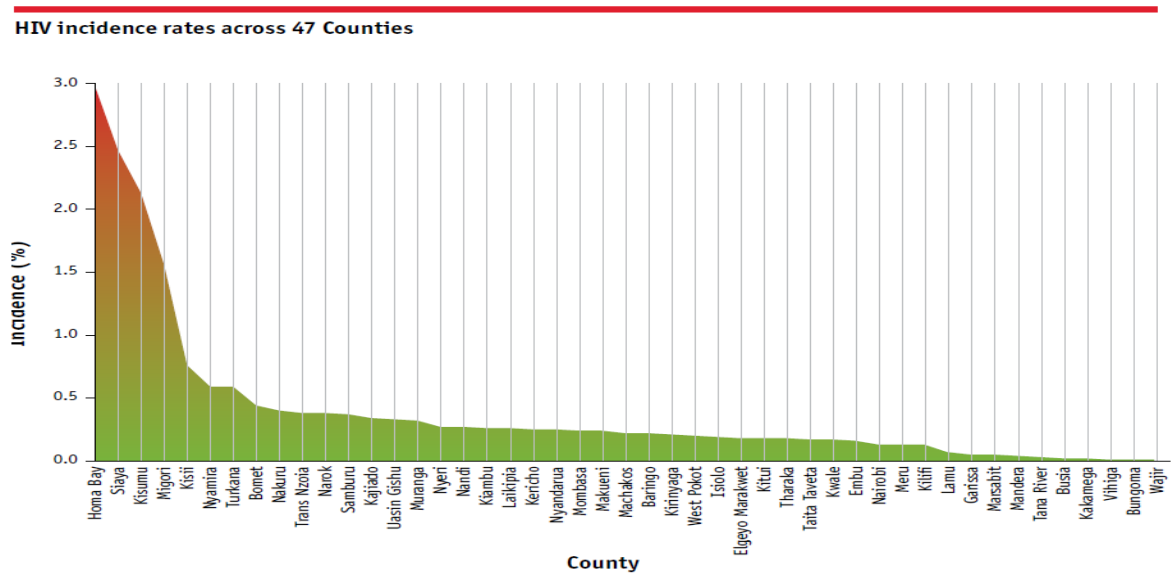
Of the new infections that occurred in among adults:-

- 93.7% were sexually transmitted
- 44% occurred among heterosexual couples in unions
- 21% of all new adult infections occurred among young women aged 15-24years
- Key populations accounted for 30% of all new HIV infections even though they only constitute 2% of the general population;
  - *15.2% of new adult HIV infections occurred amongst men who have sex with men (MSM) and Prisoners*
  - *14.1% amongst sex workers.*

Regional disparities in the incidence of HIV have been demonstrated[7]. 65% of the new infections occurred in 9 Counties, namely; Homa Bay, Kisumu, Siaya, Migori, Kisii, Nyamira, Nakuru, Turkana and Bomet[8]. This underscores the need to rapidly implement effective geographical and population targeted prevention and treatment programs.

Mortality: Since 2003 annual AIDS related deaths have declined. In 2013, approximately 58,465 people died of AIDS related causes compared to 167,000 in 2003. The decline has been attributed to the expanded access to ART. In 2013, a quarter

Figure 2: HIV Incidence rates across 47 counties[9]



4 MOH. Kenya HIV Estimates. 2014
5 NASCOP KAIS 2012
6 KASF 2014
7 MoH Kenya HIV Estimates. 2014
8 MoH Kenya HIV Estimates. 2014
9 MoH. HIV Prevention Revolution Road Map 2014

of all AIDS related deaths occurred among children and adolescents 0-19 years, a reflection of the dispropritionately low ART coverage among these sub populations.

Orphaned and Vulnerable Children: Cumulatively, about 1.1 million children have orphaned by HIV & AIDS as per the 2014 National HIV Estimates[4].

2.2 HIV Care and Treatment Response Analysis

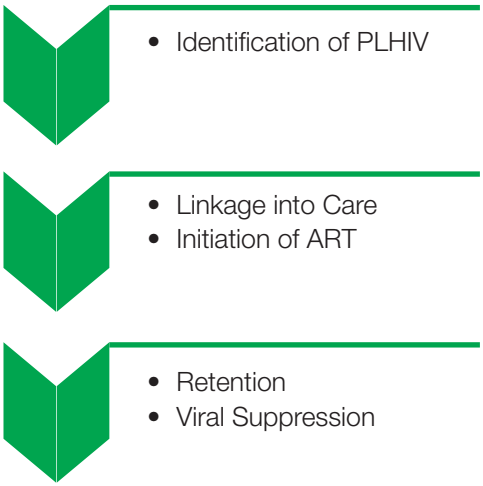
2.2.1 Access to antiretroviral therapy

Kenya has made significant progress in increasing access to HIV care and antiretroviral therapy through the collaborative effort of the Government of Kenya, Implementing and Development Partners. By end-2014, over 700,000 persons living with HIV were receiving ART, including 68,000 children aged 0-14 years. Based on the expected 90% target for ART, this translates to ART coverage of 55% among adults above 15 years and 53% for children 0-14 years[10]. Though treatment coverage remains low, ART uptake among adults aware of their HIV status is as high at 84.5% according to KAIS 2012[11].

The 2014 Kenya Guidelines for use of antiretroviral medicines for treating and preventing HIV Infection have moved to earlier HIV diagnosis and treatment for children, adolescent and adults, including HIV-infected pregnant, breastfeeding women, sexual partners in sero-discordant relationships, TB and Hepatitis B co-infected persons. This shift has resulted in the increase in the number of people living with HIV who need to be put on ART[12].

Treatment analysis of PLHIV along the HIV continuum of care is typically depicted using a 5

Cascade of HIV Care



stage cascade, namely; diagnosis of HIV infection, linkage to care, receipt of antiretroviral therapy, retention and achievement of viral suppression. This concept, also known as 'cascade of care', has helped the Country to identify HIV service provision gaps, which prevent PLWH from realizing the benefits of antiretroviral therapy. In Kenya, the numbers in care are used as a proxy of identified PLHIV, linked and in care, since linkage is not routinely tracked.

The cascades show HIV care and treatment response analysis and the progress towards achieving the 90:90:90 targets set for end of 2019. This data used below to develop the cascades is derived from programme data[13] for three sub populations:

a) Children aged 0-9 years.
b) Adolescents aged 10- 19 years. Data, on adolescents is not routinely captured and documented as existing reporting tools capture HIV infected persons in two categories; children aged 0-14 years and adults aged more than 15 years.
c) Adults aged 20 years and above.

10 NASCOP DHIS 2 reports 2014
11 KAIS 2012
12 NASCOP Guidelines for antiretroviral therapy in Kenya, 2014
13 NASCOP DHIS 2 reports 2014

A. Paediatric Cascade of Care

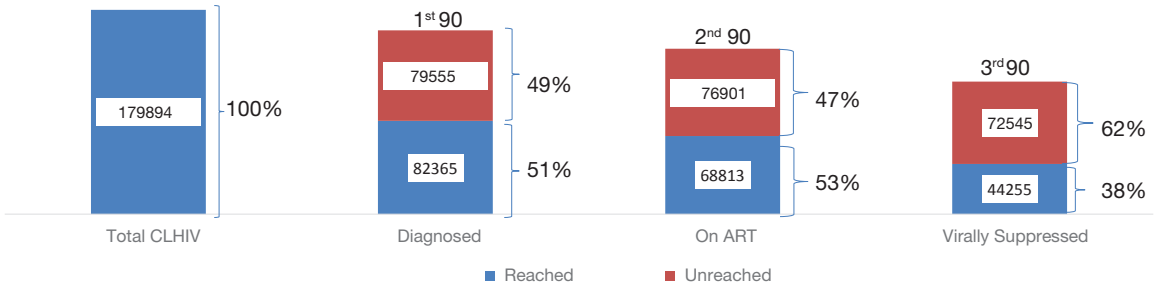


Figure 3: Paediatric HIV Care Cascade

To demonstrate the achievements made in the care and treatment of Children living with HIV, Figure 3 above shows the following:

Identification and Linkage: According to programmatic data, only 51% of HIV infected children have been diagnosed and linked into care. These low testing rates are expected as KAIS 2012 showed that only 40.5% of parents of infected children know of their children's HIV status. Low testing rates and low parental knowledge of HIV status have resulted in the low identification rates. There is limited national data on linkage however programmatic data indicate that linkage is low for children.

Access to DNA PCR testing is estimated at 67% from programmatic data, in part due to challenges in laboratory infrastructure and a centralized laboratory referral system. Additionally, Longitudinal surveillance of Paediatric HIV treatment and Care in Kenya Survey (LSPCTIK) showed that HIV diagnosis is late, with those less than two years being identified at 14 months IQR (7-19) and those above 2 years at 84 months IQR (56-118)[14].

Initiation of Treatment: As at end-2014, 53% of targeted children were receiving ART. The LSPCTIK survey data showed that the median age for initiation of treatment of children less than 2 years is 18.8 months (IQR 11.6-24.4) and 83.1 months (IQR 55.2-117.0) for children 2 years old and older.

Viral Suppression: Determination of viral suppression rates in children has been calculated from national survey data which showed that 65% of children on ART achieve suppression[15]. Based on this study data, it has been estimated that only 38% of children expected to be suppressed against the 90% target in the cascade above are virally suppressed.

The LSPCTIK Survey found that only 46% and 56% of children aged <2 years and >2 years respectively at enrolment were active in care after a median follow time of 25.6 months[16]. Better retention rates were observed among children on HAART compared to those not on ART.

14 NASCOP/CDC, LSPCTIK survey 2012.
15 MOH/CDC 2013
16 NASCOP/CDC, LSPCTIK survey 2012.

B. Adolescent Cascade of Care

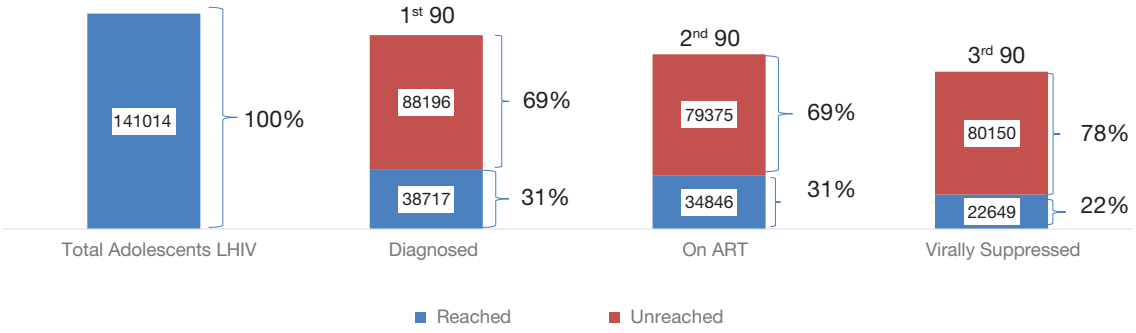


Figure 4: Adolescent HIV Care Cascade

The National HIV Estimates 2014 was used to model the number of adolescents living with HIV. The graph above indicates the following:-

Identification and Linkage: Based on the 90% target depicted in the cascade, only 31% of adolescents aged 10-19 years living with HIV had been identified and enrolled care by december 2014. Linkage is not systematically tracked. However programmatic data indicate that linkage is low for adolescents.

Initiation of Treatment: Programmatic data showed that majority of the identified adolescents in care, access ART; 90% (34,846). However this represents only 31% of those targetted for treatment.

Viral suppression: Access to viral load testing for adolescents on ART is suboptimal at 65%.

C. Adult HIV Care Cascade

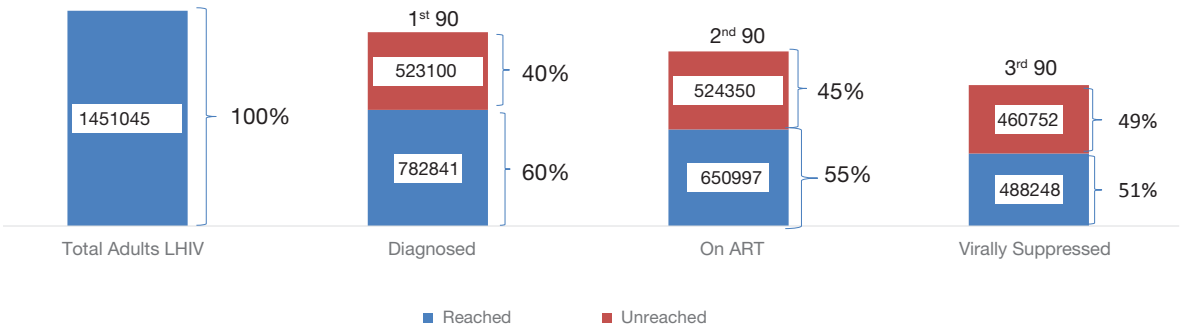


Figure 5: Adult HIV Care Cascade

From the above figure, the number of adults living with HIV was estimated to be 1,451,045 in 2014.

Indentification and Linkage: Of those adults living with HIV, only 54% had been identified and were currently in care. This coverage represents about 60% of those targetted for identification by end of 2019. KAIS 2012 indicated that only 47% of HIV infected adults were aware of their positive status indicating that identification remains a major gap.

Available data from KAIS 2012 suggests that linkage may be less of a problem among adults than children; 89% of infected persons who knew their HIV status were enrolled in HIV care with the majority (81%) enrolling within 3 months of HIV diagnosis[17]. However linkage data is not routinely collected.

Initiation of Treatment: Programmatic data indicates high uptake of ART among those in HIV care. Over 83% adults living with HIV and enrolled into care, were on ART. However this represents only 55% of those in need of ART to reach the 90% target.

Viral Suppression: KAIS 2012 data showed 75% viral suppression among adults on ART. This suppression applied to program data suggests that only 51% of the expecetd 90% suppression is achieved[18].

