Kenya

Operational Plan Report

FY 2013

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.

Operating Unit Overview

OU Executive Summary

Kenya FY 2013 Country Operation Plan (COP)

I. Background

HIV Epidemic in Kenya:

- HIV Prevalence in adults 15-49: 6.3% (Kenya Demographic and Health Survey (KDHS), 2008-09).
- Estimated Number of Orphans due to AIDS: 1.1 million (UNAIDS Estimates, 2011)
- Estimated Number of HIV-positive People: 1,600,000 (The Kenya AIDS Epidemic Update 2012).
- Estimated Number of Individuals on Anti-Retroviral Therapy (ART) as of September 2012: 580,000 (PEPFAR 2012).
- Number of deaths averted in 2011: 68,000 (The Kenya AIDS Epidemic Update 2012)
- Number of deaths from HIV: 49,126 (Kenya HIV/AIDS Epidemic Update 2012)

HIV prevalence varies considerably by geographical region, age, sex, location and socio-economic status. Starting with geographical differences, in 2008, HIV prevalence in Nyanza was estimated at 13.9%, the highest in the country compared to only 0.9% in North Eastern province (KDHS). Significant differences also exist in HIV prevalence by age and gender. For pregnant women, ante-natal care (ANC) HIV prevalence currently stands at 7.4% (ANC sentinel surveillance 2011). People in the top wealth quintiles have higher prevalence at 7.2% compared to those of lower quintile (4.6%) (Kenya AIDS Epidemic Survey 2011). In 2011, 91,000 adults and 12,894 children were newly infected with HIV (Kenya AIDS Epidemic Survey 2011). The majority of new infections occur among persons in marital or cohabiting relationships (44.1%), casual heterosexual sex (20.3%) and the Most-at-Risk Populations (MARPs). Despite lack of national level data on MARPs, prevalence among MARPs continues to be higher compared to the general population and account for more than a third of new infections (Gelmon et al., 2009).

Host country policies and guidelines governing programming around MARPs have been developed with active involvement of the United States Government (USG). There is strong Government of Kenya (GOK) leadership in sensitizing law enforcement and health providers to provide a supportive environment for the right to health care by all populations. Structural interventions still require more focused linkages to ensure that there is a standardized understanding to guarantee services for MARPs.

The GOK has also expanded Prevention-of-Mother-To-Child-Transmission (PMTCT) services as part of comprehensive ANC services at most public health facilities in line with the goal towards implementing Option B+. In late 2012, the GOK launched the Elimination-of-Mother-To-Child-Transmission (eMTCT) policy and guidelines as part of this transition process. The GOK and USG teams are looking forward to the new WHO treatment guidelines to be released in 2013 to boost the efforts to increase the number of Kenyans receiving ARVs. Owing to the financial gap and programming implications the new guidelines will have, the GOK has launched a national sustainable financing strategy review process involving all HIV stakeholders.

After PEPFAR, the Global Fund (GF) is the second largest supporter of the GOK in the provision of anti-retrovirals (ARVs). The World Bank, through its Total War on AIDS (TOWA) project which ends in 2013, has worked with the National AIDS Coordination Council (NACC) in building the capacity of civil society organizations to lead the HIV response. PEPFAR Kenya is part of the HIV Development Partners in Health Kenya (DPHK) consortium where donor and development partners' health and HIV integrated agendas are promoted and shared. As part of the HIV Development Partners' Forum, formed in January 2011, the USG team is better placed to inform donor-supported strategies and high priority HIV issues. Outside these fora, PEPFAR continues to work closely with UNAIDS and the GF to coordinate advocacy, policy and programming efforts. More specifically, PEPFAR and UNAIDS are active in working with NACC to provide policy and fiscal support. The GF and PEPFAR Kenya continue to work together on the National Commodities Security Committee coordinating efforts and support towards ARVs, reagents and test kits provisions for Kenya.

Under the leadership of the Kenya Private Sector HIV/AIDS Business Council (KHBC), the private sector has been on the frontline of the development of national sustainable financing for HIV/AIDS with key Corporate Chief Executive Officers (CEOs) holding numerous meetings with the government. The private sector is also represented at the HIV/AIDS Inter-Agency Coordinating Committee (ICC) at the NACC and the Kenya Coordination Mechanism (KCM) of the GF. The sector also reaches out to the general public with various responses and partners with communities all over the country. The USG continues to leverage and harness private sector partnership through its Public-Private Partnership (PPP) efforts. These innovative initiatives have included: the Partnership for an HIV-free Generation's (HFG), the Phones for Health Project supporting the implementation of mobile health (mhealth) information systems for the GOK; CDC Foundation and the Ministries of Health (MOH) work with the private sector to develop mobile platforms to relay secure and timely programmatic, logistical, surveillance and other health related data; and Becton Dickinson's (BD) ongoing work with NASCOP to scale-up the safe phlebotomy trainings as part of the integrated Labs for Life regional initiative.

Devolution: The USG Team is in discussion with the GOK on the current and future implications of the

new Constitution on the health and HIV sector as it relates to national role of the Ministry of Health and devolution of authority to the Counties. [REDACTED] In COP13, the USG and GOK will review the Partnership Framework (PF) and The Partnership Framework Implementation Plan (PFIP) to enhance sustainability and ensure an appropriate transition to country ownership of all HIV related services and programs as well as health systems strengthening and health financing serving as core principles guiding the way forward.

II. PEPFAR focus in FY 2013

Treatment Scale-up: In COP13, PEPFAR will continue to support HIV services in line with GOK treatment priorities. Based on WHO recommendations, consultations will be held with the MOH to revise the Kenya guidelines to increase the CD4 cut off for ART initiation to 500 cells/mm3. In addition to sustain scale-up, new strategies will be adopted to increase the number of patients on ART including the provision of treatment to HIV+ partners in discordant relationships.

E-MTCT support to include the roll out of Option B+: Under the leadership of the GOK, PEPFAR will continue to support efforts to roll out option B+ for pregnant women as part of OGAC and UNAIDS Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive (Global Plan). The program will support effective partnerships with the government, community, private sector and other partners in leveraging resources to support maternal and neonatal child health services towards elimination of MTCT. The PMTCT program will create and maximize synergies with HIV treatment and care programs.

Strengthened collaboration with the Global Fund: The HIV program in Kenya is closely integrated with all stakeholders (GOK, GF, Clinton Foundation and PEPFAR) contributing support to ART services such as capacity building of health care providers, lab services and drugs. In 2012, USG strengthened its engagement with the GF Kenya Principal Recipients (PRs) and Local Fiduciary Agents (LFA) as well as the Geneva Secretariat. The USG continues to be an active part of the National Oversight Committee (NOC) and the ICC-HIV committee at the NACC where the GF HIV SSF PRs report regularly. The USG team has also involved the GF LFA and MOF-Kenya teams in the COP13 planning process. Through USG's participation in the National Commodity Security Committee, we continue to review areas of duplication and address any short falls on major commodities. A GF Liaison will be hired in 2013 to lead the joint efforts in coordination, planning and programming with the GF.

Strengthened Supply Chain management system: In expanding its Government to Government approach, PEPFAR will continue to support the GOK in strengthening its supply chain systems with substantial funding and technical support. In addition, this support will aid the GOK in the development and

distribution of improved monitoring systems for commodities supply and disbursement as well as monitoring and evaluation of key HIV and blood safety services at public health facilities. In COP13, USG will continue to ensure effective donor coordination and procurement planning, in particular with regard to the GOK, development partners and GF financed HIV commodities. Human resource capacity and systems for assuring medicine quality and tracking commodities will also be strengthened.

III. Progress and Future

The five year PF between the GOK and the USG was signed in December 2009. The purpose of the framework is to support progress towards achieving the goals laid forth in the Kenya National AIDS Strategic Plan (KNASP) III, as well as the goals laid forth in Kenya Vision 2030. The PFIP was developed by the USG in close collaboration with the GOK and under the leadership of NACC in 2010. The PFIP provides a five year roadmap with the purpose of monitoring progress of commitments made by the USG and GOK in the PF. Reporting by the GOK on the PFIP scorecard continue to be a challenge. In 2013, three PFIP indicators that focus on GOK's financial commitment in their response to HIV will be closely followed. From the time the PF has been in existence, the GOK has continued to increase direct budget support through recurrent expenditure for procurement of ARVs by a minimum of 10% annually. (See PFIP scorecard in the document library). Over the same period of time, the USG has continued to maintain a 65% annual support for the national ARV procurement needs. During FY10/11, the Ministry of Medical Services returned a total of $2.5 million to the treasury. Information on the funds returned from the Ministry of Public Health and Sanitation is currently not available. The PFIP will run through the period of 2013 as the USG continues to dialogue and develop plans for the revision/modification of the current PFIP with the GOK for relevancy. PEPFAR will use this opportunity amongst others to reflect on sustainability and the implications that the devolved system of government in Kenya will have on the USG's position in the HIV response from 2013 forward. This may also change the way USG conducts its business and affairs with the GOK on health priorities for Kenya at National and County levels.

The USG team continues to work with the GOK in advancing Kenya's health financing commitment and reporting framework on HIV as stipulated under the PFIP. Systems and supply chain strengthening efforts have also progressed with the GOK's capacity to manage all commodity procurement and supplies now under the leadership of the Kenya Medical Supplies Agency (KEMSA) and the National Commodities Security Committee. In addition to this, the GOK under NASCOP is now taking the lead in rolling out the new reporting tools and strengthening capacity to manage an integrated logistics management information system (LMIS).

The new Constitution mandates the GOK to take a three-year phased approach to transition to a full devolved government. Taking this into account and the need for the National and County Governments to

harness full operating capacity, we will consider a year's extension for the PF and PFIP. This will allow the USG and the GOK to be better placed in reviewing the key priorities and gaps towards attaining shared HIV prevention, treatment and care goals at both National and County levels. Meanwhile, in keeping the gains made towards Country Ownership, PEPFAR will work with the government to strengthen the new health system, with emphasis on sustainability and prioritization of funding for health in COP13.

IV. Program Overview

Prevention: The overall strategy in prevention is to stop new infections by expanding coverage to target populations where the most impact can be realized. Kenya's prevention program intends to reach 616,648 PLHIV and discordant couples, 157,047 key populations (FSWs, MSMs IDUs), 112,993 populations with increased vulnerability (fisherfolks, truckers, prison population and uniformed services) and 1,072,280 youth who are the majority of the Kenya populations will be targeted with locally adopted and nationally developed efficacious evidence informed behavioral interventions (EBIs). The EBIs which include Healthy Choices I & II, Families Matter Program, Shuga I&II, Respect, Sister to Sister, Eban Stepping Stones, and Community Prevention with Positives which are nationally disseminated focus on partner testing, discordant couples, risk reduction, condom use, disclosure, adherence, STI reduction, and family planning. Members of the general population will also be reached with evidenced-based prevention interventions. Quality assurance of all EBIs is through a technical assessment of interventions, curriculum-based training and certification of facilitators, support supervision, and site visits. Monitoring and evaluation is done through partner reporting, Kenya HIV/AIDS program monitoring system (KePMS) data analysis, EBI TWG assessments, stakeholder meetings, national surveys and project evaluations. PEPFAR will support the Ministries of Health (MOH) through the National EBI TWG to collaborate with Kenya Institute of Education (KIE) to assess nationally developed KIE Life Skills Curriculum targeting young people in school to ensure it contains elements found in effective HIV prevention programs. This year, medication assisted therapy will be provided for the first time in Kenya to reach 15,000 people who inject drugs (PWID) while ARVs will be availed to key populations at Drop in Centers (DiCEs) as part of the combination prevention package of services. Quality improvement and service scale-up will be closely tied to improved monitoring and reporting.

PEPFAR supports the KNASP III expansion of HIV testing and counseling (HTC) services with the objective of 80% of individuals 15-64 years knowing their HIV status by 2013. HTC services have expanded in scope and approach and include over 5,000 sites and incorporation of services into health care facilities. PEPFAR will support the GOK to provide high quality HTC services to 6.4 million Kenyans in COP13 through different prioritized strategies and approaches that have a higher yield in identifying majority of HIV positive individuals and sero-discordant couples in a cost effective manner. Key strategies

used in HTC service delivery are client and partner initiated testing and counseling (CITC and PITC, respectively) delivered in health care facilities and community settings, such as stand-alone VCT, home-based testing and counseling (HBTC), and outreach/mobile services. In COP13, acceptability and feasibility of using self-testing strategy in the general public will be evaluated. The HTC program will ensure all individuals receive education, behavior change counseling and link 100% of those identified as HIV infected to care.

In COP13, resource allocation is based on regional variation in population density, HIV prevalence and testing gaps which allocates a lower cost per target for PITC and higher cost for community HTC services. Hard-to-reach areas of the country have a slightly higher cost per target. Data from national surveys reveal low knowledge of HIV status among couples, MARPs and men in rural areas; these groups will be a priority for HTC. PITC or HTC in health care settings, a low-cost model, will be promoted and scaled-up significantly. HBTC and outreach services will be provided in regions of high HIV prevalence with poor access to services. Ultra-rapid test kits (RTKs) will increase the number of people being tested over the same amount of time. Strategies for strengthening referrals such as use of community strategy will ensure HIV infected individuals and their families' access care and support services. In COP13, evaluation of different linkage models will be done with an aim of identifying better approaches that improve linkage to treatment.

A national Voluntary Medical Male Circumcision (VMMC) task force has spearheaded policy and guidance development since 2008 and developed a clinical manual, a VMMC strategic plan, and communication and M&E strategies. Four provinces contribute nearly 90% of the VMMC need in Kenya: Nyanza province (14.9% HIV prevalence; MC prevalence 17.5%); Nairobi (9.2%; 80%); Rift Valley (6.2%; 16%); and Western province (5.7%; 10%). The 2009-2013 national target is to have 860,000 men circumcised, with 360,000 of those men having been circumcised as of September, 2012. PEPFAR's target is to reach 183,000 in COP13 as part of contributing to the 5 year National target. Efficiencies, such as the forceps-guided method, task shifting/sharing, use of diathermy where applicable, outreach, and mobile and moonlight approaches will continue to be promoted to address gaps. PEPFAR will continue to support the MOH-led VMMC program in the priority regions. VMMC services will be available in MOH facilities, as well as in FBO health centers and other outreach/mobile/moonlight sites. Support includes renovations of theatres, procurement of VMMC surgical equipment and supplies, and capacity building of MOH facility staff. VMMC includes behavior change communications (BCC), HTC, STI screening, and referral and linkages to relevant health services. Eligible men will be referred to VMMC sites, while linkages to care and treatment services for all HIV infected individuals. Demand creation and awareness-raising will continue employing targeted approaches, which include interpersonal communication by satisfied MC clients, media (radio and TV) and road shows. This campaign is age and gender-sensitive and acknowledges the major role women play in VMMC. In COP13, the USG team will

support the GOK in piloting an infant circumcision intervention.

Clinical Services: By September 2012, Kenya had initiated 580,000 patients on ART (~55,000 children) and ~900,000 enrolled on HIV care (~90,000 children) in ~1,800 health facilities in Kenya. In the past two years, ~60,000 patients newly initiated ART annually, including ~10,000 children. The sustained scale-up achieved in 2012 is attributed to collaborative efforts of the PEPFAR, the GOK and GF. In 2012, 95% of comprehensive ART/Care services were supported by PEPFAR. Key 2012 achievements included launching of the new ART guidelines, development and dissemination of an adolescent package of services, assessment of early warning indicators for ART drug resistance, completion of the longitudinal surveillance of pediatric HIV care and treatment in Kenya and expansion of access to targeted viral load for monitoring. Compared to 2011, in 2012 the proportion of TB patients tested for HIV increased from 91% to 93%, and the proportion of TB-HIV co-infected patients started on cotrimoxazole and ART increased from 95% and 64% to 98% and 72% respectively. TB screening in HIV settings and infection control were scaled-up to most facilities in Kenya, and MDR-TB surveillance and treatment were strengthened. In 2012, PEPFAR was supporting ARVs for 60% of patients; while the GOK and GF supported the rest. The GOK currently allocates about $10,000,000 annually to procurement of ARVs. In COP13, we plan to enroll 100,000 new patients on care and initiate 127,000 patients on ART, bringing the total number of patients on care and ART to 1.1 million and 817,000 respectively. Emphasis will be put on identifying and linking children to care and ART; continuing improvement of quality of care and working with MOH to harmonize quality assessment tools; adoption of routine viral load monitoring; and increasing access of ART to most at risk populations. PEPFAR will also continue to strengthen TB/HIV collaborative activities including management of drug resistant TB.

Guided by the PEPFAR Blueprint and the GOK priorities, the laboratory program will continue to develop and strengthen integrated quality-assured networks of tiered laboratory. In FY13 HLAB will pay particular focus on accurate and timely performance of rapid HIV tests, ART monitoring tests including viral load and drug resistance testing for HIV and TB, detection of opportunistic infections, and, HIV/TB surveillance. Cognizant of the impact of inaccurate HIV testing, HLAB prioritizes implementation of the ten step approach for QA in rapid HIV testing. Emerging point of care technologies will be validated to enhance access of diagnostic services in far-to-reach health facilities. Accreditation of laboratories through the WHO prescribed step wise process has been pivotal in turning around laboratory quality systems. This initiative will continue to be supported. Laboratory leadership and management will be strengthened through ongoing support for pre-and in- service training including the Field Epidemiology/Laboratory Training Program (FELTP).

PEPFAR supports the MOH in implementation of a National Blood Transfusion Service (NBTS) based on voluntary non remunerated blood donors. Identification of populations at low risk for HIV, screening of all

blood for HIV, hepatitis and syphilis and institutionalization of hospital transfusion committees promotes access of HIV free. PEPFAR also supports development of policies and guidelines for blood and injection safety, universal precautions, infection control, biosafety and waste management. Infection prevention, waste management, biosafety and blood safety guidelines, standard operating procedures (SOP) and job aides will be disseminated in 2013/2014. PEPFAR will promote sustainability of the blood safety program by integrating its procurement system with the MOH, supporting the NBTS to remain national in the new devolved government system with a budgetary allocation and supporting cost recovery initiatives. Sustainability for Injection safety program will be achieved through pre-service training and integration into all programs.

Community Care and Support Services: Kenya has made tremendous progress in the provision of HIV care and support services. This sustained scale-up has ensured provision of care services to an estimated 1.5 million adults living with HIV as of December 2012, with over 80% of HIV+ adults who know their status enrolled into care. Over 1,000 health facilities across all the 47 counties, offer HIV care and support services. PEPFAR HIV care and support activities are aligned with GOK priorities as outlined in KNASP III and PEPFAR Blueprint document. In COP13, PEPFAR will continue the provision of minimum package of care and ART services that every provider should offer to every HIV+ patient. This includes confirmation of HIV status; ART eligibility assessment; immediate ART provision for those eligible; laboratory monitoring; cotrimoxazole prophylaxis (CPT); psychosocial counseling; adherence counseling; nutritional assessment/supplementation, such as food by prescription (FBP); basic care kit (BCK); prevention counseling and opportunistic infection (OI) management.

Every HIV+ patient will be linked to community programs for prevention interventions such as education by peer educators; retention strategies through community networks; use of support groups to provide prevention, adherence and psychosocial support messaging; and economic empowerment projects. Care and support services will be provided to hard-to–reach and marginalized populations such as refugees, prisoners, MARPs. Initiatives will be customized to address the needs of youth, the elderly and disabled populations. In COP13, provision of BCK will continue. This is expected to improve household and individual morbidity for up to 1.75 million Kenyans. Collaborative TB/HIV activities and MDR-TB control will be emphasized as outlined in Kenya's 5-Year national AIDS and TB strategic plans. New priorities including strengthening community TB screening and laboratory networks; linking "TB suspects" or their sputum specimens to early TB diagnosis; HIV screening and TB treatment; strengthening referrals to improve access to BCK, CPT, ART, nutritional support; defaulter tracing and expanding the community approach to MDR-TB care.

To improve MDR-TB surveillance, a phased introduction of geneXpert will be conducted to link pooled community laboratory specimen collection networks and health facilities with this new diagnostic tool. TB

treatment and CPT will be provided to 100% of all eligible co-infected Kenyans. TB screening will be done in at least 80% of HIV + persons during enrollment into care. Additionally, HIV testing to over 90% of TB patients, their partners and families and increased referrals between HIV and TB service points will be emphasized. Aggressive case-finding of dually-infected children will continue to be prioritized, and TB diagnosis and treatment in HIV clinical settings will be expanded.

In COP12, PEPFAR supported 680,000 orphans and vulnerable children (OVCs) in Kenya. PEPFAR will maintain the same target OVCs in COP13 but with greater emphasis on improved quality of care. Ten percent of the PEPFAR OVC budget will be allocated to setting up an OVC M&E system. This will provide critical data for evaluating the effectiveness and quality of OVC services nationally. The M&E systems for collecting, collating and reporting community-level program data will also be strengthened. Other innovations to be implemented in COP13 include strengthening the social protection framework; availing scholarships for older OVCs to attend rural vocational training centers; continuing scale-up of HTC services in OVC programs and establishing an environment conducive to the sensitivities of testing children. USG will further explore PPP opportunities to support the development of age-appropriate pediatric formulations, including fixed dose combinations of ARVs and TB drugs particularly for infants and young children at the highest risk of dying without treatment.

Maternal Neonatal and Child Health: In COP12, the PEPFAR program supported 4,500 existing facilities in Kenya to offer a minimum package of PMTCT services. In line with the global plan for eMTCT, Kenya launched the eMTCT framework that targets to eliminate new HIV infections among children and to keep mothers alive through comprehensive PMTCT services. This plan is aligned to the PEPFAR blueprint, the National Health Sector Strategic Plan III (2012-2017) and the KNASP III. The USG team aims to counsel and test 1,365,000 pregnant women and provide ARVs to 86,000 HIV positive women and their infants who will be in need of ARVs. The program will adopt new strategies to identify more HIV infected women by scaling up testing in women not currently reached by the mainstream health facilities and re-testing in high prevalence sites.

In COP13 PEPFAR will expand an integrated approach in PMTCT programming with HIV services being integrated into existing Maternal Child Health (MCH) and family planning services. The follow-up of mother infant pairs will be stream-lined and defaulter tracing will be done using mentor mothers and community health workers. The program will continue the scale-up of early infant diagnosis (EID) services currently estimated at 3,863 facilities and embrace innovative new strategies (e.g. HIV infant tracking system, Phones for Reproductive Health, county specific eMTCT work plans) to address the challenges currently being faced such as long turnaround time for EID test results, high dropout rate in the PMTCT cascade and high transmission rates in some geographical zones.

Strategic Information/Informatics: During COP13, USG will continue working closely with GOK, other development partners and all PEPFAR implementing partners to strengthen strategic information systems and structures through surveys and surveillance, health information systems, and monitoring and evaluation. Majority of the earmarked SI activities will have a national focus cutting across all targeted populations in HIV programming.

Under the GOK's enhanced capacity, USG will continue to support its effort to strengthen existing national M&E system through printing, training, mentorship rollout and distribution of the national health management information systems (HMIS) tools to ensure that all the essential reportable NGIs are tracked. Efforts to integrate the current parallel HIV reporting systems will be enhanced through strengthening of District Health Information Systems (DHIS) as well as tracking of both standard and custom indicators to ensure that they are correctly defined interpreted and calculated. PEPFAR funds will also support systems development to assist the GOK to scale-up standard electronic medical records (EMRs) which are key in improving patient identification, tracking, reporting and management. Improving efficiency in service delivery will be enhanced through mhealth solutions such as short message service (SMS) notification for; EID, commodities tracking, blood donors and post exposure prophylaxis for health care workers. Surveys and surveillance activities will include but not limited to setting up systems for HIV case based surveillance, PMTCT and treatment outcome and HIV morbidity and mortality monitoring. Support to national surveys as such KAIS II and KDHS will also be prioritized as well as tracking the national HIV response through non routine output level data thorough operations research, and implementation science. Other earmarked activities will include strengthening systems for measuring effective referrals and linkages, design, pilot and rollout of unique persons' identification system for MARPs.

Health Systems Strengthening: The GOK continues to overhaul the existing policy, legal and strategic framework for health to conform to the requirements of the new Constitution and a devolved health sector. For the health Ministries, health systems strengthening (HSS) is at the core of this agenda. This past year, both Ministries (Public Health and Sanitation, and Medical Services) reviewed the Constitution's provisions that would impact the health sector, identified issues that would need to be elaborated, and established various ministerial committees and working groups to bring together the emerging issues and positions into a coherent sector framework. These processes continue to inform and guide the USG's strategic investments for COP13 along the lines of key health system 'building blocks' (health workforce, medical products, health financing, leadership and governance, health information and service delivery) that are delineated within current health policy. With country ownership serving as a core principle of the work in Kenya, USG is redoubling efforts to build country systems for long-term impact, positioning its work in HSS to ensure that PEPFAR support can positively influence and be aligned with the transition to a devolved healthcare system.

The transfer of health service delivery to County governments requires new capacity building and technical support to both establish County health management systems and to sustain key health functions of National government. Under COP13, PEPFAR will continue assisting the GOK to strengthen governance structures and functions; institutionalize management, leadership and governance curricula; and improve access to relevant training courses to ensure County readiness to assume new devolved functions and responsibilities. The USG will also assist the new health Ministry to finalize key policies and guidelines stemming from the new Constitution thus ensuring a smooth transition to a devolved health sector.

The creation of new County governments may strengthen local management and development of health workers who will be better responsive to local needs. Yet current staffing inequities may worsen if Counties are unable to finance, attract and retain qualified staff, especially in underserved areas. Thus, PEPFAR will continue supporting pre-service training to increase production of key staff cadres that are in line with country needs and will contribute to PEPFAR's targets. Focus is on expanding capacity of training institutions and increasing financial access for students from rural and hard to reach areas. In-service trainings will be better coordinated, delivered in widely accessible modes and incorporated into professional annual licensing systems. Ongoing support to the GOK's Human Resources Information Systems (HRIS) will result in more effective workforce planning and forecasting. New for COP13, USG will help strengthen human resources for health (HRH) functions of new national and county health systems post-election and will continue working to transition health workers hired under PEPFAR-funded programs to the GOK payroll. Other PEPFAR investments will continue strengthening HRH policies, regulatory and professional bodies, and newly established government departments/divisions responsible for ensuring quality of care. Key DPs in this will include DANIDA, JICA and AMREF.

The high cost of healthcare remains a major barrier to access, especially for the poor who spend a larger share of their household income to meet their healthcare needs. Moreover, the expected transfer of national revenues to Counties may impact health service delivery as Counties may not immediately have capacity to optimize use of devolved health resources. PEPFAR investment in this area is part of a longer term strategy for sustainability. USG partners are assisting the GOK to develop health financing policies/strategies to reduce financial barriers to accessing HIV and other essential health services; promote efficiency gains and increased effectiveness and equity in the use of national/county health resources; and promote increased public and private spending for health. USG continues to explore alternative ways to finance HIV/AIDS services, including work thru the private sector to increase health insurance coverage through new and expanded private health financing mechanisms that will expand availability of HIV services. For COP13, USG will support innovative private health financing mechanisms that target increased coverage for the poor and those lacking access to care; conduct technical analyses

such as the cost of an outpatient primary health care benefit package under the National Hospital Insurance Fund; and to inform national health financing policy, conduct a household health expenditure and utilization survey to generate information on the health seeking behavior of clients and household spending on health. USG will work to leverage funding from other donors supporting health financing, including GIZ, World Bank, DFID, DANIDA and JICA to maximize impact of PEPFAR-funded activities.

The USG has assisted the KEMSA for several years and the signing this year of the new direct funding agreement signals USG intent to have KEMSA begin undertaking procurement and distribution of all health commodities, including USG-funded HIV/AIDS commodities currently managed under parallel programs. The USG will also continue to focus on health facilities' commodity management systems including record keeping, data use, forecasting and quantification; and building human resource capacity and systems for assuring medicine quality and tracking commodities. New activities for COP13 will address supply chain needs at County levels as Counties will have the freedom to procure medical products despite KEMSA being the desired first point of call.

V. Response to Ambassador Goosby's PEPFAR Kenya Memo:

Building on the GHI principles, the Let's Live Campaign (LLC) strategy and GHI strategy both called/call upon us to have greater efficiencies and effectiveness, less duplication, and more innovative and sustainable ways to impact the healthcare system. Our priorities have not changed. Kenya's original GHI strategy focused on: Health systems strengthening; Integrated service provision; and Creating awareness to create demand for available services. These broad areas would have their greatest measurable health benefits in substantially reducing unacceptably high rates of maternal, neonatal and child mortality and morbidity and mortality from neglected tropical diseases. Kenya's LLC strategy focused on four broad programs in COP12; the intersection of these programs with PEPFAR will occur to meet the needs of HIV infected and affected populations. The platforms for these programs are already in place as PEPFAR and other USG resources have developed mature and successful programs over the years in Kenya. As we harness strategic linkages with non-PEPFAR funded programs, integration remains a key principle. From the partnerships established through USAID Education programs and the OVC initiatives under PEPFAR to CDC/KEMRI and DOD-led Walter Reed Research to USG's Feed the Future initiative to President's Malaria Initiative, PEPFAR will continue to strategically build on the GHI gains as part of program expansion through integration. We hope to achieve this by further strengthening the existing partnership with the GOK and other multilateral and international organizations to develop more integrated and cost-effective approaches in the areas of HIV/AIDS and associated illnesses. In COP 12, in collaboration with the GOK, we are strengthening cervical cancer screening, training HCW for maternal/newborn health and IMCI, Maternal Health BCC campaigns in communities and providing ORS and funds for HBHC for non-communicable diseases.

The USG PEPFAR program, together with other USG health investments in Kenya, is one of the largest USG health portfolios globally. The PEPFAR interagency team recognizes the need for purposeful and strategic integration of efforts and resources in order to maximize impact. Program integration is not new to Kenya. One of our three GHI goals was to intensify program integration across agencies with host government and to measure health outcomes related to maternal, neonatal and child health (MNCH). We recognize the opportunities that exist within USG programs to ensure more integrated planning and coordination without duplication of efforts, we practice a whole-of-government approach, strengthening and leveraging partnerships within and outside of USG, thereby increasing our impact through strategic coordination and integration. In COP13, PEPFAR will continue to coordinate our efforts with PMI, TB and ensure family planning is integrated within our existing programs. Kenya's funding allocation for HVTB (to include new funds and pipeline) are as follow: COP11 - $18,490,947, COP12 - $18,595,947 and COP13 - $17,370,270.

With the support of the USG, the GOK has made progress in scaling up the number of qualified practitioners to provide cervical cancer screening in clinics. The cadres trained are mainly nurses and other middle level staff as they are the ones working in the lower level facilities. Training for specialized screening and treatment is now part of the curriculum in the residency programs of the teaching institutions thus; health care workers are graduating with skills to support cervical cancer screening. One of our implementing partners has been funded to scale-up trainings. Last year, 10 practitioners, most of whom were from the GOK, attended two week training in Zambia on cervical cancer screening techniques. In COP13, the USG will continue to support the GOK in this endeavor to ensure quality service for all patients.

[REDACTED]

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	1,400,000	2011	AIDS Info, UNAIDS, 2013			
Adults 15-49 HIV Prevalence Rate	06	2011	AIDS Info, UNAIDS, 2013			
Children 0-14 living with HIV	220,000	2011	AIDS Info, UNAIDS, 2013			

Deaths due to HIV/AIDS	62,000	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults	91,000	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults and children	100,000	2011	AIDS Info, UNAIDS, 2013			
Estimated number of pregnant women in the last 12 months	1,529,000	2010	UNICEF State of the World's Children 2012. Used "Annual number of births as a proxy for number of pregnant women.			
Estimated number of pregnant women living with HIV needing ART for PMTCT	87,000	2011	WHO			
Number of people living with HIV/AIDS	1,600,000	2011	AIDS Info, UNAIDS, 2013			
Orphans 0-17 due to HIV/AIDS	1,100,000	2011	AIDS Info, UNAIDS, 2013			
The estimated number of adults and children with advanced HIV infection (in need of ART)	745,824	2011	WHO			
Women 15+ living with HIV	800,000	2011	AIDS Info, UNAIDS, 2013			

Partnership Framework (PF)/Strategy - Goals and Objectives

Number	Goal / Objective Description	Associated Indicator Numbers	Associated Indicator Labels
1	Focus Area #1: Increase HIV Financing Please note that our PF has numerous goals and objectives. In this COP sumbission, we have highlighted Focus Area 1: Increase HIV Financing which have clear indicators and targets; this was agreed upon with the GOK. Please refer to the Partnership Framework, Partnership Framework Implementation Plan and the Kenya PFIP Custom Indicators, Targets and Justification document in the document libary for details.		
1.1	USG Committment #3:Seek to maintain support for ARV treatment costs based on GOK regimens current throughout the Partnership Framework timeline for all persons on USG-procured ARVs as of September 30, 2009 (1.3.1)	H3.1.N	H3.1.N Domestic and international AIDS spending by categories and financing sources
		KE.253	KE.253 Maintain support for ARV treatment costs based on GOK regimens current throughout the Partnership Framework timeline for all persons on USG-procured ARVs as of September 30, 2009
		KE.254	KE.254 Percent of budgeted appropriations for health that are returned unspent to Treasury annually
1.2	GOK Committment #5: A) Seek to increase general budget appropriations for health by minimum of 10 percent annually for each year of PF period	H3.1.N	H3.1.N Domestic and international AIDS spending by categories and financing sources

	(4.2.1); B)Seek to reduce the % of budgeted appropriations for health that are returned unspent to Treasury by at least 20% annually for each year of PF (4.2.1);C)Seek to provide exemption from VAT, import duties, and other taxes for all programs supported under PEPFAR, including USAID, HHS/CDC, DOD/US Army Medical Research Unit and Peace Corps (4.2.1)	KE.253	KE.253 Maintain support for ARV treatment costs based on GOK regimens current throughout the Partnership Framework timeline for all persons on USG-procured ARVs as of September 30, 2009
		KE.254	KE.254 Percent of budgeted appropriations for health that are returned unspent to Treasury annually

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

How is the USG providing support for Global Fund grant proposal development?
At this time, there is no Global Fund grant proposal development under way for Kenya.

Are any existing HIV grants approaching the end of their agreement (Phase 1, Phase 2, NSA, CoS, or RCC) in the coming 12 months?
Yes

If yes, please indicate which round and how this may impact USG programming. Please also describe any actions the USG, with country counterparts, is taking to inform renewal programming or to enable continuation of successful programming financed through this grant(s).
The round 7 grant managed by Care Kenya comes to an end in March 2014. Phase II of the HIV SSF government grant managed by the Ministry of Finance (MOF) should start by 1st July 2014. Notably, transition periods between grants have caused delays in programming, commodity procurement and supply. The USG team continues to collaborate with key stakeholders to ensure that commodities are available, and that programs experience limited disruption during such transition periods.

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To date, have you identified any areas of substantial duplication or disparity between PEPFAR and Global Fund financed programs? Have you been able to achieve other efficiencies by increasing coordination between stakeholders?

Yes

If yes, how have these areas been addressed? If not, what are the barriers that you face?

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Public-Private Partnership(s)

Created	Partnership	Related Mechanism	Private-Sector Partner(s)	PEPFAR USD Planned Funds	Private-Sector USD Planned Funds	PPP Description
2011 APR	Becton Dickinson Safe phlebotomy	13061:Advancement of Public Health Practices in Kenya	Becton Dickinson	500,000	500,000	BD Safe Phlebotomy PPP started in 2009 when an MoU was signed to support 5 PEPFAR countries. Kenya was the first to pilot this PPP in 8 MoH sites. The PPP has since grown nationally and lessons learnt in Kenya have been used to established projects in Zambia, Tanzania and Rwanda. The

						PPP had 3 objectives: 1) Improve quality of phlebotomy and other blood drawing procedures critical to management of HIV/AIDS patients; 2) Strengthen needle stick injury prevention, surveillance and PEP to identify practices and procedures that pose risks to health workers and patients; 3) Assist in the development of policies, guidelines, Standard Operating Procedures for phlebotomy and other blood collection. Objectives have been achieved to certain degrees. A 2nd phase of the

						PPP was the establishment of a Center of Excellence in the Kenya Medical Training College (KMTC) in Feb 2012 to support training in the pre-service school. This has been scaled up to reach 5 more KMTC colleges nationally.
2013 COP	Labs for Life (L4L)		Becton Dickinson	500,000	1,500,000	The United States Government, Department of State- Office of Global AIDS Coordinator, -(OGAC), Becton Dickinson Company (BD) and CDC signed a memorandum in July 2012 to renew an expanded form of the just ended Laboratory PPP. This new PPP focuses on strengthening specific laboratory

						projects relevant to core PEPFAR goals for HIV/AIDS prevention, care and treatment. The five year MOU-2012 – 2017, will focus on quality improvement for laboratory services, laboratory human resources for health, equipment maintenance and bio-safety, integration/innovation and strengthening institutional capacity/country ownership. The PPP will target Kenya, Uganda, Mozambique Ethiopia and India. In the current year Kenya will form an interagency/multi stakeholder steering

						committee to identify national priorities and develop a work plan to be shared with OGAC and BD. Selected projects will be implemented with the objective of creating sustainable practices within the Ministry of Health systems
	Partnership for an HIV Free Generation		Grassroots Soccer, Johnson and Johnson, Microsoft, Telkom	0	3,448,671	HFG proposed PPPs: TechnoServe (TNS) will provide 2,500 young women with entrepreneurship skills training. TNS will further reach indirectly 10,000 young women. Housing Finance Foundation will build the skills and absorb 1,650 youth

						artisans in the building and construction industry. The Village Africa will empower 10,000 youth with entrepreneurship skills and internship in addition to mentoring 30,000 youth through the digital platform. Rafiki wa Maendeleo Trust will provide 2,500 youth with vocational and entrepreneurship skills. Royal Media Services will reach 1.5 million youth aged 10-14 years with life skills and HIV prevention messages through a TV drama series. Liverpool will expand the One2One hotline to provide on line counseling

						to 300,000 youth aged 15-24 years. Africa Alive will organize a soccer tournament & deliver skills training for 3,600 9-13yr. olds in school. SC Johnson focuses on developing 2,000 youth shoe shining businesses.
	Phones for Health	9093:Phones for Health	CDC Foundation	550,000	100,000	The objective of the Phones for Health PPP is to support the implementation of mHealth information systems for the GOKCDC Foundation and the MOH works with the private sector to develop mobile platforms, identification systems, and systems integration

						interfaces that enable timely and secure transfer and access of programmatic, logistical, surveillance and other health related data. CDC Foundation in the mHealth Kenya project emphasizes on the PEFAR three pong approach: i) to create country owned programs that utilize local implementors thus promoting economic development and sustainability, ii) to approach HIV from a development context, specifically with an eye towards integration with other US government funded projects, and iii) to

						increase efficiencies by working towards a coordinated effort to maximize US government funds across programs. The FY 2012 detailed planning and project initiation to leave FY2013 for activity implementation and roll-out.

Surveillance and Survey Activities

Surveillance or Survey	Name	Type of Activity	Target Population	Stage	Expected Due Date
Surveillance	ANC-PMTCT data for surveillance transition	Evaluation of ANC and PMTCT transition	Pregnant Women	Development	09/01/2013
Surveillance	Assessment of utility of using PMTCT data for HIV surveillance among pregnant women	Evaluation of ANC and PMTCT transition	Pregnant Women	Development	09/01/2013
Survey	Costs of Comprehensive HIV Treatment at Out-Patient Clinics in Kenya (ART costing study)	Other	Other	Data Review	07/01/2012
Surveillance	Demographic Surveillance Systems (DSS)	Other	General Population, Other	Planning	12/01/2020

Survey	Etiologic Surveillance for Genital Infections Among HIV-infected Adults in HIV Care Programs in Kenya	Other	Other	Development	01/01/2014
Survey	Evaluation of PMTCT and MCH in Kenya (PMTCT-MCH)	Other	Pregnant Women	Publishing	12/01/2013
Survey	Fisherfolk survey in Nyanza	Population-based Behavioral Surveys	Other	Planning	10/01/2013
Survey	HIV Case reporting	Other	General Population	Implementation	09/01/2013
Survey	Kenya AIDS Indicator Survey (KAIS II)	Population-based Behavioral Surveys	General Population	Planning	12/01/2013
Survey	Kenya AIDS Indicator Survey (KAIS)	Population-based Behavioral Surveys	General Population	Planning	12/01/2013
Surveillance	Longitudinal surveillance of adult care and ARV treatment in Kenya	Other	Other	Planning	12/01/2013
Surveillance	Longitudinal surveillance of ARV outcome among treated pediatric patients in Kenya	Other	Other	Other	08/01/2012
Survey	Most at Risk Population (MARPS) Survey	Population-based Behavioral Surveys	Female Commercial Sex Workers, Injecting Drug Users, Men who have Sex with Men	Data Review	09/01/2014
Surveillance	Paediatric HIV Surveillance	Other	Other	Other	08/01/2012

Survey	PLACE Study	Other	Female Commercial Sex Workers, General Population, Injecting Drug Users, Men who have Sex with Men, Street Youth	Evaluation	09/01/2011
Survey	Prevalence study for the Kenyan Defense Forces	Population-based Behavioral Surveys	Uniformed Service Members	Planning	07/01/2014
Survey	Respondent Driven Sampling surveys in Nairobi, Nyanza, and/or Coast (MSM, IDU, FSW)	Population-based Behavioral Surveys	Female Commercial Sex Workers, Injecting Drug Users, Men who have Sex with Men	Other	09/01/2014
Survey	Service Provision Assessment (SPA)	Other	Other	Planning	09/01/2014

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source			Total
	GAP	GHP-State	GHP-USAID	
DOD		23,000,000		**23,000,000**
HHS/CDC	5,415,044	160,928,062		**166,343,106**
HHS/HRSA		4,209,531		**4,209,531**
PC		1,377,427		**1,377,427**
State		936,510		**936,510**
State/AF		97,505		**97,505**
USAID		79,035,921	0	**79,035,921**
Total	**5,415,044**	**269,584,956**	**0**	**275,000,000**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency								Total
	State	DOD	HHS/CDC	HHS/HRSA	PC	State/AF	USAID	AllOther	
CIRC		1,375,713	9,913,664				1,115,813		**12,405,190**
HBHC	12,333	1,242,072	9,372,799	0		47,505	2,770,121		**13,444,830**
HKID	12,333	1,072,691	1,357,726			50,000	20,468,771		**22,961,521**
HLAB		994,065	7,182,442				5,700,000		**13,876,507**
HMBL			4,620,297				1,072,775		**5,693,072**
HMIN		187,939	3,077,337				6,062		**3,271,338**
HTXD		674					5,934,911		**5,935,585**
HTXS		7,013,642	52,922,807	200,000			13,638,377		**73,774,826**
HVAB		882,574	2,850,800	731,500	218,027		49,126		**4,732,027**
HVCT		1,424,022	13,125,167	0			5,475,491		**20,024,680**
HVMS	850,177	1,081,891	3,564,043		924,000		4,146,340		**10,566,451**
HVOP		1,545,424	13,130,372	0	235,400		1,158,608		**16,069,804**
HVSI	61,667	1,047,609	10,214,658	3,278,031			362,200		**14,964,165**

HVTB		1,362,697	9,026,544	0			0		**10,389,241**
IDUP			1,309,308				2,684,671		**3,993,979**
MTCT		2,624,346	13,891,939	0			9,396,018		**25,912,303**
OHSS		2,696	4,889,810				805,161		**5,697,667**
PDCS		307,977	1,678,205	0			144,043		**2,130,225**
PDTX		833,968	4,215,188	0			4,107,433		**9,156,589**
	936,510	**23,000,000**	**166,343,106**	**4,209,531**	**1,377,427**	**97,505**	**79,035,921**	**0**	**275,000,000**

National Level Indicators

National Level Indicators and Targets

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Policy Tracking Table

Policy Area: Access to high-quality, low-cost medications						
Policy: Guidelines for ART in Kenya						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date			TBD	November 2010		TBD
Narrative			Pending: development of 3rd line regimens; policy guidelines on integration of ART into MCH and TB clinics; guidelines on viral load testing and use of viral loads for patient monitoring.	Kenya MOH launched the Guidelines for antiretroviral therapy in Kenya 4th Edition 2011.The guidelines lists the possible third-line ART agents and an algorithm on managing suspected second-line failure treatment cases.These guidelines also recommends integration of ART into MCH	Implementation and dissemination of guidelines by NASCOP is ongoing. MOH is utilizing the mentorship approach in collaboration with partners.	Evaluation of implementation of these guidelines will be done through Monitoring and Continous Quality Improvement of key indicators in collaboration with NASCOP.

				settings and ART into TB clinics. It also recommends the use of targeted viral load testing to rule out treatment failure		
Completion Date			NOV 2011		JAN 2013	
Narrative			The use of 3rd line ARV regimens and targeted viral load testing for patient monitoring have already been included in the revised ART guidelines released in November 2011.		The Government will release guidelines on rollout of option B+ for PMTCT in January 2013. There are ongoing discussions regarding strategic use of ARVs and raising the CD4 cut-off to < 500 for initiation of ARVs in line with the expected	

					release of WHO guidelines.	

Policy Area: Counseling and Testing						
Policy: National Guidelines for HIV Testing and Counseling in Kenya						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date			2008		2010/2011	2012
Narrative	An estimated 50% of the Kenyan population have not accessed counseling and testing services.	In order to reach the 80% coverage in knowledge of HIV status, there is need to expand scope of and approaches in HTC service delivery in order to increase the population's access to HTC services. According to KAIS 2007, 33.9% of	The National HTC guideline was revised in 2008 and clearly outlines approaches for HTC	National HTC Technical working group developed operational manuals to support the implementation of the HTC policy	i) National Quality Assurance on HTC developed in 2012 to ensure all quality aspects of the HTC program. (ii)The National HTC training curriculum package developed in 2010. (iii)The Community Based HTC and PITC operational manuals developed	i) Over 4,500 counsellors enrolled in Proficiency Testing Panel as part of the QA strategy. (ii) Results from the Proficiency testing panel program used to inform capacity building plans of HTC counselors.

		adults aged 15-64 reported that they had recieved an HIV test at least once in their life time. This proportion had increased to approximately 50% by 2008/2009 KDHS			2011 to standardize implementation of services and guide scale up of services. (iv) National Lab register developed for data collection at all HTC service delivery points	
Completion Date			2008	2010/2011	2010/2011	2012
Narrative	The KAIS 2007 showed that 83.6% respondents found to be HIV-infected were not aware of their status. Moreover, lower testing rates were observed among rural (35.4%	Perception of low risk was the most common reason among women (43.3%) and men (51.2%) for not having been tested for HIV.	The Ministry of Health through the NASCOP HIV Testing and Counseling Technical Working Group led the process in the review and development of the HTC guideline (2008) that	The National HTC Technical Working Group led the process of developing the following operational manuals to guide the implementation of HTC services: Operational	There has been expansion of HTC services in the country. HTC services are routinely provided in all outpatient and inpatient settings, while targeted Home	The 2009 Kenya Demographic Health Survey showed that close to 50% adults had received an HIV test. As per 2011 APR, over 6 million individuals were reached with HTC

	women and 20.6% for men) as compared to urban residents (57.4% women and 39.7% men). In the effort of increasing opportunity to HIV Prevention, Care and Treatment services, there was need to expand access to HIV testing and counseling services which is the gate way to these services.		outlines strategies for achieving 80% national testing coverage.	Manual for Community-based HIV Testing and Counseling; Operational Manual for Implementing Provider Initiated HTC in clinical settings .	Based HTC services are provided in an effort to reach individuals who have never received HTC services.	services. The current KAIS (2012) will provide additional key information on HTC coverage.

