2020-2030

# THE KAKAMEGA COUNTY HIV, AIDS AND STI CONTROL POLICY

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**FOREWORD**

Kakamega County has about 52,976 PLHIV (NACC, 2018). This gives a prevalence rate of 4.5% of the general adult population. HIV remains to be the leading underlying cause of death in Kakamega County. For instance, according to Kenya Health Information System (KHIS, 2019), out of a total 1,346 deaths that occurred in 2016 and 609 deaths in 2019 at the Kakamega County General Hospital, 8.3% in both years were HIV related. This was much higher than any other single cause of mortality in the County. To reduce HIV related mortality as well as minimize the rate of HIV transmission to other people, there is need for the infected population to receive excellent care and antiretroviral treatment. It is also imperative to step up HIV prevention to reduce new infections and thereby preserve the population. To this end, an estimated 83% of the estimated PLHIV have been put on anti-retroviral treatment with a viral load suppression of over 90% (KHIS, 2020). Lowering Mother to child transmission rate, currently at 13.1%, remains high on the agenda so as to bring it down to the WHO goal of below 5% (NACC, 2018).

A key challenge in the County response to HIV has been lack of a County government policy guide to inform strategic planning and implementation. As a result, the county has been doing numerous efforts to control HIV but with sub-optimal coordination. This has resulted in duplication of efforts and over-dependence on donor support for HIV/AIDS and STI control. It is for this reason that in close consultation with stakeholders, the County Government of Kakamega through the Department of Health Services came up with this policy document to promote coordination of HIV/AIDS and STI control activities in the county.

The adoption of this policy document will ensure synergy of resources and inform development of County Government legislation through the County Assembly in order to guarantee resource mobilization from state and non-state actors towards HIV/STI Control. Finally, the policy will ensure a well-structured coordination of such resources while giving a legitimate technical guide to the interventions carried out by the County Government to combat HIV/AIDS and STIs.

The County Government of Kakamega once more affirms its commitment to the achievement of HIV/STI control and move towards zero HIV infections, stigmatization, and ultimately, HIV-related deaths.

Dr. Collins Kizito Matemba, Ph.D.

**County Executive Committee Member**

**Department of Health Service**

**ACKNOWLEDGEMENTS**

The development of this policy document heralds a shift in the way the County Government of Kakamega has over the years dealt with the responsibility of taking charge of HIV/STI Control activities among its population. The shift in policy will not only ensure an AIDS free county but also give Peer Educators representing PLHIV and Key Populations the needed link with the over 43,000 people on anti-retroviral treatment (ART) in the county .

On behalf of the department of Health Services, I wish to thank all those who participated in the development of this policy. The technical advice of the National HIV, AIDS and STI Control Program (NASCOP), National AIDS Control Council (NACC), all County implementing partners in the H IV/STI control, County Health Management Team (CHMT), County and sub county HIV/STI program Coordinators all of whom were very instrumental in putting together evidence proven policy directions.

Further, we recognize the special role played by the County Law Office, Chief Officer of Medical Services, County Directors of Education and Adult Education, Directors of Medical Services and Public Health.

Special recognition also goes to the dedicated technical team comprising of NACC Regional Coordinator, NASCOP DMA, FHOK, CGH CCC, AMPATH, SCASCOs, CASCO, KCCB KARP, TK, PMTCT, EGPAF and AYP for putting together the initial draft.

Finally, my appreciation to all our stakeholders including National and County line departments and ministries. To the PLHIV, I give you a big thank you for your great input towards the drafting of this policy.

Dr. John Otieno, MBChB, MPH.

Director- Health Services

**COUNTY GOVERNMENT OF KAKAMEGA**

## EXECUTIVE SUMMARY

As at the end of 2018, Kakamega County had a prevalence rate of 4.5% of HIV. Out of this, the prevalence among men is 3.4% while that among females is 5.6%. This translates to an estimated 52,976 Persons Living with HIV. During the same period, there were also approximately 2,198 new infections with 989 HIV related deaths across all ages (NACC, 2018). The Kakamega HIV, AIDS and STI Control Policy has been aligned to the National Framework, the Kenya AIDS Strategic Framework (KASF II) as well as the Kakamega County Integrated Development Plan (CIDP).

The Kakamega County HIV, AIDS and STI Policy is the guide to the County's response to HIV, AIDS and STI. This policy seeks to contribute to the attainment of Universal Health Care (UHC) through comprehensive and sustainable HIV, AIDS and STI prevention, treatment and care for all the people. Specifically, the policy outlines the interventions aimed at reducing new infections by 75 percent, reducing HIV related mortality by 50 percent, reducing HIV related stigma by 75 percent, reducing mother to child transmission rate to below 5 percent and to progressively increase domestic financing for the HIV and STI response.

To address these challenges, the policy document seeks to intervene through six areas of programming. First is the prevention of HIV infection which includes behavioral HIV prevention interventions, biomedical approach, structural interventions, Key Population Prevention services and elimination of mother to child transmission.

Secondly is care and treatment that will look at the linkage to care, ART initiation, ART monitoring and retention to care and treatment, management of opportunistic infections, viral suppression among children, adolescents and adults and differentiated service delivery. Thirdly is the health system strengthening that seeks to address health financing and resource mobilization, commodity and supply chain management, strategic information, research and innovation, HIV/STI control workforce, leadership and governance and health infrastructure.

The fourth area will be focus on Community systems strengthening that targets community health strategy, community health workers, community peer educators, community models of HIV care, Community ART groups and the school health program. Finally, focus will shift to an enabling environment and human rights approach to HIV response and a strong program coordination mechanism.

## ABBREVATIONS AND ACRONYMS

AAC - Area Advisory Council

AGYW - Adolescent Girls and Young Women

AIDS - Acquired Immuno- Deficiency Syndrome

ANC - Antenatal Care

aPNS - Assisted Partner Notification Services

| | |
|---|---|
| ART | - Anti-Retroviral Treatment |
| ARVs | - Antiretrovirals |
| AYP | - Adolescent and Young People |
| CAC | - Constituency Aids Coordinator |
| CALHIV | - Children and Adolescents Living With HIV |
| CARGS | - Community ART Groups |
| CASCO | - County HIV/AIDS and STI Coordinator |
| CASP | - County AIDS Strategic Plan |
| CBK | - Central Bank of Kenya |
| CCC | - Comprehensive Care Centre |
| CEC | - County Executive Committee |
| CECM | - County Executive Committee Member |
| CHV | - Community Health Volunteer |
| CIDP | - County Integrated Development Fund. |
| CLHIV | - Children Living With HIV |
| CME | - Continuous Medical Education |
| COG | - Council of Governors |
| CQI | - Continuous quality improvement |
| CSS | - Community Systems Strengthening |
| DCC | - Deputy County Commissioner |
| DMA | -Data Management Assistant |
| DNA | - Deoxyribo-Nucleic Acid-it is a Carrier of Genetic Information |
| DRT | - Drug Resistance Testing |
| DSD | - Differentiated Service Delivery |
| EBI | - Evidence Based Information |
| HER | - Electronic Health Records |
| EID | - Early Infant Diagnosis |
| EMR | - Electronic Medical Records |