2.2.2 Access to Non–ART care

The national treatment guidelines make recommendations for a comprehensive package of support and care for PLHIV other than ART, such as co-morbidities/non-communicable diseases management, prevention and treatment of opportunistic infections (OIs), reproductive health services, home/community and palliative care[19]. Some of the interventions aimed at preventing illnesses include provision of clean water, hygiene education, nutrition counselling and support,

Comprehensive Package for Non-ART Care

- Treatment of Co-morbidities including NCDs
- Prevention and treatment of OIs including TB
- Reproductive Health Services
- Palliative and Home Care
- Counselling & Psychosocial Support
- Nutritional Assessment, Counselling & Support

cervical cancer screening and management, cotrimoxazole, isoniazid and malaria prophylaxis among others.

Progress on Provision of Non-ART Care

Cotrimoxazole preventive therapy: Survey data has revealed that 89% of adults[20] and 96% of children living with HIV[21] on care are receiving Cotrimoxazole.

TB screening and prophylaxis: Programmatic reports indicate that there is over 95% screening for TB among all PLHIV in care. Reporting on use of Isoniazid preventive therapy (IPT) for TB among PLHIV is poor.

Screening and management of non-communicable diseases: The national guidelines recommend routine screening for non-communicable diseases among PLHIV using clinical and lifestyle history, examination and selected laboratory tests. Screening focuses mainly on determining cardiovascular disease risk, and identifying PLHIVs with hypertension, diabetes

17 KAIS 2012
18 MOH HIV Drug Resistance In National ART Program 2013
19 NASCOP Guidelines for ART in Kenya. 2011
20 KAIS 2012
21 LSPCTIK 2012

and mental health (depression). Limited available program data from a cohort of 1,510 patients in South Nyanza, suggests the prevalence of hypertension is about 8.3%[22], while that of other co-morbidities is largely unknown. Majority (87%) of these patients had been on ART for a median time of 2.6 (IQR: 1.3 - 4.2) years.

Nutrition assessment, Counselling and support

Levels of malnutrition among PLHIV are high in Kenya. A national survey conducted by Ministry of Health (MOH) and World food Program (WFP) among PLHIV in care and on ART showed significant levels of malnutrition and overall 15% of households had some degree of food insecurity[23].

Levels of Malnutrition in PLHIV:

Adults:

- Obese or overweight- 20%
- Thin or wasted- 16%

Children:

- Stunted - 44%
- Underweight - 19%
- Wasted - 9%

Source: MOH/WFP Report 2013

Sexual and reproductive health services (SRH):

The national guidelines recommend STI screening and management, provision of FP services, screening and management of RH cancers and in particular cervical cancer. The total fertility rate (TFR) is 3.9 births per woman in 2014, denoting a reduction from 4.6 in 2009 according to the KDHS 2014[24]. It is also expected that 6.3% of women of reproductive age (aged 15-49) would get pregnant. A significant proportion of women (18.1%) began child-bearing during their adolescent years, between 15-19 years.

Although contraceptive prevalence rates have steadily increased over time, from 39% in 2003 to 58% in 2014[25], there remains an unmet need for family planning among HIV infected women.

In one study 68.7% women living with HIV infection reported the use of family planning[26], this is in keeping with the unmet need for FP according to the KAIS which lies at 38.9%[27] indicating sub-optimal uptake of a key component of PMTCT services.

Cervical cancer screening coupled with outpatient treatment of precancerous lesions has the potential to prevent the development of a large number of cervical cancers among HIV-infected women[28]. It is feasible and acceptable to provide SRH services within the setting of an HIV care and treatment clinic as evidenced by Huchko et al. where it has been demonstrated that models of integration have the largest effect by maximizing limited resources to improve outcomes[29].

According to the reproductive health road map, Kenya intends to strengthen integration of SRH/FP and HIV services in all facilities by 2015 as one of the main priority activities for reproductive health programs[30].

22 Personal Communication, Mark Hawken 2015.
23 MoH/ WFP. 2013
24 KDHS 2014
25 KDHS 2014:
26 Ngugi et al J.AIDS. Vol.66, Supplement 1, 2014
27 KAIS 2012
28 Huchko MJ, et al, 2011
29 Huchko MJ, et al, 2011
30 MoPHS, MoMS 2010.

2.2.3 Multi-sectoral Response to support Care and Treatment

Multi-sectoral response to support care and treatment began when the Government declared HIV&AIDS a disaster in 1999. Following this declaration the MOH established forums and mechanisms to guide the coordination of the various actors and implementers from different sectors and organizations. This ensured synergistic response, while allowing for flexibility to address region specific challenges.

Key actors in the response included the stakeholders from key government ministries and departments, faith-based communities, people living with HIV, the private sector, non-governmental organizations, community based organizations and other civil society formations at the national level.

Progress on Multi-sectoral Response

Multi-sectoral coordination resulted in significant gains that have been sustained over time. Some of these results include increased access to care and treatment, reduction in HIV incidence, morbidity and mortality. Further, the collaboration has resulted in health systems strengthening for care and treatment such as increased capacity building, provision of equipment and other resources. Additionally multi-sectoral response has increased networking among partners and community based stakeholders.

At the national level technical working groups (TWGs) have been effective coordination mechanisms that have supported the development of care and treatment guidelines, strategies and tools to guide the health sector's response to HIV[31].

National Ministries, State departments, corporations and agencies have established AIDS Control Units that have focused on HIV condom distribution, testing and reduction of stigma.

Other key sector achievements include:

- Education sector has invested the development of an HIV/AIDS policy for the Education sector. Thereafter guidance on sexuality and education, life skills education, university common units in HIV and AIDS and capacity development of teachers have were institutionalized in schools and scaled up[32].
- Labour and Social security sector has invested in social protection of Orphans and vulnerable children[33]. As a result, OVCs have been supported with regular subsidies.
- Agricultural sector has focused on improving food security by implementing policies such as national seed; national food security and nutrition.

In spite of the fact that significant gains made through multi-sectoral collaboration, other mechanisms intended to ensure effective implementation and stakeholder coordination did not take full effect, especially at the decentralized levels[34]. County governments have the opportunity to take advantage of lessons learnt at the national level and improve multi-sectoral coordination and response within their respective regions.

31 End Term Review Kenya National AIDS Strategic Plan III 2009/10-2012/13 Final Report

32 End Term Review Kenya National AIDS Strategic Plan III 2009/10-2012/13 Final Report

33 Ministry of Health, Kenya AIDS Strategic Framework 2014-2019

34 End Term Review Kenya National AIDS Strategic Plan III 2009/10-2012/13 Final Report

3.0
Key Barriers and Gaps

Despite the significant progress made in increasing access to care and treatment, there remain key health systems bottlenecks and barriers that require to be addressed. Strengthening health systems is foundational to realising the acceleration of HIV care and treatment goals, as well as contributing to universal access. The bottlenecks are described using health systems building blocks.

Thematic Area 1: Leadership and Governance

Though strategic policy frameworks and oversight structures exist, there remains a number of gaps that will hamper increased identification and treatment of PLHIVs. Age of consent for services is not clearly defined. As a result unaccompanied adolescents can not access care. Additionally there are no policies on testing /retesting of high risk populations and task sharing.

Previously the national program has been responsible for planning and coordination of the HIV response. In line with the Constitution 2010, devolution of health services to county governments has been implemented[35]. However there are gaps in the leadership, ownership, coordination and technical capacity at county level. Additionally, HIV care and treatment programming is not institutionalized at county level nor is it mainstreamed into county planning and coordination processes.

Thematic Area 2: Service Delivery

A. Coverage of interventions along the cascade of care

Identification of HIV infected persons remains a major barrier to accessing treatment and care. Although access to ART among adults receiving HIV care is high, ART coverage remains low, among children and adolescents.

Key gaps exist in this area, including;

- Lack of a national system for ensuring and routinely tracking linkage to care. Barriers to timely linkage include stigma, poverty, health worker attitudes as well as health system factors.
- Inadequate age and population specific adherence, treatment illiteracy, defaulter tracking and psychosocial support systems.

However numerous health facilities have established effective retention strategies and patient tracking systems that can be scaled up including periodic audits.

B. Equity and access to Care and Treatment Services

Only 25% of the more than 10,000 health facilities in Kenya provide antiretroviral therapy. Majority of facilities providing care and treatment services are in Counties with high HIV burden.

Although over 60% of facilities providing ART are health centres and dispensaries, 70% of patients are managed in Level 4 and 5 facilities that comprise about 30% of treatment facilities. Other access barriers include patient and societal factors such as stigma, discrimination and lack of information on service availability.

C. Organization of HIV care services

HIV Care services are provided in vertical Comprehensive care clinics across the health care system. This is not sustainable in the long term due to the increasing numbers of PLHIV who need chronic HIV care and treatment.

The country does not have demonstrable effective models of care for integration and decentralization of ART services. Further, there is little use of community platforms to increase access to treatment and provide components of HIV treatment, and more needs to be done in this area.

35 The Constitution 2010,

D. Quality of care

National guidelines provide standards and define the package of services provided for PLHIV in care and treatment. However routine and structured Quality Assurance systems have not been institutionalized. Service quality assessments are conducted on an adhok basis.

Further, the National HIV Quality improvement framework[36] has not been widely disseminated. Many health care facilities lack capacity to conduct routine clinical, data and health system audits as well as use it to improve health services and outcomes.

E. Community strategy for HIV/AIDS continuum of care

In 2006, the MOH adopted the Community Health Strategy to improve health indicators by implementing critical interventions at the community level[37]. An evaluation of the strategy in 2010 indicated that the strategy had potential to achieve better health outcomes but its implementation required additional investment in human resource support (employment and training of community health workers), finances and improvement of the community based health information management.

Additionally strategies and activities tailored to deliver HIV & AIDS continuum of care at the community level have not been comprehensively articulated. As a result implementation of the community strategy to support adherence, defaulter tracing and other aspects of HIV care and treatment has been suboptimal, poorly coordinated and ineffective. Further, there are weak linkages between health facilities and community services.

Thematic Area 3: Health Products and Technologies (HPT)

Barriers in HPT include inadequate and inconsistent supply of HIV commodities, low capacity of Health workers, weak supply chain and commodity management systems at all levels of health care. In addition, there are inequities in the distribution of HIV technologies and their related infrastructure such as laboratory systems for early infant diagnosis (EID) and viral load testing.

Further, strengthening of laboratory systems has lagged behind scale up of treatment programs. This has contributed to suboptimal diagnosis and management of HIV&AIDS, medication related toxicities, OIs and co-morbidities. In addition, EID testing is conducted through a national referral network as functional services are not available in many regions. These networks experience major challenges including long turnaround times occasioned by inefficiencies and poorly organized systems for sample transportation and return of results.

Some of the opportunities to address this barrier lie in the recent advancements of point of care (POC) testing technology for, HIV diagnosis and treatment monitoring tests.

Thematic Area 4: Human Resource for Health (HRH)

Inadequate health work force in terms of numbers, cadre, competencies, deployment and distribution plagues the health system and is a key barrier to accelerated HIV service delivery. For instance, adolescent health specialists, paediatricians, mental health specialists, nutritionists, clinical psychologists are not available below the County referral facilities.

36 MoH KHQIF 2014

37 MoH. Community strategy 2007.

The Kenya National Health Sector Strategic and Investment Plan (KHSSP) 2014 – 2018[38], outlines a staffing level of 68,185, which is less than a fifth of the national need (385,467 health workers) as recommended by the Kenya Essential Health Package (KEPH).

The staff shortage has been further compounded by the fact that appropriate task sharing[39] and health worker mentoring has not been fully implemented.

Thematic Area 5: Information Management and Research

Currently the health management information system is largely paper based, resulting in high workload, inaccuracies, data management challenges and lack of timely data for decision making.

Additionally, paper based systems are not very effective in the provision of quality health care in chronic care patients as frequent audits and longitudinal follow up are needed. Only a third of ART sites use electronic medical record (EMR) systems, most of them are real time and are therefore not used in the management of the patients.

Another key gap that requires to be addressed is the suboptimal use of data for decision making in the management of the patients and health systems strengthening. This would significantly contribute to improving patient outcomes and HIV/AIDS programs country wide.

Thematic Area 6: Communication Strategy

Kenya has developed a national HIV testing and services (HTS) communication strategy (2014-2018) which aims to raise awareness on HIV and generate demand for HTS services as well as promote behaviours that lower the risk of acquiring HIV. The strategy is not age and population specific but uses HTS as entry point to wider HIV services.

Additionally there is need for a Communication strategy that will mobilize the general population for testing and retesting, enhance knowledge of HIV status, highlight importance of linkage into care and treatment and retention. Population and age specific treatment literacy and adherence promotion materials are also required.

Thematic Area 7: Health Financing

The Government of Kenya (GOK) allocation towards the HIV & AIDS response has more than doubled under the Kenya National AIDS strategic Plan (KNASP) III implementation period; from $57.5 million in 2006/7 to $153 million in 2012/13 (NACC, 2014). Data from the Kenya National Health Accounts of 2012/13 show that HIV/AIDS took the largest share of resources for health at 18.7 percent[40].

Despite increased allocation, funds to roll out and sustain ACT are insufficient. In addition, donor dependency is high; 68% of the national AIDS response is externally funded[41]. However it is estimated that eliminating inefficiencies in resource utilisation of available funds will accomplish twice as much output[42].

38 MoH KHSSP 2014
39 WHO 2008
40 MoH. NHA 2015.
41 MoH KAIS 2014
42 MoH KAIS 2014

4.0
Implementation Plan for Accelerating Care and Treatment

To address the gaps along the cascade, and achieve the national targets by 2017, the country has identified strategies to accelerate HIV Treatment for children, adolescents and adults living with HIV. These startegies include those implemented by national government and county governements to support rapid scale up of HIV care and treatment.

As service delivery is a function of county goverments, this plans outlines strategic guidaince to counties for development of county specific acceleration plans.

Thematic Area 1: Leadership and Governance

Policies and guidelines that facilitite accelerating treatment are necessary. The HIV testing guidelines will be reviewed to address retesting for general populations , key populations , pregnant and post-natal mothers, point of care and operational guidance on high yield strategies that increase indentification, linkage to care , enhance adherence to treatment and retention in care provided.