Policy Area: Gender						
Policy: Gender						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date			TBD	TBD	TBD	TBD

Narrative	Gender equality in health and economic status has long been a problem in Kenya, and there is growing realization of the magnitude of the incidence of gender-based violence (GBV) in the country. This all contributes significantly to the spread of HIV.	There is a need for GOK and USG to implement programs and policies supporting gender equality, prevention of GBV and prosecution of GBV offenders.	Support will be provided to MoMS progress on the national FP/FH integration strategy. Sexual Offences Act passed in 2006.	Policies to be reviewed and revised include: the process of reporting/prosecuting GBV; policies surrounding the entire process of reporting through prosecuting GBV, including Sexual Offenses Act of 2006; Policies to reduce gender disparities in health (male involvement in all program areas, girls' empowerment, economic empowerment, FP, etc.)	Support will continue for the gender policy literacy; access to appropriate legal services at both national and community levels; implementation and policy training on the Sexual Offences Act; GoK 1997 Sessional Paper No. 4 on HIV/AIDS - it provides a policy framework within which the gender mainstreaming strategic plan was formulated and the Gender and HIV/AIDS	An evaluation of the gender and GBV policies and programs will be done in the coming years.

					technical subcommite e.	
Completion Date						
Narrative	The 2010 Violence Against Children Survey (VACs) report was completed. The report provides data on prevalence of sexual violence during childhood among male and female respondent s age 13-24 years. The VACs Report and National Response Plan will be launched in late November 2012	While VACs findings are embargoed, they highlight the magnitude of sexual violence during childhood, gaps in reporting, accessing and receiving services and health and other consequenc es of sexual violence				

Policy Area: Human Resources for Health (HRH)						
Policy: National HRH Strategic Plan and Training Policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date			2009	2010	2010	2011
Narrative	The major problems were a lack of a structured approach to HRH issues in the country as well as poor coordination and accreditation of health workforce training.	Weak HRH structures hindered an understanding of needs and gaps, resulting in an uneven and ineffective allocation of resources within the health workforce. Trainings and curricula to equip the workforce were uncoordinated and unregulated, preventing gaps from being addressed.	The larger strategic plan commenced in 2008 and was costed in 2009; development of various training policies and coordination methods are ongoing.	The strategic plan has been endorsed by the Ministries of Health in Kenya; related training policies are still being costed to receive Cabinet approval.	The strategy came in to effect in 2010, after two years of design and discussions that were led by GoK but supported by USAID/K Capacity project. The strategy is clearly costed, with time lines and detailed interventions for the country's HRH interventions.	Mid 2011 the annual evaluation was done and findings shared among stake holders.
Completion Date						

Narrative	This policy on health workforce training was costed and resubmitted to parliament for approval. However parliament has been busy on other bills and policies in trying to meet the set deadlines in the implementation of the new constitution. Some of the components of the policy have been overtaken by events given that some of the proposed structures will be					

	affected by the devolved system of government, the new health bill and the proposed National health sector strategic plan III.					

Policy Area: Orphans and Other Vulnerable Children						
Policy: Kenya Children Policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	2005		2009	TBD	TBD	TBD
Narrative	"The Ministry of Gender, Children and Social Development, through the Department of Children Services developed this document as a	The government and other stakeholders came up with several interventions to address the problem of OVC but this has remained inadequate in the face of the	The GOK merged all separate national policies on various profiles of children into the Kenya Children Policy. It includes the establishment of social and child	Currently awaiting cabinet approval	All OVC implementing partners will refer to and make use of the provisions of the revised NPA (2011-2015) and Kenya Children policy and closely work	Revise and edit the NPA (2007-2010) NPA for OVC to NPA (2011-2015).

	response to the ever increasing OVC countrywide. Estimated number of orphans by 2005 was 2.4 million, 48% from HIV/AIDS. This figure is besides a higher number of children rendered vulnerable by poverty, insecurity, emergencies, amidst other factors. "	increasing number of OVC. A rapid assessment, analysis and action planning process conducted in 2004 identified the need to urgently develop a National Plan of Action to address the needs of OVC and to guide OVC interventions in the country.	protection mechanisms as a specific policy objective.		with the Department of Children Services to ensure that the rights of OVC are protected and respected.	
Completion Date	2010	2012	2012	2012		
Narrative	In 2010 Violence Against Children Survey (VACs) was undertaken and report	Athough the data is embargoed. The study was to respond to existing gaps i.e. a	TWG representatives of the GOK and civil society guided the VACS process. In	Children Policy approved by Cabinet a waiting Gazettement.The VACs Report and	OVC implementing partners will make use of appriopriate VACS reponse	

	was completed in 2012.The report provides data on national prevalence of sexual, physical and emotional violence against boys and girls aged 13 -24 years during childhood; identified risk and protective factors and prevention; health consequences of multiple forms of violence and areas for further research.	part from data in the KDHS and there was no nationally representative estimates for violence against boys or men in kenya. As well, there is a dearth of data on girls without partners (if the perpetrator was someone other than an intimate partner/husband and a lack of evidence on the risk and protectative facotors influencing sexual violence against children.	2012, GOK put in place a reponse team to come up with a National Response Plan.	National Response Plan will be launched late November 2012.	plan while working with the Children's Department and partners to prevent, respond and safeguard the rights of OVC.	

Policy Area: Other Policy						
Policy: Commodities & Logistics						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date			TBD		TBD	
Narrative			Pending: develop and integrate strategy for Pharmaceutical, Laboratory and Logistics Information Systems (manual and electronic); develop a list of Essential/Standard Equipment and Reagents for Medical Laboratories; develop policy on preventative maintenance of medical equipment.		The following will be reviewed and revised, as appropriate: 1) Kenya National Health Policy Framework (1994) - MOPHS; 2) Kenya National Pharmaceutical Policy Implementation Plan; 3) Kenya Laboratory Policy Implementation Plan; 4) Health Acts (MOMS).	

Completion Date	September 2011	March 2012	June 2012	December 2012	TBD	
Narrative	Develop a List of Essential/Standard Equipment and Reagents for Medical Laboratories:An essential List of products is selected based on the health care needs of the majority in a population. It improves availability, through increased efficiencies in supply chain management, promotes evidence based prescribing; focuses training of	The ability of a facility to perform a test depends on availability of several reagents and consummables. There are records of reagents expiring because the whole"kit" is not available. A defined list will provide for the requirements of one test. In addition, lab products are currently not tax exempt because a defined list has not been	"Developed a list of Essential Reagents and consumables for Medical Laboratories; Also drawn a tracer list for inclusion in the supervision tools "	This is contained in the Kenya Medical Laboratory Policy, 2012. The KMLTTB strategic plan has included the essential laboratory commodity list to facilitate validation and registration for quality assurance.	A national laboratory commodity management technical working group has been appointed and waiting for official launch of the policy.	

	health care workers and informs patient education. Also facilitates registration of products.	lodged with the KRA				

Policy Area: Other Policy						
Policy: Community Strategy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date			TBD			TBD
Narrative	Financing of the community health units is unclear hence uncoordinated remuneration of CHW, funding of the CHW kit, supervision and training approaches. Secondly it is not clear how	There is need to have a clear policy and guidelines in terms of the costing and funding of the community strategy interventions in a sustainable way. Secondly there is no clear guideline on	Support the Community Health Services Department of GoK to develop a policy and guidelines regarding CH strategy funding that various stakeholders can use. In addition there is need to develop	GoK department of Community Health Strategy	GoK Department of Community Health Strategy in collaboration with the various stakeholders should ensure effctive implementation and enforcement of the policies in terms of	Review Costing and Funding Strategy - agreed upon Community Health Worker remuneration/compensation package (e.g. performance based rewards), CHW kit funding,

	the CU lines with other sectors,CBOs and CSO at the community levels.	the CU linkage with other GoK sectors, CSO and CBOs at the community level.	guidelines on the linkage between CU other GoK sectors, CBOand CSO at the community level one of service delivery		funding, training, implementation, supervision and evaluation. Secondarily ensure synergies with other GoK sectors, CBOs and CSOs to maximize utilization of available resources.	training support, supervision activities and linkages with GoK sectors, CBO and CSOs. Review and disseminate guidelines.
Completion Date	2012					
Narrative	Policy on community health services financing is ongoing. USG has supported a study tour by GoK and key stake holders to Bangladesh and Ghana, to learn how they					

	finance community services. The report was submitted to the interagency coordination committee (ICC) for review and policy adjustment. USG has also supported the establishment of a scheme of service for Community health extension workers. This will enable GoK to fund CHEW salaries in support of community services.					

Policy Area: Other Policy						
Policy: Prevention of Mother-to-Child Transmission (PMTCT)						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date			March 2012		April 2012	TBD
Narrative	In 2010 Kenya revised the PMTCT guidelines in line with the WHO guidelines and agreed to adopt Option A. There is growing evidence that treatment for prevention will further contribute towards reduced rates of transmission.	An National PMTCT Impact Evaluation study in late 2010 showed tranmissions of 7.8% at 14 weeks. In early 2011 Kenya began pilot projects in selected Districts geared towards elimination of PMTCT. Lessons learnt have contributed towards the development of the eMTCT framework. Along with	The development of standards and guidelines for institutionalization of a Kenya mentor mother program and the eMTCT frame work are almost complete. The revised guidelines to include option B+ are in the last stages of edition.	The documents are developed by the PMTCT TWG, and endorsed by the Directors of Medical services, the Permanent secretaries and the Minister of Health.	This will be in the form of guidelines and policy documents. A launch of the documents is expected at National level and thereafter desseminati on plans at regional and District levels. Orientation packages will be developed as is appropriate.	Not currently planned for.

		this the PMTCT program identified peer support groups as key to minimizing the loss to follow up of PMTCT clients.				
Completion Date			December 2012		March 2013	June 2013
Narrative	An increasing number of known HIV+ women are getting pregnant. This was evident in the 2011 sentinel surveillance and the recent data abstraction exercise.	As the PMTCT program continues to mature there will be a substanial number of HIV+ women on Option A; this recurring episodes of starting and stopping ARVs for prophylaxis can/may lead to resistance.	The National AIDS and STI coordination program has been tasked with coming up with guidelines/standard operating procedures to roll out option B+ before the end of the year. The eMTCT framework	The updated PMTCT guidelines that include Option B+ have been signed off by the Ministry of Health.	Dissemination plans for the eMTCT framework have been completed.	National Evaluation of Prevention of Mother-to-Child Transmission of HIV-1 and Maternal Child Health in Kenya.

		Hence there is a need to move towards Option B+ to minimize resistance as well as initiate pregnant women on treatment within the shortest time frame	has been developed and peer reviewed. The launch date will be in the next reporting period			

Policy Area: Other Policy						
Policy: Voluntary Medical Male Circumcision						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date				2008	2010	2012
Narrative	Studies have shown that VMMC conferes men 60% protective effect against aquiring HIV heterosexually from infected partners. WHO/UNAI	MOH Kenya had no prior policy to guide implementation and scale up of VMMC. There were also no operational, training, or service guidelines. An	Kenya set up a Male circumcision taskforce, comprising stakeholders - MOH, Implementing partners, researchers, PEPFAR- to develop policy and strategy	Policy developed and adopted by MOH in 2008	Clinical manual for VMMC, MC scale up strategy, Training guidelines, Monitoring and evaluation tools were developed to guide implementation and	Over 380,000 men currently circucmsied in Kenya and a Mid term review planned in early 2012 to evaluate progress made

	DS recommended scale up of VMMC in countries with high HIV prevalence and low rates of VMMC. Kenya's Nyanza Province has low rates of circumcision at 48% and high HIV prevalence at 14.9%	implementation and communication strategy was also neded.			completed in 2010	
Completion Date						
Narrative	The KAIS 2007 showed that over 90% of uncircumcised males in Kenya reside in 4 provinces. About half of the uncircumcised males	The VMMC policy was developed, and in addition, a strategic plan for VMMC scale up, a communication strategy to guide communicat	The Policy document has remained the reference document as Kenya makes great advance in promoting VMMC for	As above	As above	As of Oct 2012, over 480,000 boys and men have already been circumcised in Kenya. Most of these are in Nyanza province,

	reside in Nyanza (52.9%), while 16.7%, 10.2%, 9.7%, and 11.2% reside in Rift Valley, Nairobi, Western and other provinces, respectively .72% of the estimated 1.4 million HIV-infected persons in Kenya reside in the same four provinces: Nyanza (n=417,000), Rift Valley (n=304,000), Nairobi (n=183,000), and Western (n=115,000). These were prioritised	ion and demand creation, operational and training guidelines, as well as M&E tools were developed to support the VMMC scale up in Kenya	HIV prevention in the 4 priority regions.			the province which had the lowest MC rates and highest HIV prevalence. The Mid term review process is nearly complete and will provide guidance on how best stakeholders should work together to reach 80% of the uncircumcised men in Kenya by end of 2013.

	for VMMC scale up					

Policy Area: Stigma and Discrimination						
Policy: Policy on HIV prevention, care and treatment for MARPS						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date			2012	TBD	TBD	TBD
Narrative	Stigma and discrimination around HIV is still a significant problem in Kenya, especially for Most at Risk Populations including sex workers and men who have sex with men. This stigma has a negative impact on the health-seeking behavior of those infected and hinders prevention programs.	There has been very little policy regarding stigma and discrimination in Kenya until recently.	Pending: develop legal and policy guidelines to support implementation of HIV prevention, care and treatment services among MARPS	Policies developed and to be adopted by GOK.	Policies to be implemented by all health care providers, providing a safe, secure, and stigma-free environment for MARPS and PLHIV to access services.	Review existing protections for PLHIV.

Completion Date			2012			
Narrative	No update from previous reporting period.		The Constitution of Kenya is clear on the rights of all Kenya's to have access to the highest level of health services. The constitution is also clear that sex work, drug use and men having sex with men are all illegal in Kenya. Kenya's health sector has embarked on ensuring that all health service guidelines and statements address	Not applicable	2010: national guidelines for HIV/STI programs for sex workers were developed. In 2012, draft guidelines for MSMs were developed. In 2012, draft service guidelines for People Who Inject Drugs are being developed and will be completed in 2013.	

			reducing discrimination and stigma as it relates to health services.			

Technical Areas

Technical Area Summary

Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	13,444,830	0
HKID	22,961,521	0
HVTB	10,389,241	0
PDCS	2,130,225	0
Total Technical Area Planned Funding:	**48,925,817**	**0**

Summary:

Overall Programmatic Strategy in Care and Support:
Over the last seven years Kenya has made tremendous progress in the provision of adult HIV care and support services. This sustained scale-up has ensured provision of care services to an estimated 1.3 million adults living with HIV as of September 2011, with over 80 percent of HIV+ adults who know their status enrolled into care. Over 1,000 health facilities (including all national, provincial, and district hospitals, most health centers and some dispensaries) across all the 47 counties, offer HIV care and support services.

To align the PEPFAR II activities with the 2009-2012 Kenyan National Strategic Plan (KNASP III), the USG and Government of Kenya (GOK) co-developed a Partnership Framework (PF) that outlines the roles of both governments in the implementation of HIV services and promotes sustainable commitments from both governments. For the fiscal year (FY) of 2012 and 2013, PEPFAR activities are formulated within the context of KNASP III, the PF, and the Partnership Framework Implementation Plan. The USG will continue to facilitate joint review meetings with the GOK and other partners to ensure continued joint commitment towards achieving these goals. In line with KNASP III the National AIDS and STD Control Program (NASCOP) coordinates all care and support activities for HIV and oversees development and implementation of care policies, guidelines, and HIV training curriculums.

In 2011, a minimum package of care and ART services was developed to outline the services that every provider should offer to every HIV+ patient. This includes confirmation of HIV status; ART eligibility assessment, including WHO staging and CD4 testing; immediate ART provision for those eligible; laboratory monitoring, including biannual CD4 testing and viral load testing for suspected treatment failure; cotrimoxazole prophylaxis (CPT); psychosocial counseling; adherence counseling; nutritional assessment/supplementation, such as food by prescription (FBP); basic care kit (BCK) ; positive health, dignity and prevention counseling (including support for family testing, supportive disclosure, condom provision, family planning, and STI services); sexual and reproductive health services; opportunistic infection (OI) management, including TB, prophylaxis, diagnosis and treatment; defaulter tracing; alcohol and substance abuse support and management; and comprehensive services for family members. In addition, every HIV+ patient is linked to community programs, for prevention interventions such as education by peer educators; retention strategies through community networks; use of support groups to provide prevention, adherence and psychosocial support messaging; and economic empowerment projects. In FY12 and FY13, provision of comprehensive quality services through receipt of this minimum package of services will continue to be emphasized.

PEPFAR resources will continue to fund provision of care and support services to hard-to–reach and marginalized populations such as refugees, prisoners, most at risk populations (MARPS). Initiatives will also support tailored services to meet the needs of youth, the elderly and disabled populations. Strategies to increase male enrollment in care and support services will include support to male peer educators, mentors and support groups, and supporting women to disclose and bring their male partners for HIV testing and counseling.

Since 2009 over 400,000 patients received a BCK, and home-based care (HBC). This initiative will continue throughout FY12 and FY13 with a special emphasis on promoting consistent implementation of the GOK guidelines and wider availability of better-equipped BCKs. Deployment of 750,000 BCKs to HIV-affected households is expected to improve household and individual morbidity for up to 1.75 million Kenyans during FY12. Along with the BCK PEPFAR-Kenya worked with partners to develop a comprehensive tool kit, including curricula for water, sanitation and hygiene (WASH) services integration into all health care worker service delivery trainings. PEPFAR supported the advocacy for policy changes to expand access of opioid pain medication for adult HIV patients in health facility settings and a curriculum for training health workers on palliative care. In the community setting, positive health, dignity and prevention guidelines were developed and rolled out to all PEPFAR partners.

To improve care service delivery in the facility setting, PEPFAR funds have been earmarked for renovation of provincial and high volume district hospitals. The renovations will follow a standardized construction plan and will include infection control elements. Training efforts have also been intensified to improve Health Care Worker (HCW) HIV skills. Pre-service and in-service trainings will continue to be supported, ensuring pre-service trainings for 1,100 HCWs in FY12 and 900 in FY13; and in-service training for 3,340 HCWs in FY12 and 2,500 in FY13. A standardized curriculum for both classroom training and mentorship has been established.

Innovations that will be implemented in FY12 include continued scale up of HIV Testing and Counseling (HTC) services in OVC programs and establishing an environment conducive to the sensitivities of testing children. Kenya will continue to provide a range of essential services that reduce vulnerability to 680,000 OVC and their families and to strengthen the capacity of families to advocate for services and care for OVC. In FY12, a special focus on addressing gender-based violence and protection issues, strengthening the social welfare workforce and economic strengthening activities that increase families' capacities to provide and care for children in their custody will be developed. There will also be a greater emphasis placed on strategies for enhancing household economic strengthening with a focus on the family/caregiver.

Funds will be used to provide TB treatment and CPT to 100 percent of eligible co-infected Kenyans and to screen for TB in at least 80 percent of HIV + persons during enrollment into care. HIV testing to over 90 percent of TB patients, their partners and families will also be provided increasing referrals between HIV and TB service points will be emphasized. More aggressive case-finding of dually-infected children will continue to be prioritized, and TB diagnosis and treatment in HIV clinical settings will be expanded.

The GOK, DFID, UNICEF and World Bank have provided support for a cash transfer program for families caring for OVC and evaluation of the community programs. The GOK and UNICEF also supported the establishment of Community Health Units (CHUs) to provide integrated community-based services. The GOK has further committed funds to establish CHUs across the country as part of the wider community health strategy. The USG will continue to plan with the GOK and other development partners so that HIV service implementation and activities will continue to transition to local indigenous organizations and community-based organizations to increase coverage and country ownership.

Adult Care and Support:
The GOK recommends that all HIV-infected adults and children, regardless of their immunological status, have access to a minimum preventive package of services through the distribution of basic care kits. The BCK targets some of the opportunistic infections that cause the highest burden of morbidity and mortality in HIV-infected individuals; notably, diarrhea, malaria and sexually transmitted infections (STI). The kit consists of a number of

low-cost and practical interventions that reduce HIV-related morbidity and mortality and prevents HIV transmission. The components include long-lasting insecticide treated nets (LLITN), safe water system (SWS), condoms and information, educational and communication (IEC) materials for Person Living with HIV (PLHIV) and multivitamins tablets. The BCK is implemented nationally in accordance with the Ministry of Public Health and Sanitation 2010 National Guidelines for the implementation of the Basic Care Package. In addition to provision of the BCK commodities, client education through the use of IEC materials facilitates a better understanding of OI prevention, and subsequent behavior change. The primary target recipients of the BCK are PLHIV who know their HIV status and are registered at a health facility, specifically in the HIV clinic. Any adult who tests HIV positive irrespective of his/her religion, age, or ethnic heritage is eligible to receive the BCK. Recruitment of clients/patients is carried out either within a health facility by the HCW or through referral from the community settings by trained Community Health Workers (CHW).

All HIV infected adults are eligible to receive community-based services. This package of services includes HIV testing to the partner and the family members of the index patient and enrolling or referring/linking those that test HIV+ to care and support; nutritional assessment by the CHWs and referral for FBP to all eligible HIV+ patients; positive health, dignity and prevention counseling; and WASH. PLHIV also receive education by peer educators who coordinate the formation of support groups to provide adherence messaging, effective and efficient defaulter tracing and patient follow up. Patients are linked from the community to the facility and vice versa using referral forms, patient escorts and community desks established at the facilities. This linkage will be further strengthened by the establishment of the community health units and the national community health information systems (CHIS).

To improve patient retention, a key strategy is the use of the minimum package of care and ART services in the management of the HIV-infected patients in GOK health facilities. This will contribute largely to ensuring that non-ART patients receive services that were previously mainly accessed by the ART cohort. Another strategy is the community-based treatment services; a team-based service model that includes the patient, the family, the community, the physician and the nurse provision of care.

PEPFAR will continue to strengthen the GOK's monitoring and evaluation capacity and support the modification of care indicators to capture adult patients as "currently enrolled" or "ever or cumulative enrolled," and newly initiated or enrolled in the HIV care program. PEPFAR will also work with GOK to develop indicators to better capture the number of people receiving community and/or facility care to avoid double counting. This will be achieved through the adoption and revision of the next generation indicators (NGIs) and the development and use of an electronic medical records system in accordance with the GOK Ministry of Health (MOH) guidelines.

Accurate and timely data collection and reporting will continue to be supported at all levels to increase and improve reporting to the MOH and PEPFAR. At the MOH, there is an ongoing effort to integrate HIV data reporting with overall disease reporting through the Health Management Information System unit, further, this system will incorporate the NGIs and TB indicators in addition to being incorporated into HIV care and ART reporting to capture active TB cases and ART uptake among HIV/TB co-infected patients. Several implementing partners currently use electronic databases to capture patient and program data. Other implementing partners will be assisted for feasibility regarding the adoption of these recommended systems.

The recently concluded ART costing study will inform strategies that increase program efficiency. This study assessed the cost of HIV care and treatment services to inform the program on the cost-effectiveness of different service delivery models.

Pediatric Care and Support:
In 2011, PEPFAR funds supported over 1.4 Million patients in care, of whom 10 percent were children. This was well above the targeted goal of 750,000 including children in 2010. To accomplish this goal, in 2010 PEPFAR supported the identification of more children, and expansion of the provider capacity to deliver and document quality pediatric HIV services. PEPFAR also utilized CHWs or peer educators for task-shifting and supported the establishment and strengthening of pediatric care policies. Implementing partners used CHWs and peer educators,

including PLHIVs, for monitoring adherence and provided psychosocial and disclosure support to households in order to improve defaulter tracing and follow-up of pediatric patients. The funds supported disclosure training for health care workers (HCWs) and formation of support groups for caregivers and their children.

The majority of exposed/infected children identified were enrolled into care at MCH or HIV clinics and provided with care services including: cotrimoxazole, immunizations, growth/disease monitoring, safe water systems, bed nets, feeding services, counseling, and social support services. Between March 2009 and October 2011 over 43,000 children received BCKs, constituting 11 percent of all the BCKs distributed. Of the 43,000, 50 percent were not on ARVs. PEPFAR also supported youth-friendly, gender appropriate HIV clinical services to adolescents. HIV-infected youth received specific positive health, dignity and prevention messages and interventions and were able to access reproductive health/family planning services as necessary. The HIV-exposed youth also received post-exposure prophylaxis. Additionally, funds supported several community-based organizations (CBOs) to provide specific referrals for children and families needing HIV care services in order to expand the number of HIV clinics that offer pediatric support groups.

In 2012, funds will be used to align HBC services into the MOH community health strategy, revise and review the HBC guidelines and strengthen community and health facility linkages while supporting the development of the monitoring and evaluation system. A QA/QI system for community care services will be established to support these priority areas, which will be carried out by CHWs within the various established CHUs under the supportive supervision of community health extension workers (CHEWs). CHWs will provide support for end of life care as well as provide linkages with other sectors that provide direct and indirect support to HIV-infected children.

With the Division of Child Health and other stakeholders, funds will be used to promote healthy behaviors at the household level for the following interventions: exclusive breastfeeding for children below six months; appropriate complementary feeding; dietary diversity targeting from conception to 24-months; use of LLITN; hand washing with soap; safe water storage and treatment; and total sanitation. Furthermore, PEPFAR aims to increase utilization of life-saving interventions at home such as management of diarrheal diseases among under-fives with oral rehydration salts and therapy (ORS/ORT), zinc, and de-worming; introduction of community case management (CCM) of malaria, uncomplicated pneumonia and tuberculosis in areas with poor access to care and referral of complicated cases to the facility level; and improvement of home screening, detection, and referral of acute malnutrition by CHWs.

In FY13, support will be provided to facilitate behavior change communication activities to promote healthy practices and motivate mothers to seek timely and appropriate care. This will be achieved through the introduction of ORS and zinc and expanding other child health commodities (e.g., LLITNs) into the national social marketing system to improve access and prevent mortality due to preventable childhood diseases. Similarly, the program will increase use of routine vaccines using an integrated approach with other interventions, such as Vitamin A and de-worming tablets, to leverage standard practices to improve healthcare.

Support to reduce barriers to accessing care, especially for the poor and underserved, to address health equity for those most at risk by increasing coverage of essential child survival interventions among the urban and rural poor and to advocate to the MOH to eliminate economic barriers to services for under-fives (e.g., eliminate user fees and increase health insurance coverage) will also be provided. To improve the quality of services in communities and healthcare facilities to augment existing investments in childhood health, PEPFAR will work to improve the quality of care and procedures at the facility level (e.g., integrated management of childhood illnesses (IMCI) training, staffing, equipment, and supply chain), increase appropriate diagnosis and management of diarrhea, pneumonia, tuberculosis, and malaria, and improve therapeutic management of severe malnutrition

TB/HIV:
Collaborative TB/HIV activities and MDR-TB control are prioritized in Kenya's Five-Year National AIDS and TB Strategic Plans whose shared objectives are to identify and comprehensively care for "all HIV co-infected TB patients", to reduce the burdens of both illnesses and to contain MDR-TB. Of the 105,781 TB cases notified in 2010,

44 percent tested HIV+ with co-infection rates as high as 70 percent in some settings. According to the 2008 Kenya Demographic and Health Survey (KDHS) the average national HIV prevalence among adults is 6.3% percent, although this is as high as almost 15 percent in some settings in western Kenya. To support policy, coordination and monitoring, the USG provides direct technical and financial assistance to the national HIV and TB programs. The USG technical staff participates in the national TB and HIV inter-agency committees which, among other mandates, coordinate efforts to maximize complementary funding from all sources. USG agencies support TB/HIV activities through implementing partners rationally allotted to Kenya's administrative districts to ensure maximum geographic coverage. The USG and Kenyan MOH recognize the synergistic and sustainable value of linking facility and community-based TB/HIV. Accordingly, facility and community activities are factored into the MOH's National, Provincial and District Annual Operation Plans (AOPs).

Under the Community Health Strategy (CHS), the MOH is establishing CHUs to reach approximately 1,000 households, within which TB/HIV activities will be strengthened and expanded to provide quality services. Community TB and HIV mobilization, diagnostic, treatment, referral and monitoring networks will be strengthened at all levels, building on accomplishments with a focus on new priorities for the next 2 years.

In the 2011 Annual Program Results (APR), Kenya provided 35,917 HIV+ patients with TB treatment. New priorities include strengthening community TB screening and laboratory networks; linking "TB suspects" or their sputum specimens to early TB diagnosis; HIV screening and TB treatment; strengthening referrals to improve access to BCK, CPT, ART, nutritional support, HIV and TB prevention interventions [(PWP and isoniazid prevention therapy (IPT)]; defaulter tracing and expanding the community approach to MDR-TB care. To improve MDR-TB surveillance, a phased introduction of geneXpert will be conducted to link pooled community laboratory specimen collection networks and health facilities with this new diagnostic tool.

Home-based HIV counseling and testing (HBCT) will be intensified, and clients testing positive screened for TB. Those with active TB will be treated and those without considered for IPT. Appropriately motivated CHWs will be hired or trained to coordinate and document patient/client encounters and referrals to health facilities in a more structured and accountable manner.

TB/HIV co-infected patients undergo routine nutritional assessment and counseling, and those that qualify are provided with FBP. They are also empowered by giving them access to initiatives to grow supplementary food through the PEPFAR Community Grants Program (PCGP). As part of supporting the overall Health Information Management System (HIMS), community monitoring and evaluation (M&E) systems will be strengthened to improve linkages between facility and community TB/HIV activities and to monitor progress and outcomes. Greater ownership of TB/HIV activities will be achieved through improved dialogue between strengthened community and facility health committees and other coordinating platforms. By strengthening M&E systems we will have the necessary data needed to attribute resources to interventions which prove to be most effective. It is anticipated that TB/HIV achievements attributed to community efforts will be clearer in the future, and will provide a foundation for sustainability in the future.

In collaboration with the Ministry of Public Health and Sanitation (MOPHS), focus will be on decreasing TB morbidity and mortality through improving case detection and treatment success. Additionally, efforts to improve coordination of USG partners working in TB/HIV, helping to clarify the roles of all the various partners particularly as they relate to the overall National TB Strategic Plan will continue to be a priority. Further, the MOPHS, with technical support from USG, will provide national oversight and the conduct of implementation science to measure impact and track outcomes.

Food and Nutrition:
Integration of nutrition assessment, counseling and support (NACS) within HIV/AIDS care and treatment programs in Kenya has been achieved through various strategies, including the adoption of one national training curriculum. In addition, NACS has been adopted in all care and treatment programs as a critical component of the minimum package; the scale-up strategy is in line with the ART program. The MOH has also integrated NACS – FBP

implementation into the job descriptions for nutritionists and other frontline health cadres. Efforts to harmonize the management of nutrition commodities by all partners and to aggregate this data for national level reporting are on-going. Harmonization of data collection tools, as well as the creation of multi-disciplinary teams to advance the QI/QA agenda, including integrated reporting of all services under care and treatment, are being piloted and will be scaled up. PEPFAR funding has led to the formation of QA/QI teams and coaches in 3 Districts in Nyanza Province (Rarieda, Bondo and Siaya). These teams have identified and are tracking key nutrition indicators to guide their QI/QA efforts. Lessons learned from Nyanza are being documented and will be shared with other programs countrywide for adoption.

PEPFAR partners support NASCOP with technical assistance (TA) as well as commodity procurement (fortified blended flours and ready to use therapeutic food [RUTF]) and warehousing and distribution through local private sector sub-partners. KEMSA supports the supply chain management and distribution of Global Fund commodities, and WFP has its own supply system. Therapeutic milks are imported mainly by UNICEF. The Kenya Bureau of Standards provides TA for small- to medium-scale local producers to meet the required minimum standards. Also, USG has supported safety and quality standards audits for 3 food manufacturing companies, and is working with them in ensuring that the gaps identified have been fully addressed. Clinical and community partners are provided with HBHC funding which includes NACS and MNCH funds to address national level activities on infant feeding in HIV.

In most regions PEPFAR funded clinical partners also double as the community partners and therefore include nutrition referrals and linkages as part of their overall care and support functions. The NHP has supported the capacity building of CHWs and CHEWs within pilot CBOs in ensuring effective bidirectional linkages and referrals between the clinic and community, which include a food and nutrition component. The CHWs are supported by the care and support implementing partners. The Feed the Future Initiative has led to the engagement of health care partners and agriculture partners in integrating nutrition within the value chains, as well as in linking clients to income, production and marketing support. Some PEPFAR supported implementing partners work with WFP partners to address Economic Strengthening /Livelihoods Support/Food Security through support to group income generation projects, demonstration farms and food support for extremely vulnerable groups.

Orphans and Vulnerable Children (OVC):
According to the KNASP III, approximately 2.4 million (12 percent), of Kenyan children below 18 years of age are orphans. Approximately one million (42 percent) have been orphaned due to HIV and AIDS, and this number is expected to increase in the future. At the national level, the Department of Children Services (DCS) under the Ministry of Gender, Children and Social Development plays a major role in coordinating various sectors and stakeholders in responding to the OVC issues in Kenya. At the regional level, the DCS is represented through Provincial and District Children's Offices which are responsible for coordinating community efforts in close collaboration with Area Advisory Councils (AACs) and Locational OVC Committees (LOC). As of September 30, 2011, PEPFAR was supporting 558,036 Kenyan OVC with direct services.

In 2009, the GOK merged all separate national policies on various profiles of children into the Kenya Children Policy which is currently awaiting cabinet approval. The national policy on children provides the framework for addressing issues related to children's rights and welfare in a holistic and focused manner. It includes the establishment of social and child protection mechanisms as a specific policy objective.

PEPFAR supported the development of the 2007-2010 National Plan of Action (NPA) for OVC that provides the framework for a coordinated multi-sectoral and sustainable approach to supporting OVC in Kenya. This plan has been finalized, printed and disseminated. The NPA identifies the need for OVC programs to ensure access for OVC to essential services. This emphasis aligns with PEPFAR's support to OVC through the seven core program areas: food and nutritional support; shelter and care; protection; health care; psychosocial support; education and vocational training and economic opportunity/strengthening.

There is need for an increased focus on quality improvement in OVC services. First, sexual abuse against children

has been on the increase over the years, but many cases are not reported. Police reports indicate that 1,626 cases of attacks against children were recorded in 2007. The number rose to 1,984 in 2008, representing an increase of over 300 or over 18 percent (2008 Kenya Police crime report and data). Second, insufficient human resources affect the DCS's capacity to effectively deal with OVC issues in Kenya, a situation exacerbated by the increased workload from the GOK/World Bank, DFID and UNICEF-funded cash transfer program. Third, the lack of Children's Offices in all districts, particularly the newly-created districts, hinders the identification, targeting, and receipt of care and support to children at risk. Lastly, service delivery challenges, for instance, shortage of human resources for health, have hindered the scale up of pediatric HIV testing, early identification of HIV-infected children and subsequent linkage to care and treatment. This issue has particular implications for OVC who often lack legal guardians to provide consent for testing. Kenya's cash transfer program has expanded dramatically from a pre-pilot project beginning in 2004 supporting 500 households in 3 districts to a project in Phase II now funded by development partners and contributed to by the GOK in 47 districts covering more than 60,000 households and approximately 198,000 OVC. The objective is to expand to 300,000 beneficiaries in 2012. While PEPFAR does not provide financial support to the cash transfer program, it continues to provide support to the largest number of OVC in Kenya and provides necessary linkages that enable caregivers to access health services for OVC. PEPFAR provides wider coverage to reach more OVC that are not currently benefiting from the cash transfer program so that they too can receive the care and support they need.

To address the need for quality improvement, PEPFAR, since 2009, has been supporting the national OVC Quality Initiative aimed at developing and disseminating OVC service standards. The standards have been finalized and will be launched and rolled out in early 2012 with an appropriate communication strategy and dissemination plan. In 2012, PEPFAR will continue to build on the Quality Initiative efforts and will support dissemination of service standards right to the point of service delivery.

In spite of policy challenges related to pediatric HIV diagnosis, Kenya's integrated program continues to identify and link HIV+ positive children to care. In 2010, PEPFAR supported the development of pediatric HTC guidelines to address barriers in the early identification of HIV-positive children. With PEPFAR support, partners have developed and are implementing strategies for identifying HIV-infected children using home-based care platforms and linking them to care. In addition, PEPFAR has supported implementing partners to identify and build the capacity of genuine grassroots organizations at the forefront of providing care to OVC, helping them provide quality care to these OVC and to reach out to more children in need. PEPFAR continues to work through extended families and communities as the first line in responding to children orphaned and made vulnerable by HIV/AIDS. PEPFAR partners have focused on initiatives that support family and community efforts. By working through umbrella organizations and multiple grassroots organizations, PEPFAR has been able to improve coverage while ensuring that local organizations remain at the forefront of the response to OVC issues. These efforts are also enhanced through the PEPFAR Community Grants Program (PCGP).

PEPFAR will continue to contribute towards national OVC goals and activities outlined in KNASP III. A key output of KNASP III is increasing the number of civil society organizations (CSOs) supported to deliver HIV services at the community level in a manner responsive to the local context. PEPFAR support will build the capacity of these CSOs in creating demand for services as well as enhanced service coverage to serve approximately 35 percent of the total OVC population at the provincial level, based on disease burden and the OVC population.

The USG will continue to collaborate and hold joint review meetings with the GOK to ensure mutual commitment towards achieving OVC goals. USG implementing partners will continue to integrate programming for OVC into the GOK annual district operational plans. PEPFAR will continue to advocate and support evidence-based programming, including support to the GOK to undertake OVC service mapping that will facilitate informed decision-making and support regional coordination of OVC stakeholders. A greater focus will be on providing care and support to OVC in high prevalence areas (including Nyanza and Rift Valley) as well as identifying underserved and at risk populations.

In 2012, PEPFAR partners will continue to strengthen the capacity of families and provide the range of essential

services in line with the National Plan of Action for OVC and the USG Guidance for OVC programming. With PEPFAR support, implementing partners have been able to provide an increased number of services to individual children and their families. In 2012, PEPFAR will target 680,000 OVC and their families with essential services that reduce their vulnerability. Family-centered care for OVC will be enhanced as this empowers families to care for their own OVC. PEPFAR partners will focus on supporting children in and through families by enhancing approaches that keep parents alive, making every effort to keep children within families, enhancing care of OVC in family settings, empowering families to educate their children and building community systems that provide child protective services. One specific focus will be to bolster economic strengthening activities that will increase families' capacities to provide and care for children. Partners will be supported to ensure that economic strengthening activities and vocational training for older OVC and caregivers are adequately linked with market conditions. Prevention will continue to be a specific focus of PEPFAR in Kenya; PEPFAR will continue to work with its partners and with the GOK to continue to integrate prevention activities among OVC, especially for out-of-school youth.

In 2012, PEPFAR partners will continue to support and strengthen local committees in the identification, targeting and support of vulnerable children. The USG will support the review of the CHS to ensure that OVC issues are comprehensively incorporated and integrated in health service delivery.

The 2008-09 KDHS indicated a worrying trend in Kenya for gender-based violence. A recent 2009 report released by the non-profit making NGO CRADLE indicates that sexual abuse of children continues to rise, two years after the enactment of the Sexual Offences Act. Abuse of children accounts for 73 percent of all reported cases. The GOK and other key stakeholders have developed a comprehensive child protection system that will address the continuum from prevention to response, including violence against children. USG will support the establishment of community-based mechanisms and build community capacity, with particular focus on male adolescents and youth, to prevent and respond to gender-based violence with specific focus on sexual violence. In 2012, PEPFAR will continue to support GOK's efforts in rolling out the recently finalized OVC draft service standards and disseminate these standards to all stakeholders implementing OVC programs.

PEPFAR will continue to support provider-initiated, home- and community-based HIV-testing as an entry for OVC into care and support services as well as ensure that appropriate linkages and referral protocols are in place and effectively used to link OVC to health facilities for services. Partners working in urban areas will provide services to street children, especially addressing HIV prevention and providing linkages to care and treatment.

To enhance strategic decision-making for OVC programming, PEPFAR will continue to strengthen the capacity of its partners to collect, store, retrieve report on, and analyze data for effective program implementation.

PEPFAR will continue to collaborate with GOK and key stakeholders such as UNICEF, World Bank and DFID to ensure a more comprehensive approach for bringing OVC programs to scale.

Cross Cutting Areas:

Public-Private Partnerships:
The private sector will play a major in advancing key priorities in provision of care. For example the GOK partnered with Unilever to provide hand washing supplies and build hand washing centers in selected primary schools in Kenya. The funding was generated from the sale of one of their products. We plan to engage other partners in similar arrangements to support other elements of the care technical area.

Gender:
Based on a review of the most recent APR results for males and females, there are no gender disparities in delivery of care services. For example the PEPFAR implementing partners identify child/adolescent-headed households and care-givers, and implementing targeted programs to meet needs, including programs that keep girls in schools, help them manage households, address stigma, and compensate for lost family income.

MARPs:
All eligible HIV-infected persons in the country, including MARPs, receive clinical care services.
All HIV infected patients, including MARPS, receive the same care and support package of services as listed in the text. For additional services MARPS are linked to the prevention program.

For example, a PEPFAR implementing partner may receive funding for a range of HIV services, including care and treatment and MARPs activities. This ensures that the MARPs are linked to appropriate, accessible and friendly HIV prevention and support services. The Kenya program is advocating for supportive policies or addressing legal barriers to provide services to MARPs and creating an enabling environment for MARPs accessing services by working closely with the GOK.

HRH:
The Kenyan program has a number of implementing partners that are charged with recruiting, training, deployment and retaining of an adequate health workforce. This is aligned with the overall PEPFAR HRH strategy and national HRH plan. In addition, the Kenya program will use CHWs in the various areas as described in the main text.

Laboratory:
There is a tiered system of laboratories that serve HIV and TB diagnosis and both internal and external quality assurance systems are in place to ensure accuracy of testing.

Strategic Information:
The USG strategic information (SI) team plans to strengthen M&E systems including health information systems for collecting, collating, reporting and using community-level program data for program improvement. As much as possible, and where applicable surveillance and survey activities on community activities will be strengthened and/or developed and operationalized.
Currently, there exists a weak community based health information system capable of capturing data on community level care and support activities. MOH has developed standardized CHIS data collection tools for some community based care and support programs but lacks a system to monitor and provide information on linkages across care and support programs as well as facility - community referrals. This will be addressed through support to strengthen CHIS, community level M & E activities, referral systems as well as institutional capacity building for the division of community health services and to health care workers to correctly record and report data on revised CHIS data collection tools. Information use remains to be weak at the community, facility, district and provincial levels. Data use for planning and program improvement decision making at the provincial, district, facility and community levels is weak and will be one focused area for support. Efforts to link community health information systems with facility-level information systems will be enhanced to further strengthen community – facility referral systems. Capacity building of community structures and organization on the generation and use of care and support program data will be supported.

Technical Area: Governance and Systems

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	13,876,507	0
HVSI	14,964,165	0
OHSS	5,697,667	0
Total Technical Area Planned Funding:	**34,538,339**	**0**

Summary:

Introduction:

In recent years the Government of Kenya (GOK) has been implementing numerous health sector reforms with health systems strengthening at the core of the agenda. Following the promulgation of the new Constitution (August 2010), the two health Ministries (Public Health and Medical Services) reviewed the Constitution's provisions that would impact the health sector, identified issues that would need to be elaborated, and established ministerial task forces along the six health systems "investment areas" (health workforce, commodities, financing, policy, information systems and service delivery) to bring together the emerging issues and positions into a coherent sector framework. The key Constitutional provisions with direct implications for the health sector include: the Bill of Rights which contains the right to the highest attainable standard of health for Kenyans; and Devolved Government which includes the transfer of key functions and authorities from national to downstream county governments. The devolution process and its implications with respect to governance (including the expected merger of the two Health Ministries), health workforce, commodities, financing and health information as well as stakeholder partnerships and community demand, will drive decision-making for the short and long-term, with regard to health systems investments. This and the desire to achieve sustainable impacts for integrated health programs will inform the scope of activities under COP12.

For successful implementation, USG will continue to dialogue with GOK and other partners on Kenya's priorities and challenges to ensure that PEPFAR support for health systems will have a positive impact and will be aligned with Kenya's new developments. USG will engage key departments within the Ministries (e.g. HR, Planning, Pharmacy, Disease Control and Epidemiology) and participate in stakeholder forums and thematic working groups to provide input to the position papers and policy documents that will inform the implementation of key health reforms under the new Constitution. The coordination mechanisms including the Health Sector Coordinating Committee, District Stakeholders Meetings, and Interagency Coordinating Committees (ICCs) and Technical Working Groups (corresponding to key technical programs as well as the health systems building blocks) will ensure effective harmonization of USG and other stakeholder resources.

Let's Live Campaign and the Global Health Initiative (GHI):

The - Let's Live Campaign is Kenya's GHI strategy. In line with the Government of Kenya health priorities, the Let's Live Campaign aims to significantly reduce preventable deaths that are associated with four primary killers: HIV/AIDS, non-communicable diseases, maternal/newborn and child mortality. The initiative envisions a whole of government collaboration to achieve greater returns for the investments made in health, using 'SMART' integration of USG assets to realize greater efficiencies as well as broader health impact. The strategy builds on the existing PEPFAR interagency governance system under which USG agencies (Embassy, US Peace Corps, Walter Reed, CDC, & USAID) have successfully planned and implemented for many years, and recognizes that opportunities exist within USG programs to strengthen planning and coordination without duplication of efforts.

Let's Live integrates all USG partners and health funding sources in Kenya and engages GOK and bilateral, multilateral, non-governmental organizations and private sector to bridge the divide across vertical approaches. It emphasizes integration to address a variety of specific disease priorities and interventions, resulting in strengthened health systems capable of delivering more efficient and effective services, including those for HIV/AIDS.

Using PEPFAR funding as well as PMI, MCH, nutrition, TB, and RH/FP resources, specific interventions under each of the four major thematic areas will be complemented by cross-cutting strategic investments in key 'building blocks' of the health systems i.e. Strengthening leadership and governance; developing human resources for health; improving supply chain and logistics management; building health information systems and ensuring efficient and equitable health care financing. With country ownership serving as a core principle of these investments, USG will redouble efforts to work within existing host country management and coordination structures in line with the PEPFAR/GOK Partnership Framework, the principles of the Three Ones, and the Code of Conduct governing stakeholder involvement in the health sector.

Leadership, Governance and Capacity Building:
The devolution of government poses major challenges to the health sector in terms of governance and management systems. The transfer of health services to county governments requires new capacity building and technical support to establish operational county health management structures and systems. The national level health ministry continues to grapple with developing policy positions and proposals to define the structure and functions of a unified Ministry of Health (assuming a merger). Health sector coordination mechanisms and a common framework for planning and implementation exist, yet partnership processes at various levels remain weak leading to inefficiencies in the use of available resources.

PEPFAR -funded programs have been supporting the Government of Kenya to strengthen governance structures and functions. For example, the GOK with PEPFAR support has reviewed and set guidelines for the selection and training of hospital boards and committees tasked with providing oversight and governance of health facility resources. In addition, PEPFAR has continued to support various activities to improve the management, leadership and governance skills at various levels of the health sector. A 2008 assessment supported by GOK and PEPFAR found that 70% of doctors and nurses who form a majority of managers in the health sector lack leadership and management skills. Training curricula for the health workforce have not adequately addressed these areas, and available courses are not always accessible to health personnel who may want to update their skills and knowledge. The structural and institutional systems of management are based on clinical experience rather than leadership and management qualifications (i.e., there is no career ladder for health managers).