| | |
|---|---|
| eMTCT | - Elimination of Mother to Child Transmission |
| FIF | - Facility Improvement Fund |
| FSW | - Female Sex Workers |
| FY | - Financial Year |
| HAPCA | - HIV/AIDS Prevention and Control Act |
| HCW | - Health Care Workers |
| HE | - His Excellency |
| HEI | - HIV Exposed Infants |
| HIS | - Health Information Systems |
| HIV | - Human Immunodeficiency Virus |
| HPV | - Human Papilloma Virus |
| HRH | - Human Resource for Health |
| HTS | - HIV Testing Services |
| IEC | - Information Education Communication |
| KDHS | – Kenya Demographic Health Survey |
| KENEPOTE | - Kenya Network of Positive Teachers |
| KMLTTB | - Kenya Medical Laboratory Technicians / Technologists Board |
| KNBS | - Kenya National Bureau of Statistics. |
| KP | - Key Populations |
| M&E | - Monitoring and Evaluation |
| MCH | - Maternal and Child Health |
| MERL | - Monitoring Evaluation Research and Learning |
| MNCH | - Maternal Neonatal Child Health |
| MOE | - Ministry of Education |
| MOH | - Ministry of Health |
| PMTCT | - Prevention of Mother to Child Transmission |
| POC | - Point of Care |
| PrEP | - Pre-Exposure Prophylaxis |

| | |
|---|---|
| PWDS | - People with Disabilities |
| PWID | - People Who Inject Drugs |
| RH | - Reproductive Health |
| RMNCAH | - Reproductive Maternal Neonatal Child and Adolescent Health |
| SCASCO | - Sub-County Aids and STI Coordinator |
| SCHMT | - Sub-County Health Management Team |
| SCMOH | - Sub-County Medical Officer of Health |
| SGBV | - Sexual Gender Based Violence |
| SOPs | - Standard Operation Procedures |
| SRH | - Sexual Reproductive Health |
| STI | - Sexually Transmitted Infections |
| TWG | - Technical Working Group |
| UHC | - Universal Health Coverage |
| VAC | - Violence Against Children |
| VL | - Viral Load |
| VMMC | - Voluntary Medical Male Circumcision |
| WHO | - World Health Organization |

## DEFINITION OF OPERATIONAL TERMS

**Acquired Immune Deficiency Syndrome (AIDS):** a condition characterized by a combination of signs and symptoms, resulting from depletion of the immune system caused by infection with the Human immune-deficiency Virus (HIV).

**Adolescent and youth Friendly Health Services:** Health services delivered in ways that are responsive to specific needs, vulnerabilities and desires of adolescents and youth. These services are offered in a non-judgmental and confidential way that fully respects human dignity.

**Adolescents:** Persons aged between 10 and 19 years.

**Age Appropriate Comprehensive Sexuality Education (AACSE):** An age-appropriate approach to teaching about sexuality by providing scientifically accurate, realistic and non-judgmental information.

**Age Appropriate:** Suitability of information and services for people of a particular age, and developmental stage.

**Child Abuse:** Child maltreatment, sometimes referred to as child abuse and neglect, includes all forms of physical and emotional ill-treatment, sexual abuse, neglect and exploitation that results in actual or potential harm to the child's health, development or dignity.

**Child Marriage:** A situation where marriage, cohabitation or any arrangement is made for such marriage or cohabitation with someone below the age of 18 years.

**Child:** An individual who has not attained the age of 18 years**.** In the context of choice of ARV based on organ maturity, a child is a person below age of 15 years.

**Competent:** Refers to capable, knowledgeable, skilled and proficient service providers who are providing services according to national guidelines.

**Comprehensive:** Health care that comprise of many elements of care such as promotive, preventive, curative and rehabilitative services. Comprehensive SRH services bring together all the elements of SRH to prevent, manage conditions.

**Consent**: Permission given without any coercion, fraud or threat and with full knowledge and understanding of the medical and social consequences of the matter to which the consent relates.

**Health:** A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

**HIV:** A virus that spreads through certain body fluids that attacks the body's immune system, specifically the CD4 cells/T cells (special cells that help the immune system fight off infections).

**Key populations:** Groups who, due to specific higher-risk behaviors, are at increased risk of HIV infection irrespective of the epidemic type or local context.

**Life Skills Education:** A structured program of needs and outcomes based participatory learning that aims to increase positive and adaptive behavior by assisting individuals to develop and practice psycho-social skills that minimize risk factors and maximize protective factors.

**Maternal mortality ratio**: Number of maternal deaths per 100,000 live births.

**Morbidity**: A condition of suffering from a disease.

**Mortality:** Death resulting from a disease.

**Non-State Actors:** An entity that is not part of any state or a public institution. Non-state actors range from community organizations, non-governmental organizations, faith based organizations, philanthropic foundations, academic institutions, and etcetera.

**Orphan:** A person below 18 years of age who has lost one or both parents.

**Orphans vulnerable children:** Children below 18 years who are orphaned, or live outside family care, disabled or are made vulnerable due to HIV and AIDS (HIV positive, HIV exposed infants or child, living without adequate adult support in household with chronically ill caregiver or child headed household).

**Persons With Disability**: Any person with physical, sensory, mental, psychological or any other impairment, condition or illness that has a substantial or long term effect on their ability to carry out day-to-day activities.

**Post-exposure prophylaxis**: The administration of one or a combination of anti-retroviral drugs after probable exposure to HIV, for the purpose of preventing transmission.

**Reproductive health**: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, its functions, and processes.

**Sexual Health:** A state of physical, emotional, mental and social well-being in relation to sexuality.

**Sexual Offences**: Actual attempted or threatened sex without consent such as defilement, rape, incest, sodomy, bestiality and any other offence prescribed in the Sexual Offences Act (2006).

**Sexual, Reproductive Health and Rights:** The exercise of control over one's sexual and reproductive health linked to human rights.

**Transgender:** An umbrella term for people whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth.

**Vulnerable Populations:** People at high risk of lacking adequate information, care and protection. For the purpose of this Policy, the term includes OVC, adolescents, people with disabilities; PLHIV, key populations and the aged.