The Ministry will develop a policy framework on task sharing to address human resource gaps. Standard operating procedures (SOPs) for testing and age-specific disclosure to increase identification will be developed.

The national and county governments will provide leadership and coordination for accelerating HIV treatment and undertake regular and continous perfomance monitoring to ensure targets are met.

Thematic Area 2: Service Delivery

A. Service delivery in health facilities

Counties are responsible for service delivery. County governments will scale up an appropriate mix of high impact and high yield interventions that suit the county HIV burden and sub-populations and address existing gaps; provide the necessary resources for service delivery; build capacity of health facilities to provide services, promote integration of services, routinely monitor service quality and provide a platform for multi-stakeholder participation in the county response.

Selected Leadership and Governance interventions for Counties

- Conduct monthly faclity levels CMEs to disseminate guidelines
- Conduct quarterly county level progress review meetings
- Develop county ,sub-county level perfomance dashboards
- Support facilities to develop and display site level cascades
- Intergrate HIV progress reporting into monthly CHMT and facility managers review meetings'

In addition, counties should provide greater focus on and identify specific strategies targeting underserved populations that include children, adolescents and youth.

Table 1: Selected scale-up high yield intervention packages for Counties suited to HIV burden

Cascade Area	Population	Interventions for High/ medium burden counties	Interventions for Low burden counties
Identification of HIV infected persons	Children	Integration of EID/HIV testing in all MCH clinics	Integration of EID/HIV testing in high volume MCH clinics
		PITC for all in OPD and IPD settings	HTS for symptomatic and acutely malnourished children
		Index client listing and Testing for all patients in care at facility and community levels	Index client listing and Testing for all patients in care
		Testing for OVCs	Testing for OVCs
	Adolescents	PITC for all in integrated or stand-alone settings	HTS for symptomatic persons and mature minors
		Community and facility PITC for Key populations	Index client listing and Testing for all patients in care
		Index client listing and Testing for all patients in care	
	Adults	Community and facility PITC for Key populations	Index client listing and Testing for all patients in care
		PITC for all in OPD and IPD settings	Analyse site level data for high yielding sites and implement PITC
		Index client listing and Testing for all patients in care at facility and community levels	
		Enhance post natal testing for mothers previously testing negative	
Linkage to HIV Care	All	Escorted referrals to HIV care clinics	Escorted referrals to HIV care clinics
		Phone follow ups for newly diagnosed clients	Phone follow ups for newly diagnosed clients
		Create county directories of CCCs and Peer educator contacts to enhance referral	Create county directories of CCCs and Peer educator contacts to enhance referral
		Integrate HIV services with MNCH, TB, OPD	Integrate HIV services with MNCH, TB, OPD
		Home/community follow up visits for newly diagnosed in high yield sites	Home visits for newly diagnosed in high yield sites

Increasing access to Care and Antiretroviral therapy	All	Set and share Facility Level Targets	Set and share Facility Level Targets
		Line list all of all patients on non-ART care to determine eligibility	Line list all of all patients on non-ART care to determine eligibility
		Monthly Facility Performance review meetings and clinical audits	Monthly Facility Performance review meetings and clinical audits
		Performance Based Incentives for HCWs to increase coverage	Performance Based Incentives for HCWs to increase coverage
	Children, adolescents	Special Clinics (weekend, holidays) for children and adolescents in High & Medium yield sites	Special Clinics (weekend, holidays) for children and adolescents in high volume sites
		Integrate ART into YFS, MNCH, TB clinics, Key pop services	Integrate ART into YFS, MNCH, TB clinics, Key pop services
Optimize adherence, retention and Viral suppression	ALL	Recruit and train Peer educators / supporters in high volume facilities	Recruit and train Peer educators / supporters in high volume facilities
		Implement appointments systems with specific timings for client visits	
		Utilize mobile phone technologies for appointment reminders and adherence support	Utilize mobile phone technologies for appointment reminders and adherence support
		Maintain defaulter tracking logs/ missed appointment and follow up records	Maintain defaulter tracking logs/ missed appointment and follow up records
		Establish support age appropriate support groups for children, adolescents and adults	Establish support age appropriate support groups for children, adolescents and adults
		Provide age appropriate treatment literacy	Provide age appropriate treatment literacy
		Community follow up for high volume facilities	
	Children, adolescents	Train caregivers on disclosure and treatment support	Train caregivers on disclosure and treatment support
		Train teachers to support children and adolescents with HIV in schools	Train teachers to support children and adolescents with HIV in schools with high numbers of PLHIV
Improving quality of care		Implement continuous improvement initiatives at facilities	Implement continuous improvement initiatives at facilities
		Conduct routine service quality and clinical audits	Conduct routine service quality and clinical audits

B. Service Delivery at the Community Level

Successful acceleration of treatment will require community involvement and utilisation of community-based support systems.

The role of the community in achieving the set ACT goal cannot be overemphasized. The devolution and the 'Nyumba Kumi' initiative being rolled out countrywide provide opportunities to engage afresh with the communities to support ACT. This plan envisions that counties will map existing and potential community structures that can support continuum of care.

Further, the Plan will leverage on community structures including local administration to increase care seeking behaviour as well as support identification, referral, treatment adherence, retention, Stigma reduction, resource mobilization and provision of adjunct services.

Thematic Area 3: Health Products and Technologies

Commodity security is crucial to increase access to HIV treatment. Commodities that support diagnosis, treatment and monitoring of treatment outcomes will be required in adequate quantities, desired quality and in a timely manner.

Both levels of government will periodically conduct forecasting and quantification exercises to determine commodity requirements based on burden of disease. Capacity to improve commodity and supply chain management will also be strengthened by providing technical assistance, finances, information management tools and other resources. Monthly stock taking exercises will guide resupply and procurement decisions.

Laboratory systems strengthening including point of care diagnostics and monitoring capacity will be enhanced to support counties meet targets. At health facility level QA/QC systems will be implemented in the laboratories.

Thematic Area 4: Human Resources for Health

Adequate numbers of skilled health care workforce are needed to support achievement of targets. National and county governments will determine health care worker gaps (numbers and competencies) and put in place mechanisms to ensure development and management plans are supported for an enhanced workforce.

The national government will provide technical assistance to Counties to determine gaps and develop plans to address specific skills and competency gaps. Appropriate task-sharing measures should be implemented.

Thematic Area 5: Information Management and Research

Kenya's strategic information system will be strengthened and realigned to the Plan's indicators. The acceleration plan will leverage on existing routine monitoring and evaluation and surveillance systems to monitor progress towards achieving the accelerated targets. Further existing data and reporting tools will be reviewed to provide disaggregated data and monitor key performance indicators and data used to measure performance.

To ensure data accuracy and quality, capacity building and regular data quality audits will be will be prioritized. Recent technological advances provide an opportunity for improving data access, quality and evidence based decision-making. This plan targets to expand use of electronic medical records and other technologies such as mobile technologies for patient follow up, data analysis and management.

Thematic Area 6: Communication Strategy

A communication strategy to support the Plan will be developed to include, age, population and region appropriate, specific culturally appropriate messages for wider HIV services such as adherence, retention and treatment literacy. Implementation will take place at both national and county levels.

Thematic Area 7: Health Financing

Domestic resources for the HIV response have been limited to support for general infrastructure and human resources. With the planned rapid scale up of services and the need to sustain the gains realized through various initiatives, substantial domestic resource mobilization will be required. This will require a multi-pronged strategy to increase domestic resources as outlined in the Kenya AIDS strategic framework.

The National and county governments will identify synergies and opportunities for resource mobilisation, including from non-traditional sources. In view of diminishing external resources, priority efforts will focus on developing financial and human resources sustainability strategies. Identifying and aligning budgets to County and epidemic priorities, reducing inefficiencies and enhancing County ownership will maximize impact of the available resources.

5.0

Implementation Matrix for Accelerating Care and Treatment Plan

5.1 National Level Implementation Matrix

Table 2: National Level Implementation Matrix

NATIONAL LEVEL IMPLEMENTATION MATRIX													
No.	**Strategy**	**Key Acceleration activities**	**Expected Outputs**	**Implementation Timeline**								**Responsible Party**	**Budgetary Implications**
				FY 2015-2016				**FY 2016-2017**					
				Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**		
Thematic Area 1													
1.1	Develop/review and disseminate policies and guidelines to support acceleration	1. Release and disseminate revised 2015 HTS guidelines	Dissemination done in the 47 Counties		X	X	X					NASCOP	Document dissemination activities; communication, workshops, printing, distribution
		2. Develop and disseminate National Policy on task sharing	Task sharing policy completed and disseminated to 47 counties	X	X	X	X	X	X	X	X	NASCOP	
		3. Develop and disseminate National Policy on point of care testing	Point of care testing policy completed and disseminated to 47 counties	X	X	X	X	X	X	X	X	NASCOP	
		4. Develop SOPs for - index client sexual contact tracing and testing - family testing - linkage to care and treatment - adherence and retention in care - Point of care testing - Age specific disclosure	SOPs developed and disseminated to 47 counties										
		5. Update and disseminate service delivery standards for health facilities and community	Dissemination conducted in the 47 Counties		X	X	X					NASCOP	Document dissemination activities; communication, workshops, printing, distribution
		6. Develop package of care for children and adolescents living with HIV in learning, corrective and other institutions	Dissemination conducted in the 47 Counties		X	X	X					NASCOP MOE and other stakeholders	
1.2	Strengthen management and Coordination	1. Convene the National ART Taskforce to address and periodically monitor the National Acceleration agenda	ART Taskforcein place	X	X	X	X	X	X	X		NASCOP	Meeting costs,
		2. Provide TA to counties to develop National Acceleration Plans	47 counties supported to develop plans	X	X	X						NASCOP	Transportation,
		3. Map partners, HIV services and develop a national directory	Directory of partners and services in the country		X	X	X					NASCOP	Communication, Meeting, Travel costs, database and document development and distribution costs

NATIONAL LEVEL IMPLEMENTATION MATRIX

No.	Strategy	Key Acceleration activities	Expected Outputs	Implementation Timeline								Responsible Party	Budgetary Implications
				FY 2015-2016				FY 2016-2017					
				Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun		
1.3	Ensure quality of services across counties	Conduct regular service and data quality audits for standards of care	Quality of care indicators improved	x		x		x		X		NASCOP	D&SQ audits and monitoring visits
1.4	Performance monitoring against set targets	1. Develop a dashboard and other tools for performance monitoring	Performance monitoring tools in use in 47 counties	x								NASCOP	Dashboard and tools development costs,
		2. Convene Regular review forums	Performance reports										
Thematic Area 3. Health Products and Technologies: Commodity and Laboratory Management Systems													
3.1	Ensure availability of commodities for management of HIV/AIDS, OI and co morbidities	1. Conduct forecasting and quantification (F&Q) at national level	F&Q reports	X				X					Quantification exercise workshop and report
		2. Conduct Procurement and distribution of commodities	Availability of commodities	X	X	X	X	X	X	X	X	NASCOP, KEMSA,	Procurement, warehouse and distribution of commodities
3.2	Strengthen commodity and supply chain management	1. Build capacity of county HMT on commodity and supply chain management	County HMTs trained		X	X	X	X	X	X	X	NASCOP	Training Workshops
		2. Review and provide LMIS tools for all levels	LMIS tools in place	X	X	X						NASCOP	LMIS tool review, printing and dissemination activities
		3. Conduct monthly stock status monitoring at national level	Stock status reports at national level	X	X	X	X	X	X	X	X	NASCOP KEMSA	Periodic / monthly stock taking exercises
3.3	Strengthen laboratory systems to support acceleration	1. Provide TA to counties to develop and implement laboratory strengthening plans	47 counties with trained laboratory teams		X	X	X	X	X	X	X	NASCOP	Workshop costs, communication
		2. Develop and implement plan for improving laboratory diagnostic and monitoring services	Laboratory infrastructure improvement plan and implementation reports				X	X	X	X	X	NASCOP	Document development and infrastructure improvement costs, HR, Training costs
		3. Conduct F&Q, procurement and distribute of laboratory reagents and equipment	Laboratory requirements determined. Timely procurement and distribution done	X		X		X		X		NASCOP KEMSA	Procurement of supplies , warehousing and distribution costs
		4. Conduct monthly stock status monitoring of lab commodities	Stock status reports at national level	X	X	X	X	X	X	X	X	NASCOP KEMSA	Periodic / monthly stock status exercises
		5. Support scale up and strengthening of laboratory networks	Functional lab networks	X	X	X	X	X	X	X		NASCOP	Network infrastructure costs, communication and transportation costs
		6. Develop and Support Implementation of an integrated national Lab LMIS	Lab LMIS utilized to manage lab services	X	X	X	X	X	X	X	X	NASCOP	Technology infrastructure, training, per diem, LMIS software
		7. Implement QA/QC systems in labs at facility level	Lab QA/ QC reports with recommendations implemented			X		X		X		NASCOP	QA/QC system implementation costs

NATIONAL LEVEL IMPLEMENTATION MATRIX													
No.	**Strategy**	**Key Acceleration activities**	**Expected Outputs**	**Implementation Timeline**								**Responsible Party**	**Budgetary Implications**
				FY 2015-2016				**FY 2016-2017**					
				Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**		
Thematic Area 4. Human Resource for Health (HRH)													
4.1	Ensure adequate number of skilled workforce	Provide TA to counties to conduct assessment of HW numbers and skills	Report on HCW numbers and Training needs available for 47 counties			X	X					NASCOP	Assessment costs
4.2	Improve HRH skills and competencies to support continuum of care	1. Develop and implement a capacity building and management plan	Capacity building and HRH management plan in place.				X	X	X			NASCOP	Capacity building costs
		2.Provide TA to counties to conduct training needs assessment (TNA)	TNA report available for 47 counties			X	X					NASCOP	Assessment costs
		3.Train county trainers to meet identified competency gaps	TOT available at county level			X	X	X	X	X		NASCOP	Training costs, per diem, travel costs
		4.Develop/review and disseminate capacity building materials.	Updated capacity building materials and resources	X	X	X	X	X	X	X		NASCOP	Material development/review and dissemination costs
		5.Maintain a national capacity building database	Data base of trained HWs, National Acceleration plan activities and resources		X	X	X	X	X	X	X	NASCOP	Soft ware costs, Data base development and maintenance costs
4.3	Capacity Build education and other relevant sectors to support institutionalized patients	1.Develop/review and disseminate capacity building materials/ resources targeting learning and other social protection institutions	Updated capacity building materials and resources	X	X	X	X	X	X	X	X	NASCOP	Material development/review and dissemination costs
		2.Participate in TOT for teachers and care givers in collaboration with the education sector	TOT for education and other key sectors in place	X	X	X	X	X	X	X	X	NASCOP	Training costs
		3. Contribute to development of age appropriate sexuality education training materials	Age appropriate sexuality education training materials in place	X	X	X	X					NASCOP	Workshop costs, document development costs