PEPFAR funding will continue to support capacity building courses and trainings to improve the skills of current leadership and management at all levels of the health sector. Activities will include strengthening management, leadership and governance curricula development, and roll out within the health workforce training institutions. Other activities will improve training institutions to ensure accessible and responsive leadership, management and governance courses through distance education, e-learning, and m-learning models etc.

PEPFAR will assist GOK and key departments to review and develop appropriate policies and structures that support effective health sector leadership, management and governance. PEPFAR partners will support the functions of the devolved health institutions at the various levels (alignment of MOH, national, county, district and community level), including supporting ongoing review of the Health Acts to align them with the new constitution. Further assistance will be provided to help the development and implementation of a new Health Policy Framework and a new Health Sector Strategic Plan. PEPFAR partners will also continue supporting and strengthening health sector coordination mechanisms (e.g., Interagency Coordinating Committees (ICCs)) to improve planning, coordination and utilization of resources. These PEPFAR investments will serve to improve governance and accountability for decision-making and resource management. Interventions are geared towards building local capacity and country-ownership (e.g., engaging local training institutions to sustain quality training in leadership, management and governance skills; and supporting key processes and structures to enable the GOK to achieve its devolution objectives).

Strategic Information:
HSS has continued monitoring essential indicators for pre-service and in-service graduates. However, there were challenges in uniform interpretation of certain HSS indicators. Discussions are already underway between USG SI together with GOK to harmonize interpretations and develop national Indicators and data collection tools (where applicable) to track HSS indicators during COP 2012.

PEPFAR funds will also support organizational development, capacity-building and systems development to assist the GOK to establish an integrated, web-based, National Health Information System (NHIS) that will serve as the main source of data for all health sector stakeholders, eventually eliminating the need for vertical monitoring and reporting systems. Transitions will occur at the community, facility, subnational and national levels to reform and unify HIS infrastructure and ensure ownership, interoperability and effective use of the revised system. USG will also initiate efforts to integrate currently parallel HIV reporting systems i.e. the PEPFAR Program Monitoring System (KePMS) and Community-Based Program Activity Reporting System (COBPAR) managed by NACC, as well

as other priority information systems including the Community Health Information Systems (CHIS), District Health Information System (DHIS2), Human Resources Information System (HRIS) and supply chain/logistics information systems, into the unified NHIS.

Service Delivery:
Delivery of cost effective, safe, quality and accessible health care services requires a well-functioning health system, one where all health system strengthening (HSS) building blocks are being addressed in a holistic and sustainable manner. Various systems gaps and weaknesses have negatively impacted overall quality, efficiency, and efficacy of service delivery in the country. Recent PEPFAR-funded assessments have identified many of these gaps (in addition to those mentioned in previous sections), such as inadequate legal and institutional frameworks for licensure, quality assurance and accreditation, limited enforcement of existing standards and regulations, and inadequate infrastructure to support quality service delivery.

In addition, community-based interventions are needed to ensure greater access to services closer to the home. The Community Strategy was launched by the GOK to promote service delivery at community level (Level 1). However, of the 8,000 total CUs required nationally, only about 20% have been established. Nyanza, Western, Rift Valley and Coast Provinces which have the highest rates of mortality and bear the greatest burden of disease are in need of CUs. Scale-up is affected by recurring problems of retention and remuneration of community-based health workers as well as weak referral linkages to health facilities.

PEPFAR will work together with other stakeholders to support the roll out of the GOK's community strategy as a means to deliver preventive, home based HIV services at the community level. In particular, PEPFAR will help strengthen the regulatory, oversight and coordination role of the MOH to oversee the roll out of the community strategy; support the formation and sustainability of functional community units to deliver essential health services to the community; and strengthen supervision, monitoring and evaluation of community level interventions. This work will be done alongside efforts to strengthen the quality of services and improve infrastructure and equipment needs at the health facility level, especially in high-need, hard-to-reach areas.

PEPFAR will help to provide much needed support to national-level departments and institutions to enable them to fulfill their key mandates of providing leadership, managing health resources, regulating the sector, and ensuring delivery of accessible and affordable services of the highest attainable quality. Key activities will include support to ensure that unified and autonomous bodies are in place for professional licensure, quality assurance and facility accreditation. This will include work with the Department of Quality and Standards and other key MOH departments, as well as the Kenya National Accreditation Service and professional regulatory boards, to help strengthen existing quality systems and build capacity within these institutions to more effectively develop, disseminate, monitor and enforce service standards and regulations.

Human Resources for Health (HRH):
Kenya is categorized by the WHO as one of the 57 Human Resources for Health (HRH) crisis countries, with a health worker to population ratio of 1.69/1,000 compared to the WHO recommended 2.3/ 1,000. It is estimated that between 2008 and 2012 the country will have produced 16,444 health workers against a requirement of 27,141 within the same period, leaving a 39% gap (HRH strategic plan 2009-2012). Migration of health workers to other countries has continued to widen the production-demand gap.
The HRH distribution is skewed in favor of urban settings compared to rural and hard-to-reach areas and in favor of large hospital versus dispensaries (district hospitals have 120% fill rates for nursing; rural dispensaries are at 20%). Retention of highly skilled health workers in the public sector has been low, with rural and hard to reach regions most affected. Northern and arid lands suffer from low retention given that the region produces very few health workers and socio-cultural and political factors make it difficult for those from other regions to work there. Other factors that contribute to low retention include poor infrastructure, staff housing and remuneration (which are higher for those who work in urban areas).

According to a PEPFAR-supported performance needs assessment in 2011, competency of health workers is low.

The various investments applied to in-service trainings needs to be well coordinated, institutionalized and offered through ways that widen access (e.g., e-based and m-based modalities). Regulatory bodies need strengthening to better address both the quality of training and standards of service.
Despite 70% of the annual MOH budget being spent on staffing, management of human resources is weak. Through PEPFAR support there are interventions to improve HRH planning and management including development of a robust Human Resource Information System (HRIS), personnel filing system, HRH forecasting, and HRH financing and sector coordination. In the wake of the new constitution and devolved government systems, more support to HRH planning and management is needed if gains made through PEPFAR support are to be sustained.
PEPFAR will also address pre-service training to increase production of various key cadres of staff in line with country needs and in response to PEPFAR's contribution of 140,000 new health workers by 2014. Focus will be on expanding the absorptive capacity of training institutions, faculty capacity and financial access for students from rural and hard to reach areas. In-service trainings will be better coordinated, delivered in widely accessible modes and incorporated into professional annual licensing systems. Continuing the process that has been made in establishing pre-service and in-service training within the GOK training institutions is critical for the sustainability of these training programs. Appropriate data systems capturing health workforce trainings (pre-service/in-service) will enable the GOK to undertake more effective forecasting, evaluating and tracking of skills.

PEPFAR partners will continue strengthening HRH functions of the MOH, FBOs and private sector in addressing health workforce shortages, support hiring of health workforce to meet service needs in rural settings and hard to reach regions and strengthen mechanisms to transition workers from donor-funded programs to the GOK payroll. Through PEPFAR, activities will include support to attract and retain staff in rural and hard to reach areas through activities such as non-monetary motivators (e.g. housing, communication, and improved work environment) and improved remuneration. Other PEPFAR investments will continue to support strengthening of regulatory bodies, accreditation bodies, professional bodies, government departments, and divisions that promote quality of service delivery. PEPFAR will continue to support the various MOH departments to better plan and manage HRH systems, including HRIS, financing, forecasting, use of data in decision-making, and an HRH policy framework in line with a devolved government. PEPFAR will also continue to support improved models of service delivery, including through task-shifting/task sharing, introduction of new cadres and integration of community health workers in the continuum of care (see also Gender section).

The above interventions are based on the USG and GOK's Partnership Framework Implementation Plan and the National HRH Strategic Plan which have a country-wide focus and involve multiple stakeholders (e.g., government, development partners, private sector and community). In line with GHI principles, these actions are focused on building country systems for long-term impact. Some examples include expanding the training facilities for higher HRH production, advocating for increased budgetary allocation (GOK, FBO and private sector) for HR hiring, engaging the private sector in retention activities in rural and hard to reach areas, and supporting policy for equitable HRH distribution and coverage. Strengthened HRH national coordination through the Interagency Coordination Committee, chaired by the GOK, will further ensure effective synergies and leveraging of donor and other support.

Laboratory Strengthening:
Kenya has a good network of laboratories, however the current physical infrastructure is old and was not designed specifically for laboratory use and therefore lacks sufficient space or design to accommodate required laboratory equipment and staff. A recent MOH survey to inform the programming process revealed that 70% of laboratories fail to meet minimum national laboratory design standards. Building of new laboratories and upgrading and renovations of current laboratory buildings to meet minimum area and designs standards are priority areas.

Kenya has embraced the PEPFAR initiated 'Strengthening Laboratory Management Towards Accreditation' (SLMTA). The MOH has formed a national laboratory accreditation steering committee to create a national roadmap for laboratory accreditation. PEPFAR will continue to directly support 27 MOH laboratories and train at least 80 quality officers and laboratory auditors.

Kenya's overall health supply chain is weak and relies heavily on donor-funded/managed supply chain systems. In 2012/2013, PEPFAR will focus support to the public laboratory supply chain by initially supporting development of an essential list of laboratory commodities for the country. Eventually, HIV/AIDS laboratory supplies and reagents will be transitioned from the PEPFAR - warehousing and distribution mechanisms to those of GOK. Strengthening the public supply chain will explicitly contribute to Objective Number 6 of the Partnership Framework: GOK health commodity projection, procurement, warehousing and distribution systems each increased from mutually agreed baselines and in a manner that builds on Millennium Challenge Corporation Threshold Program.

PEPFAR will also support improvement of laboratory systems to advance overall diagnostic capacity for other diseases beyond HIV/AIDS. PEPFAR supported infrastructure improvements and procurement of common lab equipment, testing techniques, and human resource strengthening will improve access to quality basic laboratory services for all patients.
Additionally, PEPFAR will support revision and implementation of laboratory national policy and strategic plan guided by the respective heads of lab services in the Ministry of Medical Services and Ministry of Public Health and Sanitation and the laboratory interagency coordination committee.

Health Efficiency and Financing:
Kenya has inadequate financial resources to meet the substantial requirements of the health system. Out-of-pocket expenditures account for 25% of financing for health care, with little evidence that such spending offers value for money. The high cost of healthcare remains a major barrier to access, especially for the poor who spend a larger share of their household income to meet their healthcare needs. Risk-pooling through health insurance contributes a small share (11%) of health expenditures. Weak financial management systems and capacity contribute to inefficiencies in the allocation and use of resources as well as inequitable distribution across the country. Current sector planning (Annual Operational Plan-AOP) and technical planning processes are not well aligned, and as a result, resource needs identified in the AOP do not inform budget allocation to the MOH through the medium term expenditure framework, MTEF) process.

Although the national HIV/AIDS response has seen major increases in funding over the last decade, most has come from development partners (87%) in the form of off-budget support, with government contributing 13%. As donor funding is not expected to increase in the coming years, though actual needs are projected to rise, the GOK, with assistance from PEPFAR and other development partners, is exploring alternative ways to finance HIV/AIDS through mobilization of domestic resources such as increasing government allocation to the health sector, increase enrollment in the National Hospital Insurance Fund (NHIF) and creation of an HIV Fund. Several donor-supported initiatives are underway including performance-based financing and output-based aid that link funding to achievement of results, as well as directly funding health facilities through the (Health Sector Services Fund (HSSF) and , Hospital Management Services Fund (HMSF). Currently, the GOK is developing an overarching health financing strategy that will help guarantee universal access to quality health care in line with the devolution framework and reform agenda.

For this relatively new area of PEPFAR investment in Kenya, USG will assist GOK to develop health financing strategies to reduce financial barriers to accessing HIV and other essential health services, ensure more efficient and equitable allocation and use of available resources, and promote increased public and private spending for health. Key priorities include: support to relevant devolution policies and planning processes under the new constitution; assessments of performance-based financing pilots and other innovative financing approaches to identify successful models for expansion; support for cost studies on HIV/AIDS program effectiveness, efficiency and integration of services; support for public/private partnerships; continued support to strengthen institutional capacity for undertaking National Health Accounts (NHA), including analysis of sub-account for HIV/AIDS; and support to elaborate and implement the national Health Financing Strategy. USG will work to leverage funding from other donors supporting health financing, including GIZ, World Bank, DFID, DANIDA and others, to maximize impact of PEPFAR-funded activities.

The above actions will contribute to sustainability by building capacity and skills within government to better plan

and manage its health resources, including those for HIV/AIDS. Successful implementation of the health care financing reforms envisioned by the new constitution and other policy documents will in the long term impact on all aspects of the health delivery system and will contribute to improved access to quality services and reduced out-of-pocket payments. This will achieve significant impact especially for the poor and most vulnerable groups, and promote efficiency gains and increased effectiveness through the governments' use of health resources.

Supply Chain and Logistics:
PEPFAR support in the area of supply chain and logistics include supply chain system strengthening targeted at the national supply chain organization, Kenya Medical Supplies Agency (KEMSA) following the Millennium Challenge Corporation's support that ended in 2009. As KEMSA strengthens, PEPFAR has maintained its own supply chains to ensure continued commodity support to the HIV/AIDS program. PEPFAR has also built capacity of the priority programs of the MOH (including the Division of Malaria Control (DOMC), Division of Reproductive Health (DRH), National AIDS and STI Control Program (NASCOP), and Division of Leprosy, Tuberculosis and Lung Disease (DLTLD) to undertake supply chain related forecasting and quantification of health commodities. In 2010, Kenya received global recognition through the World Health Organization for putting in place an elaborate, internationally acceptable pharmacovigilance system to monitor quality of medicines at various service delivery levels for patient safety with PEPFAR support to the Pharmacy and Poisons Board. Medicines and Therapeutic Committee at the national level has been strengthened to support regular reviews of the Kenya Essential Drug List. Kenya has in place the Kenya National Pharmaceutical Policy (2009) and the National Laboratory Services Strategic Plan (2006-2011) supported through PEPFAR funds. Donor coordination and leveraging of other donor inputs for supply chain strengthening activities continues at different levels under PEPFAR support. Through PEPFAR funding, supply chain data is collected and analyzed to improve its availability and use in the decision making process for the HIV/AIDS program. Donor coordination continues to occur at various levels (e.g., coordination in strengthening KEMSA by USG, World Bank and DANIDA).

Despite these successes, gaps still exist particularly with regard to the development of strategic plans specific to the supply chain management of health commodities for use in the health sector including non-pharmaceuticals. The Procurement and Supply Chain ICC has been inactive since 2010, thus coordination between partners in both private and public sector, together with GOK has been compromised. Regulatory framework for quality assurance of health commodities still presents a major weakness mainly from the supply end which allows for a number of unregistered products to circulate within the market. Strengthening of KEMSA by USG supported efforts has been heightened within the last few months and will need to be scaled up consistently until KEMSA is self-sufficient. However a phased-out approach in utilizing KEMSA to manage USG commodities will be required to mitigate eventual risks. Health facilities at the periphery have very weak commodity management systems which are not focused on quality and efficiency. Tracking systems are not well developed to assure accountability for each unit of health commodity. The Supply chain workforce is insufficient both in numbers and skills. Stores for health commodities present a major infrastructural gap across all levels of healthcare in Kenya particularly for non-pharmaceuticals.

Priority activities include completion of the draft Health Policy Framework in line with the new constitution as transitional structures are set up for Medical Products and Technologies. Development of a revised strategic plan for laboratory services incorporating laboratory commodities supply chain is essential, as well as a strategic plan to implement the Kenya National Pharmaceutical Policy (KNPP). Support for the strengthening of procurement and supply chain inter-agency coordination committee (PSC-ICC) and Laboratory ICC, and eventual development of one national supply chain strategic plan for health commodities will be supported. Focused strengthening of KEMSA in key functional areas (e.g., governance and legal mandate, inventory management tracking and accountability, warehousing, distribution and organizational performance management) will be undertaken in the next two years after which direct support will be considered. In the first year of COP2012, PEPFAR procured HIV/AIDS test kits will be warehoused and distributed through KEMSA followed by other laboratory supplies the following year. Procurement will be moved to KEMSA from USG's parallel systems upon assessment of KEMSA's capacity to manage it effectively, efficiently and transparently. Targeted strengthening of peripheral health facilities' commodity management systems including record keeping, data use, forecasting and quantification will be

supported. Systems for assuring medicine quality and tracking commodities for accountability will also be strengthened. Replication of national commodity security committees and medicine therapeutic committees at regional level are short-term priorities to fast track improvements in the supply chain area at the regional level in a devolved system of governance. Infrastructural improvements for commodities stores at both health facilities and district stores is needed as a matter of priority to enhance tracking and accountability and minimize stock outs through improved commodity management. Strengthening competencies of the supply chain workforce and employing a deliberate capacity building approach will ensure an adequately trained supply chain workforce within MOH.

Strengthening KEMSA will facilitate the integrated national supply chain organization to effectively undertake procurement and distribution of all commodities including HIV/AIDS commodities currently managed under parallel programs, thus aligning it to respond adequately to the needs on the ground. Focusing on periphery level support (health facility, district, county, and provincial levels) will enhance sustainability through strengthening the entire supply chain as a whole and not in the procurement and distribution system only. Over time, supporting policy development and implementation in line with the new constitution and the health sector coordination framework at the national and county levels will ensure sustainability through transitional structures. Infrastructural support will ensure optimal storage of health commodities, minimize loss through poor stores management, and enhance institutionalization of systems for sustainability.

Gender:
GOK data estimates that women comprise approximately 47% of the total government workforce; however they dominate traditionally "female" careers of nursing, while only 33% are doctors. Women also make up only 27% of public health officers/- technicians. A growing number of PEPFAR-supported implementing partners have gender advisors on staff in response to the need for attention to this area. The GOK recognizes that social, educational, legal, and economic barriers affect access to and use of HIV services for men and women in Kenya, and the usage of these services frequently does not match the burden of disease. Mainstreaming policies as well as a Gender policy are articulated through the Ministry of Gender, Children & Social Development. The Kenya PEPFAR Team has an interagency Gender Working Group that drives the gender agenda for the PEPFAR program.

The Kenya National Human Rights and Equality Commission (National Commission on Gender and Development, The Ministry of Gender, Children and Social Development) is collaborating with the Ministry of Health to provide training on gender mainstreaming which includes sexual gender-based violence as a key issue. Additionally, as part of the gender strategic planning process, gender-related program indicators are in the process of being developed to provide more comprehensive measures of gender equity in activities and services. Targets will be set and performance assessments against these targets will be used to inform and adapt current programming. Priority activities focus on establishing and/or increasing gender equity in HIV/AIDS activities and services, reducing violence and coercion, addressing male norms and behaviors including increased engagement of men in PMTCT, counseling and testing, and care and treatment services. The Partnership for an HIV-Free Generation, a public-private initiative focused on youth ages 10-24, offers a unique opportunity to mainstream gender norms on a broad scale focused on youth. The program includes targeted interventions to both boys and girls, examining traditional gender roles and promoting positive and healthy lifestyles.

The new Constitution provides an opportunity to promote gender responsive reforms and affirmative action for women in public offices. These reforms would radically reduce discrimination and increase participation of women in Kenyan society. Collaboration with the Government of Kenya will continue to ensure implementation and policy training on the Sexual Offences Act. PEPFAR partners also address community concerns through training on legal rights for widows, wife inheritance, sustainable income-generating activities, and gender sensitization workshops for the media, community chiefs, and elders.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	10,566,451	0
Total Technical Area Planned Funding:	**10,566,451**	**0**

Summary:
(No data provided.)

Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
CIRC	12,405,190	0
HMBL	5,693,072	0
HMIN	3,271,338	0
HVAB	4,732,027	0
HVCT	20,024,680	0
HVOP	16,069,804	0
IDUP	3,993,979	0
MTCT	25,912,303	0
Total Technical Area Planned Funding:	**92,102,393**	**0**

Summary:
Overview: The PEPFAR Kenya program continues to intensify HIV prevention activities by increasing coverage of the minimum packages of services for all target populations. Key initiatives include improving quality and enhancing program efficacy through a combination of behavioral, bio-medical and structural interventions. Target populations include: discordant couples, youth 10-24 years, males 30-44 years, women attending maternal newborn child health (MNCH) clinics, people with STIs, people living with HIV (PLHIV), widows, and most-at-risk populations (MARPs). PEPFAR supports the development and implementation of national policies, guidelines, and packaged evidence-informed behavioral interventions (EBI). PEPFAR also provides support to health system strengthening, human resources, facilities renovations, commodity/equipment support and referral system linkages. The PEPFAR Team participates in the national multi-sectoral technical working group (TWG) led by the Ministries of Health (MOH) comprising all government and partner stakeholders, which provides leadership in the scale up of combination prevention interventions, including Positive Health and Dignity Prevention (PHDP), EBI, and MARPs size estimation and mapping. Biomedical interventions include: blood and injection safety, Voluntary Medical Male Circumcision (VMMC), HIV Testing and Counseling (HTC) and prevention of mother-to-child transmission (PMTCT). Behavioral/sexual transmission interventions include: abstinence and be faithful (AB) programs, condoms and other prevention activities, and MARPs activities. MARPs and other drivers of the epidemic (multiple partners, uncircumcised males, and low condom use) will be key areas of focus in 2012.

PEPFAR Kenya's prevention efforts are aligned with Government of Kenya's (GOK) Kenya National AIDS Strategic Plan (KNASP) III. For COP 2012 planning, the prevention team has used data from recent surveys, known

level of coverage and disease burden estimates in various regions/provinces to determine the level of effort that needs to be directed in each region, ensuring minimal overlap and duplication of efforts in prevention scale up. Due to this evidence and the drivers of the epidemic in Kenya, the focus on Other Prevention (OP) activities and resulting budget is much larger than the AB program area. Behavioral interventions are led by the EBI TWG and uses a four-pronged approach: 1) systematic assessment of interventions currently in use to determine if they are EBIs; 2) identification of local EBIs with demonstrated efficacy for scale up; 3) adaptation of EBIs developed in other countries for implementation within Kenya and repackaging for scale-up; and 4) operational research to improve EBIs. In the last year, PEPFAR Kenya's key achievements include: over 184,000 males circumcised; 7.4 million people tested for HIV; 1.27 million women received PMTCT services; key national guidelines developed for MARPs and PHDP; bio-behavioral surveillance conducted for MARPs; and, adopted and scaled up EBI approaches.

PMTCT: In Kenya approximately 96,300 babies are exposed to HIV annually and without PMTCT interventions, an estimated 27% will acquire HIV through vertical transmission. The University of Nairobi PMTCT Impact Evaluation in 2010 showed a 7.8% transmission rate nationally with regional variations between 3% and 15%. Currently, 4,500 of 6,000 health facilities (~75%) offer a minimum package of PMTCT services. An estimated 92% of pregnant women attended antenatal care (ANC) at least once. A total of 1,189,050 (79%) mothers received counseling and testing (CT) as of the 2011 annual program results (APR). In ANC out of 60,259 women diagnosed as HIV+, 93% of women and 75% of infants received antiretroviral (ARV) prophylaxis. In 2010, 55,604 (55%) of exposed infants were reached through polymerase chain reaction (PCR) testing. PEPFAR supported the MOH to adopt and implement PMTCT Option A through revision of guidelines and tools, development and distribution of information, education and communication (IEC) materials, trainings and supervision. Currently taking place is a further revision of guidelines to include Option B and even take this a step further to uninterrupted highly-active antiretroviral therapy (HAART) for all HIV+ pregnant women (Option B+) for facilities able to provide adequate monitoring services. PEPFAR will support the roll out of Option B+ using a phased approach by systematically strengthening the monitoring systems required as well as procuring the commodities.

In June 2010, the Global Expanded PMTCT/pediatric care and treatment Interagency Task Team (IATT) and PMTCT stakeholders led by GOK undertook a joint and participatory review of PMTCT and pediatric care and treatment programs in Kenya. Gaps identified included late ANC attendance with 56% home deliveries; high dropout rates for subsequent PMTCT interventions; 60% unmet need for family planning (FP); low rates of exclusive breastfeeding (EBF); low retention in care and treatment; low male involvement; low community engagement; and inefficient overlap of implementing partners (IP). Based on these gaps, the National PMTCT program developed an Elimination of MTCT (e-MTCT) implementation framework aligned to the KNASP III. In COP 2012 PEPFAR targets are to reach 1,365,000 (91%) pregnant women with HCT and 86,000 HIV-infected pregnant mothers with prophylaxis. Laboratory services will be expanded to reach 80% of HIV-infected pregnant women with baseline laboratory tests at diagnosis; 65,000 (81%) HIV-exposed babies with both infant prophylaxis and PCR testing; and all HIV-infected children <24 months of age initiated on ART. PMTCT will scale-up and decentralize services to 5,000 (83%) of 6,000 sites, train 2,000 service providers and 2,000 pre-service candidates and reach 390,000 (30%) male partners with HCT services. HIV positive women will receive a comprehensive package of reproductive health care services including cervical cancer screening. PEPFAR will continue to support the PMTCT communication strategy ("Kata shauri" campaign) that seeks to increase awareness and information on PMTCT so as to increase behavior change in the country. PEPFAR will also support implementation of the national e-MTCT framework focusing on health system strengthening (HSS), community systems strengthening, and effective partnerships. PEPFAR projects will strengthen MNCH services, setting up a Center of Excellence for MNCH in each county and community health systems that promote safe motherhood initiatives with male participation. These activities will contribute to the Let's Live Campaign which seeks to improve health outcomes for pregnant mothers and newborns. PEPFAR will support effective partnerships with the MOH, community, private sector and other partners in leveraging resources and linkages with other programs areas. The initiatives will also support coordination between MNCH and HIV treatment programs to enable more accurate forecasting, procurement and supply management. In FY2012-13, targets will be allocated to implementing partners based on expected pregnancies, minimum package of care, performance of implementing partners, geographic locations

including new priorities and level of infrastructure development. On average it costs $18.50 to reach a mother-child pair with ANC services including PMTCT. The remaining funds will be used to support central commodity procurements, the MOH, and partners who contribute indirectly to achievement of quality indicators such as supervision, development of policy and curricula guidelines, documentation tools, IEC materials and participating laboratories for EID. Program success will be measured by impact indicators such as reduced rates of vertical transmission at the different time points (6 weeks, 12 and 18 months).

HTC: PEPFAR supports the KNASP III expansion of HTC services with the objective of 80% of individuals 15-64 years knowing their HIV status by 2013. HTC services have expanded in scope and approach and include over 3,000 sites and incorporation of services into health care facilities. Key strategies used in HTC service delivery are client and partner initiated testing and counseling (CITC and PITC, respectively) delivered in health care facilities and community settings, such as stand-alone VCT, home-based testing and counseling (HBTC), and outreach/mobile services. The program will ensure all individuals receive education and behavior change counseling. During COP 2011, the proportion of clients who received HTC through PITC was 55.7% while 44.3% were reached using the community approach. For 2012 resource allocation is based on regional variation in population density, HIV prevalence and testing gaps which calculates a lower cost per target for PITC and higher cost for community services. Hard-to-reach areas of the country are also given a slightly higher cost per target. PEPFAR will support HTC services with an emphasis of identifying HIV infected individuals who are unaware of their HIV status and couples in sero-discordant relationships whereby a positive test is a critical point of action for effective referral to care. Data from national surveys reveal low knowledge of HIV status among couples, MARPs and men in rural areas; these groups will be a priority for HTC. PITC or HTC in health care settings, a low-cost model, will be promoted to cover all inpatient populations and at least 50% of clients in the outpatient department. HBTC and outreach services will be provided in regions of high HIV prevalence with poor access to services. HTC and care and treatment programs will implement models that provide information on linkages to treatment and care that is identifiable and measurable. Use of unique identifiers to track clients from HTC to HIV service delivery points is under discussion at the MOH. Currently Kenya's community strategy is being rolled-out by the MOH. It will strengthen referrals and establish mechanisms to ensure HIV infected individuals and their families access care and support services. Furthermore, it will ensure that HIV-negative individuals are referred for prevention services. Enhanced communication between the HTC sites and other service delivery points will enhance referrals and retention.

Condoms: The goal of condom programming is to ensure every sexually active person has access to quality condoms and is motivated to use them consistently and correctly. GOK leads this effort through a condom TWG with members from MOH and other national groups, implementing partners, and donor agencies which provide male and female condoms. The GOK funds condom procurement supported through a World Bank loan to UNFPA, and DFID procures the socially marketed condoms. Condom supply and distribution has been fairly smooth over the years with the exception of early 2011 when there were stock-outs due to delays in the clearing process by the Kenya National Bureau of Standards; USG procured condoms as an emergency response. Warehousing and distribution of condoms is supported by GOK through the Kenya Medical Supplies Agency (KEMSA) and the USG. USG supports the training of health care workers, distribution, social marketing, social-behavior change and condom promotion and emergency procurement, quantification and forecasting. Male condoms are distributed nationally through the KEMSA regional depots, health facilities and community outlets. The socially marketed condom Trust is available in retail outlets, bars and lodges. Approximately 3 million female condoms are procured annually for distribution to MARPs through CBOs and peer drop-in centers. This number is expected to increase to 6 million in FY13, through partner and GOK funding. Current GOK forecasts indicate that Kenya will have funding to cover condom needs until the end of 2012. The Condom TWG is working closely with GOK and donors to secure funding for condom coverage 2013, but as this is still undetermined, GOK has requested that PEPFAR consider a condom contingency fund to mitigate the imminent condom stock out in 2013. This is included in COP12.

VMMC: Since the release of guidance by WHO/UNAIDS in 2007, the GOK adopted VMMC as a key HIV prevention intervention. A national VMMC Task Force was set up in 2008 and has developed policy guidance, a clinical manual, a strategy, and communication and M&E strategies. Four provinces contribute nearly 95% of the VMMC

need in Kenya: four counties in Nyanza province (14.9% HIV prevalence; MC prevalence 17.5%); Nairobi (9.2%; 80%); Turkana county in Rift Valley (6.2%; 16%); and Busia county in Western province (5.7%; 10%). The Kenya VMMC strategy estimates that in 2008, the number of uncircumcised men aged 15-64 in the key priority regions was 1.2 million with approximately 50% residing in Nyanza. The 2009-2013 national target is 860,000 men circumcised, with 300,000 of those men having been circumcised as of December, 2011. PEPFAR's target is to reach 285,000 in COP12 as part of contributing to the 5 year National target. Current efficiencies, such as the forceps-guided method, task shifting/sharing, use of diathermy, outreach, and mobile and moonlight approaches will continue to be promoted to address gaps.
PEPFAR will continue to support the GOK-led VMMC program in the priority regions. VMMC services will be available in MOH facilities, as well as in FBO health centers and other outreach/mobile/moonlight sites. Support includes renovations of theatres, procurement of VMMC surgical equipment and supplies, and capacity building of MOH facility staff. VMMC includes BCC, HTC, STI screening, and referral linkages to relevant health services. Eligible men will be referred to VMMC sites, while linkages to care and treatment services for all HIV infected individuals. Demand creation and awareness-raising will continue employing targeted approaches, which include Interpersonal communication by satisfied MC clients, media (radio and TV) and road shows. This campaign is age and gender-sensitive and acknowledges the major role women play in VMMC.
PHDP: Approximately 1.6 million Kenyans are PLHIV and 6% of all couples are in discordant relationships (KAIS, 2007). PHDP, implemented by trained health care providers and lay counselors, includes: ART provision, adherence counseling and support; partner and family testing; provision of PEP to the discordant spouse; safe pregnancy counseling and FP; risk reduction and alcohol counseling, condoms, STI screening, EBI for discordant couples and treatment and meaningful involvement of PLHIV. Treatment as prevention initiatives may be included if approved by the MOH. PHDP has been shown to be 68% effective in preventing transmission.

Providers, using a card and scripted illustrated flipchart, address five key prevention steps at each visit: assess and address risk behaviors; assess medication adherence; identify and treat STIs; address FP needs; and provide condoms. Providers also deliver tailored prevention messages about partner testing and disclosure. Each encounter ends with helping the patient set a prevention goal and distributing condoms, handouts, and referrals if needed. Quality assurance of counseling services is achieved through training and certification of peer educators using national curricula, standard job-aids and guidelines and regular supervision. In 2012/2013 IPs will work with national TWGs to support integration of HIV prevention into care and treatment programs linking them to HIV community programs. PLHIV will be linked to STI and FP services with patient escorts. Monitoring of PHDP is done through the review/input of IP's implementation plan, quarterly reviews, and semiannual and annual reports. Evaluation of services will be conducted through operation research of combination HIV prevention and periodic surveys. National guidelines for PHDP in Clinical and Community settings have been developed including a monitoring and evaluation framework. National job aids and IEC materials have been developed and are in use by all health facilities and IP and implementation is ongoing.

MARPs: Recent MARPs bio-behavioral surveillance study estimates HIV prevalence of MARPs as: female sex workers (FSW) 29.3%; Fisher folk 26.4%; injection drug users (IDU) 18.3%; and men who have sex with men (MSM) 18.2%. Population size estimates and program evaluations will be conducted in the coming years. The Kenya national guideline defining a package of services for sex workers is being revised to include other MARPs. A draft addiction treatment protocol for persons who use or inject drugs (PWID/PWUD), National Standards for Peer Education for MARPs, and a training curriculum for health care providers on MARPs are also in development. MARPs programs provide the comprehensive combination prevention services per national guidelines and activities include STI surveillance for drug resistance with a proposed updating of the national protocol for STI management; promotion and distribution of condoms and lubricant; access to FP/RH services; referrals to other services; community outreach services; HTC; access to ART, care and support; services; impact evaluation of adherence and retention; and treatment as prevention once approved. Additional services for IDUs include screening for hepatitis and TB, and in collaboration with GOK and other partners the provision of medicated therapy and needle and syringe exchange programs. The GOK, in conjunction with the U.S.-based IDU TWG and other stakeholders, will carry out a Heroin Shortage Crisis Assessment in March 2012, which will assess the ramifications of the countrywide shortage of heroin supply in December 2010. The assessment will provide recommendations on

developing appropriate IDU interventions to mitigate any recurrences of the negative effects of this shortage on the health system and the well-being of the IDUs themselves. There is strong GOK leadership in sensitizing law enforcement and health providers to provide a supportive environment for the right to health care by all populations. Structural interventions still require more focused linkages, to ensure that there is a standardized understanding to ensure services for the most-at-risk populations. Funding will not be used to procure needle and syringe commodities.

General Population/Youth: Small group and individual level EBIs are supported for the General and Youth Populations in both community and clinic settings. These focus on partner testing, discordant couples, risk reduction, condom use, disclosure, adherence, STI reduction, and family planning. Quality assurance of all EBIs is promoted through rigorous training and certification of facilitators, support supervision, and site visits. Monitoring and evaluation is done through partner reporting, Kenya HIV/AIDS program monitoring system (KePMS) data analysis, EBI TWG assessments, stakeholder meetings, national surveys and project evaluations.

The Kenya Institute of Education (KIE) project has a standard school-based life skills curriculum that covers students of all ages. Sexuality and HIV education has been well integrated in all subject areas. PEPFAR will support the MOH through the National EBI TWG to collaborate with KIE to assess the life skills curriculum to ensure it contains elements found in effective HIV prevention programs. A skills-based pre-service teacher training relevant to HIV/AIDS has been developed and will continue to provide support for teacher trainees on integrating HIV/AIDS into teaching." This program will also support establishment of youth-friendly centers in Teacher Training Colleges. PEPFAR support for the in-school youth program by the Catholic Church in 1,679 schools will be continued in 2012/2013.

HSS/HRH: PEPFAR has funded several capacity building umbrella organizations to strengthen NGO, CBO and FBOs in the following areas: leadership and governance for sustainability; capacity to deliver evidence-based continuum of HIV/AIDS prevention and care and treatment services; and efficient grants management for implementation of HIV/AIDS prevention, care and treatment activities.

Medical Transmission (MT): PEPFAR supports the MOH in guideline policy development for blood and injection safety, universal precautions and waste management. PEPFAR supports logistics, service delivery and QA. MT cuts across HIV prevention, care and treatment services. The current policy for blood safety outlines rational use of blood and blood products, proper donor selection and sets standards of quality. It links infected donors to care and treatment and refers uninfected to prevention. General precautions and waste management guidelines and standard operating procedures (SOP) will be put in place in 2012/2013. In- and pre –service training will be conducted for health care workers, especially for PEP. Blood safety QA will be undertaken using the approved WHO/CDC SOP and providing appropriate supplies and equipment. PEPFAR will continue support for the laboratory accreditation program. PEPFAR ensures sustainability of the blood safety program by integrating its procurement system with the MOH and supporting cost recovery initiatives. For injection safety, sustainability is achieved through pre-service training.

Gender: PEPFAR will continue to support and expand its initiatives to reduce HIV/STI risks, improve access to health services, increase economic empowerment, and reduce gender-based violence (GBV). GBV prevention activities are a key focus for Kenya as presidential elections will be held in late 2012, and there is great momentum in the country to work to avoid a repeat of the widespread 2007 post-election violence. Additionally, the Kenya Violence Against Children Study has recently been completed, and the preliminary data indicates a shockingly high rate of physical and sexual violence against children and adolescents. GBV activities include education and communication skills building, training of community health workers and other community providers, counseling, post-rape care services, policy analysis, and legal and child protection services. PEPFAR will support the MOH and Ministry of Gender to define a GBV prevention package that can be integrated into EBIs, clinical interventions and life skills curricula. These efforts will address cross-generational and transactional sex, PEP, girls' empowerment and include interventions with men to reduce violence and increase income-generating activities. PEPFAR will expand to a national level the "Sita Kimya" (Kiswahili for "Speak Out") GBV

communication/advocacy campaign, which addresses male norms, violence reduction, women's empowerment and awareness of GBV and will support regional communication campaigns in all eight provinces. In FY13PEPFAR will support the MOH to establish five decentralized GBV recovery centers to provide comprehensive post-rape services, including legal, psychological, and medical support; in FY14 3 additional centers will be supported. PEPFAR will also support the GOK to promote awareness, understanding and enforcement of the Sexual Offences Act of 2006 and work toward increased property and inheritance rights for women.

Strategic Information (SI): The USG SI team will continue to strengthen the information base of prevention activities through an integrated approach which includes surveillance and surveys, monitoring and evaluation (M&E) and health information systems for program management. Key challenges include lack of standardized data collection tools for prevention programs such as MARPs and EBIs, and lack of data elements in existing facility level Regional Health Information System tools supportive of NGI indicators for PMTCT and HTC programs. PEPFAR will continue to support the MOH through the EBI TWG to adapt and standardize national level EBI M&E tools for integration into the national systems. To inform and evaluate national GBV prevention and interventions, PEPFAR will support the Ministry of Gender to build capacity to use data for decision making, advocacy and policy formulation. PEPFAR will continue to support efforts towards improved data quality and use, institutional capacity building and surveillance of fisherfolk in Nyanza to inform planning of services. Information from KAIS II data, when available, will inform national prevention planning and implementation.

Capacity Building (CB): CB supports the development of strategic national HIV prevention investments which will enhance HSS, sustainability and efficiency. CB components include collaboration with the GOK in support of national and regional HIV prevention trainings; strengthening national partners; development of national assessment tools and roll out of EBIs; development of guidelines and policies; establishment of comprehensive packages for specific populations; and collective supportive supervision to partners. These initiatives are fully aligned with GOK strategies and priorities and other stakeholders to avoid duplication of activities. Capacity Building will result in improved service delivery, reduced HIV incidence, strengthened systems, and better geographical coverage. Monitoring and evaluation activities will include establishment of SOPs, comprehensive program monitoring, use of formative assessment to improve design, implementation, revision, messaging, focus, and relevance of interventions, and impact evaluation. The GOK will continue to lead and manage resources and programs by supporting a coordinated and sustainable national response.

Technical Area: Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXD	5,935,585	0
HTXS	73,774,826	0
PDTX	9,156,589	0
Total Technical Area Planned Funding:	**88,867,000**	**0**

Summary:

Adult Treatment:

Over the last seven years Kenya has made tremendous progress in the provision of HIV care and antiretroviral therapy (ART) services. Sustained scale-up has ensured provision of care services to an estimated 1 million people living with HIV, and ART to 493,865 individuals by September 2011. Each month, an estimated 8,500 HIV-infected people initiate ART. Over 1,000 health facilities (including all national, provincial, and district hospitals, most health centers and some dispensaries) offer care and ART services.

This successful and massive expansion of care and treatment is attributed to funding and scale-up primarily through the President's Emergency Plan for AIDS Relief (PEPFAR), the Government of Kenya (GOK), Clinton Health Access Initiative (CHAI) and Global Fund (GF) support. By September 2011, PEPFAR supported provision of ART services to over 90% of the patients through the purchase of opportunistic infection drugs (OI drugs), laboratory reagents etc as well as other health system strengthening activities. With regards to ARV drugs, PEPFAR was supporting ARVs for 65% of patients; while the GOK and GF supported 25% of patients; CHAI 9%; and Medecins Sans Frontiers (MSF) 1% of patients. Despite the scale-up, the GOK funding allocation for ARV procurement and other commodities remains low. In FY 2011/12, GOK allocated approximately $10 million for ARVs to cover 10% of patients on generic first-line regimens; however, given the current rate of scale-up, the GOK will have to significantly increase its allocation for ARV provision (Note: the GOK has established a high level sustainability committee to address the funding of ARVs after the loss of GF round 9). To align PEPFAR II with the 2009-2012 Kenyan National Strategic Plan (KNASP III) HIV activities, the USG and GOK developed a Partnership Framework (PF) that outlines the roles of the GOK and USG with respect to the implementation of HIV services which demonstrates a joint commitment from both governments and promotes sustainability. With regards to ARV drugs, the GOK has increased its allocation over time by more than 10% from the previous year's allocation. In FY12 and 13, PEPFAR activities are being formulated within the context of the KNASP III and the PFIP. The USG will continue to collaborate and hold joint review meetings with the GOK and other partners to ensure continued joint commitment towards achieving these goals.

The National AIDS and STD Control Program (NASCOP) coordinates all ART activities and oversees development and implementation of ART policies, guidelines, and HIV training curriculums. A national care and ART taskforce, chaired by NASCOP, whose membership includes USG, WHO, UNAIDS, MSF and other donors, meets quarterly to deliberate on emerging care and ART issues and emerging science. NASCOP has established technical teams at regional levels to plan, manage, mentor, and supervise implementation of HIV services. PEPFAR funds will continue to support capacity building at national and regional levels for effective and efficient HIV program leadership, coordination and oversight.

In 2010, the Kenya ART guidelines were revised to raise the CD4 cut off for adult and adolescent ART initiation to 350 CD4 cells/mm3 or WHO stage III or IV, recommended the provision of ART to all HIV-infected TB patients, incorporated safer and more efficacious first-line antiretroviral (ARV) regimens, revised second-line regimens and the provision of third-line ARV options for patients who fail second line treatment.
Recent scientific evidence documenting the power of HIV treatment as a prevention tool to reduce new HIV infections from the HPTN052 done in Kenya, showed that HIV treatment reduces new infections by more than 96%. These dramatic findings are further supported by modeling data from Kenya presented to the PEPFAR Scientific Advisory Board documenting the power of expanding access to HIV treatment as a practical way to end the AIDS epidemic. The data modeling demonstrated that extending HIV treatment to an additional 323,000 Kenyans by 2015 (with the majority being reached in 2012) above the current pace could reduce new HIV infections by 31% in 2015, while actually reducing overall costs by as much as 33% over five years. The Government of Kenya has taken a more conservative approach, borne in large part out of concerns about long term sustainability of the costs of such a rapid scale-up. This has resulted in COP12 planned treatment scale-up being more in line with previous years' scale-up rates (of approximately 100,000 new patients on treatment) rather than with the more aggressive treatment as prevention modeling. The GOK has agreed that implementing treatment as prevention is important, and are looking to develop a phased approach to this, based on epidemiology, target populations (e.g., discordant couples, MARPs), and the strengths/weaknesses in the healthcare system.

The current ART guidelines (Guidelines for antiretroviral therapy in Kenya 4th Edition Pg. 33) acknowledges that treating the HIV-infected partner in a discordant relationship markedly reduces the risk of HIV transmission to the HIV-negative partner; Kenya has not yet adopted this recommendation. Discussions by GOK and other stakeholders, are ongoing towards the use of treatment as prevention among the discordant couples and MARPS in a phased approach in the next one year. Access to viral load testing to assess ART treatment failure is being expanded to all regions according to the current national guidelines, while a robust lab network for CD4 testing is

in place. Efforts will continue to decentralize ART to additional lower level facilities to improve coverage. PEPFAR funds will support these continued efforts for the expansion of ART access to ensure 537,300 Kenyans in FY12 and 618,000 in FY13 are on treatment and directly provide ARV drugs for approximately 65% of the patients.
To support sustainability efforts, over 90% of the care and treatment programs are within MOH facilities and the PEPFAR implementing partners' annual work plans are integrated into the MOH annual district operations plans. Implementing partners will continue to build the capacity of County, Provincial and District Health Management Teams to coordinate, provide mentorship and supervise the implementation of HIV services. USG partners will engage the GOK in joint supportive supervision ART site visits to improve the quality of services offered and promote program ownership by the GOK. Implementing partners will also build the capacity of local indigenous organizations and strengthen local capacity as part of the transition plan to move all services to MOH for sustainable long-term HIV patient management in Kenya. Cost-effective approaches will be adopted to ensure that the resources available are used to support a larger number of HIV patients on ART.

In 2011, a minimum package of care and ART services was developed which outlines the services that every provider should make available and every HIV+ patient should receive. These include: confirmation of HIV status; ART eligibility assessment, including WHO staging and CD4 testing; immediate ART provision for those eligible; laboratory monitoring including biannual CD4 testing and viral load testing for suspected treatment failure; cotrimoxazole (CTX) prophylaxis; psychosocial counseling; adherence counseling; nutritional assessment/supplementation; basic care package provision (including safe water vessel, mosquito nets, condoms, education materials); prevention with positives [PwP] (including support for family testing, supportive disclosure, condom provision); sexual and reproductive health services, including cervical cancer screening and treatment referral; OI (including TB) prophylaxis, diagnosis and treatment; defaulter tracing; alcohol and substance abuse support and management; and comprehensive services for family members. In addition, every patient should be linked to community programs including prevention interventions for HIV+ individuals such as education by peer educators; retention strategies through community networks; use of support groups to provide prevention, adherence and psychosocial support messaging; and economic empowerment projects. In FY12 and FY13, provision of comprehensive quality services through the minimum package will continue to be emphasized.

Providing ART to TB patients has improved considerably. In FY11, 47% of HIV infected TB patients were initiated on ART. The revised ART guidelines stipulate that ART should be provided to all HIV-infected TB patients regardless of the CD4 count. Efforts to integrate ART into TB clinics have resulted in 68% of TB clinics offering ART. As of September 2011, ART uptake for TB patients has increased to 76%. These efforts will continue in FY12 and 13 to ensure optimal access of ART for TB patients. Implementation of infection control activities, according to the national guidelines, including baseline assessments and development of infection control improvement plans and implementation are ongoing. Most TB clinics are screening HIV patients for TB using MOH developed algorithms and those with active TB receive treatment. Guidelines and tools for implementation of Isoniazid Preventive Therapy (IPT) have also been developed. Roll out of IPT use is underway. The National TB program continues to register more patients with MDRTB. To improve MDR-TB surveillance, sputum from all TB patients on retreatment will be subjected to drug sensitivity testing. This effort will be augmented by phased introduction of GeneXpert machines in selected facilities.