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NACC National AIDS Control Council,

FSW Female Sex Workers

CHAPTER 1

# INTRODUCTION

## 1.1 Geographical Location

Kakamega County occupies approximately 3050.3Sq kilometres of land with a population of about 1,867,579 million people. Of the total population, 49% are male while 51% are female. According to the Kenya National Bureau of Statistics, the county has an annual population growth rate of 2.5% (KNBS, 2019). Majority of the population is rural with a poverty index of 46% (KDHS, 2019). Geographically, Kakamega County lies between longitudes $34.20^0$ and 35E and latitudes $0.15^0$ and 1N of the equator. It is bordered by Vihiga and Siaya Counties to the south, Busia and Bungoma to the west, Trans-Nzoia and Uasin Gishu counties to the North and Nandi to the East. Administratively, Kakamega County is divided into 12 sub-counties namely; Lugari and Likuyani which form the Northern Region, Shinyalu, Lurambi, Malava, Navakholo and Ikolomani – the Central Region, while Mumias East, Mumias West, Khwisero, Butere, and Matungu constitute the Southern Region.

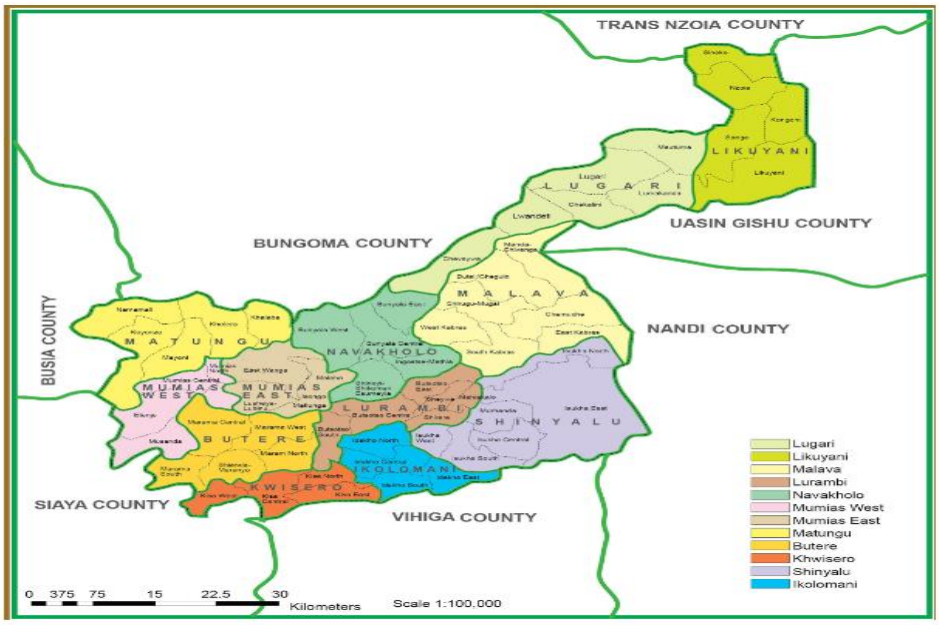


**Figure 1: Kakamega County Map**

## 1.2 Situation Analysis

There were an estimated 37.9 million PLHIV at the end of 2019. As a result of concerted international efforts to respond to HIV, coverage of services has been steadily increasing. However, HIV has continued to be a global burden despite the progress made in prevention and treatment. Globally, in 2019, 68% of adults and 53% of children living with HIV (PLHIV) were receiving lifelong antiretroviral therapy (ART). During the same period, 1.7 million people became infected with HIV with 20.6 million PLHIV being in Sub-Saharan Africa. The majority of these people are in Eastern and Southern Africa (UNAIDS, 2019).

Kenya has the fourth–largest HIV burden in the world with a prevalence of 4.9%. Approximately, there are 1.5 million PLHIV (PLHIV) out of whom, 73% (1.1m) are on Anti-Retroviral Treatment (ART). An estimated 52,800 people are new infection cases across all ages (NACC, 2018). Kenya has a slightly higher ART coverage of 73% than the world coverage of 65%. In 2018, Kenya had approximately 28,200 AIDS (acquired immunodeficiency syndrome) related deaths leaving an estimated 2,543,838 orphans and vulnerable children in the country (NACC, 2018). Many PLHIV still face high levels of stigma and discrimination, a factor that has hindered full accessibility to HIV services (NACC, 2014).

In Kakamega County, HIV prevalence stands at 4.5% which is slightly lower than the National prevalence of 4.9% (NACC, 2018). Among adult males aged 15-49 years prevalence stands at 3.4% while that of females is 5.6% with an incidence rate of 1.8/1,000 persons. It is estimated that of the 52,976 PLHIV 44,000 are currently on ART (KHIS, 2020). Of the 52,976 PLHIV, 48,752 are aged 15 years and above, 4,050 are adolescents aged 10 to 19 years, 6,986 are young adults aged 15 to 24 years while 4,224 are children aged below 15 years (NACC, 2018). HIV and AIDS remains one of the leading causes of death in Kakamega County. Currently, it has a mortality rate of 14.2% compared to the national average of 10.5% (MOH, 2018). It is the single highest cause of in-patient based mortality in the county at 8.3% (KHIS, 2019). It is also worth mentioning that 90% of the 44,000 people currently on ART have achieved viral load suppression. (93%) percent (40,920) of the PLHIV are expected to be retained on ART (KHIS, 2019).

According to NASCOP (2017), there are 1,751 female sex workers (FSW) and 637 men are estimated to have sex with men (MSM). Among the FSW, HIV prevalence is estimated at 29% while 18% represents prevalence among men who have sex with men (Musyoki et al., 2018). Statistics from NACC (2018) indicate that there were about 2,198 new HIV infections across all ages in 2017. These included 1,761 adults, 596 young adults, 187 adolescents and 437 children. Key populations including FSW and men who have sex with men contribute about 30% of new infections making them significant drivers of the HIV epidemic in the county. In the said year 2017, there were 989 HIV related deaths across all ages of whom 794 were adults, 126 young adults, 93 adolescents and 195 children (NACC, 2018). According to the 2020 Kenya County HIV

Profiles by NACC, MOH (Kenya HIV estimates 2018) Kenya, Kakamega County has 19,361 orphans arising from HIV and AIDS related deaths.

Stigma and discrimination index remains at a high of 45% (The National HIV and Aids Stigma and Stigmatization Index Report, 2014) in the county despite the awareness campaign on HIV and AIDS. This Stigma and discrimination has contributed greatly to the prevention of PLHIV from accessing HIV services (NACC, 2014). It is estimated that 56,133 out of 71,122 pregnant women who received antenatal care in the year 2018, 2,176 were HIV positive. This translated to a positivity rate of 3.9% (KHIS, 2018). Mother to Child Transmission (MTCT) rate in the county stood at 13.2% compared to the national rate of 11.5% (NACC, 2018). This is much higher than the WHO target rate of below 5%.