NATIONAL LEVEL IMPLEMENTATION MATRIX													
No.	**Strategy**	**Key Acceleration activities**	**Expected Outputs**	**Implementation Timeline**								**Responsible Party**	**Budgetary Implications**
				FY 2015-2016				**FY 2016-2017**					
				Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**		
Thematic Area 5. Information Management and Research													
5.1	Strengthen management of strategic information	1.Develop/revise and disseminate HMIS tools to support acceleration	Revised HMIS tools Available for use at the counties.	X	X	X	X	X	X	X	X	NASCOP	• Meeting costs • Printing • Databases creation costs creation/revision • Back up • Dissemination costs
		2. Monitor use of tools and ensure data quality	Monitoring reports on data accuracy and completeness	X	X	X	X	X	X	X	X	NASCOP	Monitoring costs
		3. Provide TA to counties to Scale up EMR and disseminate national standards for EMRs	EMR in prioritized service delivery points in place	X	X	X	X	X	X	X	X	NASCOP	Training costs, dissemination costs
5.2	Support data quality and use	1. Best practice/results sharing meetings held periodically	Reports of meetings for data and best practice sharing	X	X	X	X	X	X	X	X	NASCOP	Meeting Costs
		2. Develop capacity for use of Data for decision making	Data use for improving National Acceleration plan implementation		x	x	x					NASCOP	Workshop costs
		3. Conduct regular data quality audits	DQA reports with implementation of recommendations		x		x		x		x	NASCOP	Data auditing costs
5.3	Institutionalize operational research (OR) to inform National Acceleration plan	1. Identify areas for OR	OR plan developed	X	X	X	X	X	X	X	X	NASCOP	Assessment costs
		2. Mobilize resources for OR activities	Resources available for OR	X	X	X	X	X	X	X	X	NASCOP	Advocacy and resource mobilization meeting
		3. Establish collaborations for implementation of OR for National Acceleration plan	Collaboration agreements	X	X	X	X	X	X	X	X	NASCOP	Networking costs
		4. Conduct OR and disseminate results to inform acceleration	OR results, dissemination and implementation plan	X	X	X	X	X	X	X	X	NASCOP	Proposal development , Research Implementation and dissemination costs

NATIONAL LEVEL IMPLEMENTATION MATRIX													
No.	**Strategy**	**Key Acceleration activities**	**Expected Outputs**	**Implementation Timeline**								**Responsible Party**	**Budgetary Implications**
				FY 2015-2016				**FY 2016-2017**					
				Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**		
Thematic Area 6: Communication Strategy													
6.1	Optimize communication to support National Acceleration plan	1. Develop and implement a targeted national communication plan	Targeted national communication strategy		X	X	X	X	X			NASCOP	Communication strategy development and implementation activities.
		2. Develop and disseminate culturally, age and population appropriate IEC materials	IEC materials to support acceleration	X	X	X	X	X	X	X	X	NASCOP	IEC material development/ review. Translation costs.
		3. Engage stakeholders to include National Acceleration plan as an agenda in their plans	Advocacy for National Acceleration plan among stakeholders	X	X	X	X	X	X	X	X	NASCOP	Advocacy costs
		4. Conduct advocacy campaigns for awareness and demand creation	Campaign plan and implementation reports	X	X	X	X	X	X	X	X	NASCOP	Depends on chosen media
Thematic Area 7. Health Financing													
7.1	Resource mobilization and distribution for the National Acceleration Plan	1. Analyse resource gap and develop funds mobilization strategy/plan	Resources gap analysis report and a mobilization strategy/plan	X	X	X	X	X	X	X	X	NASCOP	Advocacy Meeting costs, resource gap analysis
7.2	Resource utilization for acceleration	2. Monitor use of resources to meet the National Acceleration Plan targets	Available resources maximized to achieve acceleration goal	X	X	X	X	X	X	X	X	NASCOP	Implementation plan development and monitoring

5.2 County Level Implementation Matrix

Table 3: County Level Implementation Plan Matrix

COUNTY LEVEL IMPLEMENTATION MATRIX													
No.	**Strategy**	**Key Acceleration activities**	**Expected Outputs**	**Implementation Timeline**								**Responsible Party**	**Budgetary Implications**
				FY 2015-2016				**FY 2016-2017**					
				Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**		
Thematic Area 1 : Leadership and Governance													
1.1	Adapt, Disseminate and Implement policies, guidelines and tools	1. Disseminate and Implement Policies at sub county level	Task sharing policy and HTS guidelines, policies and tools disseminated to sub-counties			X	X	X	X	X	X	County	Dissemination workshops, travel costs
1.2	Adapt and Operationalize SOPS	1. Disseminate and operationalize SOPS	SOPS available at all HIV testing and linkage SDPs at sub-counties			X	X	X	X	X	X	County	Dissemination workshops, travel costs
		2. Disseminate revised minimum package of care for at SDPs	Minimum package of care available at HIV SDPs		X	X	X	X	X	X	X	County	Dissemination workshops, travel costs
		3.Disseminate revised minimum package of care for at SDPs	Minimum package of care available at HIV SDPs		X	X	X	X	X	X	X	County	Dissemination workshops, travel costs
		4. Disseminate minimum package of care for children and adolescents in learning, corrective and other institutions	Minimum package of care for children and adolescents available		X	X	X	X	X	X	X	County	Dissemination costs

COUNTY LEVEL IMPLEMENTATION MATRIX													
No.	**Strategy**	**Key Acceleration activities**	**Expected Outputs**	**Implementation Timeline**								**Responsible Party**	**Budgetary Implications**
				FY 2015-2016				**FY 2016-2017**					
				Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**		
1.3	Strengthen management and Coordination	1. Convene the County ART Taskforce to address and periodically monitor the County Acceleration agenda	Quarterly multi-sectoral acceleration coordination meetings held		X	X	X	X	X	X	X	County	Transportation, Workshop costs Communication
		2. Develop county acceleration implementation plans	CHMT capacity built to implement County acceleration plans developed	X	X	X						Counties	Transportation, Workshop costs Communication
		3. Develop county Acceleration performance targets	Targets developed along HIV cascade of care.	X	X	X						Counties	Workshop costs, communication costs
		4. Provide TA to Sub-counties to develop Acceleration implementation plans	SCHMT and facility HMT capacity built on Plan implementation		X	X	X	X	X	X	X	County	Transportation, Workshop costs Communication
		5. Map partners and HIV services and develop a county HIV service directory	Directory of partners and HIV services in the county	X	X	X						County	Transportation, Workshop costs Communication
1.4	Ensure quality of services across sub-counties and facilities	1. Conduct regular service and data quality audits for standards of care	Quality of care indicators improved	X		X		X		X		County	D&SQ audits and monitoring visits
1.5	Performance Monitoring for acceleration	2. Adapt, disseminate and implement use of ACT dashboard and other tools for performance monitoring	Performance monitoring tools in use in all the sub-counties		X	X	X					County	Transportation, Workshop costs Communication
		3. Convene regular review forums	County utilizing data to inform progress		X	X	X	X	X	X	X	County	Transportation, Workshop costs Communication

COUNTY LEVEL IMPLEMENTATION MATRIX													
No.	**Strategy**	**Key Acceleration activities**	**Expected Outputs**	**Implementation Timeline**								**Responsible Party**	**Budgetary Implications**
				FY 2015-2016				**FY 2016-2017**					
				Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**		
Thematic Area 2. Service Delivery													
2.1	Optimize and scale up high yield, targeted HIV testing to identify positive clients	1. Develop and monitor HIV identification targets at county, sub-county and facility levels	County targets developed and monitored on a monthly basis	X	X	X	X	X	X	X	X	County, sub-counties, facilities	Workshop costs
		2. Adapt high yield HIV testing strategies at both HF and community level suited to the county's HIV burden	Increased identification of HIV positive clients		X	X	X	X	X	X	X	County , health facilities and community health committees	HIV test kits, OJT of HWs,
		3. Support HF to Scale up integration of HIV testing services in high yield SDP (MCH, Immunization clinics, TB, Nutrition, IPD)	Increased identification of HIV positive clients		X	X	X	X	X	X	X	County and health facilities	HTS start-up costs,
		4. Capacity building of sub-county and HF management teams on the use of the EID system	Improved use of EID systems		X	X	X					Counties	Infrastructure and technology for transmission and tracking of results, communication costs
		5. Conduct regular service quality audits (SQA)	Progress on HIV client identification audited and missed opportunities reduced		X	X	X	X	X	X	X	County	Service audits of HIV client identification activities against set targets and conformance with testing guidelines

COUNTY LEVEL IMPLEMENTATION MATRIX													
No.	**Strategy**	**Key Acceleration activities**	**Expected Outputs**	**Implementation Timeline**								**Responsible Party**	**Budgetary Implications**
				FY 2015-2016				**FY 2016-2017**					
				Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**		
2.2	Optimize linkage to care	1. Integrate HIV care and treatment in targeted SDP (e.g. TB/RMNCH/YFS, key population settings)	Improved linkage of HIV positive clients to care and treatment services		X	X	X	X	X	X	X	County	HIV commodities for testing, care and treatment including POC equipment and supplies, infrastructure, tools, HRH
		2. Develop referral system SOP and HIV service directory	Improved inter- and intra-facility referral of HIV clients for continuum of care, adjunct services		X	X	X	X	X	X	X	County	Infrastructure/ technology for identification and tracking clients – Paper/ card and biometric
		3. Regular audit of linkage of patients for optimal continuum of care	Minimized drop-out of patients along the cascade of care			X	X	X	X	X	X	County	Linkage audit and report development exercises
2.3	Increase access to Care and treatment	1. Map current available HIV services, and develop decentralization/integration plan	Decentralization/ Integration plan developed		X	X	X					County and Stakeholders	Baseline assessment, meeting costs
		2. Prioritize, decentralize/ integrate comprehensive care and treatment with considerations of sub-populations	Increased number of SDPs offering Care and Treatment specific to sub-populations		X	X	X	X	X	X	X	County	Site readiness assessments ART commodities, HW training, tools , Treatment literacy materials, POC for CD4
		3. Carry out quarterly clinical and programmatic audits to monitor care and treatment coverage	Improved quality of care and treatment services provided to clients		X	X	X	X	X	X	X	County	Costs for development of audit systems, audit exercise, training,

COUNTY LEVEL IMPLEMENTATION MATRIX													
No.	**Strategy**	**Key Acceleration activities**	**Expected Outputs**	**Implementation Timeline**								**Responsible Party**	**Budgetary Implications**
				FY 2015-2016				**FY 2016-2017**					
				Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**		
2.4	Optimize adherence, retention and viral suppression in patients on treatment	1. Avail SOPs for adherence, disclosure, retention and patient follow up to HIV SDPs	Improved patient adherence, retention		X	X	X	X	X	X	X	County	Dissemination costs, Transport
		2. Support HFs to implement appointment and defaulter tracking systems	Increased no. of facilities with functional appointment and defaulter tracking		X	X	X	X	X	X	X	County	Appointment and defaulter tracking tools (Paper based or electronic), support supervision visits, home visit costs
		3. Support use of technology and peer support to enhance adherence and retention	Increased HF capacity to implement appointment and defaulter tracking systems		X	X	X	X	X	X	X	County	Tools revision, Printing and dissemination
		4. Scale up establishment of age- and population specific support groups	Improved adherence and retention of clients (sub-populations)		X	X	X	X	X	X	X	County	Communication costs, meeting costs for age and population appropriate groups, transport costs
		5. Engage with learning institutions and social-protection service providers to support adherence and retention in care	Improved adherence and retention of clients in care		X	X	X	X	X	X	X	County	Communication/ sensitization costs, Infrastructure for patient support structures, technology, logistics
		6. Carry out quarterly audits on use of appointment and patient tracking systems	Audit reports with implementation of recommendations		X	X	X	X	X	X	X	County	Audit costs, Data management costs, Tools.