Appropriate support and collaboration with the maternal and child health clinics will ensure that all HIV + pregnant women receive ART for prophylaxis (Option A) or treatment (Option B) based on the national guidelines, in order to achieve virtual elimination transmission rate of <5% from the current ~8%. The new MOH guidelines (Nov 2011) recommend that all women initiated on Option B for PMTCT should continue on lifelong ART post-delivery ("Option B+"). Kenya targets to initiate at least 50% of the women eligible for prophylaxis on Option B+. Given the percentage of pregnant women who are already started on HAART for their own disease, this target will be a minimum of a 10% increase over the current number of pregnant women started on full HAART for life. There are ongoing efforts to integrate ART in MCH clinics, and ensure provision of comprehensive care and ART packages to pregnant women to improve their health and that of their unborn infants.

PEPFAR funds will continue to support provision of ART services to hard-to-reach and marginalized populations

such as refugees, prisoners, and MARPS, as well as supporting tailored services to meet the needs of youth, elderly and disabled populations. Strategies to increase male enrollment in care/ART services will include support to male peer educators, mentors and support groups, and services to support women to disclose and bring their male partners for HIV counseling, testing and ART.

According to the 2007 Kenya AIDS Indicator Survey (KAIS), among HIV-infected people who knew their status, 81% of those eligible for ART were on ART. In 2010, increased emphasis was placed on identifying HIV-infected persons early. PEPFAR-supported care and ART partners incorporated provider-initiated HIV testing and counseling (PITC) into clinical services. In addition, home-based counseling and testing (HBCT) have linked 50-70% of HIV-infected individuals identified to care and treatment facilities. Strategies employing peer educators and community health workers are ongoing in order to improve linkages. In FY12 and 13, all implementing partners will continue to leverage care and ART funds to support PITC in clinical facilities. Support for couple and family testing within the local facilities and community settings will continue. HIV-infected persons will be linked to comprehensive care services, including ART.

Training efforts have also been intensified to improve HCW HIV skills. Adult ART training has been incorporated into the Integrated Management of Adult Illnesses curriculum for lower cadre HCW, and there are efforts towards developing an integrated training curriculum to incorporate different HIV program areas (care, ART, PMTCT, PITC, etc.) so as to provide comprehensive HCW training packages. Pre-service and in-service trainings will continue to be supported, ensuring pre-service training for 1,100 HCWs in FY12 and 900 in FY13; and in-service training for 3,340 HCWs in FY12 and 2,500 in FY13, These trainings will be through both classroom training and mentorship. A standardized curriculum has been developed and piloted.
There are ongoing efforts to improve the quality of services, quality of life and outcomes of patients on ART. In order to support implementation of quality ART services, NASCOP and implementing partners have adopted services quality assessment using Clinical Quality Indicators (CQI) and HIVQUAL. Efforts are ongoing, and will continue in FY12 and 13 to integrate these quality assessments into routinely collected data and use the results to evaluate and improve clinical outcomes. A longitudinal survey to assess HIV care and ART provision, building on a similar 2007 survey, is planned for 2012.

By September 2011, of the 444,473 current adult patients on ART, 3% were on second-line regimens, with an even smaller percentage requiring 3rd line regimen. In accordance with WHO recommendations, a Kenya national HIV drug resistance/early warning indicators (DR/EWI) Technical Working Group (TWG) was established in 2007. The TWG includes representatives from NASCOP, WHO, the Kenya Medical Research Institute (KEMRI), USG, and university members who have a diverse expertise related to ART and prevention and measurement of HIV drug resistance (HIVDR). The group has developed and already begun to implement a strategy for prevention and monitoring of HIVDR in Kenya. However, as the number of ART experienced patients increase, ARV resistance surveillance is imperative. In 2005, a threshold ANC sentinel resistance survey showed no primary resistance, a second survey is ongoing. NASCOP has piloted monitoring for early warning indicators and plans for countrywide scale-up are underway. A secondary ARV resistance surveillance protocol has been developed and is awaiting approval.

Accurate and timely data collection and reporting will continue to be supported at all levels to increase and improve reporting to the MOH and PEPFAR. At the MOH, there are ongoing efforts to integrate HIV data reporting with overall disease reporting through the Health Management Information System unit. Kenya will incorporate the new generation indicators. TB indicators have been incorporated into HIV care and ART reporting to capture active TB cases and ART uptake among HIV/TB co-infected patients. The Kenya SI PEPFAR funds will be used to support GOK to roll out the EMR system nationally. This is expected to improve the quality of data collected by our partners and also improve the time it takes to submit the reports to the national level.

The ART costing study to inform strategies that increase program efficiency is complete. The report and dissemination is expected in June 2012.This study will assess the cost of HIV care and treatment services, and inform the program on the cost-effectiveness of different service delivery models.

PEDIATRIC TREATMENT

Kenya has made great strides in ART provision for children. By September 2011, 722 health facilities in Kenya were providing pediatric HIV treatment to 49,392 children below 15 years (10% of all patients on ART), with 1,415 children initiating ART monthly. This expansion is due to collaborative efforts by NASCOP which coordinates all pediatric care and ART activities; PEPFAR which supports the MOH to implement comprehensive ART services; CHAI which procures early infant diagnosis (EID) commodities, supports specimen transport and procurement of all pediatric ARVs; WHO and UNAIDS which provide technical support to NASCOP; and GF which supports limited pediatric OI drug procurement. NASCOP chairs the National Pediatric Care and ART Taskforce, whose membership includes the USG, CHAI, WHO, UNAIDS, MSF, and other development partners. This taskforce meets regularly to deliberate on emerging pediatric care and ART issues. Based on the recently revised Kenya ART guidelines raising the threshold for ART eligibility for children to a CD4 count <20% (or CD4 count <500 cells/mm3) and < 25% for children 5-12 years and 18-59 months respectively, and all WHO stage III and IV, it is estimated that 158,000 children will require ART. PEPFAR will support scale-up efforts to increase the number of pediatrics currently on treatment to 62,702 in FY12 and 72,108 in FY13.

The FY12 and 13 priorities will maximize access to ART with increased focus on improving the quality of care and ART for HIV+ children; scaling up ART to all the eligible children; improving monitoring and follow-up; ART adherence; and retention on care and treatment.
Access to pediatric ART will continue to be supported through decentralization of services from the major hospitals to the smaller health facilities according to the national Decentralization and Mentorship Guidelines. Referral mechanisms will also be strengthened to make sure that different levels of service are accessed. The capacity and confidence of clinicians in pediatric ART sites will be strengthened through training, support supervision and mentorship.

In 2011, the MOH defined a minimum package of pediatric care and ART services that should be provided to all HIV+ children. These include: screening for exposure status; EID as per the national algorithm for exposed children or PITC for older children and for exposed children: regular follow up; appropriate infant feeding options; CTX preventive therapy; and ARV prophylaxis as per the national guideline. For both exposed and infected children the minimum package includes: regular follow up with growth and development monitoring; immunization as per the Expanded Program on Immunization (EPI) Guidelines; nutrition assessment, counseling and support/supplementation; TB screening at every clinic visit; regular presumptive de-worming; and health education and counseling to the caregiver will be required. For the HIV infected child: timely linkage and enrollment into care; immediate initiation of ART for all children < 2 years; timely ART eligibility assessment for children > 2 years, and ART initiation for those eligible; adherence counseling; CTX preventive therapy; prevention of TB with IPT; clinical and lab monitoring (6 monthly CD4, targeted viral load testing for patients with suspected treatment failure, and resistance testing where necessary); psychosocial support; provision of comprehensive care to other family members; linkages to support groups and other community programs, including programs for orphaned and vulnerable children and legal services; and defaulter tracing will be required. In FY12 and 13, PEPFAR will continue to support implementation of comprehensive services, in line with this minimum package. Ongoing efforts to implement quality services, and assess quality of programs using CQI and HIVQUAL will continue.

Kenya has been a global leader in establishing national EID networks. PEPFAR-supported dried blood spot (DBS) Polymerase Chain Reaction (PCR) testing laboratory programs, including development of standard protocols, national guidelines and testing algorithms. From 2005 to 2010, approximately 55,600 children received polymerase chain reaction (PCR) testing through MCH or HIV care sites in 1,700 EID sites, with PCR tests done in 5 regional EID laboratories. Nonetheless the EID coverage still remains low at an average of 50-60%. The major challenges have been late identification of HIV exposed infants and a long turnaround time of PCR results. Some of the strategies to address this include: decentralizing EID to all PMTCT sites in the country; strengthening of EID networks and integrating pediatric HIV into MCH which are being adopted.
Kenya has also developed and implemented national policies and guidelines including a pediatric psychosocial counseling and disclosure package. In FY12 and 13, there will be emphasis on sensitization, mentorship and

implementation of these new ART guidelines.

Due to the success of the Kenyan Pediatric HIV program, HIV infected children are surviving into adolescents and adulthood. These adolescents and young adults form a unique group with special needs. To meet their needs, the revised guidelines address adolescent treatment and care issues. NASCOP with support from the USG and other stakeholders is also developing a package of care for the HIV infected adolescents/young people covering issues related to school, adherence, disclosure, sexuality/reproductive health and stigma. Emphasis will be placed on formation of adolescent support groups and provision of adolescent friendly services. There will be continuous mentorship, supportive supervision and training of health care workers on adolescent package of services.

Approximately 6% of children on ART are on 2nd line regimen. There are ongoing efforts to support regional viral load testing capacity to improve access to viral load testing, and improve monitoring and identification of treatment failure cases. In FY12 and 13, PEPFAR will continue to support laboratory infrastructure development and commodity security to ensure that partners meet national guidelines for immunologic and virologic monitoring for HIV infected children.

Jointly with the MOH's Division of Child Health and other stakeholders, integrated pediatric HIV services will be strengthened at MCH clinics to incorporate the child survival strategies including growth monitoring, routine immunization, micronutrient support, improved infant and young child feeding, and treatment of life-threatening common childhood illnesses, e.g. malaria. This will reduce morbidity and mortality and impact all children; reduce multiple referrals at facility level; and strengthen linkage to care hence reducing loss to follow-up.

To improve maternal and pediatric follow-up after delivery, strategies to strengthen the use of the combined mother-baby booklet in MCH will be adopted. This booklet, which the mother brings with her to every clinic visit, has information including; maternal HIV status, PMTCT prophylaxis, baby ARV prophylaxis, PCR test status, CTX initiation, infant feeding option, growth monitoring, EPI data, etc. This strategy has addressed some of the challenges of identifying HIV exposed infants in clinical settings and established links between PMTCT, MCH, and ART programs. To optimize identification of HIV infected children, PITC and family testing will be strengthened both at the facility and community level.

Data management will be strengthened especially by supporting dissemination of the recently revised HIV exposed infant monitoring and evaluation data tools, training HCW on data collection, reporting and cohort analysis. Data use for decision making and policy improvement will be emphasized at both the program and national level.

PEPFAR is offering financial and technical support to NASCOP to conduct the first national pediatric ART survey - Longitudinal Survey on Pediatric HIV Care and Treatment in Kenya (LSPCTIK) - which will be completed by April 2012. The report and dissemination of results is expected by June 2012. This will provide valuable information on the implementation and outcomes of the pediatric program and will form a baseline for future surveys in Kenya.

Since the first phase of Fixed Dose Combinations (FDCs) of ARVs launch in 2009, there has been a tremendous effort to roll-out pediatric FDC's to all central sites. However, there has been slow uptake of pediatric FDC's. According to a recent data quality assessment (DQA) only 18% of facilities evaluated had minimum FDC set and 34% had at least 1 FDC in stock. Use of FDC's is expected to improve the level of adherence to ART hence improving the general outcome of treatment. PEPFAR will focus on increasing awareness to health care workers on the advantages of FDC's and ensuring availability of the FDC's in the facilities. Stavudine phase out is ongoing with only 15.4% of pediatrics currently on Stavudine based regimens, while 49.7% are on Zidovudine based and 27.6% on Abacavir based regimens.

Cross-cutting Priorities

Supply Chain:
The Kenya HIV Program has two sub-committees that are spearheaded by NASCOP: The Forecasting &

Quantification Sub-Committee that convenes at least once every year and National Commodity and Security Sub-Committee that convenes monthly. All the HIV stakeholders, including GOK, USG, CHAI, GF, JICA, WHO and MSF, are represented in these committees. The Forecasting and Quantification Sub-Committee provides product quantification for all HIV products including ARVs, rapid test kits, condoms, laboratory reagents, etc. The quantification is based on consumption data, national guidelines, disease morbidity, and availability of resources.USG offers technical assistance and supports data flow from the facilities to the National Logistics and Monitoring Unit (LMU). Generic ARVs are procured whenever available to ensure cost effectiveness to make ARVs available to more people.

The country adopted a 'stock sharing system' between the GOK and USG pipelines and information on stock status in each of the pipelines is collated and shared in the Commodity Security Sub-Committee. This is captured in the '2 Pager' summary on ARVs and laboratory reagents that is shared with all stakeholders on a monthly basis. The stock sharing system has ensured that there is both minimal wastage and works to ensure minimized stock outs. Kenya has recently completed the supply systems harmonization process that has ensured one supply chain per facility for ARVs and selected OI drugs. The country is now working towards a robust and comprehensive commodities logistics system for all the commodities (i.e., drugs, lab supplies and nutritional supplies), so that the information is collected and collated at the national level in a systematic manner. USG will actively support this process.

To promote sustainability and country ownership, the committees as stated above are GOK led. There is also an effort by all stakeholders such as USG, CHAI, WHO, World Bank and others to improve efficiencies and systems at KEMSA and LMU that are GOK owned. The plan is to transition to one government pipeline - KEMSA. To assure the quality of drugs, USG will continue to build the capacity of Pharmacy and Poisons Board and the National Quality Control Lab (NQCL) to carry out Pharmacovigilance to include: registration and quality analysis of drugs, post-marketing surveillance, reporting of ADRs and poor quality medicines.

ARV Drugs – Pediatrics:
By September 2011, Kenya had 49,392 pediatrics on treatment of which 60% rely on the USG ARV pipeline. The Forecasting and Quantification Sub-Committee is responsible for the selection and forecasting of the pediatric ARVs while working closely with the NASCOP Pediatric Technical Working Group. Since the inception of the ART program in Kenya, CHAI has been supporting the procurement of pediatric ARV drugs which are distributed through both the GOK and PEPFAR supply chains. CHAI support will come to an end in March 2012. This was taken into consideration in the GF Round 10 application; hence, GF resources will be used to fill this gap. The country is moving towards using more of the FDCs for pediatrics which are easier to administer and therefore expected to improve drug adherence.

The major challenges in procurement of Pediatric ARVs has been the limited number of FDA approved products for some of the pediatric formulations and also the limited availability of third line ARVs to treat children failing on second line regimens.

Laboratory:
Through FY 12 and 13, the PEPFAR laboratory program will continue to develop and strengthen integrated quality-assured networks of tiered laboratory services in order to provide quality diagnostic tests to meet national and PEPFAR goals for prevention, treatment, and care of HIV-infected persons and the broader health system. Key activities will include the implementation of the multi-step approach for integrated quality assurance of HIV testing. A saturation approach which commenced in FY11 with MOH Divisions of Malaria, HIV, Tuberculosis and Microbiology will be scaled-up beyond the initial 20 districts. The MOH, National Laboratory Accreditation Steering Committee will be strengthened to take ownership of laboratory accreditation and directly drive the implementation process. A minimum of 39 laboratories will be involved in the WHO Step-wise approach towards accreditation. Laboratory leadership and management training will be expanded to an additional ten facilities through the practice-based Leaders that Lead program, introduced at 13 health facilities in FY11 as part of the post Strengthening Labs Management Towards Accreditation (SLMTA) activities. Kenya will continue the centralized

purchase of equipment and commodities with special focus on strengthening laboratory supply and equipment management systems at the facility level including: forecasting, tendering process, warehousing, distribution, and inventory management. Laboratory information systems, monitoring and evaluation will be scaled-up both centrally and at the facility level. Pre-service and in-service training and retention of laboratorians and biomedical engineers will be addressed through the development of harmonized curricula, training of regional based trainers and review of MOH HR policy. Up to 1,035 laboratory workers will be trained. The Field Epidemiology and Laboratory Training Program (FELTP) will continue to be supported. The recently launched Africa Society for Laboratory Medicine (ASLM) will advocate for competitive pay, opportunities for advancement and links with professional organizations. All the PEPFAR partners will take a comprehensive approach to synergistic laboratory components to standardize best laboratory practices, provide for uniform quality assurance measures, and standardize common equipment, commodities and supportive maintenance. A national survey to determine the number of laboratories that can perform HIV related testing and measure coverage of HIV/AIDS patient laboratory monitoring will be conducted. To increase access to quality diagnostic services, the laboratory program will support MOH driven decentralization to the County level which will become the government's administrative centers. PEPFAR will also support establishment of centers of laboratory excellence to serve as laboratory networks for sample referral, specialized testing and training. Sample referral and use of point-of-care diagnostic technologies including CD4, TB, OI and viral load will be promoted as appropriate with evaluations of innovative instruments and new technologies. Laboratory infrastructure remains weak with inadequate bench space, water and electricity required to support HIV diagnostic services. This limits the ability to expand access to laboratory services. Management of laboratory commodities and the supply chain also falls behind that of pharmaceuticals.

Gender:
In Kenya according to KAIS 2007 and Kenya Demographic Health Survey (KDHS) 2009, the ratio of male to female HIV prevalence in the 15-49 years age group was 1:2 respectively. As per PEPFAR's Annual Progress Report (APR) 2011, a total of 493,865 PLHIV (49,392 less than 15 years of age and 444,473 more than 15 years of age) were on ART. Of those on ART, 35% were males, though there was no significant difference between boys and girls amongst children less than 15 years. Even though the adult access to treatment maybe in line with the distribution of PLHIV on ART, fewer men access treatment.

The MOH, in collaboration with the USG through PEPFAR's support, has ensured access and provision of treatment to both males and females through various services including Pre-ART adherence counseling, initiation of ART, treatment monitoring, PwP, psychosocial support through support groups for adults (male and female combined, male only and female only) and pediatrics (children and adolescents) through the ART program. However, fewer men access testing and counseling or other services during PMTCT visits due to various reasons including cultural barriers, clinic setup and activities. Additionally, access to Post Exposure Prophylaxis (PEP) for both males and females is suboptimal which may be attributed to low public awareness on availability of services, limited number of health care workers with knowledge and skills on use of PEP as part of post rape care, occupational exposure and non-occupational exposure, stigma amongst health care providers and general population, cultural barriers which are especially oppressive to women.

The MOH, in collaboration with PEPFAR, will continue to support PMTCT services and ensure that all pregnant women are linked to a health facility, tested and all those eligible initiated on ARVs. In addition couple counseling and testing to increase male involvement through public awareness messages and IEC materials on the importance of males to accompany their spouses to MCH clinics will be expanded. USG will also support the provision of incentives to facilitate the uptake of services for both males and females, strengthen linkages to RH/FP, infant feeding, nutritional assessment counseling; support disclosure; expand a family centered approach to care and treatment; and support male friendly MCH services in the clinic. PEPFAR will continue to support youth friendly services including health education, recreational facilities, and psychosocial support through peer education, support groups, psychosocial counseling and disclosure and ensuring that adolescents and young people are involved in planning their treatment and in decision making. Other support includes PEP services training of health care workers on post rape evaluation, care and provision of ARVs as PEP; ensuring availability and accessibility of ARVs in casualty or in accident and emergency departments of health facilities and increasing public awareness on

PEP. Pediatrics (both boys and girls) services including identification and addressing barriers to accessing treatment, comprehensive care and treatment including PEP; vulnerable children like OVCs, child headed homes and street youth, family approach to care and treatment, strengthen linkages to other services, integrated pediatric services in FP/RH, MCH, management of OIs and follow up of HIV Exposed Infants (HEIs) will be supported. Linkages to other services including gender based violence, legal support, community based programs, economic improvement programs, child protection and cervical cancer screening for women and also ensure drugs availability through proper commodity management will be supported.

Strategic Information (SI):
The Kenya USG SI team has been working closely with the GOK SI team and other partners to strengthen and improve the country's treatment surveillance, monitoring, evaluation and health information systems. The USG will continue to support one M&E system in the country. There are efforts to have a single set of data collection and reporting tools which can be used by all partners and facilities in country. These have been developed jointly by GOK in collaboration with all stakeholders.

The GOK has conducted an assessment of all the electronic medical records (EMR) systems in the country and is developing the strategy to support a wider rollout of a few selected systems. These systems will be upgraded to ensure they meet MOH standards for EMRs to enable data exchange between the systems. This is expected to unify and improve the quality of data collected and improve reporting of treatment data. One-off funding has been allocated in FY12 to support the roll out of EMR nationally to about 50% of HIV treatment sites in FY12-14. Data utilization at the facility level is minimal. GOK with stakeholders has developed a package on the use of data for decision making. Working closely with GOK, USG will support a number of surveillance and evaluations to monitor treatment outcomes in the country in FY12 and 13.These include Longitudinal Surveillance of Pediatric Care and Treatment in Kenya (LPCTIK) and Longitudinal Surveillance of Treatment in Kenya (LSTIK).

Capacity Building:
Kenya's new constitution calls for decentralization of all services from the current eight provinces to 47 counties. As a result of the new constitution, the two ministries of health are expected to merge into one MOH. The USG is working with GOK and other development partners to ensure a smooth transition. Capacity building for the new County structure is one of the MOH priorities which USG will support.

Public Private Partnerships:
Up to 40% of health care services are delivered within the faith-based facilities. PEPFAR will continue to work in collaboration with faith-based organizations to sustain and expand HIV care and treatment programs. Linkages with the private health sector, which supports 10% of service delivery, will continue to be strengthened by availing national care/treatment guidelines and direct support for treatment through one of our partners. The franchised care model will be used to expand access to comprehensive and quality HIV care and treatment, TB and malaria in the private sector, through a network of accredited providers.

In the coming year, additional PPPs will be explored in the area of laboratory network strengthening, medical waste management and specialized training.

MARPs (CSW; MSM; Truckers; Fisherfolk):
Prevention efforts continue to be at the core of Kenya's fight against the epidemic. It is critical to scale up HIV prevention service including among the most-at risk populations such as Sex Workers (SWs) and their clients, MSMs and IDUs. MARPs including men who have sex with men (MSM), sex workers, and injection drug users, have been identified as one of the key drivers of new infections in the country, accounting for about a third of all new HIV infections in Kenya. According to the Modes of Transmission study (2008), MSM and prison populations contribute 15% of new infections, SWs and their clients contribute 14%, and IDUs account for 3.8%. Given the criminalization and stigmatization of MARPs populations in Kenya, their link to the general population includes concurrent bisexual partnerships for MSM and sexual behaviour of IDUs which contribute to infection to their partners.

HIV testing and knowledge of status is a cornerstone activity - key for individuals to access other HIV services. The most recent data from the 2007 KAIS indicate that 83.6% of HIV infected adults did not know their status. In 77.9% of all sexual partnerships in the past year, respondents had no knowledge of their partner's HIV status. An estimated 80% of adults perceive themselves to have low risk of infection. Almost 6% of couples in Kenya are discordant with one partner HIV infected; however, knowledge about the potential for HIV discordance in sexual partnerships is low. About two-thirds of HIV-positive adults report currently being in a union, yet only 50% reported ever using a condom and less than 20% used a condom at last sex with a partner of unknown status or known HIV-negative status. Condom promotion and distribution programs are important to increase condom use amongst discordant couples and MARPs.

The MOH in collaboration with PEPFAR has supported provision of biomedical interventions including provision of comprehensive HIV care and treatment and PEP to CSWs, MSMs and fisherfolk by providing services in special clinics, setting up specified timing for service provision and mobile services. Some of the access barriers to services by MARPs include stigma, legal implications for CSWs and MSMs, migratory nature of MARPs, like truckers and CSWs and hours of operation (e.g., they are mostly available at night when most service provision points are not operational).
The MOH in collaboration with PEPFAR will continue to support the provision of comprehensive bio-medical interventions for MARPS through the conduct of STI surveillance for drug resistance and updating national protocol for STI management; promotion and distribution of condoms and lubricant; access to modern reproductive health services, cervical cancer screening and counseling; referrals to other appropriate services; and MARP-friendly services.

Human Resources for Health (HRH):
Kenya has over 1,000 ART facilities; however, only 30% of these facilities are serving 85% of the patients. Most of these facilities (about 75%) belong to GOK. The rapid scale-up of HIV care and treatment services has overstretched the existing health workforce in the country with staff shortages across all cadres. The GOK has employed about 5,000 Health Care Workers (HCW) in the last 2 years and PEPFAR supports over 2,000 HCW at public facilities; 800 HCW supported in PEPFAR1 have already been transitioned to GOK. Other donors and implementing partners also employ additional clinical staff and lay workers. However, despite PEPFAR and other donor efforts, Kenyan health care facilities remain understaffed by an estimated 50%. To address this deficit, various approaches have been suggested to task-shift HCW roles and responsibilities to lay care workers and the community workers such as Peer Counselors providing adherence counseling. A GOK-led health facility ART decentralization policy has been developed as well as mentorship guidelines to encourage multi-tasking and task-shifting. In addition, the necessary tools and materials for use have been printed and distribution is in progress. The national ART guidelines appreciate the role of multi-disciplinary teams in the management of PLWHA. The facilities are encouraged to form such teams for improved patient outcomes.

The USG continues to support in-service and pre-service training of HCW by working closely with tertiary institutions. USG will also continue to support professional bodies such as Kenya Medical Association (KMA), Nursing Council of Kenya, and regulatory bodies such as Pharmacy and Poisons Boards and Kenya Medical Technicians and Technologist Board (KMTTB).The HIV treatment program supports the non-clinical and public health workforce to manage the program by offering technical assistance and in some cases, in-service training.

Technical Area Summary Indicators and Targets

Future fiscal year targets are redacted.

Indicator Number	Label	2013	Justification
KE.240	KE.240 Proportion of health facilities receiving integrated supportive supervision visits in the last 3 months (documented in supervision records)	100 %	Redacted
	Number of health facilites receiving integerated supportive supervision visits in the last 3 months	25	
	Total number of health facilities	25	
KE.242	DHS 2013 planned, conducted and final report produced as scheduled	1	Redacted
KE.243	Number of HIV-related surveys and surveillance manuscript and report writing workshops facilitated	4	Redacted
KE.244	Number of workshops held to train health managers and researchers on communication for policy makers	4	Redacted

KE.245	Number of health care workers trained on leadership and managment using approved curricula	324	Redacted
KE.246	Number of Integrated HIV/MNCH, Nutrition, Immunization National Guideline/Policies/Protocols developed and disseminated	2	Redacted
KE.247	Numbre of health facilities with improved referral system (intra and inter) facility/community linkages.	100	Redacted
KE.248	Number of new students supported who graduated from pre and in-service training institutions	984	Redacted
KE.249	Number of media stories disseminated with USG support to facilitate awareness of key public health challenges	600	Redacted
KE.250	Number of TOTs trained to roll out WASH-HIV integration using developed CHW WASH-HIV toolkit	75	Redacted
KE.251	Value of loans	0	Redacted

	disbursed to HIV/AIDS affected and infected persons		
KE.252	Number of individuals reached with BCC messages	50,000	Redacted
KE.255	Number of healthcare workers who successfully completed training using the new HIV M&E curriculum and standard operation procedures	1,200	Redacted
KE.256	Number of GOK/PEPFAR Implementing partner staff who successfully completed training in M&E including PEPFAR reporting requirements	60	Redacted
KE.257	Number of fellows who graduated from the UNITID fellowship program	0	Redacted
KE.258	Number of Health Care Workers (HCW) who trained in targeted short courses	400	Redacted
KE.259	KE.259 Percent PHARMA serviced health facilities experiencing OI drugs stock out in the	5 %	Redacted

	preceding 12 months		
	Number of PHARMA serviced facilities experiencing OI drug stockout	7	
	Total Number of PHARMA serviced facilities	143	
KE.260	A functional and up-to-date Human Resources Information System (HRIS) deployed at professional associations, university hospitals or MOH premises	5	Redacted
KE.261	An upgraded, standards-based Electronic Medical Records (EMR) System installed at a health facility	300	Redacted
KE.262	Number of health workers trained on use of EMR for patient care and reporting	600	Redacted
KE.264	KE.264 Percent complete and accurate reports for all facility based programs in the health sector demonstrated through independent data	60 %	Redacted

	quality audits 12 months after DHIS deployment		
	Number of health facilities with complete and accurate reports for all facility based programs	3,600	
	Total number of health facilities	6,000	
KE.265	KE.265 Percent of health facilities experiencing lab reagent stock-outs in the preceding 12 months	5 %	Redacted
	Number of health facilties experiencing lab reagent stock-outs in the preceding 12 months	6	
	Number of health facilities supported by KEMSA/FARA project	120	
KE.266	KE.266 Percent of health facilities implementing HIVQual in Kenya (starting with District level)	50 %	Redacted
	Number of health facilities implementing HIVQual in Kenya (starting with District level)	104	

	Number of health facilities in Kenya providing HIV care and treatment	208	
KE.267	KE.267 Percent of CSO affiliates that passed USAID pre-award responsibility determination	0 %	Redacted
	Number of CSO affiliates that passed USAID pre-award responsibility determination	0	
	Number of CSOs that the project is supporting	10	
KE.268	KAIS II Field work implementation successfully completed in a timely manner	1	Redacted
KE.269	KE.269 Percent of private sector participation in providing key health services	n/a	Redacted
	Number of of private sector facilities participating in providing key health services	0	
	Total number of private sector facilities	0	
KE.272	KE.272 Percent of	0 %	Redacted

	health facilities fully implementing Unique Persons Identification		
	Number of health facilities fully implementing Unique Persons Identification	0	
	Number of health facilities	1,300	
KE.273	KE.273 Percent of EID laboratories implementing mHealth solutions in their catchment areas	23 %	Redacted
	Number of EID laboratories implementing mHealth solutions in their catchment areas	300	
	Number of EID laboratories	1,300	
KE.274	KE.274 Percent of health facilities implementing mHealth solutions for commodities management	0 %	Redacted
	Number of health facilities implementing mHealth solutions for commodities management	0	
	Number of health facilities receiving commodities	1,300	
P1.1.D	P1.1.D Percent of	n/a	Redacted

	pregnant women with known HIV status (includes women who were tested for HIV and received their results)		
	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	1,365,000	
P1.2.D	P1.2.D Number and percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery	100 %	Redacted
	Number of HIV-positive pregnant women who received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission	85,996	
	Number of HIV-positive pregnant women identified in the reporting period (including known HIV-positive at entry)	85,996	
	Life-long ART	60,197	

	(including Option B+)		
	Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)	0	
	Maternal AZT (prophylaxis component of WHO Option A during pregnancy and deliverY)	21,499	
	Single-dose nevirapine (with or without tail)	4,300	
	Newly initiated on treatment during current pregnancy (subset of life-long ART)	0	
	Already on treatment at the beginning of the current pregnancy (subset of life-long ART)	0	
	Sum of regimen type disaggregates	85,996	
	Sum of New and Current disaggregates	0	
P4.1.D	P4.1.D Number of injecting drug users (IDUs) on opioid substitution therapy	n/a	Redacted
	Number of injecting	7,000	

	drug users (IDUs) on opioid substitution therapy		
P5.1.D	Number of males circumcised as part of the minimum package of MC for HIV prevention services per national standards and in accordance with the WHO/UNAIDS/Jhpiego Manual for Male Circumcision Under Local Anesthesia	195,501	Redacted
	By Age: <1	12,000	
	By Age: 1-9	0	
	By Age: 10-14	0	
	By Age: 15-19	0	
	By Age: 20-24	0	
	By Age: 25-49	0	
	By Age: 50+	0	
	Sum of age disaggregates	12,000	
P5.2.D	Number of clients circumcised that experience (reporting back to the respective circumcising program) one or more moderate or severe AE(s) during the reporting period, according to the date of MC surgery, and	3,670	Redacted

	disaggregated by severity (moderate and/or severe), timing of AE(s), and specific AE(s)		
P6.1.D	Number of persons provided with post-exposure prophylaxis (PEP) for risk of HIV infection through occupational and/or non-occupational exposure to HIV.	29,578	Redacted
	By Exposure Type: Occupational	10,000	
	By Exposure Type: Other non-occupational	15,000	
	By Exposure Type: Rape/sexual assault victims	4,578	
P7.1.D	P7.1.D Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of 'Prevention with PLHIV (PLHIV) interventions	n/a	Redacted
	Number of People Living with HIV/AIDS reached with a minimum package of 'Prevention of People Living with HIV	616,648	

	(PLHIV) interventions		
P8.1.D	P8.1.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	2,522,650	
P8.2.D	P8.2.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	n/a	Redacted

	Number of the target population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	872,280	
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	289,740	
	By MARP Type: CSW	139,888	
	By MARP Type: IDU	19,700	
	By MARP Type: MSM	17,159	
	Other Vulnerable	112,993	

	Populations		
	Sum of MARP types	289,740	
P11.1.D	Number of individuals who received T&C services for HIV and received their test results during the past 12 months	7,810,000	Redacted
	By Age/Sex: <15 Male	322,250	
	By Age/Sex: 15+ Male	2,900,250	
	By Age/Sex: <15 Female	322,250	
	By Age/Sex: 15+ Female	4,265,250	
	By Sex: Female	4,587,500	
	By Sex: Male	3,222,500	
	By Age: <15	644,500	
	By Age: 15+	7,165,500	
	By Test Result: Negative	7,403,965	
	By Test Result: Positive	406,035	
	Sum of age/sex disaggregates	7,810,000	
	Sum of sex disaggregates	7,810,000	
	Sum of age disaggregates	7,810,000	
	Sum of test result disaggregates	7,810,000	
P12.2.D	Number of adults and children reached by an individual, small group, or	256,868	Redacted

	community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS		
	By Age: <15	212,564	
	By Age: 15-24	16,304	
	By Age: 25+	28,000	
	By Sex: Female	104,304	
	By Sex: Male	152,564	
C1.1.D	Number of adults and children provided with a minimum of one care service	1,400,000	Redacted
	By Age/Sex: <18 Male	0	
	By Age/Sex: 18+ Male	0	
	By Age/Sex: <18 Female	0	
	By Age/Sex: 18+ Female	0	
	By Sex: Female	840,000	
	By Sex: Male	560,000	
	By Age: <18	680,000	
	By Age: 18+	720,000	
	Sum of age/sex disaggregates	0	
	Sum of sex disaggregates	1,400,000	
	Sum of age disaggregates	1,400,000	
C2.4.D	C2.4.D TB/HIV: Percent of	90 %	Redacted

	HIV-positive patients who were screened for TB in HIV care or treatment setting		
	Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	900,000	
	Number of HIV-positive individuals receiving a minimum of one clinical service	1,000,000	
C2.5.D	C2.5.D TB/HIV: Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	4 %	Redacted
	Number of HIV-positive patients in HIV care who started TB treatment	40,000	
	Number of HIV-positive individuals receiving a minimum of one clinical service	1,000,000	
C2.1.D	Number of HIV-positive individuals receiving a minimum of one clinical service	1,000,000	Redacted
	By Age/Sex: <15 Male	50,000	

	By Age/Sex: 15+ Male	278,500	
	By Age/Sex: <15 Female	50,000	
	By Age/Sex: 15+ Female	521,500	
	By Sex: Female	571,500	
	By Sex: Male	328,500	
	By Age: <15	100,000	
	By Age: 15+	900,000	
	Sum of age/sex disaggregates	900,000	
	Sum of sex disaggregates	900,000	
	Sum of age disaggregates	1,000,000	
C2.2.D	C2.2.D Percent of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	95 %	Redacted
	Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	950,000	
	Number of HIV-positive individuals receiving a minimum of one clinical service	1,000,000	
C2.3.D	C2.3.D Proportion of HIV-positive clinically malnourished clients who received therapeutic or	47 %	Redacted

	supplementary food		
	Number of clinically malnourished clients who received therapeutic and/or supplementary food during the reporting period.	75,000	
	Number of clients who were nutritionally assessed and found to be clinically malnourished during the reporting period.	160,000	
	By Age: <18	0	
	By Age: 18+	0	
	Sum by age disaggregates	0	
C4.1.D	C4.1.D Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	86 %	Redacted
	Number of infants who received an HIV test within 12 months of birth during the reporting period	73,744	
	Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positive at entry)	85,995	
	By timing and type of	22,123	

	test: virological testing in the first 2 months		
	By timing and type of test: either virologically between 2 and 12 months or serology between 9 and 12 months	51,621	
C5.1.D	Number of adults and children who received food and/or nutrition services during the reporting period	250,000	Redacted
	By Age: <18	210,000	
	By Age: 18+	25,000	
	By: Pregnant Women or Lactating Women	15,000	
	Sum of age disaggregates	235,000	
T1.1.D	Number of adults and children with advanced HIV infection newly enrolled on ART	120,000	Redacted
	By Age: <1	3,000	
	By Age/Sex: <15 Male	6,270	
	By Age/Sex: 15+ Male	37,611	
	By Age/Sex: <15 Female	6,270	
	By Age/Sex: 15+ Female	69,849	
	By: Pregnant Women	51,158	
	Sum of age/sex disaggregates	120,000	
T1.2.D	Number of adults and	690,000	Redacted

	children with advanced HIV infection receiving antiretroviral therapy (ART)		
	By Age: <1	2,800	
	By Age/Sex: <15 Male	36,054	
	By Age/Sex: 15+ Male	216,262	
	By Age/Sex: <15 Female	36,054	
	By Age/Sex: 15+ Female	401,631	
	Sum of age/sex disaggregates	690,000	
T1.3.D	T1.3.D Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy	83 %	Redacted
	Number of adults and children who are still alive and on treatment at 12 months after initiating ART	100,000	
	Total number of adults and children who initiated ART in the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to	120,000	

	follow-up.		
	By Age: <15	7,900	
	By Age: 15+	92,100	
	Sum of age disaggregates	100,000	
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	300	Redacted
H1.2.D	Number of testing facilities (laboratories) that are accredited according to national or international standards	50	Redacted
H2.1.D	Number of new health care workers who graduated from a pre-service training institution or program	984	Redacted
	By Cadre: Doctors	0	
	By Cadre: Midwives	0	
	By Cadre: Nurses	152	
H2.2.D	Number of community health and para-social workers who successfully completed a pre-service training program	0	Redacted
H2.3.D	The number of health care workers who successfully completed an	9,954	Redacted

	in-service training program		
	By Type of Training: Male Circumcision	935	
	By Type of Training: Pediatric Treatment	934	

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
2866	CENTERS FOR HEALTH SOLUTIONS	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	4,726,985
2868	FHI 360	NGO	U.S. Agency for International Development	GHP-State	0
7141	FHI 360	NGO	U.S. Agency for International Development	GHP-State	0
7142	Chemonics International	Private Contractor	U.S. Agency for International Development	GHP-State	3,793,423
7305	University Research Corporation, LLC	Private Contractor	U.S. Agency for International Development	GHP-State	0
9039	American Society for Microbiology	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	350,000
9076	ICF Macro	Private Contractor	U.S. Agency for International Development	GHP-State	64,912
9079	Partnership for	Private Contractor	U.S. Agency for	GHP-State	10,000,000

	Supply Chain Management		International Development		
9092	Catholic Relief Services	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,758,233
9093	CDC Foundation	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,525,000
9097	University of Nairobi	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	0
9108	American International Health Alliance Twinning Center	NGO	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHP-State	731,500
9110	Association of Public Health Laboratories	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and	GHP-State	580,000

			Prevention		
9127	FHI 360	NGO	U.S. Agency for International Development	GHP-State	461,039
9136	International Medical Corps	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,541,402
9139	IntraHealth International, Inc	NGO	U.S. Agency for International Development	GHP-State	0
9141	Catholic Relief Services	FBO	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHP-State	0
9143	Henry M. Jackson Foundation Medical Research International, Inc.	NGO	U.S. Department of Defense	GHP-State	2,127,384
9149	Program for Appropriate Technology in Health	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	0
9150	International Medical Corps	NGO	U.S. Department of Health and Human Services/Centers	GHP-State	0

			for Disease Control and Prevention		
9171	Henry M. Jackson Foundation Medical Research International, Inc.	NGO	U.S. Department of Defense	GHP-State	17,908,202
10826	Elizabeth Glaser Pediatric AIDS Foundation	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	6,486,238
11406	U.S. Department of State	Other USG Agency	U.S. Department of State/Bureau of African Affairs	GHP-State	97,505
12054	CHF International	NGO	U.S. Agency for International Development	GHP-State	0
12082	United Nations High Commissioner for Refugees	Multi-lateral Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	631,956
12083	Liverpool VCT and Care	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,795,627
12530	Nyanza Reproductive	NGO	U.S. Department of Health and	GHP-State	1,000,000

	Health Society		Human Services/Centers for Disease Control and Prevention		
12540	University of North Carolina	University	U.S. Agency for International Development	GHP-State	3,100,000
12551	University of California at San Francisco	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	8,100,574
12555	University of Nairobi	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	3,985,723
12585	Columbia University Mailman School of Public Health	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	16,323,854
12598	International Rescue Committee	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	990,120

12605	Care International	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	4,537,159
12612	New York AIDS Institute	Other USG Agency	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHP-State	100,000
12637	Futures Group	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	2,400,000
12656	Eastern Deanery AIDS Relief Program	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	7,544,223
12658	Mkomani Society Clinic	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	3,512,972
12664	African Medical	NGO	U.S. Department	GHP-State	1,283,499

	and Research Foundation		of Health and Human Services/Centers for Disease Control and Prevention		
12970	Johns Hopkins University Bloomberg School of Public Health	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	2,030,522
12979	Population Reference Bureau	NGO	U.S. Agency for International Development	GHP-State	0
12994	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-State	361,208
13025	Impact Research and Development Organization	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	6,473,097
13028	Community Housing Foundation	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,233,429
13040	Mothers 2 Mothers	NGO	U.S. Agency for International Development	GHP-State	1,100,000

13050	Coptic Hospital	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	3,795,185
13061	MINISTRY OF PUBLIC HEALTH AND SANITATION	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	10,618,509
13072	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-State	567,137
13097	Liverpool VCT and Care	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	2,780,081
13121	University of Maryland	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,630,000
13164	Management Sciences for Health	NGO	U.S. Department of Health and Human Services/Centers for Disease	GHP-State	2,427,214

			Control and Prevention		
13179	Association of Schools of Public Health	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	721,056
13210	Global Healthcare Public Foundation	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	630,000
13287	Program for Appropriate Technology in Health	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,200,000
13302	Hope Worldwide	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,166,855
13307	Impact Research and Development Organization	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and	GHP-State	2,096,498

			Prevention		
13309	Kenya Medical Research Institute	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	7,140,966
13312	Abt Associates	Private Contractor	U.S. Agency for International Development	GHP-State	0
13340	FHI 360	NGO	U.S. Agency for International Development	GHP-State	4,181,397
13346	World Health Organization	Multi-lateral Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	642,004
13354	Kenya Episcopal Conference	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	6,320,943
13366	Christian Health Association of Kenya	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	6,997,288
13385	University of	University	U.S. Department	GHP-State	2,875,290

	Manitoba		of Health and Human Services/Centers for Disease Control and Prevention		
13399	University of Maryland	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	5,027,321
13474	Hope Worldwide	FBO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,696,363
13481	University of Nairobi	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	2,026,576
13502	University of California at San Francisco	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,600,000
13517	African Medical and Research	NGO	U.S. Department of Health and	GHP-State	1,375,000

	Foundation		Human Services/Centers for Disease Control and Prevention		
13543	Elizabeth Glaser Pediatric AIDS Foundation	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	5,121,783
13545	U.S. Peace Corps	Other USG Agency	U.S. Peace Corps	GHP-State	453,427
13546	Henry M. Jackson Foundation Medical Research International, Inc.	NGO	U.S. Department of Defense	GHP-State	1,864,414
13548	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-State	66,907
13550	National Blood Transfusion Service, Kenya	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	2,700,000
13588	Program for Appropriate Technology in Health	NGO	U.S. Agency for International Development	GHP-State	6,465,763
13636	JHPIEGO	University	U.S. Agency for International Development	GHP-State	5,740,992
13664	Pathfinder	NGO	U.S. Agency for	GHP-State	0

	International		International Development		
13701	Kenya Medical Supplies Agency	Host Country Government Agency	U.S. Agency for International Development	GHP-State	9,008,223
13719	JHPIEGO	University	U.S. Agency for International Development	GHP-State	181,972
13802	University of Nairobi	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	3,466,149
13805	University of Washington	University	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHP-State	3,278,031
13867	Abt Associates	Private Contractor	U.S. Agency for International Development	GHP-State	95,000
13868	Population Services International	NGO	U.S. Agency for International Development	GHP-State	830,538
13870	Futures Group	Private Contractor	U.S. Agency for International Development	GHP-State	52,973
13882	Children of God Relief Institute	FBO	U.S. Agency for International Development	GHP-State	814,729
13919	Clinical and Laboratory	NGO	U.S. Department of Health and	GHP-State	300,000

	Standards Institute		Human Services/Centers for Disease Control and Prevention		
13922	African Field Epidemiology Network	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,099,419
14009	TBD	TBD	Redacted	Redacted	Redacted
14012	Moi Teaching and Referral Hospital	Parastatal	U.S. Agency for International Development	GHP-State	1,957,944
14015	IntraHealth International, Inc	NGO	U.S. Agency for International Development	GHP-State	285,531
14022	African Medical and Research Foundation	NGO	U.S. Agency for International Development	GHP-State	2,156,422
14034	Equity Group Foundation	NGO	U.S. Agency for International Development	GHP-State	1,324,656
16450	Kenya Community Development Foundation	NGO	U.S. Agency for International Development	GHP-State	445,866
16643	Columbia University Mailman School of Public Health	University	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHP-State	100,000
16644	United Nations	Multi-lateral	U.S. Department	GHP-State	400,000

	Children's Fund	Agency	of Health and Human Services/Centers for Disease Control and Prevention		
16670	University of Nairobi	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,081,584
16679	TBD	TBD	Redacted	Redacted	Redacted
16682	TBD	TBD	Redacted	Redacted	Redacted
16684	TBD	TBD	Redacted	Redacted	Redacted
16687	TBD	TBD	Redacted	Redacted	Redacted
16698	TBD	TBD	Redacted	Redacted	Redacted
16699	TBD	TBD	Redacted	Redacted	Redacted
16700	United Nations Children's Fund	Multi-lateral Agency	U.S. Agency for International Development	GHP-State	500,000
16705	United Nations Office on Drug and Crime (UNODC)	Multi-lateral Agency	U.S. Agency for International Development	GHP-State	1,765,844
16709	TBD	TBD	Redacted	Redacted	Redacted
16710	Equity Group Foundation	NGO	U.S. Agency for International Development	GHP-State	0
16711	TBD	TBD	Redacted	Redacted	Redacted
16712	Housing Finance Foundation	NGO	U.S. Agency for International Development	GHP-State	1,000,000
16713	Internews	Private Contractor	U.S. Agency for	GHP-State	533,233

			International Development		
16728	TBD	TBD	Redacted	Redacted	Redacted
17190	Life Skills Promoters	NGO	U.S. Agency for International Development	GHP-State	0
17191	Reformed Church of East Africa	FBO	U.S. Agency for International Development	GHP-State	0

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 2866	**Mechanism Name: DUMISHA/TEGEMEZA**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: CENTERS FOR HEALTH SOLUTIONS	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 4,726,985	
Funding Source	**Funding Amount**
GHP-State	4,726,985

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Centre for Health Solutions (CHS) has been awarded a cooperative agreement as a follow on to the Columbia Track 1 activity in Central Province. CHS aims to build the capacity of 4 districts in Central Province to ensure sustainable universal access to high quality HIV prevention, care and treatment services, with a focus on integration within the broader health and development context through an evidence-based, cost-effective, and sustainable model of care. In line with the Kenya GHI Strategy, they will strengthen MCH services, support laboratory capacity for diagnosis of endemic conditions, and promote good governance by supporting training in governance and leadership.