Much of the HIV related services in Kenya is heavily donor dependent, the global fund and the US President's Emergency Plan for Aids Relief (PEPFAR). PEPFAR, which funds most HIV activities in Kenya, has been cutting funding to Kenya since 2017. Despite this cut, the country remains the program's largest beneficiary. Kenya has received about Ksh.700 billion ($7 billion) from PEPFAR since it was founded in the year 2007. In the Financial Year (FY) 2017/18, Kenya received Ksh.57 billion ($570 million). This was reduced to Ksh.50 billion ($500 million) in 2019 and Ksh.37 billion ($370 million) in 2020 (https://ke.usembassy.gov/our-relationship/pepfar/). Despite declining donor support and high local burden of HIV disease, Kakamega County still heavily depends on donor resources in addressing HIV related prevention, care and support initiatives.

### 1.3 Legislation and Policy Framework

This Policy is guided by existing statutes, HIV, AIDS and STIs regulations, the Kenya AIDS strategic framework 2020-2025 and to international conventions, treaties and protocols signed and ratified by the Republic of Kenya. This Policy is aligned to various legislative frameworks to ensure its contribution to overall human development and achievement of international, regional, national and county health policy objectives. These include–

a) Constitution of Kenya 2010;
b) Global Commitment to end AIDS by 2030;
c) East Africa Community HIV and AIDS Prevention and Management Act 2012;
d) Vision 2030;
e) Kenya Health Policy 2014 -2030;
f) Kenya Health Sector Strategic Plan 2018-2023;
g) Health Act No. 21 of 2017;

h) Public Health Act Cap 242;
i) Kenya AIDS Strategic Framework 2020-2025;
j) National HIV and AIDS work place policy;
k) HIV and AIDS Prevention and Control Act 2006;
l) Children Act No.8 of 2001;
m) Education Sector Policy on HIV and AIDS 2013;
n) Sexual Offences Act No.3 of 2006;
o) Employment Act No. 11 of 2007;
p) Kenya Adolescence Sexual and Reproductive Health Policy 2015;
q) Legal Aid Act No.6 of 2016;
r) Kenya Medical Laboratories Technologists and Technicians Board Act CAP 253A;
s) Pharmacy and Poisons Board Act Cap 244;
t) National Reproductive Health Policy 2007;
u) Kakamega County Health Sector Strategic Plan 2018-2023;
v) Kakamega County HIV workplace Policy 2016;
w) Kakamega County Maternal Child Health and Family Planning Act 2017;and
x) Kakamega County Integrated Development Plan 2018-2022.

### 1.4 Problem Statement

HIV, the virus that causes AIDS, is one of the world's most serious health and development challenges. Approximately 38 million people worldwide are currently living with HIV while tens of millions of people have died of AIDS-related causes since the beginning of the epidemic. Many PLHIV or at risk of HIV infection do not have access to prevention, treatment and care and there is still no cure (UNAIDS, 2020). UNAIDS estimates that $19.8 billion was available from all sources (domestic, donor governments, multilaterals, and foundations) to address HIV in low- and middle-income countries in 2019 (ibid). Of this, donor governments provided $7.8 billion, representing a reduction from the $8 billion in 2018 and nearly the same as the funding levels of a decade ago (KFF/UNAIDS, 2020).

Kakamega County has made considerable strides in HIV, AIDS and STI control. Over 44,000 PLHIV are on antiretroviral treatment. Provision of HIV prevention and treatment services exists in all public health facilities (KHIS-2020). However, these people need sustained health care to

maintain healthy productive lives since there is no cure yet for HIV. Despite gains made, there still exists a number of challenges. These include stigma and discrimination, inadequate funding, inadequate human resource and infrastructure for HIV and STI services. However, retention of the already identified PLHIV on treatment remains the biggest challenge. In addition, the rate of mother to child transmission remains high (13.2%) with an equally high number of new HIV infections.

Kakamega County lacks a HIV, AIDS and STI control policy and legal framework to guide coordination, implementation and resourcing for the HIV, AIDS and STI control. Further, implementation of the program is resource intensive and currently donor dependent. This is not sustainable as donor funding continues to dwindle. To sustain the gains so far realized in the epidemic control, there is need for a policy to provide a unified direction for coordination of multiple stakeholders to deal with afore-mentioned challenges.

### 1.5 Vision

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

### 1.6 Mission

To provide a framework that will enhance implementation of programs for control of HIV, AIDS and STI in Kakamega County.

### 1.7 Scope

The Policy focuses on providing a policy framework to guide HIV, AIDS and STI control in Kakamega County. It focuses on HIV, AIDS and STI program co-ordination, service delivery, strategic information and financing in line with vision 2030 and Universal Health Coverage (UHC).

### 1.8 Guiding policy principles

This policy is guided by vision 2030 and the Kenya Constitution 2010. It encourages results-oriented programs and interventions guided by the following principles–

a) Political commitment;

b) Multi-sectoral approach;

c) Human rights approach;

d) Universal access and inclusion;

e) Gender responsive programming;

f) Client-centered approach, and

g) Confidentiality.

## 1.9 Objectives

The county government's main objectives are to:

a) Reduce new annual HIV infections by 75% from 2000 to less than 500 by 2030.

b) Reduce mother to child transmission rate from 13.2% to World Health Organization's target of below 5% by 2030.

c) Reduce annual HIV related mortalities by 50% from the current 989 to 495 by 2030.

d) Strengthen the capacity of the health system to support HIV, AIDS and STI control by 2030.

e) Increase domestic financing for the HIV, AIDS and STI response from the current average of Ksh. 2 Million to 2.5% of the county health budget.

f) Establish a mechanism for resource mobilization for the control of HIV, AIDS and STI.

g) Promote community systems responsible for HIV, AIDS and STI control through linkage between health facilities and organized community groups.

h) Institute measures to reduce stigma, discrimination and promote respect to human rights.

i) Provide a legal framework on which HIV, AIDS and STI control is anchored in the county.

CHAPTER 2

# POLICY ISSUES AND DIRECTIONS

## Introduction

The County Government of Kakamega needs to adopt policy directions in specific areas of response to deal with the thousands of PLHIV who require lifelong healthcare and to protect the general population from new HIV infections. These policies relate to the following areas; Prevention of HIV infection, prevention of mother to child transmission of HIV and STIs, HIV care and treatment, promoting community systems for HIV response, domestic financing of HIV, AIDS and STI response, resource mobilization for HIV, AIDS and STI response, creation of an enabling environment and human rights approach to HIV AIDS and STI response, and creating the legal framework to support response to HIV, AIDS and STI.

## 2.1 Prevention of new HIV Infections

HIV prevention requires a multi-sectoral approach in addressing the complex risks and drivers such as poverty, gender inequality and sexual violence. This involves a combination of prevention approaches include biomedical, behavioral and structural interventions.