COUNTY LEVEL IMPLEMENTATION MATRIX													
No.	**Strategy**	**Key Acceleration activities**	**Expected Outputs**	**Implementation Timeline**								**Responsible Party**	**Budgetary Implications**
				FY 2015-2016				**FY 2016-2017**					
				Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**		
2.5	Improve quality of care to support treatment outcomes	1. Implement quality of comprehensive pre-ART and ART care, OI and comorbidities management, nutrition, SRH, TB/HIV	Minimum package of HIV care offered at all HIV SDPs		X	X	X	X	X	X	X	County	Sensitization/OJT/site support supervision costs
		2. Build capacity of sub-county and HF management teams on CQI	Improved CHMT, SCHMT and HMT knowledge and hence supervision of CQI activities		X	X	X	X	X	X	X		Training, CQI tools Sensitization/OJT meetings
		3. Establish CQI team to regularly monitor activities at all levels	Quarterly CQI meetings held at HF level		X	X						County	Meeting costs
		4. Convene regular best practice forums	Bi-Annual county level best-practice forums		X		X		X		X	County	Meeting costs
		5. Carry out regular audits on use of CQI activities	Audit reports with implementation of QI recommendations		X	X	X	X	X	X	X	County	Audit costs, Data management costs, Tools.
		4. Improve infrastructure and HW capacity to support quality services	Improved infrastructure and health worker knowledge and skills to provide quality services.			X	X	X	X	X	X	County	Infrastructure, communication costs, technology, meeting costs for support structures e.g. e-health or face to face consultation forums, mentorship, CPD forums

COUNTY LEVEL IMPLEMENTATION MATRIX

No.	Strategy	Key Acceleration activities	Expected Outputs	Implementation Timeline								Responsible Party	Budgetary Implications
				FY 2015-2016				FY 2016-2017					
				Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun		
2.6	Optimize implementation of Community strategy to support acceleration	1. Map existing community structures that provide or have potential to provide HIV services	Database of community resources available to support acceleration			X	X					Counties	Communication, transport, meeting costs and database development
		2. Develop a community level coordination plan between county and stakeholders to support acceleration	Community coordination plan in place			X	X	X	X	X	X	County	Demand creation activities, communication, equipment, IEC materials, meetings
		3. Develop and implement a community mobilization and demand creation plan for Acceleration	Demand creation plan implemented			X	X	X	X	X	X	County	Demand creation activities, communication, equipment, IEC materials, meetings
		4. Adapt and disseminate and use tools at the community level that support acceleration activities and data collection	Adapted tools for HTS, referral and linkage, treatment, adherence and retention available and in use at the community level			X	X	X	X	X	X	County	Tools , sensitization meetings, technology and tools for identification and tracking clients as well as information management
Thematic Area 3. Health Products and Technologies													
3.1	Ensure availability of commodities for management of HIV/AIDS, OI and co morbidities	1. Conduct forecasting and quantification (F&Q) at county level	Commodity F&Q report	X	X	X	X	X	X	X	X	County	Quantification exercise workshop and report
		2. Conduct Procurement and distribution of commodities	Availability of HIV commodities, OI and co- morbidities	X	X	X	X	X	X	X	X	County, KEMSA,	Procurement, warehouse and distribution of commodities
		3. Conduct monthly monitoring of stocks levels at sub-county and HF level	Stock status reports	X	X	X	X	X	X	X	X	Counties	Warehouse and redistribution of commodities

COUNTY LEVEL IMPLEMENTATION MATRIX													
No.	**Strategy**	**Key Acceleration activities**	**Expected Outputs**	**Implementation Timeline**								**Responsible Party**	**Budgetary Implications**
				FY 2015-2016				**FY 2016-2017**					
				Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**		
3.2	Strengthen commodity and supply chain management	1. Build capacity of SCHMT and HMT on commodity and supply chain management	Increased efficiency of SCHMT and Facility HMTs on supply chain management		X	X	X	X	X	X	X	County	Meeting and monitoring costs
		2. Assess and act on commodity management and supply chain gaps at county level	Strengthened commodity and supply chain management at all levels	X	X	X						County	Rapid assessment costs
		3. Disseminate LMIS tools for all levels	Appropriate tools in use at all facilities	X	X	X						County	LMIS tool review, printing and dissemination
		4. Scale up the use of e-platforms for commodity management	Electronic commodity management software utilized at identified priority sites	X	X	X	X	X	X	X	X	County	Soft and hard ware costs, HR training
		5. Assess and improve storage facilities for commodities to support acceleration	Assessment reports available	X	X	X	X	X	X	X	X	Counties, health facilities	Infrastructure development/ upgrading

COUNTY LEVEL IMPLEMENTATION MATRIX												
No.	**Strategy**	**Key Acceleration activities**	**Expected Outputs**	**Implementation Timeline**								**Responsible Party**	**Budgetary Implications**
				FY 2015-2016				**FY 2016-2017**					
				Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**		
3.3	Strengthen laboratory systems to support acceleration	1. Develop and Implement plans for improving laboratory diagnostic, communication and monitoring services	Laboratory infrastructure improvement plan available		X	X	X	X	X	X	X	County	Document development cost
		2. Conduct F&Q and procurement of laboratory reagents and equipment at County level	Increased aaccess to laboratory equipment and reagents	X		X		X		X		Counties	Storage, redistribution costs
		3. Support scale up and strengthening of laboratory networks	Functional laboratory sample referral systems in place (reduced TAT, increased access to diagnostic/ monitoring tests)	X	X	X	X	X	X	X	X	Counties	Network infrastructure costs, communication and transportation costs
		4. Implement POC testing for CD4, VL and EID in identified priority facilities	Improved use of POC tests in identified priority counties				X	X	X	X	X	Counties, NASCOP	POC capacity; equipment and HR competency
		5. Develop and implement a county capacity building plan on key laboratory competencies	HR available to support laboratory services		X	X	X	X	X	X	X	Counties	HR training costs, employment/deployment
		6. Adapt and Implement the integrated national laboratory LMIS	Increased use of an integrated national laboratory LMIS	X	X	X	X	X	X	X	X	Counties	Technology infrastructure
		7. Conduct monthly monitoring of stocks levels at sub-county and HF level	Stock status reports for laboratory commodities	X	X	X	X	X	X	X	X	Counties	Warehouse and redistribution of commodities
		8. Implement QA/QC systems in lab at HF level	Lab QA/QC reports with recommendations implemented	X	X	X	X	X	X	X	X	Counties	QA/QC system implementation costs

COUNTY LEVEL IMPLEMENTATION MATRIX													
No.	**Strategy**	**Key Acceleration activities**	**Expected Outputs**	**Implementation Timeline**								**Responsible Party**	**Budgetary Implications**
				FY 2015-2016				**FY 2016-2017**					
				Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**		
Thematic Area 4. Human resource for health (HRH)													
4.1	Ensure adequate number of skilled workforce for the acceleration	1. Conduct rapid assessment of HW numbers and a training needs assessment (TNA)	HW gaps (numbers and training needs) determined – Report available		X	X	X					Counties	Rapid assessment costs
		3. Roll out trainings as per the training plan	Skilled workforce trained			X	X	X	X	X	X	Counties	Training activities
		4. Conduct mentorship, on-job training and CPD activities	improved service delivery indicators			X	X	X	X	X	X	Counties	Mentorship and CPD training costs, curriculums, mentorship tools
		5. Maintain county level database of capacity building resources, activities and HW trained	Routinely updated database in place		X	X	X	X	X	X	X	Counties	Software costs, Data base maintenance costs
4.2	Capacity Build education and other relevant sectors to support institutionalized patients	4. Adapt and use capacity building material for training teachers and care givers	Curriculum for caregivers in learning and other social protections institutions in place			X	X	X	X	X	X	County	Workshop costs, document development costs
		5. Roll out trainings in learning and social-protections institutions	Increased number of schools and children's homes trained.			X	X	X	X	X	X	Counties	Training activities to meet identified competency gaps
		6. Provide TA to develop age appropriate sexuality education training materials	Age appropriate sexuality education training materials in place			X	X	X	X	X	X	County	Workshop costs, document development costs

COUNTY LEVEL IMPLEMENTATION MATRIX													
No.	**Strategy**	**Key Acceleration activities**	**Expected Outputs**	**Implementation Timeline**								**Responsible Party**	**Budgetary Implications**
				FY 2015-2016				**FY 2016-2017**					
				Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**		
Thematic Area 5. Information Management and Research													
5.1	Strengthen strategic information management	1. Disseminate and use revised HMIS tools	Revised HMIS tools available and used at county level		X	X	X	X	X	X	X	County	Infrastructure for EMR including protection of databases/servers, dissemination costs
		2. Monitor use of tools and ensure data quality	Monitoring reports on data accuracy and completeness		X	X	X	X	X	X	X	County	Infrastructure for EMR. OJT for HW
		3. Develop and implement plans for scale up EMR	EMR in prioritized service delivery points in place		X	X	X	X	X	X	X	County	EMR soft and hard ware costs Training costs
5.2	Support data quality and utilization for implementation of the acceleration	1. Periodic data sharing/review forums at county level	Routine data review meetings held		X	X	X	X	X	X	X	County	Meeting Costs
		2. Develop capacity for use of data for decision making at sub-county and facility level	Improved utilization of data		X	X	X	X	X	X	X	County	Data auditing costs
		3. Conduct regular data quality audits	DQA reports available	X		X		X		X		County	DQA SOPs
		4. Periodic results and best practice sharing meetings at county level	Best practices scaled up within county		X	X	X	X	X	X	X	County	Meeting Costs
5.3	Institutionalize operational research (OR) to inform practice	1. Identify areas for OR to support Acceleration	OR plan developed		X	X	X	X	X	X	X	County	Assessment costs
		2. Mobilize resources for OR activities	Resources available for OR		X	X	X	X	X	X	X	County	Advocacy and resource mobilization meeting
		3. Establish collaborations for conducting OR	Collaborative agreements		X	X	X	X	X	X	X	County	Networking costs
		4. Conduct operational research to address region specific acceleration gaps	OR conducted to fill region specific knowledge gaps for continuum of care			X	X	X	X	X	X	Counties	Proposal development, Research Implementation costs

COUNTY LEVEL IMPLEMENTATION MATRIX													
No.	**Strategy**	**Key Acceleration activities**	**Expected Outputs**	**Implementation Timeline**								**Responsible Party**	**Budgetary Implications**
				FY 2015-2016				**FY 2016-2017**					
				Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**		
Thematic Area 6: Communication Strategy													
6.1	Optimize communication to support National Acceleration plan	6. Develop county specific communication plans	Targeted county communication plan developed	X	X	X						County	Communication strategy development activities
		7. Conduct advocacy campaigns	Advocacy campaign plans and implementation reports	X	X	X	X	X	X	X	X	County	Campaign costs depending on communication media
		8. Develop and disseminate age, culturally , age and population appropriate IEC materials	Acceleration awareness created at community level		X	X	X	X	X	X	X	County	IEC material development/review. Translation costs.
Thematic Area 7. Health Financing													
7.1	Resource mobilization and distribution	1. Use the costed Acceleration plan to conduct resource gap analysis to inform resource mobilization	Gap analysis report and resource mobilization plan developed	X	X	X	X	X	X	X	X	County	Advocacy meetings, resource gap analysis
7.2	Resource utilization for acceleration	1. Monitor resource use to meet Acceleration targets	Available resources maximized to achieve acceleration goal	X	X	X	X	X	X	X	X	County	Implementation plan development and monitoring
		2. Implementing performance based financing (PBF) to meet acceleration targets	PBF activities identified and implemented	X	X	X	X	X	X	X	X	Counties	PBF activities

6.0 Coordination Mechanism for the Accelerating Care and Treatment Plan

The coordination structure for the Plan will align with various legislative instruments that are defined for different levels of service delivery and coordination within the national and devolved government system. The National AIDS Control Council (NACC) maintains the overall role of multi-sectoral coordination.

In line with the Constitution 2010, National government will be responsible for national policy development, norms and standards' setting, capacity building and technical assistance to counties while county governments will be responsible for service delivery. These two levels of government will mount multi-sectoral coordination mechanisms and maintain a public-private partnership model for the delivery of the Plan.

This section summarizes responsibilities for coordination in specific relation to the acceleration of HIV Care and treatment at national and county levels. Coordination is key to achieving the ambitious targets set in the plan. Both national and county governments will be expected to coordinate the efforts to accelerate HIV treatment at their respective levels and in line with their constitutional mandates.

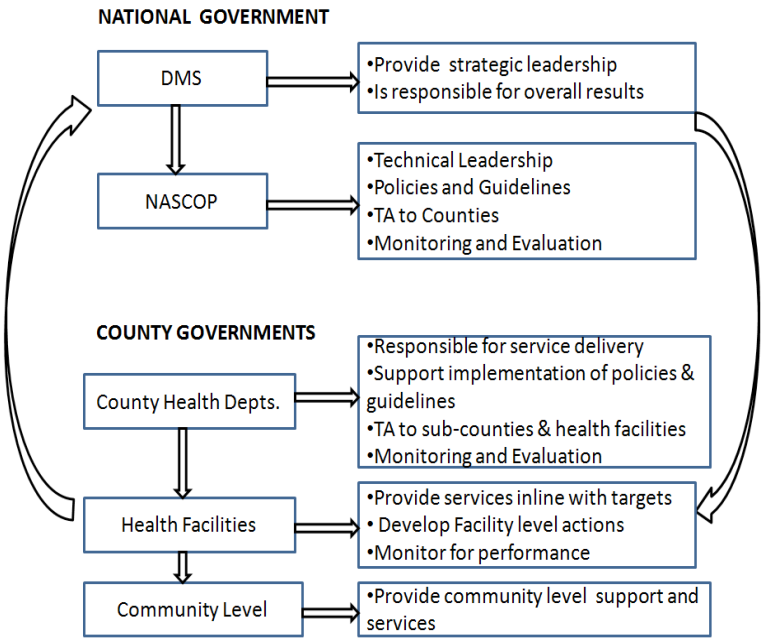
Specifically these include:

1. **National level functions will be guided by the Ministry of Health:**
   a. **Director of Medical Services:** Provide strategic leadership and play an oversight role in the implementation of the acceleration plan.
   b. **NASCOP:** Implement the national government activities laid out in the Plan.

Key functions of NASCOP will include:

- Coordinate and regularly convene all national technical working groups that support the acceleration agenda at national level. Examples of these TWGs those covering service delivery areas in the cascade of care such as HIV Testing and Counselling, Paediatric and Adult care and Treatment, PMTCT, Nutrition, among others and those covering system support such as for Human Resources for Health, Laboratory, commodity management, strategic information.
- Ensure participation of all relevant stakeholders including other relevant government agencies, ministries , implementing partners, development partners and additional local stakeholders such as New-born, Child and Adolescent Health Unit (NCAHU), MOH departments responsible for reproductive health, Nutrition, mental health, civil society including the Network of People Living with HIV/AIDS in Kenya (NEPHAK), local universities, NGOs and NACC.
- Develop and implement the monitoring tools needed for frequent review of performance data and achievement toward set targets
- Provide on-going technical assistance to counties through quarterly to semi-annually monitoring and evaluation fora, and additional technical assistance activities as needed to meet the acceleration plan targets.
- The national TWGs will support county-specific planning, work plan development, target setting and implementation, monitoring and use of data for evidence-based decision making.
- In conjunction with the County level Technical Working Groups, conduct monthly/quarterly data review to monitor progress, identify areas for improvement, and follow-up on previous recommendations and submit a report to the office of the DMS.