Cost efficiency will be addressed through integration of services, reduction of the technical teams with increased capacity building of the MOH staff, use of existing evidence-based efficient strategies, task shifting, implementing more facility-based training and mentorship as opposed to offsite training, evaluating cost effective strategies for defaulter management, lab networking, and mobilization.

Implementation will be through joint programming with MOH staff. Key focus will be to invest in MOH systems. Training and mentorship will be facilitated by MOH staff. M&E strategy will include correct use of national tools. National commodity and lab systems will be supported by ensuring regular supplies via the central supply chain.

The transition strategy will primarily be to the MOH through progressively increased program leadership and responsibility through the District/Provincial Health Management Teams, escalating from the 3rd year.

CHS will purchase 1 vehicle to be used for transport of program officers for supportive supervision and mentorship. This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	47,269
Gender: GBV	5,000
Gender: Gender Equality	10,000
Human Resources for Health	1,418,011
Motor Vehicles: Purchased	100,000
Renovation	530,970

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	2866		
Mechanism Name:	DUMISHA/TEGEMEZA		
Prime Partner Name:	CENTERS FOR HEALTH SOLUTIONS		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	600,000	0

Narrative:

Center for Health Solutions (CHS) will support HIV care and support services in Central Province, with an estimated adult HIV prevalence of 3.4% compared to the national 7.1%. Since 2010, CHS has been supporting these activities as a local transition partner to Columbia University's International Center for AIDS Care and Treatment Programs-Kenya (ICAP) in 52 treatment sites in Central Province. In 2011, CHS won a PEPFAR award to support the Implementation of HIV Care, Prevention and Treatment Activities in 44 facilities in Central Province. As of March 2011 SAPR results, CHS had enrolled 57,267 patients into care with 29,594 active in care.

CHS will work with the Ministry of Health (MoH) at the provincial, district and health facility level, to jointly plan, coordinate, implement and ensure provision of quality HIV care and support to 22,317 current adult patients in FY12 and 26,512 patients in FY13.

CHS will offer comprehensive care and support package of services including HIV testing to partner and family members of index patient and enrolling or referring/linking those that test HIV positive to care and support; provision of Basic Care Kit (safe water vessel, multivitamins, insecticide-treated mosquito nets, condoms, chlorine for water treatment and educational materials); therapeutic nutrition (FBP) to all enrolled HIV positive patients; prevention with positives(PwP); and cervical cancer screening to all enrolled women.

CHS in collaboration with MoH will support targeted capacity building (training and mentorship) for health care workers and offer continuous medical education. CHS will identify areas with staff shortages and support recruitment of additional staff as well as support good commodities management practices to ensure uninterrupted supply of commodities.

CHS will also support ongoing community interventions for HIV infected individuals, including peer education and use of support groups to provide adherence messaging. Effective and efficient defaulter tracing and follow up will continue to be supported and strengthened to improve retention in all facilities. Referral and linkages to community based psychosocial support groups; Water, sanitation and hygiene programs; Economic empowerment -

Income generating activities (IGAs); Home Based Care services; Gender based violence support programs; vocational training; social and legal protection; and food and nutrition and/or food security programs will be implemented.

CHS will adopt strategies to ensure access and provision of friendly services to youth, elderly and disabled populations. Strategies to increase access of care services by men will be employed, including supporting male peer educators, mentors and support groups, and supporting women to disclose and bring their male partners for testing and care and treatment.

CHS will continue to strengthen data collection and reporting at all levels to improve reporting to NASCOP and PEPFAR. CHS will adopt the new generation indicators support the development and use of electronic medical records system in accordance with NASCOP's guidelines. CHS will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV care and support services and integrate them into routinely collected data and use the results to evaluate and improve clinical outcomes. CHS will do cohort analysis and report retention rates as required by the NASCOP.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	500,000	0

Narrative:

Center for Health Solutions (CHS) will support four districts in Central province, which has a population of about 4.4 million people, and reported 10,623 TB patients in 2010. Over 10,000 TB patients received HIV testing and 3,531 TB/HIV co-infected patients were identified. 97% and 47% received cotrimoxazole prophylaxis and ART respectively. Since 2010, CHS has been supporting TB/HIV activities as a local transition partner to Columbia University's International Center for AIDS Care and Treatment Programs-Kenya (ICAP) in 52 treatment sites in Central province.

In the next two years covering COP 2012 and 2013, CHS, which has just won a CDC award to support HIV activities including TB/HIV in 44 facilities, will intensify efforts to detect TB cases through clinical exams, laboratory investigations and ensure successful TB treatment through provision of appropriate treatment. CHS will ensure that each facility providing TB/HIV services has adequate and well trained clinical staff supported by well equipped and staffed laboratory, including sputum specimen transport where laboratory services are unavailable. CHS will ensure that adequate supplies of anti-TB drugs are available and that the national TB treatment guidelines are followed. All TB patients on treatment will be monitored both clinically and through periodic sputum examination.

To reduce the burden of HIV in TB patients, CHS will ensure that at least 95% of TB patients are screened for HIV

and 95% TB-HIV co-infected patients are put on cotrimoxazole and ARVs as early as possible regardless of the CD4 count as per the national guidelines. CHS will support the "one stop" model that provides integrated TB and HIV services in all TB clinics. All TB clinics will be stocked with cotrimoxazole and ARVs. 200 HCWs in FY12 and 150 HCWs in FY13 will be trained as needed.

To reduce the burden of TB in HIV infected patients, CHS will support intensified TB screening for 19,837 in FY12 and 23,566 in FY13, HIV infected persons identified in their HIV care settings. 992 co-infected patients identified in FY12 and 1,178 co-infected patients identified in FY13 will be put on TB treatment and those without active TB will be provided with Isoniazid Preventive Therapy (IPT) as per national IPT protocol.

To strengthen TB infection control in HIV settings, CHS will ensure that the national IC guidelines are available at all sites and training of staff on IC is done. CHS will support scaling up of at least 2 components of the national TB infection control strategy in HIV care settings, one of which should be fast tracking of patients with cough for expedited diagnostic work up and treatment.

To improve surveillance and management of drug-resistant TB, CHS will support timely transport of sputum specimens of TB retreatment cases from health facilities to the central reference laboratory for drug susceptibility testing and ensure return of the results to those facilities. CHS will also support scaling up of drug-resistant treatment sites thus expanding access to MDRTB treatment.

CHS will also support expansion of prevention with positive (PwP) services in TB clinics, TB/HIV control activities in the prisons, strengthening linkages between facility and community-based services, and improving patient referrals and tracking systems. To strengthen HVTB program monitoring, CHS will support reporting of selected custom indicators to assist with program management, evaluation and monitoring.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	100,000	0

Narrative:

Centre for Health Solutions (CHS) will support pediatric care activities in Central Province. Since 2010, CHS has been supporting pediatrics activities as a local transition partner to Columbia University's International Center for AIDS Care and Treatment Programs-Kenya (ICAP) in 52 treatment sites in Central Province. In 2011, CHS won a PEPFAR award to support the Implementation of HIV Care, Prevention and Treatment activities in 44 facilities in Central Province.
By March 2011, CHS had 6,000 children enrolled in care with 3,263 receiving HIV care.

In FY 12, CHS will provide care and support services to 2,332 children currently on care and increase to 2,820 on

care during FY 13.

CHS will provide comprehensive, integrated quality services and scale up to ensure 2,310 HIV exposed infants are put on ARV prophylaxis and all HIV exposed children access pediatric care services.

The focus of pediatric care services will continue to be provision of comprehensive, integrated quality services including strengthening the use of the Mother-baby booklet, early infant diagnosis, universal provider initiated testing and counseling, and ensure those identified HIV infected are linked to care and ART services.

CHS will ensure children enrolled in care receive quality clinical care services including clinical history and physical examination; WHO staging, CD4 testing, and other basic tests; opportunistic infection diagnosis, prophylaxis and management; TB screening; pain and symptom relief and management; and psychosocial support. Additional key care services will include nutritional assessment, counseling and support based on the WHO and IYCF guidelines (including provision of therapeutic or supplementary feeding, support to children with growth faltering, provision of vitamin A, zinc, and de-worming); provision of safe water, sanitation and hygiene interventions (WASH) in the community and in health facilities; and malaria screening, treatment, and provision of long lasting insecticide treated nets in malaria endemic areas.

CHS will support integration of HIV services into routine child health care and survival services in the maternal child health department, including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization guidelines; case management of diarrhea, pneumonia, and other childhood illnesses; and community outreach efforts. They will also support the care of the newborn by supporting hospital delivery and ensuring that there is provision for newborn resuscitation and care (thermal care, hygiene cord care) and prophylactic eye care. Exposed children management and follow up will continue to be supported and will include enrollment, HIV testing (PCR-DNA and antibody testing) as per the national guidelines, provision of Nevirapine throughout the breastfeeding period, follow up and retention, and linkages of those positive to care and ART services.

CHS will support hospital and community activities to support the needs of the HIV infected adolescents: support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, support for transitioning into adult services, and teaching life skills.
Commodity access and infrastructure development will continue to be supported, including relevant trainings.

CHS will strengthen pediatric data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVCT	309,189	0

Narrative:

Target population: CHS will support HIV testing and counseling services in all health facilities in Nyeri, Muranga, Nyandarua and Kiambu counties in central province. Target population will include all patients, their family members and caretakers who access out and in patient services at all the health facilities in the 4 counties.
HTC Approaches: The program will utilize provider initiated opt out approach and the services will be offered within all out patient departments, TB clinics, FP, ANCs, special clinics, HIV clinics (targeting family members) and in patient departments. The counseling and testing will either be done within the consultation rooms by trained clinicians, or in counseling rooms by lay counselors within the outpatient departments if space will be available or at the laboratories.
Targets and achievements: In COP 2012, CHS will target to provide HTC services to a total of 255,000 persons of which 20% will be tested as couples and 10% will be children below the age of 15.
Testing algorithm: National algorithm is being used.
Referrals and linkages: In order to strengthen referrals, CHS will put in place several important strategies. They include: use of peer educators as patient escorts from one hospital department to the CCC; same day enrollment of clients to CCCs; use of an integrated defaulter tracing system for tracing patients who default on care or ART upon enrollment; introduction of documented referral system by use of the NASCOP referral booklet; use of mobile phones to follow up whether the client was actually enrolled.
Quality management: In order to improve and monitor quality of HTC services, CHS will put in place the following strategies: Training and continuing education of HTC providers; strict adherence to the standard operating procedures outlined in the national HTC guidelines; proper handling (storage and transportation) of HIV rapid kits as per the guidelines; putting in place a functional QA systems as provided for in the national HTC guidelines; participation in EQA- proficiency testing and finally conducting support supervisory visits.
Monitoring and evaluation: CHS will use all ministry of health' tools to capture HTC data, both for couples and individual patients. These include HTC lab Register and Monthly summary tool (MOH 711 and MOH 731). MOH approved HTC lab registers have been introduced at all HIV testing points except PMTCT.
Promotional activities for HTC: All patients attending the supported facilities will be given health talks including the need for HIV counseling and testing and the importance of couple testing. Couples are given priority services. Sexual partners of HIV positive clients will be given individualized invitations though the index clients and available avenues for testing including individualized home testing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

CHS implements comprehensive prevention, care and treatment programs in Central province. In FY 2012/13, CHS will expand HIV prevention services to include evidence based behavioral interventions (EBIs) for specific

target populations in clinical settings at comprehensive care center (CCC), TB and Maternal Child Health (MCH) clinics as part of HIV combination prevention programs. The EBIs will include Positive Health and Dignity Prevention (PHDP) targeting adult male and female and adolescents living with HIV (PLHIV); and Sister to Sister EBI (S2S) targeting sexually active HIV negative women attending the MCH clinics.

PHDP is an ongoing 5-10min group and individual level intervention that targets PLHIV in clinical and community settings. This mechanism will support this intervention which constitutes of ART adherence counseling and support; partner and family testing; provision of PEP to the discordant spouse; treatment for prevention once approved; safer pregnancy counseling and provision of modern contraception; sexual risk reduction counseling including reduction of sexual partners, alcohol counseling, promoting of consistent and correct condom use; Sexually Transmitted Infections (STI) screening and treatment and using meaningful involvement of people living with HIV/AIDS (MIPA). The efficacy of PHDP has been shown to be 68% in preventing transmission of HIV, and 96% in treatment for prevention.

S2S is a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use. Condoms are 80% effective in heterosexual relationships when used correctly and consistently.

CHS will use HVOP funding to recruit and support appropriate peer educators/counselors to reinforce prevention messages delivered by health providers as a feasible model for task-shifting in the provision of PHDP in clinical settings, and specifically promote MIPA. It will support placement of 5 Peer Educators at the MCH, TB and CCC Clinics in hospitals, and 2 Peer educators at health centers and provide appropriate counseling space. One of the peer educators will do regular client home follow up to strengthen ART adherence.

Approximately 1.6 million Kenyans are PLHIV. The Kenya AIDS Indicator Survey 2007 showed 6% of couples to be in discordant relationships. HIV Prevalence in Central province is (3.6%). CHS will reach 12571 (60%) PLHIV in FY2012 and 17453 (70%) in FY 2013 with a minimum package of PHDP. It will implement S2S EBI on a pilot basis.

Quality assurance for EBIs will be promoted through appropriate training and certification of peer educators using approved national curricula, standard job-aids and guidelines and regular supervision.

CHS will work with appropriate national Technical Working Groups (TWG) to support integration of HIV prevention into care and treatment programs in clinical settings. These programs will also be linked to other HIV community programs. PLHIV will be specifically linked to STI and FP services, as necessary, through patient escorts.

Monitoring of PHDP and S2S will be done through the review/input of CHS implementation plan, analysis of KePMS data, quarterly reviews, semiannual and annual reports. Evaluation will be conducted through operation research of combination HIV prevention and periodic surveys (Kenya Demographic and health survey, Kenya Indicator AIDS Survey, Kenya Service Provision Assessment).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,075,000	0

Narrative:

Center for Health Solutions (CHS) will support PMTCT services in Kiambu and Kirinyaga district in Central Province. Since 2010, CHS has been supporting these activities as a local transition partner to Columbia University's International Center for AIDS Care and Treatment Programs-Kenya (ICAP) in the same region. In 2011 CHS won a PEPFAR award to support the comprehensive HIV services including PMTCT activities in Central Province. By end of March 2011 SAPR CHS had counseled and tested 15,850 pregnant women and given ARV prophylaxis to 1,325 HIV positive pregnant women and 399 infants.

In FY12, CHS will offer HIV counseling and testing to 65,285 pregnant women at ANC and give ARV prophylaxis to 2,211 HIV infected pregnant women. The HIV infected women will receive a CD4 test after undergoing a WHO clinical staging. CHS will give HAART to all eligible HIV+ pregnant women in line with the revised PMTCT national guidelines. In FY13, CHS will increase the number of pregnant women counseled to 68,549, offer ARV prophylaxis to 2,685 pregnant women and 2310 infants, and do EID for 2,310 infants.

CHS will focus on 4 prongs of PMTCT: primary prevention; prevention of unwanted pregnancies; ARV prophylaxis to all HIV+ pregnant mothers and exposed infants; and care and treatment to eligible HIV positive mothers, partners, and children. The minimum care package will include health and HIV education, individual/family HTC, clinical/lab monitoring and assessment, OI screening and/or treatment, ARV prophylaxis and treatment for both mother and baby, nutritional support, psychosocial support, PWP, follow up, retention, referral and linkages. CHS will incorporate TB screening into routine antenatal care.

CHS will reach 20,565 of 1st ANC attendees with couple CT to identify discordant and concordant couples to improve primary prevention and facilitate linkage to HIV care and treatment for the eligible. CHS will support integration of ART in MCH clinics, access to FP/RH services, establish or strengthen infection control and waste management activities.

CHS will support hospital delivery through provision of delivery beds and sterile delivery packs, training, working with CHWs and TBAs to promote community-facility referral mechanism, health education, and community services providing skilled birth attendance.

CHS will support safe infant feeding practices as per national guidelines and enrollment and follow up of 2,310 of babies born to HIV infected mothers to access CTX, ARV prophylaxis, and EID services using the HIV exposed infant register till 18 months. CHS will facilitate ART initiation for those who test positive before 2 years.

CHS will adopt efficient retention strategies for mothers and babies by supporting use of diaries and registers for tracking defaulters, having a structured mentorship and supervision plan (training 60 HCP in FY12 and equal number in FY13), enhancing data quality and streamlining M&E gaps including orientation of new MOH ANC/maternity registers, and utility of data at facility level for program improvement and quarterly progress reports to CDC.

Program quality and proficiency testing will be emphasized to validate PMTCT results.
CHS will train HCWs on PMTCT and provide orientation on the revised PMTCT and infant feeding guidelines and engage in community activities for demand creation for health services such as male involvement with couple CT services, referral and linkages.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,842,796	0

Narrative:

Center for Health Solutions (CHS) will support four districts in Central Province, which has a population of about 4.4 million people and an estimated adult HIV prevalence of 3.6% compared to the national 7.1%. Since 2010, CHS has been supporting HIV treatment activities as a local transition partner to Columbia University's International Center for AIDS Care and Treatment Programs-Kenya (ICAP) in 52 treatment sites in Central Province. In 2011, CHS won a PEPFAR award to support the Implementation and Expansion of High Quality HIV Care, Prevention and Treatment Activities in 44 facilities located in four districts in Central Province. As of March 2011 SAPR results, ICAP/CHS has enrolled 31,003 patients on ART with 16,649 active on treatment.

CHS will continue to support HIV adult treatment services in the 44 treatment facilities in Central province in the next two years. In FY12, CHS will ensure provision of HIV treatment to16585patients currently receiving ART, including 3990new patients. The number of adults currently on treatment will increase to 19,581 during the FY13. The number currently on treatment is lower than SAPR 11 because some of the sites will be transitioned to University of Nairobi.

CHS will work with the Ministry of Health (MoH) at all levels to jointly plan, coordinate and implement HIV treatment services. CHS will offer training to 200 health care workers in ART provision using the NASCOP ART training curriculum in compliance with National Guidelines and mentorship to the sites. CHS will support

recruitment of additional staff as needed.

CHS will support provision of comprehensive package of services to all HIV+ patients at health facility level including clinical assessment for ART eligibility; provision of ART for those eligible; laboratory monitoring with biannual CD4 testing and viral load testing for patients failing treatment; cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); support for family testing for spouses/partners and children; supportive disclosure; family planning counseling and provision or referral of services; STI diagnosis and treatment; and improved OI diagnosis and treatment, including TB screening, diagnosis, and treatment.

Ongoing community interventions for HIV+ individuals, including peer education and use of support groups to provide adherence messaging, defaulter tracing and follow up will continue to be supported to improve retention in all facilities. CHS will do cohort analysis and report retention rates as required by the national program and discuss the analysis results with facility staff in order to improve program performance.

CHS will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services and integrate them into routinely collected data and use the results to evaluate and improve clinical outcomes. CHS will adopt strategies to ensure access and provision of friendly HIV treatment services to all including supporting peer educators, mentors, support groups, and supporting patients to disclose and bring their partners for testing and care and treatment.

CHS will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Use of an electronic medical records system will be supported and strengthened.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	300,000	0

Narrative:

Center for Health Solutions (CHS) will support pediatric HV care and treatment services in Central Province. Central Province has an estimated population of 4.4 million people with an estimated adult HIV prevalence of 3.6% compared to the national 7.1%. Since 2010, Center for Health Solutions (CHS) has been supporting HIV treatment activities as a local transition partner to Columbia University's International Center for AIDS Care and Treatment Programs-Kenya (ICAP) in 52 treatment sites. As of March 2011 SAPR results, ICAP/CHS had supported a cumulative 3,627 paediatric on ART and 2,059 were active.

In FY12, CHS will jointly work with the Ministry of Health (MoH) at all levels to continue supporting, expanding, and ensuring provision of quality pediatric HIV treatment services as per MoH guidelines to 1,739 pediatrics

currently receiving ART and 348 new pediatrics resulting to cumulative 2,083 pediatrics ever initiated on ART. In FY 13, this number will increase to 2,174 pediatrics currently receiving ART and new 314 resulting to cumulative 2,397 pediatrics ever initiated on ART.

CHS will support comprehensive pediatric ART services including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization, management of childhood illnesses; OI screening and diagnosis; WHO staging; ART eligibility assessment; laboratory monitoring including 6 monthly CD4, hematology, and chemistry (through strengthening of lab networks); Pre-ART adherence and psychosocial counseling; initiation of ART as per MoH guidelines; Toxicity monitoring; treatment failure assessment through targeted viral load testing; Adherence strengthening; enhanced follow up and retention; support EID as per MoH guidelines; PITC to all children and their care givers attending Child welfare clinics; support family focused approach; community outreach efforts; and integration of HIV services in other MNCH services.

CHS will support hospital and community activities to support the needs of the HIV infected adolescents: support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services, and support their transition into adult services.

CHS will support in-service training of 200 and 150 HCWs in FY 12 and 13 respectively, continuous mentorship and capacity building of trained health care workers on specialized pediatric treatment including management of ARV treatment failure and complicated drug adverse reactions. CHS will identify human resources and infrastructure gaps and support in line with MoH guidelines and support good commodities management practices to ensure uninterrupted availability of commodities. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will additionally be optimized.

CHS will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, CHS will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. CHS will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.

Implementing Mechanism Details

Mechanism ID: 2868	**Mechanism Name: Washplus: Supportive Environments for Healthy households and communities**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement

Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

A small but growing body of literature has identified linkages between water, sanitation, and hygiene and HIV/AIDS: opportunistic infections negatively impact PLWHAs' quality of life and can speed the progression to AIDS. Frequency of infection is tied to water and sanitation services available to households and the hygiene practices of household members. Ensuring proper WASH practices benefits the entire HIV infected household by keeping people stronger, better nourished, and able to contribute to the household. The WASH-HIV Integration program in Kenya has two phases: 1) introduction of the program, development of integration materials, and build WASH-HIV integration capacity in Coast, Nyanza, and Western (Dec 2009-July 2011); and 2) train trainers and engage programs working at the community level to incorporate these materials and activities into their work (Aug 2011-July 2012).

Phase 2 focuses on scaling up activities to the remaining five provinces and NGOs as well as supporting the initial three provinces to further activities to include CHWs. Partners are being identified and engaged in these activities. Partners will be offered the WASH-HIV Integration kit to use in their own programs. Indicators within the government monitoring and evaluation system are being reviewed to ensure that WASH-HIV integration activities can be adequately monitored. This activity supports GHI/LLC and is completely funded with pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Child Survival Activities

Safe Motherhood

Budget Code Information

Mechanism ID:	**2868**
Mechanism Name:	**Washplus: Supportive Environments for Healthy households and communities**
Prime Partner Name:	**FHI 360**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	0	0

Narrative:

FHI 360 is building capacity in support of the government's community health strategy. FHI 360 is also developing and distributing materials on WASH-HIV integration throughout the counties. Using a behavior change approach, FHI 360 has introduced the small doable action concept that community health and home-based care workers will use to negotiate with families on how to improve their individual practices in order to prevent diarrhea among people living with HIV and their families. The three practices to prevent diarrhea include: treating and safely storing drinking water, washing hands with soap, disposing of feces safely in both weak but mobile and bedridden clients, and menstrual management to prevent HIV transmission from an infected woman to a caregiver. FHI 360 is working closely with the GOK to integrate these practices into the national CHW training program as well as assuring that as policies and guidelines are developed and/or revised, they include more focused language on WASH-HIV integration.

The target audiences are people living with HIV, caregivers, and adult heads of households including women who can improve their own practices and transfer their knowledge to all family members. The program has national coverage, with an emphasis on counties where HIV prevalence is highest. The CHWs are the outreach workers targeted to receive training that they can then use to help families improve their WASH practices.

FHI 360 is working closely with the USAID/Kenya programs to extend training so that more CHWs are trained

since they work directly with community members. This includes integrating WASH and HIV activities into existing programs, identifying and strengthening the capacity of current partners as well as building strong support at the national (Ministry of Public Health and Sanitation, National AIDS/STD Control Program (NASCOP), and Ministry of Medical Services), provincial, district/county levels. *FHI 360 is monitoring program inputs and outputs and working with the government systems to include questions that will capture WASH-HIV integration. At the end of this funding cycle, FHI 360 will conduct an assessment to measure uptake of improved practices among the target population.*

Implementing Mechanism Details

Mechanism ID: 7141	**Mechanism Name: Kenya Nutrition and HIV Program**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

Insta Products	Phillips Pharmaceuticals, Kenya	

Overview Narrative

Nutrition and HIV Program (NHP) is a cooperative agreement that provides technical guidance and coordination in the integration of nutrition interventions in palliative care and support at various service points within health facilities. NHP also provides support for capacity building and commodities by i) strengthening technical and management capacities for Nutrition Assessment Counseling and Support (NACS) and Food by Prescription (FBP) service for managing clinical malnutrition in participating facilities; and ii) expanding provision of fortified blended food and Ready to Use Therapeutic Food formulations to 250 primary sites and reach at least 25,000 beneficiaries per year by 2012/13. NHP also establishes linkages between facilities providing FBP services and communities

through CBOs and FBOs providing health related services. While implementing their programs, NHP also aims to improve data capture and management and its use in decision-making.
NHP is designed as a national mechanism to support nutrition services in all care and treatment sites. Therapeutic and supplemental nutrition formulations are provided to most vulnerable patients to improve nutritional recovery (weight gain, growth and reconstitution) and improve adherence and compliance to use of ARVs and other medicines that the patients are receiving. Efforts will go towards ensuring direct reporting and ownership of the program by MoH.
This partner has not used PEPFAR funds for vehicle purchase and is not requesting funds for vehicle purchase in FY12. This partner is using two vehicles purchased by previous prime implementer and a vehicle donated to project from within the organization (FHI 360). This activity supports GHI/LLC and is completely funded with pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Child Survival Activities
Military Population
TB

Budget Code Information

Mechanism ID:	**7141**
Mechanism Name:	**Kenya Nutrition and HIV Program**
Prime Partner Name:	**FHI 360**

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HBHC	0	0

Narrative:

In collaboration with the MoH/NASCOP, NHP supports a 5-day in-service training for frontline health care workers on Nutrition and HIV as the platform for delivery of Nutrition Assessment, Counseling and support (NASCS) with Food by Prescription for malnourished patients as part of the comprehensive care package. This training is designed for nurses, clinical officers, nutritionists, pharmacists and other cadres. In regard to mentorship, onsite training of health care workers is being provided at facility level by the trained staff through continuous medical and nutrition education. A standardized CME package is under development for use in facilities to augment mentorship and on-the-job training.

The target population for supplemental and therapeutic nutrition services are vulnerable and malnourished people living with HIV. Malnourished PLHIV adults BMI < 18.5, pregnant and post-partum MUAC < 23 cm and OVC WHZ < -2 are beneficiaries.

NHP carries out site monitoring to sample primary sites. This is carried out in collaboration with the nutrition leaders and focal persons at the district and province. Materials are periodically distributed and updates are provided during the visits. On job refresher training is also carried out during the site visits to address challenges being experienced.

NHP evaluates service delivery and outcomes though analysis of patient data from the facilities. Performance is evaluated based on enrolment levels, clients receiving services including assessments, counseling and FBP and those being discharged after recovery.

The partner provides nutritional commodities for supplemental and therapeutic prescription in the management of malnourished clients under care and treatment in 200 central sites and over 300 satellite sites across the country. Estimates provided cover training and commodities for managing non-pregnant and non-lactating adult clients served in the CCCs and the HBHC clients.

The partner has facilitated decentralization services to lower level facilities including health centers and dispensaries for improved access. The partner has also engaged local CBOs to do active case finding of malnourished clients by supporting the training of community health workers to screen OVCs using MUAC and refer the malnourished clients to nearby health facilities for nutrition services including FBP. Follow up of clients at community level is also done by the CHWs that have been trained.

The outcome of these services will include improved adherence to drugs, and including a reduction of loss to follow up of clients on HIV care and treatment as well as improvement of the quality of life for the malnourished clients.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	0	0

Narrative:

The goal is to increase access to care and support for OVC in early childhood, primary school age and secondary

school age through improving access to nutrition services at the community and health facilities level. The main outcomes are elimination of clinical malnutrition among OVC who are enrolled in the program supported by community health units (CHUs) and further facilitate optimal nutrition for the OVC to achieve full growth and development potential. The service package comprises anthropometric screening and periodic assessment of household food insecurity. This is achieved through increasing the number of CBOs/FBOs and community health units (CHU) supported by NHP. In each CBO or facility based outreach with the extension nutrition services strategy, a social workers-CHW and facility based CHEW-CHW interfaces with respective communities are and strengthened through capacity building. The latter comprises of training on screening for malnutrition (active case finding), nutrition education and referrals as well as simplified household food security assessment. These activities are carried out in collaboration with other USG and non-USG implementing partners. It is expected that these measures will extend community level NACS services to over 10,000 OVCs across the country and provide useful experiences to accelerate scaling up of similar services to other CHUs and CBO/FBOs. OVC service delivery is fragmented at the CHU with CBOs being weak with respect to organic growth. The services collapse once the partner withdraws support. Collaboration among partners is central to successful programming at community level to avoid duplication and confusion, weak linkages with health facilities and verticalization of community development. Partner coordination and greater involvement of the local community are key to successful OVC programming. Monitoring of service delivery is carried out using registers and data extractions are carried out monthly.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	0	0

Narrative:

NHP has decentralized services in health facilities from the comprehensive care clinics to the maternal child clinics in order to reach children and the pregnant and post-partum women. Staff from the MCH have been trained to provide nutrition services and equipment, IEC materials, data tools and commodities which are being provided at the MCH service point.

Pediatric participation is ensured through supporting service delivery to OVCs under maternal and child health and nutrition. The services supported are NACS and FBP for those suffering from clinical malnutrition. These services are offered to children > 6 months and < 18 years irrespective of HIV status.

Expansion of services to community level through CBOs will increase the coverage of older children and adolescents whose service use has remained relatively lower than that of under 5-year olds and adults. Harmonization of FBP, OTP and SFP will strengthen integration of nutrition services into MCH. NHP is providing technical assistance to local CBOs that are being supported by other USG partners to identify malnourished individuals through MUAC screening and refer the malnourished OVCs to the health facilities for nutrition

services. Data tools, MUAC tapes, and IEC materials are provided after the training and follow up of the identified clients. Routine supervision of the CHWs is also done at site level. This should eventually lead to identification of most vulnerable households for bi-directional linkages between sites and community services. These activities should translate into improved access and adherence to care and treatment including prevention of malnutrition. *It is expected that MOH and partners will support development of common reporting tools for the three intervention strategies but most importantly use one NACS reporting tool. This will further strengthen the ongoing reporting of nutrition status of children from facilities and the implementation of the community strategy.* *NHP advocates for greater integration of nutrition service in mentorship and supervision visits. Scaling up quality improvement support under health care improvement initiative with several partners will gradually fuse with HIV quality improvement program. Monitoring and evaluation are nested in the NACS/FBP data at facility and community levels.* *Site supervision visits are carried out jointly with the national, provincial and district nutritionists. A site monitoring check list serves as a guide to address specific challenges and gather data on status and site performance as well as gaps. Data is routinely collected by the implementers at clinical sites. Monitoring the quality of services is done through assessing the quality of field data as well as service utilization patterns.*

Implementing Mechanism Details

Mechanism ID: 7142	**Mechanism Name: Kenya Pharma Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Chemonics International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 3,793,423	
Funding Source	**Funding Amount**
GHP-State	3,793,423

Sub Partner Name(s)

DHL Exel	Phillips Pharmaceuticals, Kenya	Vimta Labs

Overview Narrative

The overall objective of the Kenya Pharma project is to establish and operate a safe, secure, reliable and sustainable supply chain management system to forecast, quantify, procure, store and distribute pharmaceuticals, supplies and equipment needed to provide care and treatment of persons with HIV/AIDS in Kenya.

The strategy is to become more cost efficient over time. The project is constantly seeking opportunities to increase its cost efficiency through improved freight forwarding and improved delivery operations. The project also operates a competitive tender process for HIV/AIDS commodities with low cost being the most heavily weighted selection criterion.

Over time, a second strategy is to transition to the partner government, local organization or other donor. The Kenya Pharma project has sustainability as one of its overall program goals and is structured to maximize the use of Kenyan institutions and individuals in its provision of services. Kenya Pharma has been working with local suppliers and testing laboratories to increase the capacity of these institutions. Kenya Pharma is also in the process of becoming ISO 9001 certified to create a complete documentary file of operations for the use of any successor organization. Kenya Pharma has previously purchased 3 vehicles but does not plan to purchase any in FY12. This activity supports GHI/LLC and is funded primarily through pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	7142		
Mechanism Name:	Kenya Pharma Project		
Prime Partner Name:	Chemonics International		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	0	0

Narrative:

The Kenya Pharma project procures OI drugs for provision to implementing care and support programs within Kenya. The programs operate mostly at the facility level and target the spectrum of HIV/AIDS populations. The project supplies national coverage both through direct distribution and through stock sharing with the GoK-supported distribution system. The commodity aspects of the programs are continually monitored and evaluated using data collected from regular monthly facility-level patient, stock, and distribution reports; internal distribution records from the Kenya Pharma project; and direct customer feedback from partners and service providers (collected through a network of Kenya Pharma field representatives).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	0	0

Narrative:

Resources requested in this budget area directly support the Let's Live Campaign to ensure that orphans and vulnerable children due to HIV/AIDS have access to zinc tablets. These resources will be coupled with those from other accounts which will support other children (who do not fall into the OVC category) to receive similar services across targeted areas.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	820,000	0

Narrative:

Kenya Pharma procure Methadone for IDU combination prevention. The intervention will include weaning off Injecting Drug Users from injecting drug use through treatment with Methadone which will be done through selected public and private facilities by UNODC. Kenya Pharma will liaise with the Ministry of Health to quantify and control the distribution of the methadone.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	2,686,423	0

Narrative:

The Kenya Pharma project procures ARVs consistent with the nationally recommended guidelines for the provision

of PMTCT. All ARVs are, of course, USFDA tentatively or fully approved and also registered with the Kenya Pharmacy and Poisons Board. The project participates as an active member of the Commodity Security Committee (coordinated by NASCOP, the Kenyan HIV/AIDS coordinating body) and participates in national quantification and procurement planning exercises. The project is coordinating and collaborating with other members of the supply chain community to improve the data associated with the location and client populations of PMTCT service providers and also to put in place mechanisms to ensure that these data can be maintained in a sustainable manner in the future.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	287,000	0

Narrative:

The Kenya Pharma project procures the entire list of nationally recommended first line and second line ARVs for both adult and pediatric use. All ARVs are, of course, USFDA tentatively or fully approved and also registered with the Kenya Pharmacy and Poisons Board. The project also procures a limited list of OI drugs (antibiotics, antifungals, etc.) and drugs for co-infected TB patients. The project participates as an active member of the Commodity Security Committee (coordinated by NASCOP, the Kenyan HIV/AIDS coordinating body) and participates in national quantification and procurement planning exercises. There have been no stockouts of ARVs provided by the project in the last year and the project actively monitors stocks at all levels of the supply chain and coordinates among other members of the supply chain and among implementing partners to avoid future stockouts.

Implementing Mechanism Details

Mechanism ID: 7305	**Mechanism Name: Health Care improvement Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: University Research Corporation, LLC	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The purpose of this mechanism is to support the Government of Kenya in adapting modern quality improvement approaches, seeking to insitutionalize improvement as an integral element of health services. This support will cut across the Ministries of Health and also work with the Ministres of Gender & Children Affairs to improve OVC programming in the country. This activity supports GHI/LLC and is completely funded with pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**7305**
Mechanism Name:	**Health Care improvement Project**
Prime Partner Name:	**University Research Corporation, LLC**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	0	0

Narrative:

This mechanism will continue supporting the Minsitry of Gender and Children Affairs to enshrine QI/QA in OVC programming helping improve the quality of services that OVCs receive.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

This project will help strengthen the service delivery block falling under the Health System Strengthening approach by institutionalizing mechanisms for Quality Improvement and Quality Assurance in the Govenrment of Kenya.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	0	0

Narrative:

This mechanism will support the Ministries of Health in improving the overall quality of health care delivery particularly related to HIV/AIDS. The project will work with the Department of Standards and also the National AIDS/STI Control Program (NASCOP) to strengthen quality improvement and quality assurance mechanisms.

Implementing Mechanism Details

Mechanism ID: 9039	**Mechanism Name: Capacity Building for LAB**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: American Society for Microbiology	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 350,000	
Funding Source	**Funding Amount**

GHP-State	350,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Goals and objectives:

The following are the objectives of this mechanism:

Objective 1. Strengthen Capacity and Leadership of the Central Microbiology Reference Laboratory

This will involve continued training of CMRL staff in support of WHO/AFRO accreditation efforts. Key activities include onsite training in new reference or specialized diagnostic microbiology procedures; mentoring in quality management systems to ensure quality, efficient operation and workflow. CMRL policies will be strengthened to support leadership in IDSR activities.

Objective 2. Strengthen Microbiology Services for the Laboratory Network. A key activity will be to establish a local microbiology mentoring program to oversee county labs. This will build capacity for diagnosis of opportunistic infections in HIV infected persons.

Objective 3 – Strengthen microbiology training capacity of medical training colleges and a key activity will be training college faculty mentors in microbiology.

Coverage:

This activity with national coverage will be carried out at two reference laboratories, in six provincial and four county/district level laboratories as well as at up to ten KMTC training colleges.

Transition to country partners:

All ASM activities will be entrenched in MOH facilities and reference laboratories. Partnerships with local training institutions, universities and colleges, and professional associations will be developed to facilitate long term sustainability of all initiatives.

No vehicles will be procured in this activity. This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000

TBD Details

(No data provided.)

Key Issues

TB

Budget Code Information

Mechanism ID:	9039		
Mechanism Name:	Capacity Building for LAB		
Prime Partner Name:	American Society for Microbiology		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	350,000	0

Narrative:

The ASM is a US based NGO. ASM assisted the Kenyan MOH in strengthening microbiology capacity at central level and in selected districts through development of SOPS, on site mentoring, assistance with preparation of supply lists, advice on configuring LIMS for microbiology and lab design for efficient microbiology flow. Weak lab microbiology capacity is a major challenge in the integrated disease control and surveillance program. Development of microbiology capacity will benefit not just HIV/AIDS programs but other disease surveillance programs especially IDSR. The goal is to increase the capacity of labs to perform quality microbiology testing for HIV/AIDS-related OIs and other infectious disease and build capacity at MTCs. In FY 12 ASM will work with the NPHL to improve their microbiology testing capacity at all levels in the network. ASM will collaborate and work closely with other programs IDSR, NTP and work synergistically to strengthen microbiology capacity; support the CMRL, TB culture labs; expand the diagnostic testing at provincial level to implement assays for diagnosis of cryptococcal meningitis and other OIs. ASM will partner with established centers of excellence in Kenya and draw on a pool of microbiologists to build capacity in the public sector.

Coverage includes the MTCs, central microbiology reference laboratory, and provincial and county levels laboratories. This supports Kenya's GHI Strategy Priority Area: health systems strengthening. The mechanism will address a weakness in one of the pillars of the health system- H R capacity, by improving the quality and skills of existing laboratory personnel and build in country mentoring capacity. The mentorship program addresses both quality mgt of systems and lab tech skills, increasing the coverage of quality lab diagnosis of HIV/AIDS OIs and microbiology capacity at all levels. The IM will be more cost efficient by increasing the number of in-country microbiology mentors. Activities will include expansion of the mentorship program to MTCs and additional labs at

provincial and county level. Any gaps that may impact the quality of microbiology services or progress toward accreditation goals at those facilities will be identified. Targets are based upon indicator HR for Health - # of workers completing an in-service training program. The end goal is to transfer mentoring skills to local Kenyan lab workers in order to sustain the program. Activities in Kenya will be conducted in alignment with ASM's monitoring and evaluation framework and in accordance with MOH's. For mentoring activities, tech skill is measured through tools such as competency testing; lab progress is measured through a series of assessments and monthly quality indicators. *Obj 1. Strengthen Capacity and Leadership of the CMRL. This will involve continued training of CMRL staff in support of WHO/AFRO accreditation efforts Key activities include onsite training in new reference or specialized diagnostic microbiology procedures; mentoring in quality management systems to ensure quality, efficient operation and workflow.* *Obj 2. Strengthen Microbiology Services for the Lab Network. A key activity will be to establish a local microbiology mentoring program to oversee county labs* *Obj 3 – Strengthen microbiology training capacity of MTCs and a key activity will be training college faculty mentors in microbiology.* *This activity supports GHI/LLC.*

Implementing Mechanism Details

Mechanism ID: 9076	**Mechanism Name: MEASURE III DHS**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: ICF Macro	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 64,912	
Funding Source	**Funding Amount**
GHP-State	64,912

Sub Partner Name(s)

(No data provided.)

Overview Narrative

MEASURE DHS has supported the Government of Kenya (GoK) in the planning and implementation of all previous Demographic and Health Surveys (DHS) to assess how programs have changed attitudes and behaviors or have improved indivdual health status in a cycle of every five years through a modular capacity building arrangement. The project works in building the capacity of Kenya Nationa Bureau of Statistics, the National Coordinating Agency for Population and Development and the National Public Health Reference Laboratory on planning, implementation and management of all aspects population-based surveys. The support under this contract will also support the GoK and USG implementing partners to scale up use of Geographical Information System in spatial analysis and presentation of both routine service statistics and program coverage. The project will also build the country capacity to use available DHS and (Service Provision Assessment (SPA) information to better describe the epidemic and enhance data driven program planning. This activity supports GHI/LLC and is completely supported by pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**9076**		
Mechanism Name:	**MEASURE III DHS**		
Prime Partner Name:	**ICF Macro**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXS	64,912	0

Narrative:

This budget will support planning of DHS 2013. Specifically this will support activities on protocol development, formation and support for steering committee and technical working groups, development and engagement for sub contracts for logistical support (transport and lab), In addition, this budget will support institutional capacity building for host country organisations (NCAPD, NACC, NASCOP, KNBS and NPHL).

Implementing Mechanism Details

Mechanism ID: 9079	**Mechanism Name: SCMS**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Partnership for Supply Chain Management	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 10,000,000	
Funding Source	**Funding Amount**
GHP-State	10,000,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

***November 2011 reprogramming: the TBD for HIV Commodity Purchase and Distribution was split between KEMSA and SCMS. This new mechanism includes funds from the TBD for HMBL (for the procurement of blood safety reagents and equipment), HMIN (for the procurement of injection safety materials), HVTB (for the*

*procurement of TB reagents), and HLAB (for the procurement of lab reagents, rapid test kits, and equipment). In addition, funds have been reprogrammed to SCMS from PSI in HBHC and from Chemonics in MTCT.***

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9079		
Mechanism Name:	SCMS		
Prime Partner Name:	Partnership for Supply Chain Management		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	2,600,000	
Narrative:			
None			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVTB	0	
Narrative:			
None			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and	HLAB	5,000,000	

Systems			
Narrative:			
None			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMBL	0	
Narrative:			
None			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMIN	0	
Narrative:			
None			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXD	2,400,000	0
Narrative:			
None			

Implementing Mechanism Details

Mechanism ID: 9092	**Mechanism Name: Umbrella - SAIDA**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Catholic Relief Services	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,758,233	
Funding Source	**Funding Amount**
GHP-State	1,758,233

Sub Partner Name(s)

Adventist Centre for Care and Support (ACCS)	African Brotherhood Church	African Inland Church (AIC)
Anglican church of Kenya: Narok Integrated Development Program	Apostles of Jesus AIDS Ministry	Archdiocese of Nyeri
Christian Mission Fellowship (CMF)	Dream Kenya	Faraja Trust
JHPIEGO	Kenya Hospices and Palliative Care Association (KEHPCA)	Kenya Widows And Orphans Support Programme (KWOSP)
Movement of Men Against AIDS in Kenya (MMAAK)	Nomadic Communities Trust	Scriptures Union Centre-Hurlingham
The Kenya Scouts Association	UZIMA Foundation- Africa	

Overview Narrative

1. Goals and objectives: The mechanism goal is to develop and reinforce capacities among indigenous sub-grant local organizations (LO) to improve HIV services to individuals in underserved areas of Kenya. The project objectives include increasing capacity of LO to expand quality HIV services including abstinence and be faithful interventions and HIV testing and counseling and to provide people living with HIV access to palliative care, high quality ART services, and support. The mechanism also assists LO provide support to OVCs. The objectives are in line with Kenya's Partnership Framework and GHI.

2. Cost-efficiency strategy: The mechanism improves local partners' efficiency in program, financial management, and capacity in M&E, through assistance with development of policies, procedures and strategic plans. Trainings are conducted on policy, procedure, strategic planning and sustainability. Site visits are conducted to provide mentorship and guidance in developing these institutional documents.

3. Transition to country partners: One of the key outputs of this mechanism is to help the sub-partners be able to apply and access and manage funds on their own for future and continuing programs. CRS works with 16 indigenous partners with an aim of building their capacity to be able to in future carry on with the activities.

4. Vehicle information: Five vehicles were purchased with FY1 funds for monthly mentoring and monitoring visits by two technical teams visiting different regions/partners at the same time. During the organization and technical capacity assessments, it came out clearly that a number of partners need vehicles to facilitate their work.

This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	1,367
Education	9,562
Food and Nutrition: Commodities	13,927
Gender: GBV	5,000
Gender: Gender Equality	100,000
Water	187

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9092**
Mechanism Name:	**Umbrella - SAIDA**
Prime Partner Name:	**Catholic Relief Services**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	525,000	0

Narrative:

Catholic Relief Society (CRS) SAIDIA Project will support partnerships with local grantees to provide 3,000 OVC in FY12 and 6,000 OVC in FY13 with access to essential services in Nairobi, Central, and Eastern Provinces. CRS will train 200 caregivers and build the capacity of local, community, and/or faith-based organizations to meet the needs of OVC in their communities. CRS will support the partners to provide critical services to OVC which include a comprehensive package for education, shelter, nutritional support, psychosocial care and support, and support to OVC caretakers while linking OVC to other critical services and economic strengthening activities.