### Key issues

The salient issues to be addressed include:

a) Low knowledge and awareness on risky sexual behavior caused by weak health promotion programs targeting HIV, AIDS and STI prevention;

b) Slow identification of new positive cases especially among men;

c) Weak link between HIV testing services and HIV prevention;

d) Poor adherence to ART as a prevention strategy of containing the virus in the host;

e) Low awareness and uptake of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) as key HIV prevention interventions;

f) Inconsistent availability of safe blood for emergency transfusion needs;

g) Prevalence of cultural practices such as circumcision that do not promote HIV prevention safety practices and messages;

h) High prevalence of HIV-related sexually STI especially among key populations with poor access to STI treatment;

i) Lack of condoms and condom dispensers in public and private recreation facilities for use during sexual encounters;

j) High stigma that prevents many people from accessing HIV prevention and care services;

k) Insufficient prevention services among key populations such as female sex workers, men who have sex with men and people who inject drugs; and

l) Inadequate services targeting HIV prevention and care for vulnerable population groups of orphans and vulnerable children (OVC), the elderly and people with disability.

### Policy Directions

The county government of Kakamega shall–

a) Develop and disseminate comprehensive and targeted information education communication materials on HIV, AIDS and STI prevention using multiple appropriate media;

b) Promote targeted and innovative HIV testing services, informed by evidence such as program data and recency surveillance, through strategies like self-testing, recency testing, assisted partner notification services, key populations testing and dual testing;

c) Provide HIV prevention services to all clients receiving HIV testing services irrespective of HIV results;

d) Enhance follow up and support mechanisms for adherence and retention among PLHIV on ART;

e) Accelerate awareness and demand for PrEP and PEP and integrate into appropriate service delivery points and programs such as comprehensive care centers, maternal and child health department, Family planning, adolescent girls, young women, key population programs and STI clinics;

f) Support the county blood transfusion center to adequately mobilize, screen, supply and monitor safe blood transfusion products in the county;

g) Promote access to standard infection prevention procedures including safe male circumcision to all groups of people and an integrated HIV prevention advocacy;

h) Provide universal access to non-judgmental, comprehensive, confidential and client-friendly STI prevention and treatment services regardless of age, gender, gender identity, sexual orientation, sexual behavior and socio-economic status;

i) Provide condom dispensers in public/private places. promote awareness and access to condoms and lubricants as an HIV prevention method for everyone, including key populations and adolescent and young persons;

j) Conduct stigma reduction campaigns including engaging with champions and networks of PLHIV towards stigma reduction;

k) Promote provision and uptake of friendly prevention, care and support services for key and priority populations and work towards integrating these services to the routine health care system; and

l) Develop and promote programs and interventions targeting HIV prevention and care for vulnerable population groups of orphans and vulnerable children (OVC); the elderly, people with disability.

### 2.2 Prevention of mother to child transmission (PMTCT) of HIV and STI

The county is working towards achieving the World Health Organization process and impact indicators for elimination of mother to child transmission validation. The indicators are 95% coverage of 1st antenatal attendance against the county's 79%, HIV and Syphilis testing and treatment for all eligible pregnant women as opposed to only 66% of estimated HIV Positive pregnant women, and less than 5% PMTCT of HIV by end of 2021. The overall mother to child transmission rate in the county stands at 13.2%.

#### Key issues

The main issues to be addressed include:

a) Lack of a county specific strategy on elimination of MTCT;

b) Recurrent stock out of commodities for PMTCT such as point of care early infant diagnosis commodities, dual test kits for HIV and Syphilis, and infant ARV Prophylaxis;

c) Low coverage of antenatal care, HIV and syphilis testing in pregnancy and skilled delivery among pregnant women particularly among HIV positive pregnant women;

d) High teenage pregnancies and lack of adolescent and youth responsive prevention of MTCT services;

e) High HIV stigma prevalence in the county is a barrier to women accessing services for PMTCT of HIV and STIs;

f) Nonstandard quality of care and reporting on services for PMTCT, maternal new born and child health;

g) Few mentor mothers and other PLHIV peer educators well skilled to support community on PMTCT; and

h) Lack of structured monitoring of progress towards validation of county elimination of MTCT of HIV.

#### Policy Directions

The County Government shall:–

a) Develop and implement a county specific strategy for elimination of mother to child transmission

b) Promote consistent availability of commodities for prevention of mother to child transmission including Point of care early infant diagnosis commodities, dual test kits for HIV and Syphilis, and infant ARV Prophylaxis;

c) Scale up uptake of antenatal care, HIV and syphilis testing in pregnancy, and skilled delivery among pregnant women, including deliberate strategies targeting among HIV positive pregnant women, community strategy and peer to peer mentorship;

d) Promote innovative client centered approaches including child and adolescent-friendly models to deliver elimination of mother to child transmission at facility and community level;

e) Strengthen community led HIV exposed infants' graduations as a mechanism to engage the community to reduce stigma related to HIV and prevention of mother to child transmission of HIV and STI;

f) Establish and implement mechanisms for continued improvement of quality and reporting of PMTCT services targeting both the private and public sectors, such as support supervision and continuous medical education;

g) Empower and engage community health volunteers, peer educators and mentor mothers on elimination of mother to child transmission of HIV, syphilis and viral hepatitis; and

h) Develop and utilize standard information dashboard for prevention of mother to child transmission for structured monitoring on a quarterly and continuous manner.

### 2.3 HIV Care and Treatment

Kakamega County is committed to provision of quality, universally accessible care and treatment services to all PLHIV as per the national anti-retroviral treatment (ART) guidelines. ART is a proven intervention to promote good health of PLHIV while providing public prevention. PLHIV who achieve viral load suppression through effective ART cannot transmit HIV.

#### Key issues

The major issues to be addressed include:

a) Suboptimal linkage to HIV care; and treatment;

b) Poor adherence and retention among clients newly initiated on treatment, key populations, adolescents and young people;

c) Weak client identification system is a challenge to referral, follow up and identification of PLHIV between health facilities;

d) Knowledge on HIV treatment is continuously evolving, giving need to continuous capacity building of staff to provide up to date care; inadequate continuous capacity building of health care workers due to the evolving nature of HIV treatment;

e) Mental health needs and adherence challenges are key bottle necks to successful treatment outcomes; most people who fail to suppress viral load have problems with mental health and adherence;

f) Gaps in quality of care and reporting of HIV services provided in private sector;

g) HIV treatment services are isolated from other services and this is a contributor to stigma and difficult sustainability of these services;

h) Majority of ART treatment defaulters are new clients because of low client literacy levels;

i) HIV clients require specialised regular monitoring of disease progression and treatment success;

j) Weak patient feedback mechanisms to support improvement of quality of care;

k) Inadequate and irregular supply of commodities for management of HIV related opportunistic infections;

l) Knowledge gap among healthcare workers, caregivers and parents in the provision of care to children and adolescents living with HIV;

m) Poor viral load suppression among school going children and adolescents living with HIV;

n) Alcohol and drug abuse among adolescents and men is a barrier to HIV care; and

o) High number of patients in HIV clinics requiring clinician attention hence over-burdening the health system.