Figure 6: Coordination Mechanism for the Acceleration Plan



2. **County governments**:
   a. The **Governor** will implement national and county level legislation that impacts on the implementation of the county specific Plan provide strategic leadership, guide resource mobilisation and allocation to facilitate meeting of set targets.
   b. The **County health department** will provide leadership and undertake the following functions to support acceleration:
      - Coordinate overall multi-sectoral County Technical Working Group(s) in partnership with other government agencies, implementing partners, development partners, private sector and additional local stakeholders such as civil society including the Network of People Living with HIV/AIDS in Kenya (NEPHAK), local CBOs and NGOs.
      - Provide ongoing assistance through monthly to quarterly monitoring and evaluation fora, and additional technical assistance activities as needed to meet the set targets.
      - In conjunction with the sub-County and facility level Technical teams, conduct monthly data review to monitor progress, identify areas for improvement, and follow-up on previous recommendations and submit a report to NASCOP
      - Disseminate and to health facilities targets and support development of specific facility actions to meet acceleration targets.
   c. **County Technical Working Group(s)**: Counties shall convene regular technical working teams comprising of all relevant government and non-governmental stakeholders. This may already exist or may require to be constituted if non-existent. County technical working groups shall suppprt and participate in development of implementation and monitoring of the country level work plans.

3. **Concurrent roles of both National and County Governments include:**
    - Commitment of human resources for health and leverage domestic resources to support the acceleration plan. This will be implemented in line with KASF.
    - Development of a resource mobilization, distribution and sustainability plan
    - Implement a monitoring, evaluation, and quality improvement plan for the care and treatment acceleration Initiative using key indicators.

7.0 Performance Monitoring for Accelerating Care and Treatment Plan

The ultimate goal of the results matrices is to monitor and document progress and achievements in accelerating care and treatment for PLHIV. The matrices have been developed to ensure effective monitoring of program performance during implementation of the acceleration plan. As such, they include key outcome and program implementation indicators that will be measured using regular activity reporting. Of special note are the indicators introduced to track care and treatment of populations previously not tracked such as adolescents and key populations.

Meeting the set targets is dependent on several assumptions, such as functional laboratory system (including decentralization of EID and viral load testing services), Adolescent/youth friendly services in all counties, commodity security, Service integration, PITC scale up, operationalizing the community strategy, skilled work force, and adequate resources for implementing the acceleration plan.

The HIV care and treatment acceleration plan dash board will be used to collect data for quick visualization of progress towards attainment of the overall goals. The indicators in this dashboard are designed to highlight progress made towards identifying PLHIV (especially infants, children and adolescents), documenting linkage to care, retention and viral suppression at 12 months.

The National and County performance monitoring matrices will give an indication periodically on gains made from respective level activities. The data mined will be analysed by the national and county health departments and their partners to realign plans, resources and activities towards attaining set targets.

7.1 Dashboard for the Accelerating Treatment and Care Plan

The acceleration plan dashboard is a results framework that uses key outcome indicators designed to track progress towards the 90:90:90 goals. In addition, the dashboard matrix is designed to support the National and County HIV Care and treatment Programs to correlate their key outcomes with implementation activities. It will enable implementers to quickly visualise and have a sense of progress achieved periodically against set targets.

The source of data will primarily be sourced from the District Health Information Software 2 (DHIS2), which is a web-based software designed for data collection, collation and reporting. Individual Counties will each upload their data periodically into DHIS2, on a quarterly basis.

The Logistic management information system (LMIS) and EMR will also be used to supplement the data. The uploaded data will allow key actors and stakeholders explore and analyze their data for evidence-based decision making and realignment of activities towards achieving set targets.

Table 4: Dashboard for HIV care and treatment acceleration plan

	Indicator	Unit of Measure	Indicator Definition	Reporting frequency	Source	Baseline		Targets	
						Value	Year	2015/16	2016/17
1.0 Knowledge of HIV infected persons: 90% of PLHIV know their HIV positive status by 2019									
1.1	Uptake of Early Infant Diagnosis	Percent	Numerator: Total no. of HEI tested using DNA PCR s at age of 2 months Denominator: Total no. of HEI	Quarterly	EID Database	50%	2014	60%	80%
1.2	Percent of HIV infected Children identified	Percent	Numerator: Total No. HIV infected children identified and enrolled on care Denominator: Total No. of children estimated to be living with HIV	Quarterly	DHIS/ AIDS indicator Surveys	57%	DHIS	70%	80%
1.3	Percent of HIV infected adolescents identified	Percent	Numerator: Total No. HIV infected adolescents identified and on care Denominator: Total No. of adolescents estimated to be living with HIV	Quarterly	DHIS/ AIDS indicator Surveys	31%	DHIS	50%	80%
1.4	Percent of HIV infected adults identified		Numerator: Total No. of HIV infected adults identified and on care Denominator: Total No. of adults estimated to be living with HIV	Quarterly	DHIS/ AIDS indicator Surveys	67% (national estimate)	DHIS 2014	80%	90%
1.5	Percent of PLHIV identified	Percent	Numerator: Total No. of PLHIV identified and on care Denominator: Total No. of People estimated to be living with HIV	Quarterly	DHIS/ AIDS indicator Surveys	66%	DHIS 2014	80%	90%

	Indicator	Unit of Measure	Indicator Definition	Reporting frequency	Source	Baseline		Targets	
						Value	Year	2015/16	2016/17
2.0 Linkage to care: Increased linkage to care within 3 months of HIV diagnosis for 90% of children, adolescents and adults quarterly									
2.1	Percent of HIV positive identified and linked into care within 3 months of HIV diagnosis	Percent	Numerator: Total No. newly diagnosed HIV positive persons enrolled in Care within 3 months Denominator: Total number of newly identified HIV infected persons 3 months ago	Quarterly	DHIS	Not available	NA	50%	90%
2.2	Percent of HIV infected children linked to care within 3 months of HIV diagnosis	Percent	Numerator: No. of newly identified HIV positive children, newly enrolled into care within 3 months of diagnosis Denominator: Total no. of children newly tested HIV positive 3 months ago	Quarterly	DHIS	Not available	NA	60%	90%
2.3	Percent of HIV infected adolescents linked to care within 3 months of HIV diagnosis	Percent	Numerator: No. of newly identified HIV positive Adolescents, newly enrolled into care within 3 months of diagnosis Denominator: Total no. of Adolescents newly tested HIV positive 3 months ago	Quarterly	DHIS	Not available		60%	90%
2.4	Percent of HIV infected adults linked to care within 3 months of HIV diagnosis	Percent	Numerator: No. of newly identified HIV positive adults newly enrolled into care within 3 months Denominator: Total no. of adults tested HIV positive 3 months ago	Quarterly	DHIS	Not available	NA	80%	90%
3.0 Antiretroviral Therapy: Increase ART coverage to 90% by 2019 for children adolescents and adults									
3.1	Percent of PLHIV on ART	Percent	Numerator: No. of PLHIV years currently on ART Denominator: Number of PLHIV eligible for ART	Quarterly	DHIS / Estimates	61%	2014	70 %	90%

	Indicator	Unit of Measure	Indicator Definition	Reporting frequency	Source	Baseline		Targets	
						Value	Year	2015/16	2016/17
3.2	Percent of HIV infected children < 15 years eligible for ART on ART	Percent	Numerator: No. of HIV infected children <15 years currently on ART Denominator: Number of HIV infected children < 15 years eligible for ART	Quarterly	DHIS / Estimates	53%	2014	65%	90%
3.3	Percent of HIV infected adolescents eligible for ART receiving ART	Percent	Numerator: No. of HIV infected adolescents currently on ART Denominator: Number of HIV infected adolescents eligible for ART	Quarterly	DHIS / Estimates	31%	2014	65%	90%
3.4	Percent of HIV infected Adults eligible for ART on ART	Percent	Numerator: No. of HIV infected Adults currently on ART Denominator: Number of HIV infected adults eligible for ART	Quarterly	DHIS / LMIS / HIV Estimates	62%%	2014	70%	90%
4.0 Retention to ART: 90% of patients retained on ART 12 months post initiation									
4.1	Percent of PLHIV retained on ART 12 months post initiation	Percent	Numerator: No. of PLHIV alive and on ART 12 months post initiation Denominator: Net cohort of PLHIV expected to be on treatment 12 months post initiation (Original Cohort+transfers in-transfers out)	Quarterly	EMR/DHIS	TBD	2014	90%	90%
4.2	Percent of children (0-14y) retained on ART 12 months post initiation	Percent	Numerator: No. of children (0-14y) alive and on ART 12 months post initiation Denominator: Net cohort of children expected to be on treatment 12 months post initiation (Original Cohort + transfers in- transfers out)	Quarterly	EMR/DHIS	82.1%	2014	90%	90%

	Indicator	Unit of Measure	Indicator Definition	Reporting frequency	Source	Baseline		Targets	
						Value	Year	2015/16	2016/17
4.3	Percent of adolescents retained on ART 12 months post initiation	Percent	Numerator: No. of Adolescents (0-14y) alive and on ART 12 months post initiation Denominator: Net cohort of Adolescents expected to be on treatment 12 months post initiation (Original Cohort+ transfers in- transfers out)	Quarterly	EMR/ DHIS	TBD		70%	90%
4.4	Percent of adults retained on ART 12 months post initiation	Percent	Numerator: No. of Adults(0-14y) alive and on ART 12 months post initiation Denominator: Net cohort of Adults expected to be on treatment 12 months post initiation (Original Cohort +transfers in- transfers out)	Quarterly	EMR/ DHIS	79.5%	2014	85%	90%
4.5	Percent of children retained on ART 24 months post initiation	Percent	Numerator: No. of children (0-14) retained on ART 24 months post initiation Denominator: No. of children (0-14) initiated on ART 24 months to assessment point	Quarterly	EMR/ DHIS	77%	2014	85%	90%
4.6	Percent of adults retained on ART 24 months post initiation	Percent	Numerator: No. of adults retained on ART 24 months post initiation Denominator: No. of adults initiated on ART 24 months to assessment point	Quarterly	EMR / DHIS	72.6%	2014	80%	79.5%
4.7	Percent of adolescents retained on ART 24 months post initiation	Percent	Numerator: No. of adolescents retained on ART 24 months post initiation Denominator: No. of adolescents initiated on ART 24 months to assessment point	Quarterly	EMR / DHIS	TBD	2014	80%	90%

	Indicator	Unit of Measure	Indicator Definition	Reporting frequency	Source	Baseline		Targets	
						Value	Year	2015/16	2016/17
4.8	Percent of PLHIV retained on ART 24 months post initiation	Percent	Numerator: No. of PLHIV retained on ART 24 months post initiation Denominator: No. of PLHIV initiated on ART 24 months to assessment point	Quarterly	EMR / DHIS	TBD	2014	80%	90%
5.0 Viral Suppression: Increased viral suppression in children and adults on ART to 90% by 2019									
5.1	Proportion of children 0-14 years who achieve viral suppression at 12 months of ART	Percent	Numerator: No. of children (0-14y) who achieve viral suppression at 12 months of ART Denominator: No. of children (0-14y) initiated on ART 12 months to assessment point with viral load results available	Quarterly	DHIS -	38%	2014	80 %	90%
5.2	Proportion of adolescents (10-19) who achieve viral suppression at 12 months of ART	Percent	Numerator: No. of adolescents who achieve viral suppression at 12 months of ART Denominator: No. of adolescents initiated on ART 12 months to assessment point with viral load results available	Quarterly	DHIS -	22%	2014	80%	90 %
5.3	Proportion of adults who achieve viral suppression at 12 months of ART	Percent	Numerator: No. of adults who achieve viral suppression at 12 months of ART 12 months post initiation Denominator: No. of adults initiated on ART 12 months to assessment point with viral load results available	Quarterly	DHIS -	51%	2014	90%	90%
5.4	Proportion of clients currently on ART who have achieved viral suppression	Percent	Numerator: No of clients whose viral loads are less than 1000 copies/ml Denominator: No. of clients with viral load results	Quarterly	DHIS/ Viral load database		80%	85%	90%

	Indicator	Unit of Measure	Indicator Definition	Reporting frequency	Source	Baseline		Targets	
						Value	Year	2015/16	2016/17
5.5	Proportion of Clients current on ART with viral loads tests	Percent	Numerator: No of clients with initial viral loads during the year (Disaggregate by adults, peds and adolescents) Denominator: Number of clients who have been on ART for >= 6 months (Disaggregate by adults, peds and adolescents)	Quarterly	DHIS/ Viral load database			80%	90%
5.6	Proportion of Children <10 years current on ART with viral loads tests	Percent	Numerator: No of children <10 years with initial viral loads during the year Denominator: No. of children <10 years who have been on ART for >= 6 months	Quarterly	DHIS/ Viral load database			TBD	90%
5.7	Proportion of adolescents (10-19y) current on ART with viral loads tests	Percent	Numerator: No. of adolescents with initial viral loads during the year Denominator: No. of adolescents who have been on ART for >= 6 months	Quarterly	DHIS/ Viral load database			80%	90%
5.8	Proportion of adults current on ART with viral loads tests	Percent	Numerator: No. of adults with initial viral loads during the year Denominator: No. of adults who have been on ART for >= 6 months	Quarterly	DHIS/ Viral load database			80%	90%

7.2 National Level Monitoring Matrix

National and County Performance monitoring matrix is a results monitoring matrix that will use key input and outcome indicators designed to track progress towards set goals. Additionally, the matrix is designed to support the National and County ART Programs and their partners correlate their achievements resulting from implementation with key outcomes. Further, it will also serve as an accountability tool for both levels of government.

It will enable implementers to measure progress periodically and contribute to decision making in a bid to achieve set targets.