CRS will target all OVC aged between 0 and 18 years and will provide "6 plus 1" services and report on at least 3 services that they provide to the OVC based on individual need. By March 2011, CRS had achieved the following:

3,840 OVC served; 2,536 of OVC received primary direct support (PDS); 1,304 of OVC were provided with Supplemental Direct Support (SDS); and 100 providers/caretakers trained in caring for OVC.
CRS continues to experience challenges in areas of capacity building, partner linkages and networking to the local partners. In the next two years CRS will focus on strengthening HIV prevention education among OVC to equip them with life skills that will reduce their vulnerability to HIV infection. CRS will start to implement OVC interventions that are evidence-based in order to achieve their two year goals.
They will also train the local organizations to strengthen the family support system and help them to establish strong linkages between PLWHAs and HIV-infected children with health care services, including ensuring that children and their parents or caregivers and other family members affected access appropriate care and treatment. CRS will work closely to link OVC with care and treatment partners to ensure that HIV-infected children receive appropriate psychosocial support and that they have a consistent caregiver to assure adherence to treatment.
CRS will continue to work closely with District Children's Department and will follow guidelines provided by the Ministry of Gender, Children, and Social Development, alongside PEPFAR guidelines. CRS will support the local partners to establish partnerships and networks among other NGOs in order to strengthen their collective voice, build a unified approach, improve coordination, and share knowledge.

CRS will embrace community and family centered approaches (such as the cash transfer program) that are preferred to institutional approaches and they will explore livelihoods OVC programming approaches. There is limited information regarding current OVC programming by CRS supported partners. CRS will undertake an OVC situation and gap analysis for its CBOs to document best practices and lessons learned for OVC to help the CBOs to explore new program approaches. CRS will also develop an OVC advocacy curriculum and provide training to CBOs and other OVC stakeholders. CRS will work with the local organizations to engage and advocate for OVC issues with key stakeholders in the Kenyan HIV/AIDS response, including donors.
CRS will work with the local partners to improve M&E systems based on rapid capacity and gaps analysis of the OVC activities they support. The program will also capture age specific services that are offered to OVC aged between 0 and 18 years.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	270,396	

Narrative:

SAIDIA's activities focus on strengthening institutional capacity building for indigenous organizations to improve HIV treatment, care and support services to marginalized people in underserved areas of Kenya. Participatory Development Consultancy was commissioned to provide technical support to the fifteen indigenous organizations supported by the SAIDIA Agencies project to develop and/or review governance systems, financial guidelines, programs management, human resource policies and strategic plans in order to not only facilitate the

implementation of the SAIDIA project but also enhance their capacity to independently bid for funds.
The process entails the following tasks: Review of capacity assessment reports for the fifteen indigenous organizations contracted by CRS in the SAIDIA project, training of board members from the fifteen indigenous organizations, workshops to train management team members on institutional guidelines/policies development, mentorship visits to the fifteen indigenous partner organizations to support them in developing individual institutional guideline and policies to ensure organizational growth, several trainings on proposal writing and presentations will be delivered.
PDC is also developing a guidance manual for good practice. This manual is part of a wider CDC/CRS indigenous organizations systems strengthening strategy which included capacity assessment of various organizations in Eastern, Central, Rift Valley and Nairobi provinces of Kenya.
Monitoring and evaluation are conducted through site visits which are conducted one to three times per quarter with every sub-grantee. Partners are contacted and dates are sent for the visit and objectives and activities of the visit are shared. Before the site visit starts previous trip reports to the partner are reviewed. During the trip there is a meeting with the partner staff to review the objectives and activities and any other issues that may need to be addressed are discussed. The site visit is conducted with the technical team from CRS occaisonally accompanied by CDC technical team, observing program activities and agency capacity. After the visit is complete a meeting is held with concerned project staff and management to review the visit, any issues that need immediate attention and any other recommendations that needs to be discussed. After the meeting a trip report is completed and shared with the partner.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	808,725	0

Narrative:

CRS works in the following provinces and counties: Nairobi, Eastern (Machakos, Embu, Kituia and Makueni), and Central (Nyeri, Kirinyaga, Nyandarua, Maranga, and Kiambu) to implement HIV-prevention, abstinence and being faithful evidence-informed behavioral interventions (EBIs) among the following priority populations (targets): 10-14-year-olds (20,000), and parents of youth 9-12 years of age (9,654).
CRS and its partners will serve youth aged 10-14 with two EBIs—Healthy Choices I (HC1) and Families Matter! Program (FMP).
FMP is an EBI for parents of preadolescents and promotes positive parenting practices, positive reinforcement, parental monitoring, and effective parent-child communication on sexual topics and sexual risk reduction. FMP seeks to delay onset of sexual debut by training parents to deliver primary prevention messages to their children.
HC1 targets in-school youth and aims to delay sexual debut by providing knowledge and skills to negotiate abstinence, avoid negative peer pressure, avoid or handle risky situations, and to improve communication with a trusted adult.
For quality assurance, CRS has put in place for all sites the following: use of approved national curricula;

emphasis of importance of fidelity to the respective curricula; use of trained and certified pair of gender balanced facilitators; trainings on EBIs are conducted by certified national trainers; observed practice of implementation is done soon after training; use of standardized, national data tools at every stage of EBI implementation; and regular field visits by trained program staff to check on delivery of EBIs and offer support supervision.
The proposed activities and EBIs are guided by the goal and objectives of the project. Targets for each of the interventions are laid out at the start of the project year which is tracked on a monthly basis through respective field reports. Results are analyzed on a quarterly basis. The targets are in line with the PEPFAR Next Generation Indicators (NGI's). Monitoring and evaluation will be conducted with EBI approved data capture / monitoring tools. Field staff will send reports on a monthly basis; these reports will be compiled into an overall report quarterly which will be submitted to CDC.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	154,112	0

Narrative:

Target population: CRS Umbrella mechanism is mandated to build the capacity of local indigenous organizations to be able to implement high quality and cost effective HIV programs. The target population for these local organizations is mainly the general population in the three provinces of Kenya (Nairobi, Eastern and Central). These regions have a generalized epidemic and the coverage of HIV testing and counseling (HTC) programs are below 50% except in Nairobi Province.
HTC Approaches: CRS sub-partners utilize both client-initiated (CITC) and provider initiated (PITC) approaches. Sub-partners that have health facilities focus mainly on PITC in the OPD, TB clinics, Wards and ANC settings. Sub- partners that do not operate within health facilities utilizes mainly static, mobile and Home based counseling and testing.
Targets and achievements: In the past 12 months, CRS had a target of 100, 000 persons and surpassed its target. A total of 52 providers were trained in HTC using the national training curriculum. For COP 2012, CRS will target 77,000 with HTC services of which 20% will be tested as couples, and 10% will be children below the age of 15.
Testing algorithm: National algorithm
Referrals and linkages: In order to achieve effective referrals and linkages, CRS has established a referral directory at all the testing points to facilitate easy referrals by the providers. It has also made actual contacts to referring facility for discussions on complete referrals. Further to this, each partner keeps a referral log to track referrals. Phone calls and in the case of CHBCT, actual home visits done to confirm that client visited. And in the cases of community units, CHWs are utilized for follow up purposes. In order to monitor successful referrals, CRS came up with data collection tools for monitoring linkages, these indicators are reported on a monthly basis, to ensure that they are performed and tracked.
Promotional activities for HTC: CRS utilizes a number of strategies to promote HTC uptake. They include use of health talks at the facility level targeting inpatient and outpatient clients; community awareness and demand

creation activities facilitated by Community Health Workers/Promoters; use of media campaigns (HTC video screening, IEC materials) targeting the general population, etc. *Quality management: Training and continuing education of HTC providers; HTC is conducted in accordance with the procedures outlined in the national HTC guidelines; HIV rapid kits are managed as per the guidelines; Functional HTC QA systems are in place as provided for in the national HTC guidelines; IQA- In-house lot testing of kits; participation in EQA- proficiency testing and finally conducting support supervisory visits.* *Monitoring and evaluation: CRS Sub-partners uses all ministry of health' tools to capture HTC data, both for couples and individual patients. These include HTC lab Register and Monthly summary tool (MOH 711). MOH approved HTC lab registers have been introduced at all HIV testing points except PMTCT.*

Implementing Mechanism Details

Mechanism ID: 9093	**Mechanism Name: Phones for Health**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: CDC Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,525,000	
Funding Source	**Funding Amount**
GHP-State	1,525,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

1. Goals:

The CDC Foundation provides technical assistance (TA) and mobile technology solutions (mHealth) to the GoK's Ministries of Health (MoH) by working with implementing and technology partners via PPPs aiming at more efficient health information systems (HIS) with wide access. mHealth activities will enable timely, secure transfer and access of programmatic, logistical, surveillance and other data to improve health services and outcomes.

In line with the country's HIS related MDGs, MoH HIS policy document and gap analyses, the objectives of the CDC Foundation activities include:

- *Provide TA, logistical support, and capacity-building to leadership, coordination and governance of HIS activities for the GoK and partners.*
- *Provide TA, logistical support, and solutions towards a national unique person's identification.*
- *Support the development of an interoperability solution among mHealth systems and other national HIS.*
- *Support the development of generic text messages to be used in health commodities tracking, early infant diagnostics, staff supervision, blood safety, and other systems identified by MoH.*
- *Support the development of national mHealth systems as identified by the MoH.*

2. Cost-efficiency strategy:
Build generic systems owned by the GoK to avoid silo systems and duplication of resources and efforts and develop local capacity to avoid foreign and expensive ventures in development/maintenance of solutions.

3. Transition to country partners:
Logistical support to be absorbed within existing GoK governance structures and capacity of MoH and stakeholders built to sustain the systems beyond the life of the project.

No PEPFAR funds have been or will be used in FY12 for vehicle purchase. This activity support GHI/LLC.

Cross-Cutting Budget Attribution(s)

Key Populations: FSW	350,000

TBD Details

(No data provided.)

Key Issues

Mobile Population

Budget Code Information

Mechanism ID:	**9093**
Mechanism Name:	**Phones for Health**
Prime Partner Name:	**CDC Foundation**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	1,175,000	0

Narrative:

Goals and objectives:
The CDC Foundation provides technical assistance (TA) and mobile technology solutions (mHealth) to the GoK's Ministries of Health (MoH) by working with implementing partners and technology partners via public private partnerships (PPP) aiming at more efficient health information systems (HIS) with wide access. mHealth activities will enable timely and secure transfer and access of programmatic, logistical, surveillance and other health related data so as to improve health services and health outcomes.

In line with the countries HIS related MDGs, MoH HIS Policy document and gap analysis discussions with the HIS Division of the MoH, the objectives of the CDC Foundation activities include:
- Provide TA, logistical support, and capacity building to leadership, coordination and governance of HIS activities for the GoK and partners via scheduled committee meetings and mentorship.
- Provide TA, logistical support, and solutions towards a national unique person's identification (NUPI).
- Support the development of an interoperability solution among mHealth systems and other national HIS.
- Support the development of a generic short message service (SMS) solution to be used in health commodities tracking, early infant diagnostics, staff supervision, blood safety, and other systems identified by MoH and test the use of innovative mHealth technologies to meet the national HIS goals.
- Support the development of national mHealth systems as identified by the MoH.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	350,000	0

Narrative:

Narrative is only 3500 characters (including spaces): see page 32 in the COP 2013 Appendices for detailed guidance and questions that need to be addressed.

Note: Each budget coded funded must have a completed narrative (please add additional space to complete this section as necessary).
This continuing mechanism includes a new budget code – HVOP that has been introduced in COP 13 following ITT

planning meetings.

HIV prevention interventions for key populations are highly effective in responding to the HIV/AIDS pandemic. Female sex workers (FSW) and their clients contribute to 14.1% of Kenya's new HIV infections (MOT 2008), and as such systems that strengthen programs for FSWs' should be initiated. The nature of FSWs work requires high mobility, connecting across Kenya's major town, and often makes rapid decisions whenever they sense opportunities. In order to create services that respond to the needs of FSWs, it is important that a centralized electronic system be established that allows them to access services across the different locations where key population services are available to the public.

This mechanism entails the development of a central database at NASCOP to hold identification information for FSW and their longitudinal health service provision data. Individuals will be identified via the use of fingerprinting and each will be provided a smart card that is capable of holding the health data for reference across service provision centers and for storing fingerprint for authentication purposes.

The implementation for this mechanism will entail a phased pilot approach and COP 13 will cover at least 50 national drop-in-centers or points of care for FSW which will be equipped with computer, smart card reader, fingerprint sensor, and GSM Modem. The smart cards will be prepared and issued to at least 10,000 FSWs attending the selected 50 sites. An application will be developed to be used at the server, point of care, and interface with existing MARPS systems. All the fifty sites will be connected to the centralized database via GSM modems. This system will require close monitoring to ensure continued connectivity. This program will work collaboratively with the public health sector and NASCOP as well as with Implementing Partners.

Implementing Mechanism Details

Mechanism ID: 9097	**Mechanism Name: HIV Fellowships**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Nairobi	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	

Funding Source	Funding Amount
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Goals and objectives:The primary goal of the University of Nairobi HIV Fellowship program is to expand human capacity for HIV leadership, management, and focused technical areas in Kenya. Specific objectives of the program include; •Implement an in-service two-year senior fellowship program in three tracks: HIV/AIDS science, Epidemiology and HIV program management; Health Informatics and Health Economics.

•Support public and private organizations implementing HIV and other public health programs to plan and evaluate programs, develop pilot interventions, strengthen health-information management systems, and develop HIV/AIDS and related public health policies and implementation guidelines.

•Implement customized short courses targeting middle to senior level public health managers in HIV and related public health programs.Cost-efficiency strategy: In FY12, the final year of this cooperative agreement, the program will strengthen University of Nairobi's capacity to develop and provide web-cast short courses previously offered by the University of Washington (a subcontract of UON). This transition will substantially reduce costs associated with residential short course trainings and increase geographic. Transition to country partners: The program will pursue formal University Senate approval of the courses offered in the fellowship program and make necessary adaptations to integrate and transition the fellowship into a postgraduate program(s) offered at cost by the University. This activity supports GHI/LLC. Vehicle information: UON purchased one project vehicle in FY07. The vehicle currently serves both the program staff and fellows enrolled in the program.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9097		
Mechanism Name:	HIV Fellowships		
Prime Partner Name:	University of Nairobi		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	0	0

Narrative:

Target population: The HIV Fellowship program aims to expand capacity for leadership and management in HIV programs at the national level. The University of Nairobi (UoN) has been implementing the fellowship which is now in the final year of the program. The fellowship targets middle to senior level public health managers in HIV and related public health programs.

Approaches: The program utilizes both didactic and web based approaches to delivering the training activities. The didactic lectures are delivered at the UNTID building at the UoN. The UoN has subcontracted the University of Washington (UW) to provide technical expertise in the design of web-based lectures and use of webcast technology. Through fellow attachments, the program provides support to host institutions working in HIV and related health programs to improve health service delivery systems. Fellows in the program undertake a funded non-research project to help the host institution address system and other barriers to effective service delivery.

Targets and achievements: The program will graduate 13 cohort I fellows in January 2012, and is currently supporting 13 cohort II fellows. In FY11 UoN have admitted 7 cohort III fellows to be supported in FY11 and FY12. In FY10, the HIV fellowship offered 8 targeted short courses to 257 participants in the health care sector across the country. In the final year of this cooperative agreement, UON will continue to implement the fellowship program and will be expected to graduate cohort III fellows. In addition, they will continue to offer targeted short courses in leadership and management, health communication, health economics, HIV epidemiology, biostatistics, efficiency and resource mobilization. The program will develop a web based resource learning center at the University of Nairobi for live webcast and archived lectures. Using the local web-based resources the program will be able to train 300 participants in these thematic areas in FY12.

Monitoring and evaluation: The UoN has hired a monitoring and evaluation expert to keep track of the courses

offered, quality, and report the achievements. The UoN has developed a concrete M&E plan to ensure the quality of the program. The plan involves routine evaluation of course facilitators and web-cast lectures by fellows, site visits to fellows in host institutions and a planned mid-term evaluation

Implementing Mechanism Details

Mechanism ID: 9108	**Mechanism Name: American International Alliance, Twinning Center**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: American International Health Alliance Twinning Center	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 731,500	
Funding Source	**Funding Amount**
GHP-State	731,500

Sub Partner Name(s)

DePaul University, Chicago ILL	Kenya Episcopal Conference and Catholic Secretariat (KEC-CS) Nairobi ,Kenya	

Overview Narrative

1.Goals and objectives: This partnership aims to increase the capacity of Kenya Episcopal Conference-Catholic Secretariat (KEC-CS) Commission for Education and Religious Education to design, implement, sustain, monitor and evaluate multiple school and community-based Abstinence and Behaviour change programs for Youth (ABY).

2. Cost-efficiency strategy: This partnership utilizes volunteer efforts in order to adapt, implement, monitor and evaluate a nationwide school-based HIV prevention intervention for Kenyan youth aged 11-14. KEC-CS leverages over 580,000 volunteer hours per year from a workforce of over 20,000 administrators and teachers while DePaul leverages nearly 2,000 volunteer hours from faculty, staff and students. This significant volunteer effort has enabled the program to scale up from reaching 10,619 youth (5,823 female; 4,796 male) per year in 2006 to

reaching 147,829 youth (79,471 female; 68,358 male) per year in 2010. To date, this program has reached over 350,000 youth since it began in 2006. 3.Transition to country partners: AIHA partnerships are volunteer-based peer-to-peer programs, with an emphasis on professional exchanges to build capacity in Kenya, voluntary contributions, and leveraging private sector resources in order to create sustainability. DePaul University increases the capacity of KEC-CS in order for them to have ability in future to acquire and manage their own funding. 4.Vehicle information: One vehicle was purchased with FY6 funds for mentoring and monitoring visits. Please note that target populations, geographic coverage, and M&E plans are addressed in budget code narrative. This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Education	201,558
Gender: Gender Equality	100,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increasing women's legal rights and protection

Budget Code Information

Mechanism ID:	**9108**
Mechanism Name:	**American International Alliance, Twinning Center**
Prime Partner Name:	**American International Health Alliance Twinning Center**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	731,500	0

Narrative:

This mechanism will continue to address unique HIV prevention needs of Kenyan youth in primary school within 25 Dioceses of the Catholic Church across all 7 Kenyan provinces. The mechanism currently implements Making Life's Responsible Choices (MLRC) program (targets 40,520) and the Families Matter! Program (FMP) (targets 12,000).

MLRC is a school-based abstinence and behavior change program for Kenyan youth (ages 11-14) that builds on elements and activities from standard HIV prevention evidence-informed interventions (EBIs) and incorporates both Kenyan and Christian cultural perspectives and activities. KEC-CS has been delivering this intervention in Catholic-sponsored schools for several years, and has been working with DePaul University on the development, implemention, evaluation, and modification of various aspects of the MLRC program since 2005. MLRC will be assessed to determine its effectiveness using the Kenyan HIV Prevention Intervention Analysis Tool and will be revised as necessary to ensure it meets the standards of being an EBI.

FMP is an evidence-based, parent-focused EBI for parents, guardians, and other primary caregivers of preadolescents ages 9–12 years. Delivered in 5 weekly sessions to give parents time to internalize new information and practice skills, the program promotes positive parenting practices such as positive reinforcement and parental monitoring and effective parent-child communication on sexual topics and sexual risk reduction. The goal of FMP is to reduce sexual risk behavior among adolescents, including delaying onset of sexual debut, by training parents to deliver primary prevention messages to their children. More effective parental communication can help to delay their children's sexual behavior and increase protective behaviors as children get older. The intervention also links parents to other critical EBIs including HTC and VMMC. Quality assurance of FMP is promoted through rigorous training and certification of facilitators, ongoing process monitoring with standardized tools, and QA site visits by a CDC activity managers and technical experts.
For further QA, this mechanism has put in place for all sites the following: use of approved national curricula; emphasis of importance of fidelity to the curricula; use of trained/certified pair of gender balanced facilitators; trainings on EBIs are conducted by certified national trainers; observed practice of implementation is done soon after training; use of standardized, national data tools at every stage of EBI implementation; and regular field visits by trained program staff to check on delivery of EBIs and offer support supervision.
Since 2005, the partnership has built and sustained an extensive M&E system across national, diocesan, and school/local levels. Monthly monitoring forms are completed by head teachers at schools and sent to KEC-CS for data collection/analysis. Monthly site visit reports are completed by KEC-CS during their monitoring visits. This partnership is implementing a targeted evaluation of the MLRC program in COP11 to measure changes in participating youth's HIV-related knowledge, attitudes and risk behaviour. The FM program has an extensive M&E system where program facilitators compile necessary M&E data and send it to the national KEC office for data collection and analysis. All data are summarized into Quarterly Reports completed jointly by KEC-CS and DePaul University and then submitted to AIHA & CDC.

Implementing Mechanism Details

Mechanism ID: 9110	Mechanism Name: APHL
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Association of Public Health Laboratories	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 580,000	
Funding Source	**Funding Amount**
GHP-State	580,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Goals and objectives:

Through this mechanism APHL will:

Objective 1. Scale up establishment of Laboratory Information Systems (LIMS) to provincial and high volume district hospitals with a focus on introduction of open source systems. Labware based LIMS already installed at six. Computer literacy of laboratory personnel will be enhanced to ensure full utility of LIMS.

Objective 2. Strengthen equipment management systems at medical engineering department Ministry of Medical Services including establishing of inventories using international nomenclature of all lab equipment, maintenance schedules and tracking system and lists of high mortality spare parts. Biomedical engineers will be trained to rehabilitate broken down equipment.

Coverage:

This activity with national coverage will be carried out at centrally located reference laboratories, in six provincial and up to 20 county/district level laboratories.

Transition to country partners:

All APHL activities will be entrenched in MOH facilities and reference laboratories. Partnerships with Ministry of

Health Departments of laboratory, Biomedical Engineering and Health Information systems as well as local training institutions, universities and colleges, and professional associations will be developed to facilitate long term sustainability of all initiatives.

No vehicles will be procured in this activity. This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9110**		
Mechanism Name:	**APHL**		
Prime Partner Name:	**Association of Public Health Laboratories**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	580,000	0

Narrative:

PEPFAR support and is harmonized with the National Public Health Laboratories strategic plan and the National Health Strategy in Kenya. The Association of Public Health Laboratories (APHL) is a non-profit organization and has worked in Kenya since 2004. APHL assisted the Kenyan Ministry of Health implement a laboratory information system in 6 sites (Central TB Reference Laboratory, Central Microbiology Reference Laboratory, Central HIV Reference Laboratory, Nakuru Provincial General Hospital, Mombasa Provincial Hospital and

Kisumu Provincial Hospital). APHL also assisted the MOH to provide training in basic computing and worked with the central data to build LIMS support capacity. At the national level, the impact of the system has started to be felt as the turnaround time is being monitored and the lab managers are able to put measures in place to reduce the turnaround time, reagent inventory can now be monitored easily reducing frequent stock out hence continues rendering of services, interface of the laboratory instrumentation with the system has led to data accuracy and reduces the waiting period occasioned by manual entry and calculation of results. Individual and summary reports can now be automatically retrieved/printed at a click of a button and management are able to assess workload per section. LIMS has contributed greatly towards laboratory accreditation.

FY12 activities will build on earlier support and expand LIMS to 8-10 additional sites. Focus will be on Open Source LIMS (Laboratory Information System) and the LIMS will be interoperable with other sub systems including the District Health Information system recently rolled out to all counties and other health information subsystems (EMR's, Logistic management systems, etc). Capacity building will continue at all levels in close collaboration with the HMIS department of MOH to roll out of LIMS. The activities during rollout of LIMS to the next phase of provincial/Country laboratories will include site assessments, collection of user requirements specifications (URS), physical infrastructure modification , basic computer training, Installation of the hardware and training on system use. This support will not only enable the country to generate reliable data for surveillance and HIV/AIDS interventions planned by the MOH but other diseases diagnosed in the laboratory as well.
Another area of focus will be strengthening equipment management systems at medical engineering department MOMS, establishing inventories using international nomenclature of all lab equipment, maintenance schedules and tracking system and lists of high mortality spare parts.

APHL will continue to build local capacity in MOMS at the central data unit and at the department of biomedical engineering.

Implementing Mechanism Details

Mechanism ID: 9127	**Mechanism Name: Prevention Technologies Agreement (PTA)/I Choose Live**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 461,039	
Funding Source	**Funding Amount**
GHP-State	461,039

Sub Partner Name(s)

I Choose Life		

Overview Narrative

This activity will: 1. Strengthen peer education on SRH in University of Nairobi (UON), United States International University (USIU) and Kenyatta University (KU), referred to as the "universities" by training an additional 150 new peer educators (PEs) and retraining 100 previously trained peer educators and equipping them with behavior change communication skills

2. Reach individuals in the "universities" and their surrounding communities with messages on prevention of HIV and unintended pregnancy, via radio messaging, thematic events, behavior change communication groups (BCCGs), promotional information materials and online social networks

3. Integrate SRH activities into existing HIV and AIDS prevention activities

4. Build the capacity of the universities (UON, USIU and KU) to carry out SRH interventions for students in the universities and enhance project sustainability

5. Assess effectiveness of integration of SRH activities in improving students' utilization of services through strengthened monitoring and evaluation

This activity supports GHI/LLC and is completely funded with pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	50,000

TBD Details

(No data provided.)

Key Issues

Family Planning

Budget Code Information

Mechanism ID:	9127		
Mechanism Name:	Prevention Technologies Agreement (PTA)/I Choose Live		
Prime Partner Name:	FHI 360		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVCT	400,000	0

Narrative:

FHI360 will continue to support ICL to provide HIV counseling and testing (HTC) targeting youth aged 18 years and above at Kenyatta University, University of Nairobi and United States International University.HTC will be provided as an entry to behavior change and identification of youth living with HIV for care and treatment referrals and support. HTC will be provided through mobile outreaches at the institutions in collaboration with trained ICL supported HTC service providers. HTC Clients will be followed up by ICL with risk reduction counseling, condom self-efficacy promotion and referrals for care and support to local comprehensive care centers offering youth friendly HIV treatment and care services. Youth living with HIV will be trained to promote HIV prevention with positives. HTC test kits will be provided by the District AIDS and STIs Coordinator (DASCO) through local health facilities.

Data on HTC including referral services will be collected through HTC registers to be provided by the DASCOs. Locally developed registers will be used to capture data on numbers of individuals trained as peer educators, BCC campus change agents and supervisors and individuals reached with BCC messages.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	61,039	0

Narrative:

Support the capacity building of the University Health Staff to provide an integrated RH/HIV services including information and also develop a transition plan to ensure sustainability of the interventions [390 USD]

FHI 360 has collaborated with and built the capacity of I Choose Life (ICL) to reduce HIV, other sexually transmitted infections (STIs) and unintended pregnancies among youth in institutions of higher learning since 2005. This collaboration to advance the ABC approach for infection prevention and averting unintended pregnancies began at the University of Nairobi (UoN) and has now been scaled up to other universities. In addition, training

of university health services staff in RH/HIV integration as well as breast and cervical cancer screening was recently added to the intervention package. *In the upcoming year, FHI 360 proposes to continue to collaborate with ICL to:* *• Support, strengthen and sustain peer education activities at University of Nairobi, United States International University, Daystar University and Kenyatta University campuses through peer education and behavior change communication activities (- train 150 on peer education, train 40 on BCC,100 on life skills & 25 as Campus Change Agents & supervisors, reach 30,000 individuals thro thematic events, reach 2,500 thro gender forums, broadcast SRH messages on 3 campus radio stations to reach 40,000 individuals, reach 6,000 through bulk text messages, print 10,000 copies of BCC materials, 20 BCCGs to reach 200 students, offer);* *• Build capacity of university health services staff to provide integrated RH/HIV services on campuses, including RH cancer screening, in collaboration with the MOH (train 10 service providers on breast & cervical cancer screening & supervision of services and provide these services and STI screening to 2,000 individuals, counsel and test 6,000 individuals & offer SRH services thro other collaborations to 5,000) ; and* *• Develop transition plans for sub recipient I Choose Life to sustain components of the intervention package in collaboration with the universities (initiate adopt-a-peer educator approach to reach 30 alumni; conduct 2 meetings with administrations of universities).*

Implementing Mechanism Details

Mechanism ID: 9136	**Mechanism Name: IMC MARPS**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: International Medical Corps	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,541,402	
Funding Source	**Funding Amount**
GHP-State	1,541,402

Sub Partner Name(s)

(No data provided.)

Overview Narrative

1. Goals and objectives:
With funding from PEPFAR IMC is currently supporting implementation of HIV Prevention and Care services in the districts of Suba and Migori in Nyanza Province, the overall goal of the project being to reduce the number of new HIV infections in Suba and Migori district in Nyanza province through Evidence Informed Behavioral Interventions (EBIs) biomedical and structural interventions.
Objectives

- *Provide 97,204 individuals with HIV testing and counseling with all receiving their test results*
- *Advocate for positive gender norms in relation to HIV/AIDS prevention and utilization of services among the targeted communities*
- *Reach 19,500 MARPs (Fisher folk 15,500, 4,000 FSWs) and 15,321 to be provided with cPwP through individual or small groups, using the Fisher Folk Peer Model strategy*
- *Provide Family matters! Program, Health Choices 1 and Health Choices 2 to 8,582 youth aged 9 – 24 years.*

2. Cost-efficiency strategy:
IMC will adopt integrated programming and leverage on MoH and other partner activities for cost efficiency. Purchase of a program car will significantly reduce cost of maintaining and hiring a car.

3. Transition to country partners [or Expected timeline for award/Calculation of funding]:
IMC is identifying local partners (in consultation with the MoH and other stakeholders) to which the program will be transited to the expiry of its implementing agreement period.

4. Vehicle information:
IMC purchased a motor boat and Toyota Land cruiser with FY 2010 funds. The vehicle was for official use for transportation of program staff to meeting and program activities and program supplies sites in Suba & Migori. This was a strategy to reduce program cost on car hiring and maintenance. This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Motor Vehicles: Purchased	37,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Mobile Population
Family Planning

Budget Code Information

Mechanism ID:	**9136**		
Mechanism Name:	**IMC MARPS**		
Prime Partner Name:	**International Medical Corps**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	107,241	0

Narrative:

IMC will support the provision of HIV prevention in Suba, Nyatike and Migoi Districts with interventions targeting 4,842 youth aged 9 to 17 years. The objective is to provide them with information to help them make informed choices about their sexual and reproductive health.

Healthy Choices (HC) I

Healthy Choices I (HCI) targets in-school youth aged 10-14 years and aims to delay sexual debut by providing knowledge and skills to negotiate abstinence, avoid negative peer pressure, avoid or handle risky situations and to improve communication with a trusted adult. HC I consists of 8 modules of approximately one hour each. It can be delivered in 4 sessions of 2 hours each or in 8 sessions of 1 hour each. Quality assurance of HC is promoted through rigorous training and certification of facilitators, ongoing process monitoring with standardized tools, and quality assurance site visits by a capacity building agency. A portion of HVAB funding will also be used to infuse abstinence / be faithful messages in EBIs that are implemented among the following priority populations: 15-19-year-olds, serodiscordant couples, men aged 30-44, and persons living with HIV.

The Families Matter! Program

FMP is an evidence-based, parent-focused EBI for parents, guardians, and other primary caregivers (hereafter referred to as "parents") of preadolescents ages 9–12 years. Delivered in 5 weekly sessions to give parents time to internalize new information and practice skills, the program promotes positive parenting practices such as positive reinforcement and parental monitoring and effective parent-child communication on sexual topics and sexual risk reduction. The goal of FMP is to reduce sexual risk behavior among adolescents, including delaying onset of sexual debut, by training parents to deliver primary prevention messages to their children. More effective parental communication can help to delay their children's sexual behavior and increase protective behaviors as their children get older. The intervention also links parents to other critical evidence-based interventions including HTC and VMMC. Quality assurance of FMP is promoted through rigorous training and certification of facilitators, ongoing process monitoring with standardized tools, and quality assurance site visits by a CDC activity managers and technical experts.

Quality Assurance
To promote quality assurance, IMC has put in place for all sites the following: use of approved national curricula; emphasis of importance of fidelity to the respective curricula; use of trained and certified pair of gender balanced facilitators; trainings on EBIs are conducted by certified national trainers; observed practice of implementation is done soon after training; use of standardized, national data tools at every stage of EBI implementation; and regular field visits by trained program staff to check on delivery of EBIs and offer support supervision. Targets for each of the interventions are laid out at the start of the project year which is tracked on a monthly basis through respective field reports. Results are analyzed on a quarterly basis. The targets are in line with the PEPFAR Next Generation Indicators (NGI's). Monitoring and evaluation will be conducted with EBI approved data capture / monitoring tools. Field staff will send reports on a monthly basis; these reports will be compiled into an overall report quarterly which will be submitted to CDC.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	268,084	0

Narrative:

Target population: IMC is implementing comprehensive HIV prevention services in Migori and Homabay counties in Nyanza region targeting the youth and general population as well as MARPs (female sex workers and fisher folk). HIV prevalence among the general population (14.9%) and MARPs (22%) is higher than the national average of 7.1%. Testing coverage varies with 63.5% among women and 39.8% in men. HTC services are provided as part of the combination HIV prevention services targeting these population groups.

HTC approaches: HTC approaches used are both Client and Provider Initiated that are provided primarily through targeted mobile/outreach services, door-to-door HTC and targeted HTC campaigns.

Targets and achievements: In the first 9 months of 2010 COP, IMC has provided HTC services to 119,250 individuals out of a target of 120,000 with an HIV prevalence of 4.6%. 66% of this target was achieved through door-to-door approach. The program also supported capacity building of service providers in Early Infant HIV Diagnosis, Proficiency testing, national re-testing recommendations and data collection tools. In FY 2012, the program will provide HTC services to 97,204 individuals of these 40% new testers, 30% couples and 18% MARPs.

Proportion allocation of funding: 40% of the budget supports HTC among the MARPS and is provided as part of the combination HIV prevention package.

Testing algorithm: The national testing algorithm is used.

Referrals and linkages: A directory of existing GoK and other HIV care and treatment facilities is maintained and all HIV positive clients are referred to these for further care using the NASCOP referral tool. A regular analysis is of the status of referral between the HTC program and the care and treatment facilities undertaken to monitor linkages and take corrective action as needed. A system is in place to provide follow up visits for clients tested at home providing opportunity for follow up of clients who have not accessed care and or treatment services.

Quality management: To maintain quality service providers are trained and certified by NASCOP. Quality Assurance systems are in place including proficiency testing and counselor support supervision system. DBS for QA is also taken for every 20th client. Use of job aids and timers ensure standardization of services. The program collaborates with the respective District Health Management Team to conduct monthly counselor supervision that includes observed practice.

Monitoring and evaluation: The program uses the national tools for both data recording and reporting. Indicators collected include individuals receiving HIV testing disaggregated by age, sex, couples, MARPs.
Promotional activities: Peer led networks are used to encourage and create demand among the MARPs to access the range of HIV prevention services. Use of mass media campaigns with targeted messages to the general population is used to promote knowledge of HIV status as a key step in protecting oneself and family. The program also works trains and works with some community members who provide information to other community members regarding accessing available HIV prevention services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1,166,077	0

Narrative:

IMC will continue to expand access to a high quality comprehensive package of HIV prevention, care and treatment services for general population and MARPS in Nyanza Province specifically in Suba, Migori and Nyatike districts.

The target populations will be FSWs (4000), fisher folk (stepping stones 10000, sister to sister 5500), cPwP (15321) in Migori and Homa Bay counties with total populations of 322,002 and 352,973 respectively. This program will continue to target high risk sexual behavior prevalent among these populations including incorrect and inconsistent condom use particularly with regular sex partners.

IMC will work with the beach management units to select, recruit and train fisher folk peer leaders on peer education and facilitation skills of peer sessions of the Fisher Folk Peer Model. Small groups of 20 individuals are identified by the peer educators based on age and gender to enhance discussion. During the peer sessions, demand creation and referrals for other services like HTC VMMC, STI treatment, HIV care and treatment services will be offered. Each group undergoes 5 sessions on various SRH topical issues to for a person to qualify. Follow up sessions will be conducted after 6 months for each group. Other behavioral risk factors that will be addressed include excessive alcohol and substance abuse, gender based violence and low adherence to treatment among fisher folk.

This mechanism will support implementation of the Combination Prevention Interventions for FSWs as defined in the National Guidelines for the package of services for SWs. These comprise evidence-informed behavioral, biomedical and structural interventions. Behavioral interventions include peer education and outreach, condom and lubricant demonstration and distribution and risk assessment, risk reduction counseling and skills building. Specific EBIs for this group will be RESPECT, Sister-to-Sister and Safe in the City. Biomedical interventions include HTC, STI screening and treatment, TB screening and referral to treatment, HIV care and treatment, RH services, Emergency contraception and Pre-exposure prophylaxis.

IMC is considering initiating Treatment as Prevention for MARPS and initiating Pre-exposure prophylaxis where feasible, malaria treatment all within its drop in and service centres. Among the discordant couples IMC will implement an EBI – EBAN with the objective of lowering the rate of risky behavior among HIV-discordant couples and promoting safe sex through increased condom uptake in this sub population. This shall be offered in an integrated setup with other services also available

3700 Youth aged 15–19 years and 20-24 years both in and out of school will be reached with Healthy Choices II (HCII) that aims to delay sexual debut, promote secondary abstinence or have protected sexual intercourse, by providing knowledge and skills on correct and consistent condom use, handling peer pressure, and learning one's HIV status.

To promote quality assurance, IMC will provide On Job Trainings, mentorships, Continuous Medical Education, exchange visits for bench marking and refresher courses where knowledge and/or skill gaps are identified and addressed. Data generated by the facilitators and other service providers will be entered into database and periodically analyzed for programming purposes. Quarterly support supervision with NASCOP, ministry of fisheries and DHMTs will ensure quality of services delivered is of the expected standard.

Implementing Mechanism Details

Mechanism ID: 9139	Mechanism Name: Capacity Kenya

Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: IntraHealth International, Inc	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

African Medical and Research Foundation	Deloitte Consulting Limited	Management Sciences for Health
Training Resources Group		

Overview Narrative

This project works to strengthen the health sector's Human Resources for Health (HRH) to improve health outcomes. The projects focus on HR issues for health including performance needs assessments, training institution's ability to address current health needs, recruitment- hiring-deployment mechanisms in the health sector to minimize imbalanced health workers distribution, retention initiatives particularly for marginalized regions, and focused planning and management of HR needs for the country. Additionally, the project supports the HRH information system as well as policy initiatives related to HRH. The Capacity Project intends to purchase 1 vehicle in FY12. This activity supports GHI/LLC and is funded primarily with pipeline in this budget cycle.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms

Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	**9139**
Mechanism Name:	**Capacity Kenya**
Prime Partner Name:	**IntraHealth International, Inc**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	0	0

Narrative:

The funds will be used to support health workers salaries and managent to ensure retention and quality of performance. The health workers supported by the funds work in the Government of Kenya facilities that are in hard to reach regions, the purpose is to ensure continutiy of services(Especialy PEPFAR supported services) in these regions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	0	0

Narrative:

The project has given support to NACC and NASCOP. This has enabled them to hire a Youth Program Officer under the Rapid Hiring Plan to support the delivery of HIV care and support services targeting OVCs. The Officer is based at NACC and oversees patient attendants, patient support staff, and CCC attendants in different regions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	0	0

Narrative:

Support has been directed to strengthening the HR capacity of the National Public Health Laboratory Services

(NPHLS). The project recruited ICT specialists to support the roll out of the Laboratory Management Information and has enabled its full implementation. The project has continued to offer technical advice to enable NPHLS to design appropriate HRH and recruitment plans. Through this support, NPHLS has gained additional partner resources to establish new positions that enable it to implement its mandate.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	0	0

Narrative:

The project hired staff under the RHP program who continue to offer services in facilities and CCs across the country (8 provinces) focused on improving access to CT. The project also supported the development of Human Resources Information System which has availed critical information on staff currently working in health facilities. Strategic information is generated from the current engagement with the Global Fund. The TA at NASCOP also trained the provincial and district level HIV coordinators and health records officers from Nyanza, Coast, and Nairobi provinces on HIVQUAL. In addition, this project will support activities which aim to improve staffing of personnel responsible for management of health data at the facility and county levels. Specifically, this project will support 12 HMIS technical advisors, 12 district/county health records and information officers, and staff for the division of Health Information System help desk for maintenance of MFL.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

The project has applied resources to strengthen systems for health services delivery with particular emphasis on HIV. These include strengthening the HR system for rapid recruitment of new staff, which GOK has applied in the recent massive hiring of over 10000 new workers under the Economic Stimulus Program. The project uses an innovative model for induction using self-directed e-learning approaches, which will enable rapid hiring of staff and improve staff performance. Similarly, the project has installed an integrated HR information system that enables MOH to make informed decisions around staff deployment, training, and performance management. The project has also demonstrated its Rapid Hiring Plan approach and enabled MOH to adapt these practices for recruitment and routine management. In addition, the project is working to strengthen institutional and HRM systems at the National AIDS and STI Control Program, Kenya Medical Supplies Agency, and the Division of Reproductive Health. This entails comprehensive HR assessment, developing institutional strategic plans, and designing interventions that can address limitations. The project is also working with the National Transitional Taskforce to design structures and strategies for health service delivery, including HIV services, and reforms needed to enable NASCOP, NACC, DRH and KEMSA to offer quality decentralized services to the new 47 counties

as outlined in the new Constitution.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

Through project support to NASCOP and NACC, the respective TA were able to support activities geared to improving VCT uptake across the country. Similarly, contract staff working in CCCs across the country have continued to support VCT promotion and VCT activities within the respective regions and facilities. The project has also recruited and deployed VCT counselors across the country in facilities in the APHIAPlus Zones, who provide direct service delivery and document data for strategic information on uptake and progression to enrolment for ARV drugs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	0	0

Narrative:

Through project support to NASCOP and NACC, the respective TAs were able to support activities geared to improving VCT uptake across the country. Similarly, contract staff working in CCCs across the country have continued to support VCT promotion and actual VCT activities within the respective regions and facilities. The project has also recruited and deployed VCT counselors across the country in facilities in the APHIAPlus Zones, who provide direct service delivery and document data for strategic information on uptake and progression to enrolment for ARV drugs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

Contract staff was hired and offers services across health facilities in 8 provinces and continue to participate in facility and regional level HIV prevention activities. Similarly, the project hired TA to support the Division of Reproductive Health (DRH) in rolling out integrated reproductive health services to both youth and adult populations. Specifically the TA has supported better leadership and management for effective and efficient coordination of high quality services through the implementation plan and has improved DRH coordination of services and commodity security through newly created teams, including separation of the FP Program into the RH Commodity Logistics Management Unit (CMLU) and the FP services program. The TA has also offered ongoing technical support to DRH programs including RT Cancer, to finalize, launch and disseminate guidelines; to revise the ASRH Policy and Guidelines and develop a more comprehensive approach to adolescent health; to revise the Master of Medicine (Ob/Gyn) curriculum; to support the Division in planning and hosting the Adolescent Sexual

Reproduction health (ASRH) Conference and co-hosting the Community Approaches to FP Regional Conference.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	0	0

Narrative:

The project will provide technical assistance in the dissemination of Nutrition and HIV information through various forums (Nutrition and HIV Advocacy); support in forecasting and quantifying nutrition and HIV commodities; development and dissemination of completed IEC Materials for harmonized Nutrition and HIV messages; dissemination at all levels of guidelines that are currently out for external review; provision of TA support in implementation of operational research on nutrition at selected sites; technical support for the completion of review processes and dissemination of a community Nutrition and HIV manual; attendance at two workshops planned by NASCOP Nutrition program to develop the QA and SOPS; participation in the dissemination that will be done through various forums with the PNOs and PCNOs; and support for the national office in the dissemination of the nutrition and HIV guidelines using innovative approaches. The funds will be used to pay health workers salaries namely nurse and clinical officers' in various health facilities within the country's rural and hard to reach areas. This will increase the number of staff in such facilities, a pull factor for mothers to seek services at health facilities and especially delivery services. More numbers of staff will enable targeted facilities to offer services on a twenty four hours basis, hence boost health facility based deliveries. The staff will also help improve on the quality and increase the scope of services offered at such facilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	0	0

Narrative:

The Project hired staff under the RHP program who continue to offer services in facilities and CCCs across the country (8 provinces) focused on improving access to CT. The Project also supported recruited TA for NASCOP with the mandate to support the formulation of policies and guidelines on ART. The TA supported the finalization and dissemination of national ART guidelines and worked with the TWG to develop the first HIV Drug Resistance country report in 2010, the design and roll out of regional sensitization on HIV Drug Resistance Early Warning Indicators (HIV DR EWIs), HIV Drug Resistance monitoring surveillance in two facilities in Kisumu, and training on HIV Drug Resistance Database for Kenya. Similarly the Project offered technical assistance in finalization of harmonized in-service curricula in HIV care and treatment sections.

Implementing Mechanism Details

Mechanism ID: 9141	Mechanism Name: AIDSRelief
Funding Agency: U.S. Department of Health and	Procurement Type: Cooperative Agreement

Human Services/Health Resources and Services Administration	
Prime Partner Name: Catholic Relief Services	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

Catholic Medical Mission Board	Futures Group	University of Maryland

Overview Narrative

Catholic Relief Services (CRS) AIDS Relief project through Track 1 funding supports implementation of comprehensive HIV prevention, care and treatment activities for Faith-based facilities (FBO) in Kenya. CRS facilitates FBO facility linkages to Government of Kenya health systems and strengthens business development and advocacy for the facilities. They offer comprehensive training for all local partner treatment facilities (LPTFs) including clinical HIV care, laboratory, adherence, community mobilization, strategic information, finance, compliance, and supply chain management. The projects goals are aligned with those of the GHI principles including decentralization of HIV services into existing clinics, maternal and child health, and TB clinics.

To increase cost efficiencies, CRS will support task shifting to ensure effective use of clinical staff, prioritized home visits, and a strengthened community-based treatment support initiative.

CRS will build local partner capacity of Kenya Episcopal Conference and Christian Health Association of Kenya by preparing incremental transfer of its functions, responsibilities, and resources for grant management, supply chain, and strategic information the end of February 2013. The project will provide mentorship on reporting the comprehensive set of required donor indicators, ensuring a high level of quality, timeliness, validity, and reliability with linkage to the national M&E framework. Quarterly dash board reviews for project progress, performance, and updates will be conducted.

This activity supports GHI/LLC.

CRS has purchased 45 vehicles between FY04-11 since the beginning of the award in 2004. CRS does not request for purchase of any new vehicle.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	**9141**		
Mechanism Name:	**AIDSRelief**		
Prime Partner Name:	**Catholic Relief Services**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	0	0

Narrative:

Catholic Relief Services (CRS) has been supporting care services in Nyanza, Western, Rift, Central, Eastern, Coast and Nairobi Provinces through Track 1 funding since 2004. CRS is in the process of transitioning these activities to local partners: Kenya Episcopal Conference and Christian Health Associations of Kenya. The first regions to be transitioned are Nairobi, Nyanza, Eastern, and Central. CRS will provide direct support in Western and Coast while continuing to provide support to the local partners in the other regions. By March 2011, CRS had cumulatively enrolled 124,842 of whom 71,737 are active and receiving cotrimoxazole prophylaxis.

CRS will work with the MOH at all levels to jointly plan, coordinate, implement and ensure provision of quality HIV care and support to 42,992 current adult patients in FY12. In FY 13, CRS will transition all the activities to the local partner, but will remain as a sub partner for capacity building.

CRS will offer a package of services including HIV testing to partners and family members of index patients and enroll those that test HIV positive to care and support; provision of Basic Care Kit (safe water vessel, multivitamins, insecticide-treated mosquito nets, chlorine for water treatment and educational materials); supplemental and therapeutic nutrition (FBP) to all eligible HIV positive patients; prevention with positives(PwP) except condom and family planning promotion.