### Policy Directions

The County Government of Kakamega shall–

a) Start all new HIV positive people identified on antiretroviral treatment in line with current guidelines;

b) Strengthen county client follow-up mechanisms such as client appointment management for all PLHIV on anti-retroviral therapy (ART);

c) Strengthen electronic medical records to promote client identification across facilities through inter-operability to improve referral, follow up and retention;

d) Disseminate and implement national ART guidelines and support regular continuous medical education;

e) Promote community and facility psychological and ART adherence support mechanisms for PLHIV;

f) Strengthen partnerships with private facilities, NGOs and other civil society organizations to enhance linkage to care;

g) Promote progressive integration of ART services in appropriate existing service delivery points; and put in place mechanisms for integration of care for other chronic health conditions and non-communicable conditions to the HIV service delivery;

h) Promote structured age/ population appropriate treatment literacy sessions especially targeting new clients in the first year of treatment;

i) Support access to specialized laboratory and imaging monitoring services through point of care and offsite laboratory networking arrangements;

j) Strengthen patient feedback (compliments, complaints and suggestion boxes) mechanisms such as regular client satisfaction surveys to inform quality improvement mechanisms;

k) Provide equitable access to diagnosis, treatment and monitoring of opportunistic infections for PLHIV and all populations, including TB, Pneumonia and meningitis;

l) Promote caregiver and healthcare worker literacy initiatives on care, treatment and support to children and adolescents living with HIV;

m) Partner with the ministry and department responsible for education to provide school health services responsive to children and adolescents living with HIV;

n) Develop and implement initiatives for control of alcohol, drug and substance abuse among adolescents and adults living with HIV; and

o) Implement innovative differentiated service delivery approaches targeting clients at varied population cohorts and stages of care in line with current guidelines; for example, express clinics, community ART groups and community dispensing.

### 2.4 Health Systems Strengthening

HIV, AIDS and STI control is embedded within the county health system. A health system consists of all organizations, people and actions whose primary intent is to promote, restore and maintain health (WHO, 2007). In the wake of the call for sustainability and a need to improve comprehensive care and outcomes for PLHIV and those at risk of contracting HIV, this policy adopts the WHO framework for health systems strengthening (WHO, 2007). The policy directions are anchored in the six health system building blocks namely; service delivery, health workforce, health information management, medical products, vaccines and technologies, health care financing and leadership and governance.

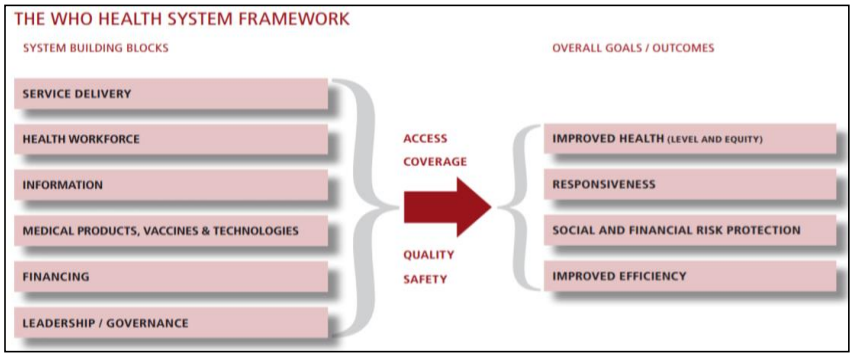


Figure 2: The WHO Health System Framework

## Key issues

The main issues to be addressed include:

a) Challenges in procurement, distribution and warehousing of commodities for HIV response require coordination across levels of the supply chain system;

b) Lack of a research unit for coordinated research agenda and innovation;

c) Challenges affecting the electronic medical records including parallel and semi-functional systems which are not aligned to national policies, lack of inter-operability and partial coverage of the whole county.

d) Minimal utilization of data for policy, decision-making and program management;

e) High donor dependence for human resources for the HIV program. More than 90% of the health workers working in the county HIV, AIDS and STI control are partner employed;

f) Gaps in retention and transition management of staff skilled in HIV management who are employed by the county government and partners;

g) Inadequate knowledge and skills among health workers which is worst among those who are not directly involved in HIV program implementation due to gaps in integration;

h) Strikes and industrial unrest which affect effective service provision;

i) Gaps in multi-sectoral coordination for HIV program interventions; and

j) Inconsistent maintenance of infrastructure leading to poor quality and break down of vital equipment.

### Policy Directions

The County Government of Kakamega shall –

a) Operationalize the Health Products and Technologies Unit to support HIV supply chain management at county level and enhance linkage with the national government;

b) Establish and sustain an active Monitoring, Evaluation, Research and Learning Unit to drive a research agenda for HIV and health care in order to provide evidence for decision making and practice;

c) Progressively scale up functional electronic medical records to digitize health systems so as to enhance their inter-operability and referral services for PLHIV on chronic care in line with national policy;

d) Invest in periodic HIV program outcomes measurement and evaluation to inform program interventions and epidemic control;

e) Progressively increase budget allocation and mobilize resources towards recruiting additional human resource to address gaps;

f) Implement strategies to retain staff skilled in HIV management to ensure continued service delivery and retention of skills;

g) Promote capacity building of staff for HIV, AIDS and STI service delivery and deployment of appropriately skilled staff to HIV, AIDS and STI service delivery points;

h) Strengthen mechanisms for employer and employee relations to enhance industrial harmony and avert strikes;

i) Provide leadership and stakeholder coordination mechanisms for the County HIV, AIDS and STI control program; and

j) Institutionalize procurement and preventive maintenance of assets and equipment for HIV/AIDS and STI control.

**Commented [h1]:** Include comment on transition of donor funded staff to CGK employment within the 5 years

## 2.5 Domestic Financing

In the wake of reducing donor funding to the HIV response, there is urgent need to increase county funding to the HIV, AIDS and STI response. This is inevitable if we are to sustain the gains made, the life of PLHIV, and advance prevention of new HIV infections.

### Key issues

The major issues to be addressed include:

a) Low annual budget allocation for the County HIV, AIDS and STI control program;

b) Implementation of the HIV, AIDS and STI control services that is highly dependent on donors, who are progressively transferring this responsibility to the county government;

c) PLHIV have not been meaningfully involved in public participation to guide county budgets;

### Policy Directions

The County Government of Kakamega shall –

a) Sustain annual county government contribution to HIV, AIDS and STI Control budget in a progressive manner;

b) Institutionalize HIV, AIDS and STI control to the county development plans and organizational structures, so that the county government drives the response.

c) Involve PLHIV in budgeting public participation through organized groups and networks of PLHIV and use their input to inform county budgets;

## 2.6 Resource mobilization for HIV, AIDS and STI Control.

The government budget alone cannot adequately meet the high cost of response to HIV, AIDS and STI. This makes the need for robust resource mobilization inevitable.