The commonest source of data will be the program reports and DHIS2. Individual Counties will each upload their data periodically onto DHIS2 for collation and reporting. The DHIS2 will allow key actors and stakeholders at each level analyze explore their data for evidence- based decision making and realignment of activities towards achieving set targets.

Table 5: National Level Performance Monitoring Matrix

National Level Performance Monitoring Matrix										
	Indicator	**Unit Of Measure**	**Indicator Definition**	**Frequency**	**Data Source**	**Base-line**	**End Target**	**Yearly Target**		**Remarks**
								2015/16	**2016/17**	
Thematic Area 1. Leadership and Governance										
1. 1	Policy development	Number	No. of Policies developed/ reviewed to support acceleration	Annual	NASCOP	none	2	x		1. Policy for task sharing 2. Point of care testing policy
1.2	Sensitization of Counties on new/revised policies	Number	No. of Counties sensitized	Quarterly	NASCOP	none	47		x	
1.3	Development/review of guidelines /protocol in support of acceleration	Number	No. of SOPs guidelines developed/ reviewed to support acceleration	Annual	NASCOP		6	x	x	Develop SOPs for 1. index client sexual contact tracing/testing 2. linkage to care and treatment adherence and retention in care 3. Point of care testing 4. service delivery standards for facilities and community 5. Revised 2015 HTS guidelines 6. Package of care for PLWHIV in institutions 7. Age specific disclosure
1.4	Sensitization of Counties on the new/revised SOPs and guidelines	Number	No. of Counties sensitized	Quarterly	NASCOP	none	47		x	
1.5	Adoption of the National Acceleration Plan agenda by the National ART Taskforce	Yes/ No	National Acceleration Plan constitutes the agenda for ART Taskforce meetings	Quarterly	NASCOP	none	8	4	4	
1.6	Development and implementation of county acceleration plans	Number	No. of Counties with and Implementing Acceleration plans	Quarterly	NASCOP	none	47	x		
1.7	Development of Directory of partners and services in the country	Yes/No	Updated directory of partners and services in the country in place	Annual	NASCOP	none	1	X	X	

1.8	Service and data quality audits reports	number	No. of Service and data quality audit reports	Bl-annual	NASCOP	0	4,	X	X	
1.9	Conduct of review forums	number	No. of review forums reports	Bl-annual	NASCOP	0	4	X	X	Reports will be used as a means of verification
Thematic Area 3. Health Products and Technologies: Commodities										
3.1	Availability of tracer ART, OI and co-morbidity medicines at national level	Percent	Numerator : No. of tracer ART,OI, and co-morbidity medicines available at national level	Quarterly	NASCOP		100%	x	x	
			Denominator: Total No. of tracer ART medicines required at national level							
3.2	Stock status audits	Percent	Numerator: No. of stock status reports	Quarterly	NASCOP		100%	x	x	Percent
			Denominator: 4							
Thematic Area 3. Health Products and Technologies: Laboratory Systems										
3.3	Development/ implementation of laboratory infrastructure strengthening plans	Ratio	Numerator: No. of laboratory infrastructure strengthening acceleration activities completed	Quarterly	NASCOP		100%	x	x	
			Denominator: Total no. of planned lab infrastructure strengthening acceleration activities							
3.4	Availability of tracer Laboratory commodities at National and County Level	Percent	Numerator : No. of tracer lab commodities available at national level	Quarterly	NASCOP		100%	x	x	
			Denominator: Total no. of tracer lab commodities required at national level							

3.5	Training of TOT for lab related courses	Number	No. of TOTs for the identified lab related courses	Quarterly	NASCOP			x	x	
3.6	Laboratory Quality monitoring	Number	QA/QC reports	Biannual	NHIVRL		4	X	X	
Thematic Area 4. Human Resources for Health										
4.1	National capacity building plan	Yes/No	National capacity building and HRH management plan in place	Annually	NASCOP	X	2			
4.2	Training Needs Assessment	Yes/No	Training Needs Assessment Report in place	Quarterly	NASCOP		4	x	x	
4.3	Complement of TOTs for identified HIV management courses	Percent	Numerator: Total No. of Counties with a complement of TOT for identified HIV management courses Denominator: 47	Annually			100%	x	x	
Thematic Area 5. Information Management and Research										
5.1	Availability of HMIS tools to support acceleration	Percent	Numerator: No. of Counties utilizing revised HMIS tools Denominator: 47	Quarterly	NASCOP			x	x	
5.2	Utilization of data for decision making	Percent	Numerator: No. of Counties using data audit for decision making Denominator: Total no. of counties capacitated to use data for decision making	Quarterly	NASCOP			x	x	
5.3	Performance monitoring for the reporting period	Percent	Numerator: No. of targets met for the reporting period Denominator: Total No. of targets set	Quarterly	NASCOP			x	x	

5.4	Development of an OR Research strategy for acceleration	Yes/No	OR Research strategy for acceleration developed	1	NASCOP	None	1	x		
5.5	Implementation of the OR strategy	Percent	Numerator. No of OR targets met for the reporting period	Yearly	NASCOP	None				
			Denominator. Total No. of targets set.							
Thematic Area 6. Communication Strategy for the Acceleration Plan										
6.1	Development of a Communication Strategy and monitoring plan	Yes/No	Targeted Communication Strategy and monitoring plan developed	At start of acceleration	NASCOP	None	1	x		
6.2	Monitoring of Communication strategy targets	Percent	Numerator: No. of communication targets met in the quarter	Quarter	NASCOP			x	x	
			Denominator: Total No. of communication targets set for the quarter							
6.3	Development of age appropriate IEC material for Treatment Literacy and adherence support	Yes/No	Age appropriate IEC material for Treatment Literacy and adherence support developed	As per communication strategy	NASCOP			x	x	
Thematic Area 7. Health Financing										
7.1	Resource gap analysis	Number	Number Resource gap analysis reports	Annually			2	X	X	
7.2	Development of a resource Mobilization Plan for acceleration	Number	Resource Mobilization plan in place	Quarterly	NASCOP	none	1	x		
7.3	Financial Reporting and compliance to budget plan (Variance)	Percent	Numerator: Total Funds used in compliance to budgetary allocation	Quarterly	NASCOP	TBD		x	x	
			Denominator: Total budget for acceleration							

7.3 County Level Acceleration Plan Performance Monitoring Matrix

Table 6: County Level Performance Monitoring Matrix

County Level Performance Monitoring Matrix										
	Indicator	Unit Of Measure	Indicator Definition	Freq-uency	Data Source	Base-line	Target	Yearly Target		Remarks
								2015/16	2016/17	
Thematic Area 1. Leadership and Governance										
1.1	dissemination of policies, guidelines and SOPs to sub county and facility level	Number	No. of counties that disseminate new/revised policies guidelines and SOPs,	Quarterly	County	None	47		x	
1.2	Dissemination of revised minimum package of care for at SDPs	Number	No. of counties that Disseminate revised minimum package of care for at SDPs	Quarterly	County	None	47		x	
1.3	Dissemination minimum package of care for children and adolescents in learning, corrective and other institutions	Number	No. of counties that Disseminate minimum package of care for children and adolescents in learning, corrective and other institutions	Quarterly	County	None	47		x	
1.4	Adoption and implementation of the County acceleration plan by the County ART taskforce	Number	No. of counties Where ART taskforce is implementing/ monitoring the acceleration plan	Quarterly	County	None	47		x	
1.5	Utilization of Acceleration performance monitoring tools by counties to track progress	Number	No. of counties reporting using Acceleration performance monitoring tools	Quarterly	County	None	47	x	x	
1.6	Development of a county HIV service directory	Number	No. of counties with an updated Directory of partners and HIV services in the county	Annually	County	None	47	X	X	

County Level Performance Monitoring Matrix										
	Indicator	Unit Of Measure	Indicator Definition	Freq-uency	Data Source	Base-line	Target	Yearly Target		Remarks
								2015/16	2016/17	
Thematic Area 2. Service Delivery										
2.1	Identification of PLWHIV	Percent	Numerator: No. of counties with > 90% identification of PLHIV Denominator: 47 counties	Quarterly	NASCOP			X	X	Collate County performance review/dashboard indicators
2.2	linkage of HIV infected clients to Care and treatment (CT)	Percent	Numerator: No. of counties with > 90% linkage of HIV infected clients to CT Denominator: 47 counties	Quarterly	NASCOP			X	X	Collate County performance review/dashboard indicators
2.3	Initiation of eligible clients on treatment	Percent	No. Counties with > 90% initiation of eligible clients on treatment Denominator: 47 counties	Quarterly	NASCOP			X	X	Collate County performance review/dashboard indicators
2.4	Access to viral load test	Percent	Numerator: No. patients on ART with at least 1 viral load test per year Denominator: Total number of patients on ART	Quarterly	NASCOP	TBD	90%			
2.5	viral suppression rates of clients on treatment	Percent	Numerator: No. of counties with > 90% viral suppression Denominator: 47 counties	Quarterly	NASCOP			X	X	Collate County performance review/dashboard indicators
2.6	Implementation of community coordination and mobilization plan	Number	No. of counties implementing a community coordination and mobilization plan	Quarterly	NASCOP/ NACC			X	X	Collate County performance review/dashboard indicators
Thematic Area 3. Health Products and Technologies										
3.1	Availability of tracer HIV commodities in the review period	Percent	Numerator: No. of counties reporting stock out of tracer HIV commodity Denominator: 47 counties	Quarterly	NASCOP		<5%	X	X	

County Level Performance Monitoring Matrix										
	Indicator	Unit Of Measure	Indicator Definition	Freq-uency	Data Source	Base-line	Target	Yearly Target		Remarks
								2015/16	2016/17	
3.2	use of an integrated national LMIS	Percent	Numerator: Total number of counties reporting accurately through LMIS Denominator: 47 counties	monthly	NASCOP		100%	X	X	
Thematic Area 4.Human Resources for Health										
4.1	Development and implementation of County capacity building and management plan.	Number	No. of counties implementing County capacity building and management plan	Biannual	County			X	X	Consider' % of counties who have achieved 65% of their HR plan
4.2	Development of a Health Workers' training database	Percent	Numerator: No.of counties maintaining HW training database Denominator: 47 Counties	Biannual	County			X	X	
4.3	Capacity Building of the education and other relevant sectors to support patients in learning and other institutions	Percent	No. of counties conducting training in learning and social protection institutions Denominator: 47 Counties	Biannual	County			X	X	(At least 60% of targeted institutions trained)
Thematic Area 5. Information Management and Research										
5.1	Utilization of HMIS to track progress	Percent	Numerator: No. of counties reporting accurately through HMIS Denominator: 47 counties	Quarterly	NASCOP			X	X	
5.2	Data quality audits	Number	No. of counties that conduct DQA quarterly	Quarterly	NASCOP	none	47	X	X	One per county per quarter
5.3	Development and implementation of an operational research (OR) plan	Number	No. of counties implementing at least 60% of planned OR activities	Annually	NASCOP	none	47	x	x	All Counties
Thematic Area 6. Communication Strategy for ACT										

County Level Performance Monitoring Matrix										
	Indicator	Unit Of Measure	Indicator Definition	Freq-uency	Data Source	Base-line	Target	Yearly Target		Remarks
								2015/16	2016/17	
6.1	Development and implementation of a communication strategy	Number	No. of counties implementing at least 60% of planned communication activities	Quarterly	NASCOP	none	47			
Thematic Area 7. Health Financing										
7.1	Resource gap analysis	Number	No. of counties with a resource gap analysis report	Annually	NASCOP	none	47	X		In all Counties
7.2	Development and implementation of resource mobilization plan	Number	Number of counties implementing at least 60% of planned resource mobilization activities	Quarterly	NASCOP	none	47	X	X	

8.0
Appendices

8.1 County Targets for Persons Living with HIV by end 2017

Table 7: County Targets showing PLHIV along Cascade of Care

	Baseline (As at December 2014)											
	Adult				Pediatric				Total			
County (A)	Adult PLHIV (B)	Target for Identification (C=80%B)	Target for Treatment (F=90% C)	Viral suppression targets (I=90% F)	Child. PLHIV (B)	Target for Identification (C=80% B)	Target for Treatment (F=90% C)	Viral suppression targets (I=90% F)	Total PLHIV (B)	Target for Identification (C=80% B)	Target for Treatment (F=90% C)	Viral suppression targets (I=90% F)
Baringo	10,100	8,080	7,272	6,545	1,307	1,045	941	847	11,407	9,125	8,213	7,392
Bomet	26,700	21,360	19,224	17,302	3,455	2,764	2,487	2,239	30,155	24,124	21,711	19,540
Bungoma	20,300	16,240	4,616	13,154	3,496	2,797	2,517	2,265	23,796	19,037	17,133	15,420
Busia	29,200	26,280	23,652	21,287	5,029	4,023	3,621	3,259	34,229	30,806	27,725	24,953
Elgeyo Marakwet	5,700	4,560	4,104	3,694	738	590	531	478	6,438	5,150	4,635	4,172
Embu	9,900	7,920	7,128	6,415	1,310	1,048	943	849	11,210	8,968	8,071	7,264
Garissa	3,100	2,480	2,232	2,009	923	739	665	598	4,023	3,219	2,897	2,607
Homa Bay	151,500	121,200	109,080	98,172	19,861	15,889	14,300	12,870	171,361	137,089	123,380	111,042
Isiolo	3,400	2,720	2,448	2,203	450	360	324	291	3,850	3,080	2,772	2,495
Kajiado	21,100	16,880	15,192	13,673	2,730	2,184	1,966	1,769	23,830	19,064	17,158	15,442
Kakamega	37,700	30,160	27,144	24,430	6,492	5,194	4,675	4,207	44,192	35,354	31,819	28,637
Kericho	20,900	16,720	15,048	13,543	2,704	2,163	1,947	1,752	23,604	18,883	16,995	15,296
Kiambu	44,200	35,360	31,824	28,642	3,794	3,035	2,732	2,458	47,994	38,395	34,556	31,100
Kilifi	20,000	16,000	14,400	12,960	2,606	2,085	1,876	1,689	22,606	18,085	16,276	14,649
Kirinyaga	11,900	9,520	8,568	7,711	1,021	817	735	662	12,921	10,337	9,303	8,373
Kisii	44,000	35,200	31,680	28,512	5,768	4,614	4,153	3,738	49,768	39,814	35,833	32,250
Kisumu	128,600	102,880	92,592	83,333	16,859	13,487	12,138	10,924	145,459	116,367	104,730	94,257
Kitui	18,400	14,720	13,248	11,923	2,434	1,947	1,752	1,577	20,834	16,667	15,000	13,500
Kwale	15,100	12,080	10,872	9,785	1,968	1,574	1,417	1,275	17,068	13,654	12,289	11,060
Laikipia	9,800	7,840	7,056	6,350	1,268	1,014	913	822	11,068	8,854	7,969	7,172
Lamu	1,300	1,040	936	842	169	136	122	110	1,469	1,176	1,058	952