CRS in collaboration with MOH will support targeted capacity building for HCWs and offer continuous medical education on care and support, e.g. OI diagnosis and treatment. CRS will identify areas with staff shortages, support recruitment of additional staff, and support good commodities management practices to ensure uninterrupted supply of commodities. Community interventions for HIV infected individuals will be supported including peer education and use of support groups to provide adherence messaging; effective defaulter tracing and follow up to improve retention in all facilities; referral and linkages to community based psychosocial support groups; water, sanitation and hygiene programs; economic empowerment/income generating activities projects; home based care; gender based violence support programs; vocational training; social and legal protection; and food and nutrition security programs. Strategies will be adopted to ensure access and provision of friendly services to youth, elderly and disabled populations. Strategies to increase access of care services by men will be employed including supporting male peer educators, mentors and support groups, and supporting women to disclose and bring their male partners for testing.

CRS will continue to strengthen data collection and reporting at all levels to improve reporting to NASCOP and PEPFAR. CRS will adopt the new generation indicators and support the development and use of electronic medical records system in accordance with NASCOP guidelines. Quality of care indicators (CQI) will be used for monitoring the quality of HIV care and support services and integrated into routinely collected data. Results will be used to evaluate and improve clinical outcomes. CRS will do a cohort analysis and report retention rates. CRS will support joint Annual Operation Plan (AOP) development, implementation, monitoring and evaluation, and health system strengthening to facilitate sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	0	0

Narrative:

Catholic Relief Services (CRS) has been supporting TB/HIV services in Nyanza, Western, Rift, Central, Eastern, Coast and Nairobi Provinces through Track 1 funding since 2004. CRS is in the process of transitioning these

activities to local partners: Kenya Episcopal Conference and Christian Health Associations of Kenya. The first provinces to be transitioned are Nairobi, Nyanza, Eastern and Central. CRS will continue to provide support in Western and Coast while continuing to support to the local partners in the other provinces. CRS provides TB/HIV services in line with the MOH Division of Leprosy, Tuberculosis and Lung Disease (DLTLD) and the National AIDS and STI Control Program (NASCOP).

Kenya's 5-Year National AIDS and TB Strategic Plans shared objectives are to ensure co-infected TB patients and suspects receive quality and comprehensive care and that the threat of drug resistant TB is contained. CRS supported training and hiring of additional staff, procurement of simple laboratory TB diagnostics, and minor renovations of TB Clinics to ensure better infection control practices. CRS used the existing national TB and HIV M&E framework and tools to report on TB/HIV Indicators.

For FY 12 and 13, CRS will continue to intensify efforts to detect TB cases through clinical exams and laboratory investigations and ensure successful TB treatment through provision of appropriate treatment. To ensure timely and accurate TB diagnosis, CRS will ensure that facility staff are well trained and supported by well equipped and staffed laboratory. CRS will ensure that adequate supplies of anti-TB drugs are available and that TB treatment guidelines are followed. All TB patients on treatment will be monitored both clinically and through periodic sputum examination.

CRS will ensure that all TB patients are screened for HIV and 95% of TB-HIV co-infected patients are put on cotrimoxazole and ARVs as early as possible regardless of the CD4 count as per the national guidelines. CRS will support the "one stop" model that provides integrated TB and HIV services in all TB clinics. All TB clinics will be stocked with cotrimoxazole and ARVs.

CRS will support intensified TB screening using the national screening tool for 38,215 in FY12 and 48,400 in FY13 HIV infected persons identified in their HIV care settings. 1,911 co-infected patients identified in FY12 and 2,420 co-infected patients identified in FY13 will be put on TB treatment and those without active TB will be provided with Isoniazid Preventive Therapy (IPT) as per national IPT protocol.

CRS will ensure that the national IC guidelines are available at all sites and that staff are trained on IC. CRS will support scaling up of at least 2 components of the national TB infection control strategy in HIV care Settings, one of which should be fast tracking of patients with cough for expedited diagnostic work up and treatment. CRS will support timely transport of sputum specimens of TB retreatment cases from health facilities to the central reference laboratory for drug susceptibility testing and ensure results are returned to those facilities. CRS will expand prevention with positive (PwP) services except condom and family planning promotion, strengthen linkages between facility and community-based services, improve patient referral and tracking systems, and increase support for TB-HIV operations research. CRS will report selected custom indicators to assist with program management

and evaluation and monitoring of new activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	0	0

Narrative:

Catholic Relief Services (CRS) has been supporting pediatric care services in Nyanza, Western, Rift Valley, Central, Eastern, Coast, and Nairobi Provinces through Track 1 funding. CRS is in the process of transitioning these activities to local partners namely Kenya Episcopal Conference and Christian Health Associations of Kenya. The first provinces to be transitioned are Nairobi, Nyanza, Eastern, and Central.

By March 2011, CRS had 23,929 children enrolled in care with 8,491 receiving HIV care and 5,133 on cotrimoxazole prophylaxis. There were also 715 children on ARV prophylaxis. In FY 12 CRS will provide care and support services to 4,602 children currently on care. These activities will be transitioned to the local implementing partner in FY 13

CRS will provide comprehensive and integrated services to ensure HIV exposed children access pediatric care services. CRS will improve access to cryptococcal antigen testing, TB screening and management, pain and symptom relief, psychosocial support (including disclosure counseling and support) provided through education, counseling, and linkages to facility or community based support groups.

CRS will strengthen the provision of therapeutic or supplementary feeding support to children with growth faltering and provision of vitamin A, zinc, and de-worming; provision of safe water, sanitation and hygiene interventions (WASH) in the community and health facilities to prevent diarrhea and other illnesses among the HIV infected, exposed and other children in the community; and malaria screening, treatment, and provision of long lasting insecticide treated nets in malaria endemic areas. Emphasis will be on enhanced follow up and retention of all identified HIV infected and exposed children.

CRS will support the integration of HIV services into routine child health care and survival services in the MCH department, including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization guidelines; case management of diarrhea, pneumonia, and other childhood illnesses; and community outreach efforts. They will also support the care of the newborn by supporting hospital delivery and ensuring that there is provision for newborn resuscitation and care (thermal care, hygiene cord care) and prophylactic eye care.

Hospital and community activities will be supported to meet the needs of HIV infected adolescents such as support groups to enhance disclosure, adherence messaging, PwP, except condom and family planning promotion, substance abuse counseling, support for transitioning into adult services, and teaching life skills.

CRS will ensure optimized linkages of children to various programs including TB/HIV, PMTCT and OVC services, and other community based programs such as education, protection, legal, and social services. CRS will also support relevant class-based and on-job trainings, including continuous medical education. CRS will strengthen pediatric data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. With guidance from the national PEPFAR office, the new generation indicators will be adopted. To improve the quality of care and strengthen pediatric services, CRS will support supervision and mentorship activities and use the quality of care indicators (CQI and HIVQuaL) for monitoring the quality of pediatric HIV services and integrate them into routinely collected data.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	0	0

Narrative:

Target population: AIDSRelief will support HIV testing and counseling services in several mission/faith-based health facilities in following counties: Migori, Homabay, Kisumu, Siaya, Bungoma, Kakamega, Kiambu, Kirinyaga, Nyeri, Nyandarua, Kitui, Embu, Tharaka-Nithi, Meru, and Taita-taveta. Target population will include all patients, their family members and caretakers who access out and in patient services in all the supported facilities.

HTC Approaches: The program will utilize provider initiated opt out approach and the services are offered within all out patient departments, TB clinics, ANCs, special clinics, HIV clinics (targeting family members) and in patient departments. The counseling and testing is either done within the consultation rooms by trained clinicians or in counseling rooms by lay counselors within the outpatient departments if space is available or at the laboratories. Targets and achievements: In COP 2012, AIDSRelief will target to provide HTC services to 87,000 persons of which 20% will be tested as couples and 10% will be children below the age of 15.

Testing algorithm: National algorithm is being used.

Referrals and linkages: In order to strengthen referrals, AIDSRelief will put in place several important strategies. They include: use of peer educators as patient escorts from one hospital department to the CCC; same day enrollment of clients to CCC; use of an integrated defaulter tracing system for tracing patients who default on care or ART upon enrollment; introduction of documented referral system by use of the NASCOP referral booklet; use of mobile phones to follow up whether the client was actually enrolled.

Quality management: In order to improve and monitor quality of HTC services, AIDsRelief will put in place the following strategies: Training and continuing education of HTC providers; strict adherence to the standard operating procedures outlined in the national HTC guidelines; proper handling (storage and transportation) of HIV

rapid kits as per the guidelines; putting in place a functional QA systems as provided for in the national HTC guidelines; participation in EQA- proficiency testing and finally conducting support supervisory visits.

Monitoring and evaluation: AIDSRelief will use all ministry of health' tools to capture HTC data, both for couples and individual patients. These include HTC lab Register and Monthly summary tool (MOH 711). MOH approved HTC lab registers will be introduced at all HIV testing points except PMTCT.

Promotional activities for HTC: All patients attending the supported facilities will be given health talks including the need for HIV counseling and testing and the importance of couple testing. Couples are given priority services. Sexual partners of HIV positive clients will be given individualized invitations though the index clients and available avenues for testing including individualized home testing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

CRS implements comprehensive prevention, care and treatment programs nationally. In FY 2012/13, CRS will expand HIV prevention services to include an evidence based behavioral intervention (EBI) for specific target populations in clinical settings at comprehensive care center (CCC), TB and Maternal Child Health (MCH) clinics as part of HIV combination prevention programs. The EBI implemented will be Positive Health and Dignity Prevention (PHDP) targeting adult male and female and adolescents living with HIV (PLHIV).

PHDP is an ongoing 5-10min group and individual level intervention that targets PLHIV in clinical and community settings. This mechanism will support this intervention which constitutes of ART adherence counseling and support; partner and family testing; provision of PEP to the discordant spouse; treatment for prevention once approved; safer pregnancy counseling; sexual risk reduction counseling on reduction of sexual partners, alcohol counseling, promoting of; Sexually Transmitted Infections (STI) screening and treatment and using meaningful involvement of people living with HIV/AIDS (MIPA). The efficacy of PHDP has been shown to be 68% in preventing transmission of HIV, and 96% in treatment for prevention.

CRS will use HVOP funding to recruit and support appropriate peer educators/counselors to reinforce prevention messages delivered by health providers as a feasible model for task-shifting in the provision of PHDP in clinical settings, and specifically promote MIPA. It will support placement of 5 Peer Educators at the MCH, TB and CCC Clinics in hospitals, and 2 Peer educators at health centers and provide appropriate counseling space. One of the peer educators will do regular client home follow up to strengthen ART adherence.

Approximately 1.6 million Kenyans are PLHIV. The Kenya AIDS Indicator Survey 2007 showed 6% of couples to

be in discordant relationships. The national HIV prevalence is (7.1%). CRS will reach 24273 (60%) PLHIV in FY2012 and 35845 (70%) in FY 2013 with a minimum package of PHDP except condom and family planning promotion.

Quality assurance for EBIs will be promoted through appropriate training and certification of peer educators using approved national curricula, standard job-aids and guidelines and regular supervision.

CRS will work with appropriate national Technical Working Groups (TWG) to support integration of HIV prevention into care and treatment programs in clinical settings. These programs will also be linked to other HIV community programs. PLHIV will be specifically linked to STI services, as necessary, through patient escorts.

Monitoring of PHDP will be done through the review/input of CRS implementation plan, analysis of KePMS data, quarterly reviews, semiannual and annual reports. Evaluation will be conducted through operation research of combination HIV prevention and periodic surveys (Kenya Demographic and health survey, Kenya Indicator AIDS Survey, Kenya Service Provision Assessment) .

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	0	0

Narrative:

Catholic Relief Services (CRS) will implement comprehensive PMTCT services to pregnant mothers in Western and Coast regions. CRS through the Track 1 mechanism has been implementing PMTCT in Faith Based Organizations facilities nationally since 2004. Activities are being transitioned to two local partners: Kenya Episcopal Conference and Christian Health Association of Kenya. By March 2011, 11,549 women were counseled and tested and 579 were given ARV prophylaxis. CRS will strengthen PMTCT services in the 16 main facilities and over 80 satellites by integrating ART into the MCH clinics.

In FY12, CRS will offer HIV counseling and testing to 13,733 pregnant women at ANC and give ARV prophylaxis to 880 HIV infected pregnant women. The HIV infected women will receive a CD4 test after undergoing WHO clinical staging. CRS will give HAART to all eligible HIV positive pregnant women in line with the revised PMTCT national guidelines. In FY13, CRS will transition these activities to the local partners since the mechanism will end in Feb 2013.

CRS will focus on 3 prongs of PMTCT: primary prevention; ARV prophylaxis to all HIV positive pregnant mothers and exposed infants; and care and treatment to eligible HIV positive mothers, partners, and children. The Minimum care package will include health and HIV education, individual/ family HIVCT, clinical/laboratory monitoring and assessment, OI screening and/or treatment, ARV prophylaxis and treatment for both mother and baby, nutritional

support, psychosocial support, PWP except condom and family planning promotion, follow up, retention, and referral and linkages. CRS will incorporate TB screening into routine antenatal care.

CRS will reach 4,120 of 1st visit ANC attendees with couple CT to identify discordant and concordant couples to improve primary prevention and facilitate linkages to HIV care and treatment for the eligible.

CRS will support integration of ART in MCH clinics, and establish or strengthen infection control and waste management activities.

CRS will support hospital delivery through provision of delivery beds and sterile delivery packs, training, working with CHWs and TBAs to promote community-facility referral mechanism, health education, and community services providing skilled birth attendance.

CRS will support safe infant feeding practices as per national guidelines and support enrollment and follow up of 660 of babies born to HIV infected mothers to access CTX, ARV prophylaxis, and EID services using the HIV exposed infant register till 18 months. CRS will facilitate ART initiation for those who test positive before 2 years.

CRS will adopt efficient retention strategies for mothers and babies by supporting use of diaries and registers for tracking defaulters, having a structured mentorship and supervision plan (train 30 CHWs in FY12), enhancing data quality and streamlining M&E gaps including orientation of new MOH ANC/maternity registers and utilizing data at facility level for program improvement and quarterly progress reports to CDC.

Program quality and proficiency testing will be emphasized to validate PMTCT results.
CRS will train HCWs on PMTCT and provide orientation to the revised PMTCT and infant feeding guidelines and engage in community activities for demand creation for health services such as male involvement with couple CT services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	0	0

Narrative:

Catholic Relief Services (CRS) AIDS Relief has been supporting treatment services in Nyanza, Western, Rift Valley, Central, Eastern, Coast, and Nairobi Provinces through Track 1 funding since 2004. CRS is transitioning these activities to local partners: Kenya Episcopal Conference and Christian Health Associations of Kenya. The first regions to be transitioned are Nairobi, Nyanza, Eastern and Central. CRS will continue to provide direct support in Western and Coast region while supporting the local partners in the other regions.
As of June 2011, CRS had supported 75,240 patients ever initiated on ART including 8,562 children; 53,680

patients were actively on ART of which 6,217 were children; 21,560 patients were newly initiated on ARVs, 2,708 stopped ART, 9,316 transferred out, 5,013 died (mortality rate 7%) and 4,423 were lost to follow up. The overall patient retention was 84%.

In FY12, CRS will jointly work with the Ministry of Health (MoH) to continue supporting expansion and provision of quality adult HIV treatment services as per MoH guidelines to 5,019 patients currently receiving ART and 397 new adults resulting to cumulative 6,023 adults who have ever been initiated on ART. In FY13, this number will increase to 5,317 currently receiving ART and 401 new resulting to 6,424 adults who have ever been initiated on ART.

CRS will support in-service training of 80 and 70 HCWs and continuous mentorship of trained HCWs on specialized treatment, including management of ARV treatment failure and complicated drug adverse reactions.
CRS will identify human resources and infrastructure gaps and support in line with MoH guidelines as well as support good commodities management practices to ensure uninterrupted availability of commodities.
CRS will support provision of a comprehensive package of services to all PLHIV including ART initiation; laboratory monitoring including biannual CD4 testing and viral load testing for suspected treatment failure (through strengthened laboratory network); cotrimoxazole prophylaxis; psychosocial and adherence counseling; referral to support groups; nutritional assessment and supplementation; prevention with positives (PwP) except condom and family planning promotion; and improved OI diagnosis and treatment including TB screening, diagnosis and treatment. Ongoing community interventions for PLHIV including peer education and support groups to provide adherence messaging, defaulter tracing, and follow up will continue to be supported to improve retention in all sites. CRS will also support strategies to ensure access and provision of friendly HIV treatment services to all, including supporting peer educators, support groups, and supporting patients to disclose and bring their partners for testing and care and treatment.
CRS will do cohort analysis and report retention as required by MoH. CRS will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services, integrate them into routinely collected data, and use the results to evaluate and improve clinical outcomes.
CRS will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, CRS will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. CRS will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient manageme

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	0	0

Narrative:

Catholic Relief Services (CRS) has been supporting pediatric treatment services in Nyanza, Western, Rift Valley,

Central, Eastern, Coast and Nairobi Provinces through Track 1 funding since 2004. CRS is in the process of transitioning these activities to local partners: Kenya Episcopal Conference and Christian Health Associations of Kenya. The first regions to be transitioned are Nairobi, Nyanza, Eastern and Central. CRS will continue to provide direct support in Western and Coast Provinces while supporting the local partners in other regions. As of March 2011, CRS had enrolled 1,337 children on ART with 945 active on treatment.

In FY12, CRS will work with the Ministry of Health (MoH) at all levels to continue supporting, expanding and ensuring provision of quality pediatric HIV treatment services as per MoH guidelines to 580 children currently receiving ART and 116 new pediatrics resulting to cumulative 696 pediatrics ever initiated on ART. In FY 13, these activities will be fully transitioned to the local partners.

CRS will work with MoH in line with the Kenya National Strategic Plan III and the annual national, provincial and district operational plans to plan and coordinate decentralization of pediatric ART services including recruitment of additional staff.

CRS will continue to build the capacity of health facilities to offer comprehensive pediatric ART services including supporting renovations to ensure access to child friendly services. They will build the capacity of the health care workers in pediatric HIV treatment including management of treatment failure and treatment complications.

To optimize identification of HIV positive children, CRS will strengthen the use of the mother-baby booklet to facilitate early infant diagnostic testing, strengthen provider initiated testing and counseling, family testing, and ensure linkage of the HIV infected children to care and ART services. Integrated pediatric services will be offered at the MCH clinic to incorporate child survival strategies including growth and development monitoring, immunization, and case management of common childhood illnesses. HIV treatment services provided will be comprehensive including clinical history, physical examination, WHO staging, assessment for ART eligibility, access to CD4 counts/percentage, hematology and chemistry (through lab capacity building and strengthening of lab networks), pre-ART adherence and psychosocial counseling, initiation of ART for those eligible, ART response monitoring, clinical assessment, and targeted viral load testing for those with clinical or immunologic failure.

Routine pediatric data collection and reporting will be strengthened at all levels including use of electronic medical records system and integrating quality of care indicators to improve reporting to NASCOP and PEPFAR.
CRS will strengthen hospital and community activities to support the needs of adolescents to enhance disclosure and adherence messaging, PwP activities except condom and family planning promotion, substance abuse counseling, teaching life skills, and supporting their transition into adult services.

CRS will collaborate with other partners supporting community activities to ensure optimal linkages in order to reduce loss to follow-up and ensure continuity of pediatric HIV services for better treatment outcomes.

Implementing Mechanism Details

Mechanism ID: 9143	Mechanism Name: Kenya Department of Defense
Funding Agency: U.S. Department of Defense	Procurement Type: Cooperative Agreement
Prime Partner Name: Henry M. Jackson Foundation Medical Research International, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,127,384	
Funding Source	**Funding Amount**
GHP-State	2,127,384

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of the KDOD HIV Program is to conserve the fighting strength of the Kenya Defense Force by preventing and alleviating HIV-related illnesses and death among 135,000 soldiers and their dependants. This is done through a comprehensive HIV prevention and treatment program supported by the WRP since 2004.
During FY12 and FY13, the program emphasis will include HTC expansion in all the treatment sites including PITC, couple and family testing at the facility level. This will contribute towards the PF goal to support implementation of the GOK HIV response as articulated in the KNASP III that seeks to strengthen the capacity of facilities and providers in increasing HCT such that 80% of Kenyan adults know their status. Other emphases will be on strengthening linkages of identified HIV positives to care, PMTCT services, EID, TB management, patient retention and overall HIVQUAL activities.In order to build on sustainability, KDOD will support the integration of HIV plans into the annual military performance contracts. The program will support and strengthen the capacity of KDOD HIV structures from the Unit HIV committees to the Armed Forces AIDS Committee at the highest level. High command sensitization will be maintained in order to promote ownership and leadership.

This partner used part of FY 07 funds for the purchase of 2 vehicles (1Toyota Land Cruiser, 1 Toyota Hiace) to support supervision, coordination and evaluation of the expansive KDOD field activities. In FY 12, the program will procure 2 new vehicles to support M&E activities.Target populations, geographic coverage, and monitoring and

evaluation plans are addressed in budget code narratives.This activity supports the GHI/LLC and is funded primarily with FY12 funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Commodities	100,000
Food and Nutrition: Policy, Tools, and Service Delivery	150,000
Human Resources for Health	600,000
Renovation	402,742

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Child Survival Activities
Military Population
Mobile Population
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**9143**		
Mechanism Name:	**Kenya Department of Defense**		
Prime Partner Name:	**Henry M. Jackson Foundation Medical Research International, Inc.**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Care	HBHC	178,560	0

Narrative:

KDOD HIV program is a national wide program serving a total population of 135,000 people including soldiers, their dependants, civilian DOD personnel and one community outreach program at Mtongwe. These are served by 9 HIV comprehensive care centers and 1 Community Outreach Clinic. The facilities are adequately staffed by both military and non military personnel even though there is high turnover of military staff due to core military activities necessitating continuous HIV training, mentorship and supervision as well as sustained civilian staffing. Each of the 10 facilities will continue to provide a comprehensive package of services aimed at extending and optimizing quality of life throughout the continuum of illness. These include provision of clinical, psychological, spiritual, social, and prevention services. Clinical care services include prevention and treatment of OIs and other HIV/AIDS-related complications including malaria and diarrhea; nutrition assessment, counseling and support; and pain and symptom relief. Psychological and spiritual support will include group and individual counseling. Prevention services will include partner/couples HIV testing and counseling, risk reduction counseling, adherence counseling and support, STI diagnosis and treatment, family planning counseling, and condom provision. The purchase of OI drugs to supplement the military procurement will continue.

In order to improve retention of patients initiated on ART, the program supports a telephone defaulter tracking system. 9 peer educators are engaged in the provision of adherence counseling and defaulter tracing. The program supports adherence promoting activities such as adherence measurement using self report, pill count, CD4 and Viral load monitoring. Activities of post test clubs and youth friendly clinics are supported and will be enhanced.

Cervical cancer screening, STI assessment and treatment, family planning services for HIV positive individuals will be integrated into routine care as much as possible and where this is not possible, strong linkages and referral systems will be enhanced. HIV positive individuals with other infections such as malaria or TB will be linked to appropriate treatment services. HIV positive pregnant women will be linked to PMTCT services. Individuals with mental health problems will be referred to on-going counseling services and support services. In addition, HIV positive individuals with alcohol or substance abuse problems will be linked with substance abuse treatment programs and needle/syringe exchange programs.

Support supervision, mentorship, monitoring and evaluation visits and data quality assessment will be supported. Review and roll out of data collection, recording and reporting tools for implementation of next generation indicators has been initiated and will continue to be strengthened. Development of quality of care indicators for monitoring the quality of HIV clinical services (HIVQUAL) was initiated in FY09 and will be re-launched and strengthened. Roll out plan for patient level EMR system will be supported at 3 treatment sites to ensure improved reporting to PEPFAR.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	37,588	0

Narrative:

In FY 2006 KDOD initiated the orphans and vulnerable children (OVC) activity following an increased number of deaths among military personnel resulting from HIV/AIDS. HIV remains a significant cause of death in the Kenya military. There are an estimated 5,000 OVC linked to KDOD members. Prior to the KDOD OVC program, these children orphaned by HIV/AIDS had no support from the KDOD as a government institution. With funding from COP FY 2006, KDOD was able to establish a program that focused on care and general support to 800 OVC located throughout the country with the assistance of the military unit commanders and local administration. In FY 2008 COP the military OVC program shifted from service provision to identification, tracking and linking the OVC to the local agencies offering services in the community. In FY 2010 the program identified a total of 1055 out of which 471 were linked to local agencies, 55 very needy OVC were supported with school fees and 4 families supported with cash transfer. Stigma surrounding HIV status disclosure among some caregivers, a bench mark for linkage to PEPFAR funded programs and absence of local agencies offering OVC services are some of the challenges affecting linkage. To overcome stigma, a total of 90 caregivers have been trained in basic care and support, stigma and discrimination reduction, basic counseling skills on psychosocial health of the child and empowered on HIV Positive status disclosure. In FY 2012/2013 additional 25 caregivers will be trained and supported to form groups geared to income generating activities for sustainability. In FY 2012/13, the KDOD will continue to identify, locate and link additional 500 OVC to PEPFAR funded partners and local agencies in the community. The KDOD OVC target will contribute to the national target of 752,700. The program will continue to take the lead in ensuring that the survivors of the servicemen and women are identified, tracked, linked and given preference in this unique OVC military activity. Timely identification and subsequent linkage of sick children to care and treatment will also be provided. The program social workers will continue to network with PEPFAR funded partners and local agencies providing services to KDOD OVC in the community. Liaison with military commanders to ensure timely OVC names submission will be enhanced. The KDOD will also continue to implement the care and support of these OVC by strengthening the capacity of caregivers and continue the tradition of communal and family support of the OVC. KDOD in line with COP 2012 guidelines will prioritize on capacity building, identification, location and linkage, paying school fees for the needy OVC and family strengthening approaches that reinforce long – term caring capacities as the basis of a sustainable response to children affected by HIV/AIDS. KDOD OVC program will continue to work closely with military unit commanders responsible for the troops, existing community services and government children agencies to augment the level of community and family based support already available to the OVC through the holistic approach to care. This approach is supported by the Emergency Plan in which the needs of the OVC are identified at the community level and subsequently cared for by strengthening existing structures already in place to tend to the needs of the OVC in the various regions throughout the country.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	181,581	0

Narrative:

The Kenya Department of Defense (KDOD) will continue to intensify the diagnosis, care and treatment of military patients with co-infections of TB and HIV (TB/HIV) by promoting screening activities of all HIV infected patients for TB as well as ensuring all TB infected patients are offered HIV testing, STI screening, HIV prevention messages including condom distribution. Those found to be co-infected will be given anti–TB, cotrimoxazole prophylaxis treatment (CPT) and ART as per the Kenya's TB guidelines. Through this concerted effort, in FY2012 and 2013, the program will provide HIV testing to all TB patients; and offer TB and HIV services to at least 100 TB/HIV co-infected patients. The program will intensify efforts of contact tracing by conducting door to door sputum testing of TB contacts. This will lead to more cases being identified and appropriate care being given in a timely manner. In order to achieve this, KDOD intends to continue improving the laboratory capacity for TB/HIV and improving capacity of the health personnel through training in management of TB/HIV. Refresher training for integrated TB/HIV activities for KDOD health professionals will be undertaken by training an additional 50 health workers on TB/MDR, TB and DTC using MOH curriculum to support the expected increased workload. TB/HIV services will continue to be supported in the 10 care and treatment centers in Deense Forces Memorial Hospital (DFMH), Moi Air Base in Nairobi, Mombasa, Mtongwe civil outreach, Nanyuki 4th BDE, Laikipia Air Base, 3KR Lanet,Gilgil Regional Hospital, 9KR Eldoret and 12 Engineers Thika. In FY2012/2013, funds will be used to enhance TB/HIV integration across the 10 ART sites so as to facilitate effective care of TB/HIV co-infected patients. KDOD will also continue extending TB/HIV services to the neighboring civil population. DFMH remains the referral hospital for all patients requiring specialized diagnosis, treatment and in-patient care including patients suspected to have failed treatment. In FY 2012 and 2013, efforts to improve the capacity in the laboratory at DFMH to perform QA in smear microscopy will be continued. In line with the national guidelines, the DFMH lab will continue to send samples to the National reference laboratory for TB cultures, drug sensitivity and resistance testing. In addition, the program will continue to ensure efficient and timely supply of TB drugs to all treatment sites while maintaining regular supervision of all TB/HIV treatment activities. Strengthening of community based adherence/follow up of patients in this program will be promoted through telephone tracking of defaulters and the use of social workers. In terms of reporting for TB, the KDOD is recognized as Kenyan Province equivalent. This recognition by the NLTP will be exploited to ensure that the KDOD tuberculosis program is developed further under the President's Emergency Plan. The KDOD program will continue to be regularly reviewed by staff from Walter Reed Project and the Division of Leprosy, TB and Lung Disease to report high-quality data using the national TB and HIV M&E framework and tools to track progress toward stated objectives/targets. In preparation towards readiness to report on the revised TB/HIV indicators, WRP has trained HCW and rolled out the newly revised tools.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	PDCS	39,939	0

Narrative:

The KDOD Program serves a population of approximately 135,000 people, with a HIV prevalence ranging from 3% to 5%. So far EP funds have been used to support pediatric care and support at 10 treatment sites. By the end of August 2011, the program had enrolled 256 children. In FY 12 and 13, KDF seeks to use PEPFAR funds to address the needs of HIV+ children by supporting 180 on treatment and 200 children on care.

Since 2009, KDF has used EP funds to support pediatric care activities including; strengthening of the DFMH to serve as a referral center for HIV/AIDS treatment and management of complicated pediatric cases. Infrastructural expansion at 4 of the CCCs is underway to create a pediatric/adolescent friendly environment, training of 25 health care workers on pediatric ART and care management based on the revised MOH pediatric guidelines, sensitization of 15 other HCW on the new pediatric guidelines, laboratory support on the monitoring of children on treatment, adherence support, pediatric nutritional assessment and counseling procurement of equipment required to carry out effective nutritional assessment, micronutrient supplementation according to WHO guidance have been provided.

In FY 12 and 13 KDOD will continue to prioritize activities geared towards improving access to quality pediatric care services across all the military treatment sites. The scope of care services to be provided will include; EID, linkage to care & treatment, clinical monitoring, prevention and treatment of OIs & other HIV related ailments, malaria, pneumonia, diarrhea, and pain symptom management. The program will also provide other components of the minimum package of pediatric basic health care and support including provision of cotrimoxazole prophylaxis, nutritional assessment and support including supplementation & treatment for nutrient deficiencies, deworming, and psychosocial counseling & support. Scaling up of pediatric HIV care and treatment services through health system strengthening will be achieved through improving pediatric diagnostic services as well as follow up and referral systems. Efforts towards networking all the 12 PMTCT sites to an EID laboratory close to their locations will be made. Expansion on the use of HIV rapid antibody testing in children will be supported. To ensure appropriate disease staging and treatment monitoring capacity, the program will support availability of CD4 cell counts and percentages as well as hematology and biochemistries. To ensure quality pediatric care provision, KDOD program will support in-service training for 30 HCWs on Basic Health Care and Support, EID, nutrition and psychosocial counseling and support. The program will support ongoing mentorship for HCWs to initiate and maintain children on care and ART with quarterly supervision by regional pediatricians and other qualified physicians. The program will put efforts on the special challenges for pediatric and adolescents psychosocial and social support needs by working with families and caregivers, supporting activities of adolescents post test clubs, holding forums to address caregivers concerns and needs as well as supporting disclosure and informing about HIV, treatment and care adherence. The program will support the development of an Electronic Medical Record System to aid systematic data collection and timely reporting on pediatric ART in line with the Kenya MOH and PEPFAR guidelines.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	263,114	0

Narrative:

The Kenya Department of Defense (KDOD) HIV program offers comprehensive health services needed to reduce HIV related morbidity and mortality within the Kenyan Military population. The Kenya Military has an estimated population of 135,000 service personnel and their families. The military population is spread out through the country and has a battalion deployed internationally for peacekeeping duties.

The KDOD program has been a key player since 2004 in the origin of PEPFAR in Kenya. In FY 2005, KDOD initiated the development of a basic data system for documentation of individual patient and will continue to phase in a data collection, recording, monitoring, reporting, dissemination system to all other treatment and prevention sites in line with the national protocols. Support in provision of the necessary data automation computerized systems and other communication equipment required for electronic entry of patient-encounter data, internet system for information sharing and real time submission of reports will be strengthened. A functional Electronic Medical Records system to all the 10 comprehensive care centers to support clinical management and program reporting with initial emphasis in ART program and a long term goal of expanding to other areas will be rolled out. In addition, strengthening of the paper based system in other medical reception stations and base medical centers within Army, Air Force and Navy to be able to collect, manage, analyze, generate routine reports and carry out cohort analysis will be enhanced. The military reporting system will be strengthened to be able to report all the health data and information needs within KDODS and link it to the national system. Supervisory support, Data Quality Assessments and mentorship visits including reporting tools for implementation and operationalization of next generation indicators will be supported. Regular stakeholder meetings to discuss disseminate/evaluate reports and Quality Improvement teams in 9 regions will be supported to enable continuous use of information for routine programming and better patient management. Capacity building to KDF for HIV behavioral and biological surveillance, surveys, monitoring program results and support to health information systems will be enhanced. Monitoring and Evaluation site visits, baseline and end term program routine assessments to identify risk factors and provide evidence based prevention services to reduce risk of transmission or acquisition of HIV infection will be conducted and a functional Surveillance system will be rolled out to all PMTCT and HTC sites to monitor HIV incidence.

Activities to strengthen KDF capacity to monitor clinical HIV programs including HIV program inputs, costs, activities, outputs and outcomes collected through routine monitoring and with special attention to data quality and data use for strategic planning and decision making including roll out of the new M and E curriculum and SOP's will be conducted. More emphasis will be geared towards capacity building, sustainability and collaborative activities in engaging with the Ministry of Public Health, Ministry of Medical services and Ministry of Defense from the highest government level to the military hospitals and medical reception stations in which direct patient care is

executed. The program will continue to support implementation and monitoring of the 5 year strategic plan in line with the national strategic plan.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	37,588	0

Narrative:

With PEPFAR support through implementing partners, VMMC services delivery in Kenya began in 2008, ensuring that the defined minimum package(opt-out HTC for VMMC client and their partners, age appropriate sexual risk reduction, counseling on abstinence during the six weeks of healing period and promotion of correct and consistent condom use) is implemented according to the national guideline. The Kenya military recruits approximately 3,500 young men in the age group 18 – 26 years old annually. This group is highly vulnerable to HIV infection and other STIs. In FY2010 KDOD received support from PEPFAR to implement male circumcision in the military in response to the KNASP Priority 1- prevention of new infections including a targeted focus. In FY2010 a total of 113 individuals were reached with VMMC services. In FY2012/13 KDOD intends to provide a comprehensive male circumcision package to 1000 male troops. This target will contribute to the national target of 671,797. The activity will focus on the troops as well as support the maintenance of healthy partner relationships that will significantly reduce risks related to acquisition of HIV. Kenya rolled out the male circumcision program in 2008 targeting uncircumcised males to reduce risk of getting HIV. KDOD will continue to align the male circumcision intervention to GOK policy and guidelines. KDOD recruits from both circumcising and non-circumcising populace. It is estimated 3 -5 % of Kenya military male soldiers are uncircumcised. In FY2012/13 KDOD VMMC services will be concentrated within the military medical establishments and detachments distributed nationally. In FY2010 a total of 28 health care workers were trained to provide male circumcision services in the military. In FY2012/13 KDOD intends to train 24 additional health care workers to ensure adequate capacity to provide services to troops deployed in static units and detachments. Core activities include training on VMMC in line with national guidelines, awareness creation, quality assurance, equipment and commodities procurement, CT provided on site, pre and post operative sexual risk reduction counseling, active exclusion of symptomatic STIs and syndromic treatment when indicated, provision and promotion of correct and consistent use of condoms, circumcision surgery and link to care and treatment. The program will leverage on the well established MAP program to disseminate correct information on VMMC. In addition Commanding Officers' barazas, Padre Hour and mobilization activities will be used to create demand for VMMC among the troops.

This activity is part of a comprehensive HIV prevention strategy within KDOD linked to other services such as CT, AB, OP, PwP and ART. This activity will target the military troops, their dependents and KDOD civilian employees. Training will target health care workers. This activity will increase the level of HIV prevention interventions among the target group in the military. Intensified campaigns to educate the troops on the benefits of VMMC will be undertaken. Monitoring and Evaluation will be undertaken to ensure the program meets its target and quality assurance procedure are adhered to. Continuous monitoring of the activity will be undertaken in line with the

national operationalised tools and practices.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	55,856	0

Narrative:

Every year KDOD appx recruits 3500 young men and women age group of 18-25 yrs. The aim of focusing on this group is to catch them early in their lives and careers and instill life skills, values and norms consistent with AB thus helping to protect them against HIV infection at an early stage in their military career which by its very nature exposes them to the high risk of acquiring HIV. In FY10 KDOD through MAPP scaled up prevention interventions that focus on the recruits and in and out of school dependents of military personnel living in the camps. This activity aims at identifying young people early at the entry point of their military careers and targeting specific behaviors that are consistent with ensuring the prevention of HIV. This program has had a positive impact in building skills that protect the military personnel against HIV infection. In FY12, the program through Evidence based intervention will focus on healthy choices, family matters and PwP to address pervasive gender stereotypes and male behaviors that are relevant and which continue to be risk factors for HIV transmission. Due to the wide distribution of KDOD military personnel in remote areas of the country, 25 peer educators will be trained on Evidence based intervention with the aim of strengthening awareness and rolling out behavior change intervention through small groups, integration of the curriculum into regular KDOD training both at the basic training stage following recruitment and into the ongoing cadre course training will also be considered. The per educators will be empowered to conduct small groups sessions of not more than 15 participants of which each group will be followed for at least 3 times. The small groups will be targeted with behavior change information messages. The evidence based intervention curriculum will be merged with other HIV prevention curriculum into standardized training material to ensure the Prevention messages remain relevant. In FY12, KDOD AB activity will also focus on the in and out of school dependents of the military personnel between 13 and 24 years with the development of a peer education program which addresses issues of youth HIV prevention. KDOD intends to promote greater command-level involvement and ownership in all aspects of HIV prevention in the military through seminars and workshops to ensure program sustainability. The major emphasis of the AB component of the program will contribute to the outcome of changed social norms that promote HIV prevention behaviors among this age group who are classified as highly vulnerable to HIV infection. In FY12 KDOD targets to reach a total of 19500 additional individuals with messages that promote HIV prevention through AB. AB activities within the KDOD program will contribute to FY12 prevention targets for Kenya, especially among young newly recruited. The involvement of both male and female in AB activities will promote increased gender equity in HIV Programs to ensure women are not left out in prevention activities. AB activity is linked to KDOD CT activity by promoting VCT/PITC services as a way of promoting secondary abstinence. It is also linked to the KDOD Condoms and OP activity by offering comprehensive prevention messages for the military community Those who are HIV -VE will be encouraged to maintain a negative status while the positives youths will benefit from early entry to care. KDOD

will conduct quarterly M&E to ensure targets are achieved & objectives met.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	93,969	0

Narrative:

Kenya's Department of Defense (KDOD) has received support from the Emergency Plan to implement a comprehensive HIV/AIDS program since FY 2004. One of the key components of this program is HIV counseling and testing (CT), which is useful, both for prevention and access to care. A large majority of the military personnel and their families are young. Military personnel can be classified as high-risk, often deployed away from their families, hence the need for comprehensive HIV/AIDS program, including CT in the military. In FY 2010 KDOD has seen scale – up in CT activities through different CT approaches including VCT – 13,120, Moonlight/outreach – 2,062 and PITC – 3,185. In FY 2012/2013 KDOD will scale up CT through an integrated approach (PITC, VCT, mobile outreach and moonlight,). In FY2010, 156 health workers were trained in PITC.KDOD intends to train additional 100 health care workers and 20 counselor supervisor who will ensure adequate capacity to provide CT services to an additional 20,000 troops, their dependants and KDOD civilian employees. In FY 2012/13, the KDOD program will intensify mobile/moonlight HCT services to the Military in Hard – to – reach high prevalence areas and detachment camps and will increase integration of CT services in the military health care system. This will improve access to HIV prevention and better care services in remote areas. To contribute to the national target of reaching 80% of population with CT services, the KDOD strategy will target Formations/units, workplace and detachment camps. Couple counseling to identify discordant couples, promote disclosure, positive living and reduce stigma at family level will be enhanced. Discordant couples will be targeted with prevention strategy and referred appropriately. Military logistics support to provide CT services to the underserved areas in the North Eastern Province with heavy military presence will be utilized. MIPA will be strengthened as one of the ways of reducing stigma associated with CT. This activity is part of a comprehensive HIV care and treatment program within the KDOD linked to other services such as AB, OP, MC, TB/HIV and ART. Referrals and linkages between CT services and care outlets will be strengthened to improve care and support opportunities within KDOD health facilities through PEPFAR funding. Intensified campaigns to educate the military personnel, their dependents and KDOD civilian employees on the benefits of HTC services, couple HTC and mutual disclosure of HIV status will be undertaken. Quality assurance (QA) for both counseling and testing will be expanded to cope with increased service uptake in keeping with national standards through 1) counselor Support supervision. 2) Sample DBS's to National reference labs and results monitored. 3) Monitoring & Evaluation for quality service delivery. Rapid assessments and surveys will be conducted to assess risky behaviors and evidence based interventions implemented, monitored and evaluated to show outcomes.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	135,034	0

Narrative:

The Kenya military population is estimated at 135,000 people (troops, dependents and KDOD civilian employees). Every year approximately 3,500 young men and women in the age group 18 to 24 years old are recruited. This group comprises of sexually active population and therefore highly vulnerable to HIV infection and other STIs. This activity aims to strengthen HIV prevention in the Kenya Department of Defense (KDOD) focusing on activities geared to promote prevention of HIV and STIs by training 30 additional health care workers aimed at integrating HIV prevention in their STI diagnosis and treatment. In addition, in FY 2012, KDOD will intensify HIV/AIDS prevention through behavior change messages that will be disseminated through seminars and workshops targeting 22,000 military personnel, their dependants and civilians working in the military. Special forums that promote knowledge, correct and consistent condom use will be strengthened. This activity will target this most at-risk population of the military personnel, their dependants, KDOD civilian employees and female sex workers (FSWs) living adjacent to military barracks within four geographical areas in Kenya specifically Gilgil, Nanyuki, Isiolo and Mombasa, all of which are known to have a high concentration of FSWs. Although STI basic care will be offered in all the military medical facilities, the program will concentrate on four military regions with a high population density which includes Thika, Kahawa, Embakasi and Moi Air Base. Liaison will be enhanced between the KDOD, National AIDS and STI Control Program (NASCOP) and the Division of Family Health to ensure high quality of care and training of health care workers in STI. In addition, KDOD will strengthen activities that focus in reducing the risk of HIV transmission among high risk occupational settings by promoting the knowledge on correct and consistent use of condoms among this high risk group. Special focus will be on the young recruits entering the military who on entry are HIV negative. Though this group is being targeted through the youth focused program referred to as "Men as Partners" (MAP) under the ABY program area, this funding will support condom education and promotion as a supplement to the ABY program activities in order to provide a comprehensive prevention program. This activity will address the issues of male norms and behaviors which promote engaging in HIV risk behavior, especially in this high-risk community of the military. KDOD also intends to continue scaling-up command involvement and support in promoting behavior change activities by conducting regular trainings, organizing seminars and workshops for the military. The KDOD OP program will also address stigma and discrimination that often is a significant obstacle to routine CT services and the use of condoms. Measures will be put in place to ensure availability of condoms in all the military formations country-wide by maintaining 40 condom outlets throughout the military bases. Regular monitoring of condom uptake by military personnel will be done on a monthly basis by the personnel under their respective commands. This activity linked to counseling and testing (CT), prevention of mother-to-child HIV transmission (PMTCT). This OP activity is also linked to ABY activity by partnering with other prevention activities that promote a comprehensive approach to prevention for the military population.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	102,519	0

Narrative:

The Kenya Department of Defense, (KDOD) program provides health care to approximately 135,000 military personnel, dependants, and civilian employees. In FY 2012/13, KDOD will continue to strengthen and expand Prevention of Mother-To-Child Transmission (PMTCT) services in 14 of the 40 military units sites nationwide. Of the total military population, approximately 30,000 are women, 16% of who are within the reproductive age group (estimated 4,800 births per year). Of these, only about 50% (2,000) births are conducted within the camps, since most families reside outside the barracks. An estimated 93% of all pregnant women will receive HIV counseling and testing (2095 in FY12 and 2200 in FY13). The PMTCT prevalence in KDOD has been estimated to be about 3.5%. This is based on surveillance data collected over a period of 3 years. 85% of all the HIV positive pregnant women will receive maternal prophylaxis. Kenya has adopted WHO option A for PMTCT, and currently 30% of HIV+ women will have a CD4 of < 350 and therefore they will be eligible for HAART. An estimated 40 % of the women will be on prophylaxis using maternal AZT. An estimated 20% of women will arrive in labor at first contact and these will receive single dose Nevirapine.

Non-breastfeeding infants and all infants of mothers on HAART will receive Nevirapine syrup daily up to 6 weeks of age. AZT syrup will be used as an alternative for infants of mothers on HAART. Breastfeeding infants will receive Nevirapine syrup daily for the duration of breastfeeding up to 1 week after cessation of breastfeeding. Lamivudine syrup will be used for infants hypersensitive to Nevirapine .Cotrimoxazole prophylaxis will be provided to all HIV exposed infants and their mothers. Counseling on infants feeding will also be provided. For capacity building and sustainability, KDOD will train 30 health care providers in PMTCT. A further 130 health care providers will receive refresher training on PMTCT using Ministry of Health guidelines. Quality assurance will be ensured through establishment of a strategic information and monitoring system that will facilitate data analysis. Regular consultations and sharing of experiences within the military and with the MOH will be undertaken in an effort to improve PMTCT services and strengthen follow up of infants born to HIV infected women. KDOD will undertake minor site PMTCT repairs as necessary. This activity will contribute to overall PEPFAR and Kenya government national goal of universal access to PMTCT services by contributing 0.1% of the overall national target. All facilities providing MCH services will be strengthened to deliver integrated PMTCT interventions around the 4 prongs. Capacity to provide essential commodities and equipment for PMTCT and strong management systems and laboratory logistics will be prioritized. Linkages between PMTCT service and care outlets will be strengthened to improve utilization of care opportunities created through PEPFAR funding. Emphasis will be placed on primary prevention for the majority of women identified as HIV negative through PMTCT programs. KDOD plans to enhance greater involvement of people living with HIV and AIDS (GIPA) through the facility and community based psychosocial support groups, Mentor Mothers, Prevention with Positive (PwP).The KDOD also will continue to offer sexual partner testing targeting 500 men through PwP initiative.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	911,044	0

Narrative:

Tremendous progress in the provision of adult ART to the KDOD program has been made in the last 6 years, ensuring provision of ART to over 1800 and HIV care services to 3500 soldiers and their dependants including populations living in the neighborhood of the military barracks. The KDOD program will continue to support 10 military ART sites.