### Key issues

The salient issues to be addressed include:

a. HIV, AIDS and STI control is expensive;
b. Implementation of the HIV, AIDS and STI control services is highly dependent on donors, who are progressively transferring this responsibility to government;
c. Lack of a proper mechanism to manage internal and external program funds (receiving, appropriating, access and accountability);
d. Out of pocket expenditure is a challenge for access to treatment support services;

### Policy Directions

The County Government of Kakamega shall:

a. Conduct robust resource mobilization for HIV, AIDS and STI control interventions;
b. Develop and implement county law that supports resource mobilization, appropriation and management of funds for HIV, AIDS and STI control services;
c. Set up a dedicated HIV, AIDS and STI fund with appropriate bank accounts to ring-fence the funds received and expended from multiple sources including county contribution, donors and private sector; and
d. Promote sustainable enrollment of PLHIV into the existing social insurance schemes such as NHIF.

## 2.7 Community Systems Strengthening For HIV, AIDS and STI Response

Community Systems Strengthening (CSS) seeks to build the community level systems, policies and frameworks to improve access to health and social services by PLHIV. It is critical to develop and implement a systematic, robust and harmonized approach to partnership between and among health facilities, community-based organizations and community actors. This will accelerate progress towards elimination of HIV.

### Key issues

The issues to be addressed include:

a) Low knowledge on HIV/STI prevention and care among the community health workforce.

b) Stigma related to HIV hinders community health volunteers from providing community support services to PLHIV within their communities.

c) Weak community structures for HIV care;

d) Weak school health program to support HIV, AIDS and STI prevention and management in schools.

**e)** Stigma and knowledge gaps in schools among students, teachers and school health care workers;

f) Weak linkage between communities, schools, adolescent health stakeholders and the health sector;

### Policy Directions

The County Government of Kakamega shall–

a) Capacity-build community health services workforce and county health promotion unit to provide HIV prevention education.

b) Train peer educators among PLHIV and work through them to support community follow up for adherence to treatment among peers- persons living with HIV, because of stigma and confidentiality concerns.

c) Implement innovative community models of care such as community ART groups, community dispensing, community peer educators, Home and community-based care in line with guidelines.

d) Strengthen an integrated and well-coordinated school health program using the health promotion unit and the HIV and AIDS/STI Control Program, to support schools in prevention and management of HIV, AIDS and STI.

e) Capacity build teachers, school health workers and learners on HIV/STI control services.

f) Support multi-sectoral coordination mechanisms to strengthen linkage between health and education sectors, child and adolescent health stakeholders and the community.

### 2.8 Reducing Stigma, Discrimination and Promotion Of Human Rights In HIV Response

A human rights-based approach is essential to ending HIV/AIDS as a public health threat. Rights based approaches create an enabling environment for successful HIV responses and affirm the dignity of people living with, affected by or vulnerable to contracting HIV.

#### Key issues

The priority issues include:

a) Lack of information among members of the public on HIV and human rights.

b) Weak systems for networking and referral of legal aid for PLHIV and vulnerable populations;

c) Complex laws and legal language that is difficult to understand by the common citizen;

d) Knowledge gap among key actors in health related laws and legal concerns.

e) Sexual and Gender Based Violence, violence against children and teenage pregnancies are contributors to new HIV infections;

f) Poor knowledge and use of the HIV Tribunal by PLHIV with and affected by HIV.

g) HIV vulnerability, prevention and care is a human rights issue.

#### Policy Directions

The County Government of Kakamega shall–

a) Sensitize the public on available on HIV/sexual related laws and legal problems;

b) Support coordinated systems for networking and referral of legal aid for PLHIV and vulnerable populations in partnership with existing networks/ institutions and support integration of human rights for HIV, AIDS and STI response.

c) Promote translation of HIV and sexual health related laws to simple language with English, Swahili, Kenya sign language and local language options;

d) Train key actors in health legal concerns, including the police, lawyers, persons living with HIV, judges, health care workers, prison inmates of wardens, key populations, PWDS, drug abusers, children, youth, employers and administration;

e) Provide prevention, legal and rescue support for sexual and gender-based violence, violence against children and teenage pregnancies;

f) Establish through the County legal office a link mechanism between PLHIV and people affected by HIV in the county and the HIV tribunal;

g) Promote a human rights-based approach to HIV response for all including key populations;

## 2.9 Legal Framework

Implementation of HIV, AIDS and STI control interventions require a supporting legal environment. This is in view of the multi-sectoral and personal nature of both the epidemic and the control programs that often require the force of law to action interventions.

### Key Issues

The major issues include:

a) There is no county-specific legal framework to support coordination, management, resourcing and implementation of HIV, AIDS and STI Control interventions; and

b) The current HIV, AIDS and STI control interventions are heavily partner driven.

### Policy Directions

The County Government of Kakamega shall-

a) Develop, enact and implement county legislation to guide the coordination, management, resourcing and implementation of HIV, AIDS and STI control programs in the county.

b) Establish a county-led coordination mechanism for HIV, AIDS and STI response that is anchored in county law.

CHAPTER 3

COORDINATION AND IMPLEMENTATION

## 3.1 MANAGEMENT, COORDINATION AND INSTITUTIONAL FRAMEWORK FOR IMPLEMENTING THE HIV POLICY

The implementation of this policy requires multi-sectoral partnerships and collaboration. Thus, there is need for proper structures to coordinate and manage the policy at County level. This policy is also alive to the functional relationship between the two levels of government in respect to accountability, service delivery, reporting and management. The County Government will implement this policy in collaboration with state and non-state actors both at the national and county levels. The key actors include, National Aids and STI Control Program (NASCOP), National Aids Control Council (NACC), government departments and ministries, international development partners, implementing partners, civil society organizations, networks of PLHIV, Faith-based organizations.

### 3.1.1 Organizational structures

The implementation of this policy will be steered by the established organizational structures within the county government and the department of health. These structures include:

a) **Office of the Governor**: H. E the Governor is the vision holder of the county and of this policy. All structures implementing the policy act on behalf of the office of the Governor.

b) **County Executive Committee** (CEC): The CEC member for health shall oversee the overall implementation of the policy. He/she shall be the executive custodian of the policy.

c) **County Assembly Health Committee:** The County Assembly shall guide legislation to enforce successful implementation of the policy. It shall also have a major role of oversight and resource allocation.

d) **County Health Department:** This includes County Chief Officers and County Health Management Teams. For effective coordination and implementation of this policy, the following units in the department shall play a key role: County HIV, AIDS and STI control program secretariat, County Health Products and Technologies Unit, Human Resources for Health, County Monitoring, Evaluation and Health and Information Systems Unit, and Finance and Planning. The actual implementation will be at the sub-county, facility and community levels. These will be headed by the Sub-County Medical Officer of Health (SCMOH), Sub-County health management teams and facility management teams.