	Baseline (As at December 2014)											
	Adult				Pediatric				Total			
County (A)	Adult PLHIV (B)	Target for Identification (C=80%B)	Target for Treatment (F=90% C)	Viral suppression targets (I=90% F)	Child. PLHIV (B)	Target for Identification (C=80% B)	Target for Treatment (F=90% C)	Viral suppression targets (I=90% F)	Total PLHIV (B)	Target for Identification (C=80% B)	Target for Treatment (F=90% C)	Viral suppression targets (I=90% F)
Machakos	27,700	22,160	19,944	17,950	3,664	2,931	2,638	2,374	31,364	25,091	22,582	20,324
Makueni	22,600	18,080	16,272	14,645	2,990	2,392	2,152	1,937	25,590	20,472	18,424	16,582
Mandera	3,700	2,960	2,664	2,398	1,102	882	793	714	4,802	3,842	3,457	3,112
Marsabit	2,600	2,080	1,872	1,685	344	275	248	223	2,944	2,355	2,120	1,908
Meru	20,700	16,560	14,904	3,414	2,738	2,191	1,972	1,774	23,438	18,751	16,876	15,188
Migori	81,800	65,440	58,896	53,006	10,723	8,579	7,721	6,949	92,523	74,019	66,617	59,955
Mombasa	58,200	52,380	47,142	42,428	7,584	6,826	6,143	5,529	65,784	59,206	53,285	47,956
Muranga	29,900	23,920	21,528	19,375	2,566	2,053	1,848	1,663	32,466	25,973	23,376	21,038
Nairobi	166,345	133,076	119,769	107,792	11,925	9,540	8,586	7,727	178,270	142,616	128,355	115,519
Nakuru	58,700	46,960	42,264	38,038	7,595	6,076	5,468	4,922	66,295	53,036	47,732	42,959
Nandi	20,800	16,640	14,976	13,478	2,691	2,153	1,938	1,744	23,491	18,793	6,914	15,222
Narok	25,700	20,560	18,504	16,654	3,325	2,660	2,394	2,155	29,025	23,220	20,898	18,808
Nyamira	25,300	20,240	18,216	16,394	3,317	2,653	2,388	2,149	28,617	22,893	20,604	18,544
Nyandarua	13,500	10,800	9,720	8,748	1,159	927	834	751	14,659	11,727	10,554	9,499
Nyeri	19,700	15,760	14,184	12,766	1,691	1,353	1,217	1,096	21,391	17,113	15,401	13,861
Samburu	6,600	5,280	4,752	4,277	854	683	615	553	7,454	5,963	5,367	4,830
Siaya	123,600	98,880	88,992	80,093	16,203	12,963	11,666	10,500	139,803	111,843	100,658	90,592
Taita Taveta	8,000	6,400	5,760	5,184	1,042	834	751	676	9,042	7,234	6,511	5,860
Tana River	1,000	800	720	648	130	104	94	84	1,130	904	814	732
Tharaka	7,800	6,240	5,616	5,054	1,032	825	743	669	8,832	7,065	6,359	5,723
Trans Nzoia	24,100	19,280	17,352	15,617	3,118	2,495	2,245	2,021	27,218	21,775	19,597	17,637
Turkana	19,600	15,680	14,112	12,701	2,536	2,029	1,826	1,643	22,136	17,709	15,938	14,344
Uasin Gishu	27,400	21,920	19,728	17,755	3,545	2,836	2,553	2,297	30,945	24,756	22,281	20,052
Vihiga	14,100	11,280	10,152	9,137	2,428	1,943	1,748	1,573	16,528	13,223	11,900	10,710
Wajir	500	400	360	324	149	119	107	96	649	519	467	420
West Pokot	8,200	6,560	5,904	5,314	1,061	849	764	688	9,261	7,409	6,668	6,001
Kenya	**1,451,045**	**1,169,576**	**1,052,619**	**947,357**	**179,894**	**144,674**	**130,206**	**117,186**	**1,630,939**	**1,314,753**	**1,183,277**	**1,064,950**

8.2 Key Health System Barriers and Opportunities

Table 8: Key Health System Barriers and Opportunities

Health Systems Determinants analyzed	Principal Barriers and Challenges	Opportunities/ Strengths
Thematic Area 1: Leadership and Governance		
Policies and Guidelines	Inadequate policies and guidelines to address key bottlenecks to ACT such as age of consent for services, task shifting, and testing/retesting high risk populations	1) There is political will and commitment to provide an enabling environment for HIV care and treatment. 2) Operational research (OR) from various HIV programs can be used to develop evidence-based guidelines
Management/ Coordination	Suboptimal ownership, governance and leadership to support ACT, workplace programs and CBOs in some of the counties	1) National Government is competent to provide TA and support. 2) KASF proposes a strong governance and coordination structure at all levels
Thematic Area 2: Service Delivery for ACT Continuum of Care		
1. Identification of HIV positive clients	Lack of unique identifier system is hampering patient tracking.	1) National identity card, biometics and birth certificates can be used. 2) There is high penetration of technology in the Country
	Low utilization of health services for testing and treatment due to fear, stigma, cultural beliefs and health system challenges.	1) Communication strategy, identified in KASF as a key intervention to implement, can be used to mobilize clients for HIV testing.
	Suboptimal access to EID due to inequitable distribution of EID capacity and tong turn-around times for receipt of EID results.	1) Strengthen use of technology for return of EID results 2) Point of care EID is available and requires to be rolled out.

Health Systems Determinants analyzed	Principal Barriers and Challenges	Opportunities/ Strengths
2. Linkage into care	Suboptimal linkage to care and late enrollment of newly diagnosed HIV infected patients	1) Integration of HIV services at various health delivery points eg MCH, TB, YFS services. 2) Existing linkage and tracking systems can be strengthened 3) Community strategy roll out – potential to improve linkage
	1) Existing patient adherence and tracking systems are in available but require strengthening and roll out. 2) county specific plans can target improving retention in care	Inadequate patient, referral, tracking and defaulter tracking systems including periodic audits
	Lack of unique identifier system is hampering patient tracking.	1) National identity card, biometics and birth certificates can be used. 2) There is high penetration of technology in the Country
	Low access to integrated services which meet needs of special populations eg children, girls, women, youth, and geriatric persons.	Strengthening and scaling up of integrated services have been shown to facilitate linkage, identification, treatment, retention and psychosocial support.
	Suboptimal linkage to HIV care for special populations (MSM, sex workers, fishermen, OVCs and children) is hampered by stigma, cultural norms, and HCW attitudes.	1) Targeted county specific interventions can be scaled up with high yield strategies. 2) Learning institutions can be used to identify and care for HIV infected children 3) Government sponsored programs that transfer money to OVCs can be used to identify and link infected children to care
3. Initiation of Treatment	Timely initiation of ART for all eligible clients is suboptimal	1) Strengthened linkages and integration of HIV services into various departments and clinics. 2) Communication strategy and Community mobilization will enhance knowledge of HIV status and opportunities for HIV care 3) Clinical audits will identify eligible clients not on treatment
	Decentralization and integration of HIV services has been suboptimal.	Devolution of Health increases opportunity strengthening decentralization.
	Continuous audit for treatment eligibility for patients on care and initiate ART is suboptimal	1) Records for patients on care exist. 2) Guidelines for initiation of treatment exist

Health Systems Determinants analyzed	Principal Barriers and Challenges	Opportunities/ Strengths
4. Retention, Care & Treatment and Viral Suppression	Geographic inequity in access to services. Only 2,500 health facilities out of 9,000 (27.8%) offer comprehensive HIV services that include treatment.	County governments can support decentralization and integration of services using county specific plans
	Inadequate age and population specific adherence systems	1) Existing patient adherence and tracking systems are in available but require strengthening and roll out. 2) county specific plans can target improving retention in care
	Lack of specialty competencies such as psychosocial support, pediatric, geriatric and adolescent health specialists at all levels	1) Higher level specialist in-service training is currently being implemented. 2) Use of technology for front line HWs for self-learning and consultation is available Thematic Area 5: Health Information HMIS
	Inadequate patient, referral, tracking and defaulter tracking systems including periodic audits	1) Existing patient tracking systems are in place but require strengthened and roll out. 2) Implementation of Community strategy will support both patient tracking and defaulter tracking. 3) Systems to identify and flag patients at high risk of defaulting have successfully improved retention. 4). Technology has been successfully used
5. Quality Assurance	Quality Assurance of testing, care and treatment services is suboptimal	1) Kenya HIV Quality Improvement Framework has been developed and is being rolled out for implementation. 2) CQI can be implemented routinely 3) Systems for QA of HIV testing are in place but require strengthening
	Routine clinical and health system audits are not done. Analyzed data should be used to improve services and health outcomes	Mentorship models available
7. Service Delivery at Community Level	Community strategy for HIV testing, and continuum of care is not comprehensively articulated.	1) Community strategy framework is in place 2) HIV community strategy could ride onto the Administrative and 'Nyumba Kumi' structures. 3) County governments to do targetted plans. Family, workplace and community door to door testing have been found to be effective.
Linkage with other sectors for specialised services	Low utilisation of opportunities in other key sectors to better health outcomes such as; agriculture sector education sector, Justice and Law, Labour and social protection	Multisectoral forums are available

Health Systems Determinants analyzed	Principal Barriers and Challenges	Opportunities/ Strengths
Thematic Area 3: Health Products and Technologies for ACT		
Availability of commodities	Inadequate supply of HIV commodities, including ARV and OI medicines and lab equipment and reagents	Quantification for requirements has been completed.
	Inequity in the distribution of HIV technologies and related infrastructure such as viral load	Focused county plans, forecasting and quantification can improve the inequity.
Supply Chain & Commodity management systems	Weak supply chain and commodity management systems at all levels resulting in periodic stock outs.	The systems at national level are in place but they need to be strengthened and rolled out to counties.
Lab services for ACT	Weak Laboratory systems to support continuum of care; Inequitable distribution, inadequate infrastructure, insufficient equipment and commodities	1) Point of care testing of CD4 and other lab equipment is increasingly becoming available 2) Expanding the infrastructure for viral load testing is planned for the near future. 3) Point of care viral load and CD4 testing exist can be scaled up. 4) Best practices can be scaled up from successful Networks
	Routine testing for viral load suppression is suboptimal.	Competent staff are available to conduct these tests can be used as TOTs and mentors.
	Inequitable access to Viral load due non availability of requisite infrastructure	Point of care testing of Viral load equipment is increasingly becoming available
Thematic Area 4: Human resource for health (HRH)		
Health Worker Complement	Inadequate health work force in terms of numbers, cadre, competencies, deployment and distribution.	1) Health worker management has been devolved to county governments to increase efficiencies. 2) Integrated National HIV training curriculum available
	Appropriate task sharing and health worker mentoring not optimal.	Mentorship systems for pediatric and commodity management have been developed. WHO task sharing guidelines available
Health Worker Competencies	Lack of specialty competencies such as psychosocial support, pediatric, geriatric and adolescent health specialists at all levels	1) Higher level specialist in-service training is currently being implemented. 2) Use of technology for front line HWs for self-learning and consultation is available
Thematic Area 5: Health Information		
HMIS	Multiple paper based tools exist for monitoring patient services, resulting in heavy workload and poor documentation. Paper based tools not sustainable for care of chronic disease patients like HIV	1) There is high penetration of technology in the Country. 2) Implementation of EMR has begun and requires up-scaling. 3) Tool revision is ongoing
	There are no comprehensive directories to facilitate referral of patients for clinical and nonclinical services	Some regions have begun utilising county specific directories. These can be shared across counties and with national referral facilities.
Monitoring and evaluation	Existing data capture, monitoring and reporting tools have limited age disaggregation including geriatrics	Pediatric tools are being revised and harmonised to capture mutiple services. There is advocacy for age disaggregation. Expansion of electronic medical records will augment age disaggregation

Health Systems Determinants analyzed	Principal Barriers and Challenges	Opportunities/ Strengths
Research and Surveillance	Use of data for decision making and improving health care at all levels is suboptimal	Audits can be used to support implementation of evidence based best practises. Periodic County meetings can be used to share better practises
Thematic Area 6: Communication Strategy for ACT		
Public Information	Inadequate knowledge, and misconceptions on HIV coupled with stigma, and discrimination hamper early identification and linkage to Care	1) Targetted communication and IEC materials is one of the KASF initiatives. The IEC materials to be developed can be age/population specific and culturally acceptable. 2) HIV Implementation of HIV/AIDS Act can minimize stigma and improve access to social justice
Patient Level Information	Treatment literacy strategies and psychosocial support systems are weak and have not been fully exploited.	1) Interventions like youth to youth approach to care have been found to be effective. 2) Family care can provide psychosocial support
Thematic Area 7: Health Financing		
Resource Envelope	Insufficient Funds to roll out and sustain ACT	1) High burden Counties will have partner support. 2) There is commitment to increase Government funding
	High donor dependancy- 68% of HIV resource envelop is financed by donors	Innovative resource mobilization strategies are proposed in KASF eg implementation of National social health insurance fund and public private partnerships.
Resource Utilization	Inefficiencies in resource utilization by HIV programs,	Realignment of implementation plans could yield twice the amount of outputs using available funds.

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