**e)** **County HIV/STI Control Program Unit:** The unit will form the secretariat for both the County HIV Committee and the County HIV Technical Working Group. It **s**hall be the implementing technical lead of the policy with a program head, the County HIV, AIDS and STI Control Program Coordinator (CASCO) who shall on behalf of the CECM Health Services engage other implementing agencies including NASCOP, NACC, and County Health Units, other county/national departments and non-state actors. The Program head

shall leverage on the County health management team and other established structures at county, Sub-County, health facility and community levels. There will be Sub-County Program Coordinators (SCASCO) who will be technical program officers at the Sub-County.

f) **Community Involvement:** The structures include community civil society organizations, Community health strategy, and community peer support mechanisms.

g) **Networks of PLHIV:** These are organized groups of PLHIV in the program care led by facility and community peer educators chosen by the networks from serving peer educators. They provide meaningful engagement of the PLHIV in the program.

### 3.1.2 Multi sectoral coordination of the county HIV, AIDS and STI control program

HIV control and sexual health is a multi-sectoral concern and can only be achieved successfully with the involvement of all relevant stakeholders. To optimize on coordination, the following structures will be applied:

**3.1.2.1 County HIV, AIDS and STI Committee:** Appointed and responsible to the County Executive Committee Member for Health in the performance of its functions. The committee consists of the accounting officer of the county department responsible for health services, who shall be the chairperson; a representative from the office of the county commissioner; the county chief officer responsible for county treasury; the county HIV, AIDS and STI control coordinator; two experts representing HIV, AIDS and STI control implementing partners and stakeholders; a representative of the National Aids Control Council (NACC); a representative of the National AIDS and STI's Control Program (NASCOP); and three people with HIV and AIDS nominated by community organizations involved in matters relating to HIV, AIDS and STI in the county one each representing the youth, persons with disabilities; and inter-faith organizations.

This is the county organ with the overall responsibility for HIV, AIDS and STI control on behalf of the CECM for health services.

**3.1.2.2 County HIV, AIDS and STI Technical Working Group:** Consists of the County director responsible for health services who shall be the chairperson; the County HIV, AIDS and STI Control Program Coordinator who shall be the secretary; county health records and information officer; county medical laboratory services coordinator; county pharmacist; county community health coordinator; county prevention of mother to child transmission of HIV focal person; national county director of education; national county director of children; national county director gender; national county director youth; a representative of National Aids Control Council; a representative of National Aids and STI Control Program; a representative of PLHIV; county reproductive health coordinator; a representative of each of HIV, AIDS and STI implementing partners and other co-opted members.

This is the structure responsible for multi-sectoral coordination of all actors in HIV, AIDS and STI control as well as technical support to the committee and the County HIV, AIDS and STI unit.

**3.1.2.3 County HIV, AIDS and STI Control secretariat:** Shall be responsible to the County HIV, AIDS and STI committee and the County HIV, AIDS and STI Technical working group in the performance of their respective functions. They shall be responsible for the day-to-day implementation of the program and shall consist of the county HIV, AIDS and STI Control Program coordinator who shall be the head of the secretariat; and such number of officers as may be determined by the county executive committee member.

**3.1.2.4 Focal person in each county department:** There shall be a designated person for matters related to HIV, AIDS and STI control program working in liaison with the secretariat to coordinate the implementation of HIV, AIDS and STI activities in the respective department and to create awareness among officers within the department on matters relating to HIV, AIDS and STI.

**3.1.2.5 Constituency AIDS Control Committee:** Will be co-chaired by the sub-county administrator and the deputy county commissioner supported by the Sub county HIV, AIDS and STI Coordinator and the constituency AIDS coordinator. This is a platform to guide multi-sectoral HIV/AIDS response in the constituency and sub-county. It brings together sub county stakeholders and reports to the County HIV/STI control program and the NACC Regional office in support to the two tiers of government.

## 3.2. Implementation

The policy will be implemented through –

a) County HIV, AIDS and STI Control Strategic plans (CASP);

b) County HIV, AIDS and STI Control Program annual work plans;

c) County PMTCT Business Plan;

d) County HIV, AIDS and STI Control Bill/Act 2020; and

e) An accompanying M&E Plan.

## CHAPTER 4
## MONITORING AND EVALUATION

Monitoring and Evaluation will assess the progress and impact of the County HIV, AIDS and STI Control policy implementation and inform future policies, strategies and interventions. Reports from monitoring and evaluation will be used to assess progress and amend previous strategies and interventions as shown necessary.

The county government through the Health department's monitoring and evaluation unit, Health Information System (HIS) team and HIV, AIDS and STI secretariat will coordinate and facilitate continuous monitoring and evaluation of the County response to HIV.

All HIV implementing partners shall submit quarterly reports of their activities to the county government through the County HIV, AIDS and STI Control secretariat.

The secretariat shall submit quarterly reports in approved formats to the technical working group, the county HIV Committee and the county executive. A report shall be submitted to the county assembly at least once annually.

## ANNEXES

**List of Contributors**

| Peer Educators | Sub county HIV/AIDS and STI Coordinators | Stakeholders |
|---|---|---|
| PEER EDUCATORS INPUTS TO THE COUI | | |
| Alice Navangala- Lumakanda County Hospital | Joseph Muyale- Khwisero | Stanley Omurunga-Family support inst.- Kenya Red cross |
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| ZakariahOneya-Sakali Disp | John Tumbo- Lugari | Benard Washika- FHOK |
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| Jones Wanda – County general hospital CCC nursing officer I/C | Zipporah Ombogo- Lurambi | Benjamin Andama- AMPATH finance office |
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| Titus Wesomga- Matungu SC Hospital | Linda Namachi- Mumias East | Dr Beatrice Etemesi- Chief Officer Medical Services. |
| Immaculate Bwonomi- Matungu SC Hospital | Consolata Makomere- Mumias West | Dr Ayub Misiani- Director Medical Services |
| Martha Bakhoya- Khwisero Health Center | Eric Soita- Matungu | Paul Manyasi- Director Public Health |
| Jones Odali- Butere County Hospital | Christine Odhiambo - Butere | Dr Mike Ekisa- County HIV/AIDS and STI Control Coordinator |
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| | | |
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| Edwin Wetoli- Mumias Sugar Dispensary | Samuel Komolo-KCCB KARP | Rose Obare- PMTCT Focal Person |
| Rev, Gerishom Shisinya CGH Kakamega | Dr Mark Makomere- AMPATH- Health Strat | Phyllis Khaoya- Physiotherapy |
| Linet Afandi- Shibwe. | Dr Eric Mudanya- AMPATH | Judith Lubanga- Deputy Director Administration |
| Patrick Wabuti- Makunga RHDC Health center | Geofrey Marita- AMPATH | Dr Gesicho David - County Dentist |
| Davis Bulimu- Champion for Adolescents and young persons (AYP) Living with HIV | Victor Kizito- NEPHAK | Jesca- County Reproductive health office. |
| | Jacqueline Chebii- CRS MWENDO | Dr Wambulwa Benard- Deputy County Pharmacist. |

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