A comprehensive package of services offered to all HIV + patients at each of the ART clinics includes assessment for ART eligibility; ART for those eligible; lab monitoring with CD4 testing; psychosocial counseling; adherence counseling; nutritional assessment supplementation; prevention with positives (PwP), OI diagnosis and treatment, including TB services and defaulter tracing. The target population is 135,000 people including military personnel and their dependants and civilians living in the neighborhood of the military barracks. Over the past 7 years, the program has employed several strategies to improve programmatic efficiencies and allow for continued expansion. These strategies include decentralization of ART services to lower level facilities, integration of ART in MCH and TB clinics, leveraging MOH and MOSD funds to support ART activities including training of HCWs, constructions, procurement of laboratory equipment and drugs for OI. Joint review and planning meetings with KDF will be continued to ensure joint commitment towards achieving the set goals.

So far more than 100 KDOD medical personnel have received in-service ART training including orientation on the newly revised MOH guidelines. However due to competing medical and other military duties, only a few remain available to run the clinic on a day to day basis. In FY 2012, 60 HCW will be trained on comprehensive adult and pediatric HIV/AIDS treatment and care. Trainings will be decentralized to 4 regions of the military. Close onsite supervision is provided on a daily basis by locally deployed HJF staff. Quarterly Monitoring and Evaluation and mentorship exercise is done jointly between HJF and KDF technical staff.

Facility Quality improvement teams have been formed to focus on quality improvement of HIV services provided at each of the treatment sites. Development of quality of care indicators for monitoring the quality of HIV clinical services was initiated in 2009. The program routinely collects data on treatment outcomes as well as program level data using both paper and electronic based database. In order to improve retention of patients initiated on ART, the program supports a telephone defaulter tracking system. 9 peer educators are engaged in the provision of adherence counseling and defaulter tracing. The program supports adherence promoting activities such as adherence measurement using self report, pill count, CD4 and Viral load monitoring. Activities of post test clubs and youth friendly clinics are supported. In order to promote transition to local ownership and build sustainability of ART service delivery, the program has continued to encourage the integration of HIV care and ART plans into the annual Military performance. The program has also continued to support and strengthen the capacity of the Kenya Defense Forces HIV structures from the Unit HIV committees at the lowest military establishment to the Armed Forces AIDS Committee at the highest level. High level command sensitization is maintained in order to promote ownership of the program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	90,592	0

Narrative:

By the end of August 2011, the KDOD program had enrolled 256 children. Of these 198 have ever been on ART and 139 were actively receiving ART. The average newly enrolled on ART is 25 children per annum. In FY 12 and 13, EP funds will be used to support 24 and 28 newly enrolled on ART respectfully, 140 and 154 current on ART respectively. This activity will contribute to Kenya's goal of providing scaling up PDTX for HIV infected children 0-15 years of age.

EP funds have been used to support pediatric treatment activities including; strengthening of the DFMH to serve as a referral center for HIV/AIDS treatment and management of complicated pediatric cases, infrastructural expansion at 4 of the CCCs has been undertaken in order to create a pediatric friendly environment. Training of 25 HCWs on pediatric ART management based on the revised MOH pediatric guidelines, sensitization of 15 other HCW on the new pediatric guidelines, laboratory support on the monitoring of children on treatment, adherence support, pediatric nutritional assessment and counseling before and during ART will be conducted. Procurement of pediatric weighing scales, stadiometers, MUAC tapes and other equipment required to carry out effective nutritional assessment will be obtained. Micronutrient supplementation according to WHO guidance will be provided. In line with the national dialogue regarding an increased role of nurses in AIDS treatment, KDOD is focusing on mentoring and training nurses on all areas of HIV in order to facilitate task shifting. ARV drugs are supplied to the sites through the distribution system of Kenya Pharma while the KDF funds the procurement of 80% of the required medications for the treatment of opportunistic infections.

In FY 12 & 13 KDOD will continue to prioritize activities geared towards improving access to quality pediatric ART services across all the military treatment sites. Several distinct efforts will be supported to accomplish this. They include support of the process of implementing the updated treatment recommendations for infants and children by holding sensitization seminars for 20 HCWs drawn from all the military treatment sites, providing in-service pediatric ART training to 20 HCWs mainly nurses, clinical officers and doctors. Printing guidelines and developing job aids and training materials for implementation at clinical sites will be conducted. The program will support ongoing mentorship for HCWs to initiate and maintain children on ART with quarterly supervision by regional pediatricians and other qualified physicians. Scaling up of pediatric HIV care and treatment services through health system strengthening will be achieved through improving pediatric diagnostic services as well as follow up and referral systems. Expansion on the use of HIV rapid antibody testing in children will be supported. Through the Lab Infrastructure, the program will support the development for EID networking between the PMTCT sites and the national EID Labs. Networks between all pediatric treatment sites with the referral lab at DFMH will be strengthened to ensure access to Viral load monitoring for all enrolled children. To ensure appropriate disease staging and treatment monitoring capacity, the program will support availability of CD4 cell counts and

percentages as well as hematology and biochemistries. The program will support systematic data collection and reporting on pediatric ART in line with the newly revised M and E tools.

Implementing Mechanism Details

Mechanism ID: 9149	**Mechanism Name: Uniformed Services Project**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Program for Appropriate Technology in Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

Elizabeth Glaser Pediatric AIDS Foundation		

Overview Narrative

The goal of this mechanism is to provide technical, financial and logistical support to improve program management and implementation capacity of the non-military uniformed services in Kenya. The project has 3 main objectives: a) Improve the capacity of the AIDS control units of the uniformed services departments b) Improve and expand activities to increase healthy behaviors among uniformed services personnel, families and surrounding communities c) improve and expand uniformed services' facility-based TB and AIDS Prevention, care and treatment services.

Implementation of this project is by officers of the Uniformed Services agencies and Ministry of Medical Services clinical personnel. This ensures efficiency in service delivery and builds upon existing structures. The HIV services are complemented by other wrap-around services provided in these institutions.

ARIFU is a capacity-strengthening mechanism with a goal of transitioning these GoK partners to full ownership of the program at the end of the five-year project period. It has developed a strong training and mentorship program

for the officers and service providers and is working at ensuring that ACUs in all regions can efficiently manage the programs.
Two vehicles were purchased in FY08 and four in FY10. All are four-wheel vehicles which are used for field work and supportive supervision to over 55 districts. Many project sites are hard-to-reach. One vehicle is assigned to each agency ie PATH, EGPAF, Police, KWS, NYS, AP for logistical support given the vehicle shortfalls within GoK.

Please note that target populations, geographic coverage, and M&E plans are addressed in budget code narratives.

This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**9149**

Mechanism Name:	Uniformed Services Project		
Prime Partner Name:	Program for Appropriate Technology in Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVCT	0	0
Narrative:			
There is no new funding for this partner. They are getting a no-cost extension.			

Implementing Mechanism Details

Mechanism ID: 9150	**Mechanism Name: Prisons Project**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: International Medical Corps	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

International Medical Corps (IMC) provides funding and technical support to build capacity for quality, integrated TB/HIV services in Kenyan Prisons Services (KPS). The goal is to reduce the new HIV infections, improve the quality of life of those infected and affected and mitigate the socio-economic impact of the epidemic in KPS countrywide. IMC goal and objectives are linked to Kenya's PF and GHI strategies and are directly aligned to PF pillars 1-3, prevention, care and mitigation, treatment, and systems strengthening. Strategies to reduce maternal and child mortality and eliminate MTCT include supporting family planning integration into HIV clinics. M&E plans will align with PEPFAR and country PF. Training on and use of MOH HMIS systems will be supported to

eliminate parallel M&E

Cost efficiency is being addressed through integration of services, use of existing evidence-based efficient strategies, task shifting, implementing more facility-based training and mentorship as opposed to offsite training. Efforts are being made to avoid duplication by holding stakeholders forums to streamline partner activities and collaborate with USG partners to leverage their activities in other areas.

IMC has put in place a system for program management that involves KPS officers at the national, provincial and station level. On a monthly basis, a joint team of program managers from Kenya prisons, MOH and IMC provides support supervision to supported sites. Plans are transition activities to KPS by the end of the of 2013

IMC has procured 4 vehicles between 2009 and 2011. Two vehicles are being requested with FY2012 funds since coverage will be expanded to more regions. These will be used by program staff for support supervision. This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Workplace Programs

Budget Code Information

Mechanism ID:	**9150**
Mechanism Name:	**Prisons Project**
Prime Partner Name:	**International Medical Corps**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	0	0

Narrative:

International Medical Corps (IMC) supports HIV care and prevention activities in Kenya prisons as a national program targeting some 50,000 inmates, over 15,000 prison staff and their families and thousands of host communities. Kenya has about 100 prisons and IMC is currently supporting 40 of these.

USG technical, capacity building and financial support to prisons HIV services are factored into District and Provincial Annual Operation Plans (AOP) jointly prepared and coordinated by the MOHand Kenya Prison Services (KPS). Building on achievements of the last 3 years, IMC will strengthen the scope and quality of program activities in 12 prisons covered to date and expand to additional prisons over the next 2 years. Cumulatively, some 7,000 patients, 1,190 of these in the first half of FY 2011, were placed on different spectra of the basic care package to extend and improve quality of life throughout the HIV illness.

This basic care included prevention and treatment of opportunistic infections (OIs), nutritional supplementation through food by prescription (FBP), adherence counseling, treatment of diarrhea and other HIV/AIDS-related complications, STI diagnosis, treatment and condom provision(non inmates) and a wide range of psychological, spiritual, social, and HIV prevention services. In the next phase, the spectrum and quality of these services will be expanded and strengthened through coordinated efforts of the MOH, IMC, KPS, USG agencies and other stakeholders. Expanded activities in old and new prisons will support 3,913 current adult patients in FY12 and 4,737 current patients in FY13.

IMC will continue to support clinical services (pain relief, safe water, multivitamins, nutritional support, prevention and treatment of OIs and other complications such as diarrhea, cervical cancer screening and Kaposi's sarcoma); psychological and spiritual services (group and individual counseling, end-of-life care, bereavement services); social services (vocational training, income-generating activities (IGA), legal services, training caregivers) and HIV prevention services (partner/couples testing, risk reduction counseling, adherence counseling, STI diagnosis and treatment, family planning and condom provision). Efforts will be made to ensure clients, especially inmates, are retained in care in case they are either transferred from one prison to another or discharged to civilian life at the end their sentences. Patients in care will be linked, in an integrated manner, to other HIV treatment, care and prevention services including TB screening, treatment and prevention.

IMC, in collaboration with MOH and KPS will support capacity building (staff training, mentorship, CMEs) for 50 health care workers in 2012 and 40 in 2013 to ensure high quality clinical and other services. The partner will also support good supply chain practices to ensure uninterrupted supply of commodities. IMC will continue to strengthen data collection and reporting at all levels and conduct cohort analysis and report retention rates as

required by the HIV program (NASCOP) and PEPFAR.

IMC will adopt the new generation care indicators and support on-going development and use of NASCOP's electronic medical records system. The partner will adopt the quality of care indicators (CQI, HIVQUAL) to monitor prisons HIV care and support services and integrate these into routinely collected data and use the results to evaluate and improve clinical outcomes.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	0	0

Narrative:

International Medical Corps (IMC) supports HIV care and prevention activities in Kenya prisons as a national program targeting some 50,000 inmates, over 15,000 prison staff and their families and thousands of host communities. Kenya has about 100 prisons and IMC is currently supporting 40 of these.

IMC supports TB/HIV activities in Kenya prisons as a national program targeting inmates, prison staff and host communities. The prisons are located in settings with diverse HIV rates ranging from 1% in North Eastern Province to 15% in Nyanza Province against a national average of 7.1%. HIV and crowded conditions fuel high TB rates especially in the prisons located in high burden regions where co-infection rates are as high as 80%.

In the first half of FY 10, a total of 373 newly diagnosed TB patients received their HIV results in USG-supported prisons. Over the same period, 12,531 clients (new inmates and patients in HIV care) were screened for TB leading to a yield of 78 active cases – overall, 228 HIV-infected clients in HIV care received treatment for TB disease. A total of 75 TB re-treatment cases were registered out of whom 70 (93%) had drug susceptibility testing with no drug resistant TB was detected over this period. In the next 2 years, IMC will continue to intensify efforts to detect and treat TB cases in the prisons through timely clinical and laboratory evaluations. Each prison will receive adequately trained and supported clinical and laboratory staff. IMC will ensure adequate supply of TB drugs administered according to national guidelines. TB patients on treatment will be monitored clinically and through periodic sputum examination.

To reduce HIV burden for TB patients, the partner will ensure that all TB patients are screened for HIV and estimated 95% co-infected patients promptly placed on CPT and ARVs in line with MOH guidelines. IMC will support the "one stop shop" model to provide integrated services in all prisons. TB and HIV clinical staff will undergo both in-services and refresher trainings to gain proficiency in management of both diseases.50 health care workers will be trained in FY 12 while 40 in FY13.

To reduce the burden of TB in HIV infected patients, 3,478 in FY12 and 4,210 in FY13 HIV infected patients will be

screened for TB in HIV care settings. 174 co-infected patients identified in FY12 and 211 co-infected patients identified in FY13 will be put on TB treatment and those without active TB will be provided with Isoniazid Preventive Therapy (IPT) as per national IPT protocol.

To strengthen TB infection control (IC), IMC will support distribution and use of national IC guidelines in all prisons and on-going reforms to decongest these facilities. Coughers will be triaged and fast tracked and inmates on TB treatment isolated. To improve surveillance and management of drug-resistant TB, IMC will support timely DSTs for TB re-treatments and ensure all MDR-TB cases are treated to cure.

IMC will continue to strengthen electronic connectivity between data management unit at the KPS HQs and the prisons as part of efforts to establish national electronic TB and HIV medical records systems. IMC will adopt the new generation TB/HIV indicators and support timely processing and uploading. Data will be used to evaluate progress and improve clinical outcomes.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	0	0

Narrative:

Target population: The primary target population for the IMC Prison project is the inmates and prison staff and their families. The project also serves the prison host community. There are 103 prisons in Kenya with a total inmate population of 51,642 at any given time point and annual turnover of 260,000. There are 19,828 prison staff with 79,312 family members. The HIV prevalence in the prison population is estimated at 15.2%. Currently HTC services are offered in 46 prisons within the Prison Medical Services. In FY2012, the project will specifically target the prison inmates, prison staff and their families that include couples and youth.

HTC Approaches: HTC services are provided through both client initiated and provider initiated approaches. PITC is offered in the health units where prisoners and staff seek medical services, while CITC is used in the stand alone VCT and outreach/mobile sessions.

Targets and achievements: In 2010 COP, IMC Prisons has provided HTC services to a total of 48,618 individuals out of a target of 20,000. Among this, there were 684 couples 37 of whom had HIV discordant results. The program supported the re-training of 24 service providers on HTC guidelines. In FY2012, the program will provide HTC services to 40,100 prison inmates and staff as part of the comprehensive HIV prevention package.

Testing algorithm: The national HTC algorithm is used

Referrals and linkages: All individuals diagnosed with HIV infection are immediately linked to HIV care and

treatment services within the prison medical services. At the point of transfer between prisons the medical transfer forms provide information on the prisoner knowledge of status and if infected the care and or treatment regimen. Peer led networks facilitate follow up of inmates to ensure access to and also adherence to care and treatment regimens. Monitoring of effectiveness of the referral mechanism is conducted through review of records. Referral forms are issued to HIV infected individuals who have been discharged from prison so they can continue accessing services in other care settings in the community. The mechanism for follow up at community level is through the prison-community reintegration structure.

Quality management: HTC services provided in the prison settings are provided in line with the national HTC guidelines. Service providers are trained and certified as mandated by NASCOP. In line with the national Quality Assurance strategy, providers participate in proficiency testing and a counselor supervision framework is in place. The use of job aids also ensures adherence to standards.

Monitoring and evaluation: The program uses national tools for data collection and reporting. These tools capture the range of national and PEPFAR indicators including information on testing provided to key populations, couple HTC and individual level data.

Promotional activities for HTC: To create demand for HTC services all inmates are given information and education on the importance of knowledge of HIV status. The information is provided as part of the combination HIV prevention package. Prison staff are also given information during parades and other capacity building forums. Information on the importance of HIV testing is also provided as part of the patient Education at the outpatient waiting bays.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

IMC implements comprehensive prevention, care and treatment programs for uniformed services (prisons) nationally. In FY 2012/13, IMC will expand HIV prevention services to include evidence based behavioral interventions (EBIs) for specific target populations in clinical and community settings as part of HIV combination prevention programs. It will target adults and adolescents living with HIV (PLHIV); sexually active HIV negative incarcerated female, prison staff, incarcerated male and youth with the following EBIs;

Healthy Choices 2 (HC2) targets youth 13-17 years, in out-of- school settings and focuses on safer sex, condom use, and negotiation and communication skills. It consists of 8 one hour modules. START is an individual level intervention targeting incarcerated males delivered at 6 pre and post release sessions and can also be adapted for individuals leaving correctional facilities. It focuses on HIV/STI/ Hepatitis health education, safe sex/condom

provision at post release, assessment of personal risk and linkage to other services.

S2S is a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use. Condoms are 80% effective in heterosexual relationships when used correctly and consistently. Respect has 2 brief individual sessions targeting general population and youth, originally for heterosexual negative persons focusing on reduction of STDs/HIV, risk reduction, condom use and clients understanding of personal risk.

PHDP is an ongoing 5-10min group and individual level intervention that targets HIV infected persons in clinical and community settings, focusing on partner testing, risk reduction, condom use, disclosure, adherence, STI reduction and family planning. The efficacy of PHDP has been shown to be 68% in preventing transmission of HIV, and 96% in treatment for prevention. IMC will support roll out of video-led EBIs such as Safe in the City to 25,000 inmates.

IMC will recruit Peer Educators (PEs) to reinforce prevention messages delivered by health providers as a feasible model for task-shifting in provision of PHDP in clinical settings, and promotion of MIPA. It will support placement of 5 PEs at MCH, TB and CCC clinics in hospitals, 2 PEs at H/C and provide counseling space. One of the PEs will do client follow up to strengthen ART adherence. IMC will procure 15 containers for counseling space.

The national HIV prevalence is (7.1%).The prevalence is higher among female youth15-24 years. Prisons contribute to 15% of new infections in Kenya. IMC will reach 2204 (60%) PLHIV in FY2012 and 3118 (70%) in FY 2013 with a minimum package of PHDP, 5000 and 10,000 of incarcerated persons in 2012 with S2S and START. 2,200 youth will be reached with HC1/2 10,000 uniformed persons and 19,999 inmates reached with Respect.

Quality assurance for EBIs will be promoted through training, certification of service providers using approved national curricula, standard job-aids, guidelines and regular supervision.

IMC will support integration of HIV prevention into care and link programs to community programs. PLHIV will be linked to STI/FP services through patient escorts.

Monitoring of EBIs will be done through review of IMC implementation plan, analysis of KePMS data, quarterly reviews and reports. Evaluation will be conducted through operation research of combination HIV prevention and periodic surveys.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	0	0

Narrative:

IMC supports HIV care and support activities in Kenya prisons as a national program targeting some 50,000 inmates, over 15,000 prison staff and their families and thousands of host communities. Kenya has about 100 prisons and IMC is currently supporting 40 of these.

IMC supports PMTCT activities in Kenya prisons. In the first half of FY 11, 1660 pregnant women received HIV counseling and testing and received their test results in the prison settings. 124 (7.5%) of these women tested HIV+ out of whom 81 (65 %) received ART prophylaxis to protect their unborn babies. All HIV+ mothers were enrolled in the prisons' comprehensive HIV care and treatment clinics while 40 of these women delivered in the prison health facilities. PCR HIV test results for HIV exposed infants are being compiled.

In FY12, IMC will offer HIV counseling and testing to 1,429 pregnant women at the ANC and give ARV prophylaxis to 119 HIV infected pregnant women. The HIV infected women will receive a CD4 test after undergoing a WHO clinical staging. IMC will give HAART to all eligible HIV positive pregnant women in line with the revised PMTCT national guidelines. In FY13, IMC will increase the number of pregnant women counseled to 1,500 offer ARV prophylaxis to 144 HIV infected pregnant women and 124 HIV exposed infants and do early infant diagnosis (by PCR-DNA testing) for 124 infants.

HIV positive pregnant women will be assessed clinically and staged using WHO criteria and baseline CD4 levels. Additional services will focus on the 4 PMTCT prongs: primary HIV prevention, FP to stem unwanted pregnancies, ARV prophylaxis for all HIV+ pregnant mothers and their exposed infants, care and treatment for eligible mothers, partners and children. The minimum care package will include health education, individual and family HIV counseling and testing, clinical and laboratory monitoring, OI screening, prevention and/or treatment, ART prophylaxis and treatment for both mother and baby, nutritional and psychosocial support. Additional interventions will include TB screening, TB treatment for mothers with active TB and TB prevention (IPT) for mothers without active disease. Among prison staff and host communities, IMC will expand couple counseling and testing targeting at least 450 of 1st ANC attendees. HIV prevention interventions will be provided to discordant couples to prevent new HIV transmissions and facilitate linkage to prison HIV care and treatment services. The partner will promote skilled deliveries and support improvement of infrastructure and adequate supply of commodities such as sterile delivery packs.

IMC will support promotion of safe infant feeding and postnatal ART prophylaxis practices in line with MOH guidelines. HEI will be monitored for HIV infection by PCR-based early infant diagnostic (EID) tool and children who test PCR positive before 2 years will be initiated on ART. Mothers and their babies will be retained in care through strategic use of community health workers and appointment diaries and registers to track defaulters.

IMC will support staff training 60 in FY 12 and 60 in FY13. This to include structured mentorship and support supervision program to ensure that prison PMTCT services produce high quality data essential for program

planning and evaluation. IMC will spend less than $18 per woman and use the same amount to cover the four PMTCT prongs and the wraparounds such as safe water and malaria prevention.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	0	0

Narrative:

IMC supports HIV care and prevention activities in Kenya prisons and services targeting ~50,000 inmates, ~15,000 prison staff and their families and host communities. The prisons are located in settings with diverse HIV prevalence ranging from 1% in North Eastern Province to 14.9% in Nyanza Province against a national of 7.1%. As per 2011 SAPR results, a cumulative 1,751 adults on ART and 1,292 were active in the IMC supported sites.

In FY12, IMC will jointly work with the MoH and KPS to continue supporting provision of quality adult HIV treatment services in the prisons to 1,334 patients currently receiving ART and 182 new adults resulting to cumulative 1,601 adults who have ever been initiated on ART. In FY13, this number will increase to 1,471 currently receiving ART and 184 new adults resulting to 1,785 adults who have ever been initiated on ART.

IMC in collaboration with MoH will support in-service training of 50 and 40 health care workers in FY 12 and FY 13 respectively; identify human resources and infrastructure gaps and support in line with MoH guidelines; support good commodities management practices to ensure uninterrupted availability of commodities.

IMC will support provision of comprehensive package of services to all PLHIV including ART initiation for those eligible; laboratory monitoring including biannual CD4 testing, viral load testing for suspected treatment failure (through strengthened laboratory network); cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH (non prisoners); improved OI diagnosis and treatment including TB screening, diagnosis and treatment. Ongoing community interventions for PLHIV including education by peer educators and use of support groups to provide adherence messaging, defaulter tracing and follow up will continue to be supported to improve retention in all sites.

IMC will continue to support inter prison referral mechanisms and linkages to other health facilities to prisoners released or pardoned for continuity of HIV services. In the prisons, IMC will support ongoing community activities including education by peer educators and use of support groups to strengthen adherence, effective and efficient retention strategies; food and nutrition programs. Additionally, IMC will do cohort analysis and report retention rates as required by the national program and discuss the analysis results with facility staff in order to improve program performance.
IMC will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services

integrate them into routinely collected data; use the results to evaluate and improve clinical outcomes and additionally support short term activities with great impact and better patient outcomes. *IMC will adopt strategies to ensure access and provision of friendly HIV treatment services to all including supporting peer educators, support groups, disclosure, partner testing and family focused care and treatment. IMC will continue to strengthen data collection and reporting at all levels to increase and improve reporting to KPS HQs, NASCOP and PEPFAR. Use of an electronic medical records system will be supported and strengthened.*

Implementing Mechanism Details

Mechanism ID: 9171	**Mechanism Name: South Rift Valley**
Funding Agency: U.S. Department of Defense	Procurement Type: Cooperative Agreement
Prime Partner Name: Henry M. Jackson Foundation Medical Research International, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 17,908,202	
Funding Source	**Funding Amount**
GHP-State	17,908,202

Sub Partner Name(s)

Africa Inland Church Litein Hospital	I Choose Life	James Finlay Limited
Kapkatet District Hospital	Kapsabet District Hospital	Kericho District Hospital, Kenya
Kericho Youth Centre	Kilgoris District Hospital	Live With Hope Centre
Londiani District Hospital	Longisa District Hospital	Nandi Hills District Hospital
Samoei Community Development Programme	Tenwek Hospital	Unilever Tea Kenya

Overview Narrative

1.Goals and objectives:HIV Program is centered in Kericho, the primary location for the USAMRU-Kenya HIV research activities, closely integrated with comprehensive HIV prevention and treatment services, thereby providing quality HIV care, treatment and prevention to the community and our research population in a previously

underserved geographic region.The program is aligned with GHI, national policies, guidelines and strategies; closely collaborates with MoH; and draws synergies from other related programs such as nutrition, PMI, child survival, safe motherhood, and FP; while addressing pertinent gender issues.
2.Cost-efficiency strategy: partnership and leveraging resources and infrastructure of already existing local institutions; tapping into pooled national procurement systems; integration and system strengthening for synergy and sustained impact; as well as undertaking cost-efficiency studies to develop best practices.
3.Transition to country partners:The SRV Program partners with the health ministries, private hospitals, FBOs, NGOs & CBOs through capacity building and systems strengthening to ensure sustainability, ownership and seamless transition to these local partners.
4.Vehicle information:Partners needed sturdy, all-terrain vehicles to facilitate coordination and supervision of program implementation across 14 districts in SRV. Since 2004, vehicles procured include: 2 (2005) and 1(2007) for office and field travels; 5 (2009) to support program activities at MoH partner sites; 3 replacements, 2 for supplies and 2 for field travels, procured in 2010. None requested in current COP. This activity supports the GHI/LLC and is funded primarily with FY12 funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

Construction	694,550
Economic Strengthening	2,500
Education	21,955
Food and Nutrition: Commodities	52,500
Food and Nutrition: Policy, Tools, and Service Delivery	21,700
Gender: Gender Equality	5,000
Human Resources for Health	161,693
Key Populations: FSW	973,404
Water	9,700

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**9171**
Mechanism Name:	**South Rift Valley**
Prime Partner Name:	**Henry M. Jackson Foundation Medical Research International, Inc.**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	902,544	0

Narrative:

HJF SRV will continue to implement adult care and support in the South Rift Valley and part of North Rift Valley in > 100 facilities of which 11 are main hospitals and the rest being level 2 and 3 facilities, in line with the GoK decentralization policy. The COP 12 PEPFAR funds will be used to support adolescents, adults and women in the general population , marginalized and MARPS such as sex workers, prisoners to access care and support services both in the community and the facility. The total number being targeted to receive a minimum of one clinical service is 22,597 and 28,170 in FY 12 and FY 13 respectively.

Early identification and linkage to care will continue to be emphasized in an effort to reduce morbidity and mortality. This will be achieved by working closely with counseling and testing programs (HTC) using the different strategies employed. Facilities will be encouraged to ensure early linkage to care at all points of diagnosis both at the facility level and community level. Initial assessment and counseling will be done by the health care workers and, where feasible, also by peer counselors to promote status acceptance and retention in care.

Integration of care and support services will be promoted at all levels and all adolescents and adults living with HIV will be offered the comprehensive package of care, as outlined in the GoK ART guidelines, including: psychosocial and spiritual support; linkage to support groups; universal prophylaxis for Cotrimoxazole and

provision of other OI drugs; adherence counseling; nutritional assessment, counseling, and where necessary supplementation; early screening, diagnosis and treatment of OI infections and STIs; pwp package in clinical and community settings); sexual and reproductive health services; defaulter tracing; alcohol and substance use counseling and support; support of and linkage to economic empowerment projects; end-of-life care and other interventions in an effort to improve and prolong the quality of life for infected and affected individuals. Cervical cancer prevention, screening and treatment will be supported in line with the GoK strategy and all women in the HIV Clinics will be screened for cervical cancer at least once a year. Selected level 4 facilities will be supported to be referral centers of excellence.

Efforts will continue to be made to improve patient retention through strengthening of the existing linkages i.e. intra-/inter-facility, and facility-community linkages. This will be achieved through emphasis on complete documentation of patient social history, use of existing community health care workers supported by the GoK, support of home and community based care component of the community strategy, patient education in the support groups, and outreach services to the community. The capacity of health care workers will also be built through in-service training, continuous medical education and mentorship to improve the quality of care offered to the adolescents and adults living with HIV and also to be able to refer these individual to services required e.g. to a high level facility for specialized care.

Monitoring of quality of care will be done through joint supportive supervision with GoK officers on the ground, continued mentorship, joint quality of care review meeting. This will involve use of existing registers and reporting tools, in house program evaluation tools and will be done in collaboration with the facility staff and leadership.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	828,370	0

Narrative:

Henry Jackson Foundation (HJF) implements Orphans and Vulnerable Children (OVC) program in the South Rift Valley Province in Kericho and Bomet and part of Narok counties. HJF and its partners are currently serving over 12,000 OVCs in SRV.

Goals of the project:

The major goal of the program is to mitigate against the impact of HIV and AIDS and prevent inequity and other challenges like stigma, lack of care and support, lack of food, shelter, health care and poor access to education. Secondly, the program aims at helping children and adolescents grow and develop into healthy, well adjusted and productive members of society by ensuring that the needs of each OVC enrolled into the program are addressed. This is in line with the US five year Global HIV/AIDS strategy to rapidly scale up compassionate care to OVC and the Government of Kenya (GoK) OVC guidelines. It aims at optimizing quality of life for HIV infected and affected OVCs and their families throughout the continuum of illness through referrals of OVCs for treatment, provision of psychosocial, spiritual, social, nutritional, economic empowerment, and prevention services. The program will target OVCs from infancy to late childhood/ adolescence (0-17). The services will be offered indiscriminately for

both males and females. It will also target people affected by HIV and AIDS by focusing on existing caregivers. In FY 2012, the program will support 13,359 OVCs.
Strategies/Activities:
HJF will continue to directly care for and support the OVCs by working in three levels: child level (by provision of food /nutrition, shelter renovation, health care, access to education, psychosocial support, legal protection, and economic empowerment); caregiver level (by training caregivers on care of OVCs); and community level (by use of existing community structures) to make sure children live within their cultural context and family set up. The programs will continue working with the relevant government ministries of education, health, and community based organizations, and other stakeholders in support of OVC program. The mechanism has strengthened partnerships with the local government systems and other community organizations in providing comprehensive and quality services to OVCs.
Strengths:
The integration of the OVC program with care and treatment programs and other prevention programs such as VMMC, HTC, and AB, will support community ownership and sustainability of the program. The programs have been able to leverage some support from the National AIDS Control Council. They have also used the multi-sector approach by working closely with the relevant ministries of health, gender and education. They have been able to link children and families to prevention, care and treatment programs and support through the capacity building of CBOs to facilitate care for more OVCs.
Challenges:
There are more OVCs than the programs can support hence the need for more funding.
Monitoring and Evaluation will be done through supportive supervision and technical assistance visits. Routine data collection and reporting tools will be used.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	1,005,861	0

Narrative:

The HJF SRV will target all males and females in general population including children, pregnant women, and MARPs like prisoners etc in South Rift and part of North Rift Valley by working with Provincial/ District Leprosy and TB Coordinators (P/DTLCs) to co-ordinate, monitor and implement TB services.
Integration of ART in TB clinics will continue to be supported in Level 4 facilities; while lower level facilities will integrate TB services into their HIV or general outpatient clinics.
TB ICF will be done and documented using the national TB screening tool, at facility and community level, including high risk contacts for PLHIV with TB. Public health officers and cough monitors will be utilized in the community to identify and link suspected cases to a facility for further work up and diagnosis. About 80% of PLHIV will be screened for TB in HIV clinics, with 5% expected to initiate TB treatment.
All individuals with TB or suspected TB in facilities will be offered PITC; those positive will be linked to care and

ART initiated immediately in line with MoH guidelines. SRV will target 75% (the current DLTLD target is 50%) to be initiated on ART. All TB/HIV Co-infected will be offered comprehensive care package including: DOTS, cotrimoxazole prophylaxis and PwP messaging to improve patient outcomes.
Isoniazid Preventive Therapy will be implemented, in a phased approach, in level 4 facilities with capacity to rule out active TB. Effective intra-/ inter-facility, and facility–community linkages and referral networks will be further strengthened so that all PLHIV benefit from IPT.
TB infection control (IC) activities in TB and HIV Clinics will be promoted and supported per MoH guidelines. Health care workers selected by DHMT, will be trained or sensitized on TB/HIV including IPT, ICF, and TB/HIV per MoH curricula to improve their capacity in TB/HIV management to: prevent new TB infections, reduce morbidity and mortality, and control MDR/XDR TB development.
Laboratory infrastructure and services like TB diagnostic capabilities using sputum smear microscopy, fluorescent microscopy will continue to be supported; with focus on quality including QA/QC. TB sputum for culture and suspected MDR cases will be sent to the Central Reference Lab. SRV will support use of Gene Xpert technology based on phased plan at the national level where procurement and placement of these machines in selected hospitals will be done.
Data is collected and reported using MoH tools; SRV will intensify use of PDA for collecting and disseminating TB/HIV reports. Continued joint support supervision, and quarterly review meetings with the DTLC and facility staff, will be supported to improve data quality and data use for decision making.
In FY 11, SRV achieved 86% treatment success rate for smear-positive disease (vs. WHO targets of 85%); TB treatment sites increased from 117 to 132 and TB diagnostic sites 70 to 89; HIV testing among TB patients- 84% to 90%; CTX prophylaxis for co-infected patients- 90% to 98% and initiation of ARVs in Co-infected patients 45% to 56%. SRV assisted MoH improve its sputum smear microscopy network through training, mentorship, and strengthening of EQA programs. Concurrently, DST for TB re-treatment cases improved from 42% in FY 10 to 63% in FY 11. Standardized TB screening (ICF tool) tools for HIV patients were successfully rolled out. SRV also contributed to the development of National TB policies and guidelines.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	221,146	0

Narrative:

HJF SRV will target all children aged 18 years and below, who will receive a minimum of one clinical service, 3,490 and 3,842 pediatrics will be reached in FY 12 and FY 13 respectively in SRV and part of North Rift Province; 95% will receive cotrimoxazole prophylaxis.
Early identification of HIV exposure and infection status remains key to effective and prompt linkage to care and treatment. To achieve this, children will be offered PITC services in all health facilities as a routine for timely linkage to care and treatment.
Exposed Infants will be followed up as per the MoH HIV Exposed Infant algorithm. HIV positive infants will be

actively followed up for early initiation of ART as per ART guidelines. The mother- baby booklet will be used to link the infant to the MNCH, Care and ART clinics. HIV exposed infants and infected infants will be followed up and offered comprehensive package including: ARV prophylaxis, timely initiation of ART for those who are eligible, appropriate infant feeding options, growth and development monitoring, immunization as per Kenya Expanded Immunization Program (KEPI). All HIV exposed infants, infected infants, children, and adolescents will be offered: TB screening; IPT for those at high risk; regular screening, diagnosis and treatment of OIs; routine nutritional counseling, assessment and supplementation; clinical and laboratory monitoring such as hematology, chemistries, CD4%, targeted VL and resistance testing, where necessary; family testing, psychosocial and spiritual support to the child and family members; training of caregivers on basic principles of treatment and palliative care, Linkage to other facility-based and community programs such OVC programs; PMI for the mother to access ITNs, Food-by-prescription programs including other children in the household, pediatric and adolescent support groups, etc. Facilities will be encouraged to have clinic days for the pediatrics and adolescents while ART is being integrated into the MNCH clinic. There is ongoing decentralization of pediatric services and creation of child friendly clinics up to the lower level facilities. Support for pediatric equipments to improve child survival will continue.

With effective programs, more children are surviving to adolescence. Since the adolescents have special needs and challenges there is need for more support for HIV infected adolescents: Facilities are encouraged to have adolescent clinic days following a successful model at Kericho District Hospital. HCWs are trained on pediatric psychosocial counseling to support the care giver on disclosure, formation of pediatric and adolescents support groups, to prepare the adolescent and caregiver for the transition into adult care services etc, linking adolescents to other programs such as youth friendly centers etc. The program will support implementation of the 'care of adolescents' package' as per MoH guidelines.

Lab diagnostic systems are in place to support 'pediatric' friendly parameters such as CD4%, VL and where necessary resistance testing. QA/QC will be supported. Laboratory networks and referrals will be strengthened to support sending of specimens and results to and from identified labs such as KEMRI WRP CRC lab.

On-site support supervision, mentorship and clinical pediatric services review, M&E will be supported to improve quality of care and to support HCWs to document, collect and report quality data for pediatric care programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	992,297	0

Narrative:

HJF SRV will target to offer Laboratory services to all males, females and children in the general population drawn from South Rift valley and part of North Rift Valley.

HJF SRV will work closely with the Government of Kenya Ministry of Health and implementing Partners to co-ordinate, monitor and implement quality Laboratory services in the region.

Leveraging on the existing research lab infrastructure, some assays will be offered centrally at the KEMRI/WRP Clinical Research Centre (CRC) Lab for specialized HIV diagnostics and monitoring tests, opportunistic infections and emerging diseases. In addition, and to promote country ownership, sustainability, decentralization and integration into existing systems, MoH and other partner hospital labs will be supported to perform routine assays. The number of Laboratories offering CD4 testing, chemistry and hematology (plus other body fluids) will be increased to ease and improve access to service delivery in a timely manner especially for expectant mothers requiring ART early in order to eliminate MTCT (eMTCT). The KEMRI/WRP CRC lab will continue offering PCR DNA for Early Infant Diagnosis (EID) and other specialized tests to the greater Rift Valley region.
Building upon existing strengths, more Laboratories will be networked to improve on geographical coverage, turn-around-time (TAT) and cost-efficiency and ensure adequate back up as necessary.
HJF SRV plans to support five Laboratories to be assessed for Accreditation using the WHO AFRO stepwise format with the applications of Strengthening Laboratory Management Towards Accreditation (SLMTA) approach.
The trainings planned, including Laboratory ART Monitoring, and SLMTA are geared towards offering quality services and improvement of project implementations. Laboratories will be enrolled in local as well as external quality assurance systems and WRP CRC Laboratory will offer biannual quality assessment activities.
Monitoring and evaluations of all the activities and tests will be done by District Laboratory Managers with support of HJF SRV Laboratory coordinator and visiting Laboratory advisors and specialists within the DoD network.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	535,626	0

Narrative:

Henry Jackson Foundation (HJF) South Rift Valley (SRV) SI program will provide technical, Monitoring & evaluation (M & E) and data management support to the South Rift Valley HIV Program. The program covers the south Rift Valley and parts of North Rift region of Kenya which includes Kericho County, Bomet County, Nandi County and part of Narok County, with a population of more than 3 million Kenyans accessing HIV prevention, care, and treatment services. The SI program will be supporting partner sites which are based at the Government of Kenya Ministry of Health District Hospitals and local health clinics as well as community based programs offering OVC support, HIV prevention and palliative care. COP 12 funds will be used to build the capacity of M & E staff through relevant M & E trainings and data analysis aimed at improving service delivery.The SI program will support District Health Records officers (DHRIOs) and data clerks in 11 treatment partner sites and 3 community based programs with equipment, Data management M & E support including M&E trainings, roll out of national reporting tools, mentorship, participation in data review meetings, data analysis, dissemination and use of data for decision making at the facilities, Data quality Audits and support supervision.The SI program will support the coordination of data management and data quality management in the PEPFAR Sites. As part of supporting

Government of Kenya (GoK) systems, SI program will be rolling out Electronic Medical Records system (EMR) in 7 district hospitals, 2 Faith based and 2 Plantation hospitals. EMR roll out to high volume satellites will be considered as EMR use stabilizes in the main facilities.In each of the Partner Hospitals, HJF SRV SI program will help in the roll out and use of the District Health and Information system (DHIS) as part of strengthening one national reporting system by GoK. HJF SRV SI program will support internet infrastructure provision and Information Technology capacity building at the District Hospitals to enable health workers access and use the DHIS system; and also improve existing communication systems.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	1,338,125	0

Narrative:

Henry Jackson Foundation (HJF) implements VMMC program activities in South Rift Valley Province in the tea estates of the following counties; Kericho, Nandi, Bomet and Narok (Transmara East and West Districts in the mining industry) targeting the non-circumcising communities including Luos, Tesos, Turkanas etc. In FY12, program will provide VMMC services to 12,879 individuals, most of whom will be 15 years and above, at existing MoH and plantation hospitals. The targets, in line with the PEPFAR NGI's, are laid out at the start of the year and tracked on monthly basis by program managers. The VMMC minimum package includes: HTC; risk assessment and reduction counseling; STI screening and treatment; referrals as appropriate for ART, psychosocial support, post test club; education on wound healing; and then circumcision.

Supportive supervision:

The program managers and other program technical experts will conduct monthly site support supervision. Also the program in collaboration with NASCOP will conduct quarterly site support supervision that includes observed practice. The areas identified to have gaps will be addressed.

Quality Assurance:

HJF has put in place for all the VMMC sites the following: use of approved VMMC national curriculum; emphasis on importance of fidelity to the respective curriculum; use of trained and certified facilitators to train clinical officers, nurses, and Medical officers who are the VMMC service providers; observed practice of the implementation is done soon after the training; use of standardized national data collection tools; and regular field site support visits by trained program staff to check on the VMMC service delivery. Reviewing of the clients is effective since most of the clients are a cohort living in the tea plantation. Monitoring and evaluation will be conducted with approved national monitoring tools. Field staff will send reports on a monthly basis which are compiled into quarterly reports and submitted to DoD SRV.

Communication activities:

VMMC communication activities will include dissemination of IEC materials targeting both males and females (to support their husbands and sons) to go for VMMC services.

HTC is a core element of VMMC services and it is offered on sites. MC is integrated with other services and is

offered as part of the comprehensive prevention package.
Training programs and materials used:
HJF works in collaboration with NASCOP which provides VMMC trainings using certified national trainers and approved national curriculum and materials. NASCOP certifies the trained VMMC service providers.
Demand creation activities: In the implementation of VMMC, the program will work in collaboration with the district Ministries of Health and Public Health and Sanitation. Also the community gatekeepers will be sensitized and given information, which will then encourage the other community members (both males and females) through snowball approach to buy the idea and own the program.
Linkage to care and treatment:
Since the services are offered in the existing MoH and plantation hospitals, the VMMC positive clients are linked and referred for care and treatment in the same facilities using the NASCOP referral tools. A regular analysis of referral status between HTC program on site and care and treatment are done to monitor linkages and correctives measure taken where gaps exist.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	187,939	0

Narrative:

HJF will contribute to the prevention of medical transmission of HIV (and other blood borne pathogens) through sharps and other medical waste management. It will support training and behavior change communication aimed at improving injection safety, phlebotomy, lancet and other high risk procedures for health workers. It will also strengthen post-exposure prophylaxis (PEP) services for health workers encountering accidental exposure to blood borne pathogens. It will promote safe medical waste management (MWM) practices by supporting dissemination of necessary policies and guidelines; training of health workers; ensuring commodities security; decreasing the use of unnecessary injections and supporting installation and maintenance of environmentally friendly medical waste management equipment.
HJF will implement its activities in DOD supported Sites and will ensure that all counties within its supported area are covered. It will target health workers, and communities as recipients of health services and those at risk of injury. It will support installation of six (6) MWM systems, and support to train at least five (5) biomedical engineers in MWM equipments to maintain and repair the equipments.
Importance will be put on integrating Bio-safety, MWM, universal precautions and infection prevention and control (IPC) measures into existing HIV programs like care & treatment, prevention, counseling & testing and other health programs such as family planning, immunizations and other clinical services. It will support these programs to have a plan and budget to address medical waste and infection control.
HJF will facilitate training of health workers through a training of trainer (TOT) model to create a pool of trainers and leaders in MWM and IPC. It will facilitate training of biomedical engineers who will ensure efficient and sustainable operation of cost-effective MWM systems. Additionally it will strengthen the County MoH coordination

structures such as the County IPC committee to make them fully operational and be able to sustain county oversight for the future.

HJF will collaborate with the MoH/FBO/Private Hospitals to leverage resources for waste management from key partners. It will also explore viable public private partnerships (PPP) eg Tea companies that support safe MWM. Quality assurance and improvements will be a key component of this program. HJF will ensure this by rolling out a strong monitoring and evaluation system with indicators for tracking along the lifespan of the project. It will also support a sharps injury surveillance system that will be used to improve programming.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	826,128	0

Narrative:

Henry Jackson Foundation (HJF) works in the South Rift Valley Province in Kericho, Bomet, Nandi and 10% of Narok County (i.e. Transmara East and West Districts) to serve youths in and out of school with abstinence and being faithful evidence-informed behavioral interventions (EBIs), Families Matters Program and Health Choices 1. The estimated population of adolescents aged 10-14 years in the counties as per 2009 Census is 413,298 distributed as follows: 99,735(Nandi), 100,147 (Bomet), 97,629 (Kericho) and 115,787(Narok). In FY 12, the program will reach 118,156 individuals; including 58,729 youth aged 10-14.

FMP is an EBI targeting parents, guardians, and other primary caregivers of preadolescents aged 9-12 years. It is delivered in 5 weekly sessions to allow parents to practice skills learnt. It aims at promoting positive parenting practices, monitoring, positive reinforcement, effective parent-child communication on sexual topics and sexual risk reduction. FMP seeks to delay onset of sexual debut by training parents to deliver primary prevention messages to their children. FMP is linked to other EBIs including VMMC and HTC.

Healthy Choices 1(HC1) targets in-school youth of 10-14 years and aims to delay sexual debut by providing knowledge and skills to negotiate abstinence, avoid negative peer pressure, avoid or handle risky situations, and to improve communication with a trusted adult. It can be delivered in 4 sessions of two hours each or 8 sessions of 1 hour each. HC1 is linked to other EBIs including VMMC.

Some of the HVAB funding will be used to promote abstinence and/or be faithful messages in the EBIs targeting the following priority populations: 15-19-year olds (44,995), discordant couples (3,329), men aged 30-44 (8,159) and persons living with HIV (2,944).

Quality Assurance: HJF has put in place the following measures for all its sites: use of approved national curricula; emphasis on importance of fidelity; use of trained and certified pair of gender balanced facilitators; trainings on EBIs are conducted by certified national trainers; observed practice of implementation is done soon after training; use of standardized, national data tools at every stage of EBI implementation; and regular field visits for support supervision by trained program staff to check on delivery of EBIs.

The implementation of the EBIs for each targeted populations is integrated with other services, such as condom

promotions, HIV Counseling and Testing, Voluntary Medical Male Circumcision (VMMC), ART etc. The proposed activities and EBIs are guided by the goals and objectives of the project. Targets for each of the interventions are laid out at the start of the project year and tracked on a monthly basis through respective monthly reports. Results are analyzed on a quarterly basis. The targets are in line with the PEPFAR Next Generation Indicators (NGI's). Monitoring and evaluation will be conducted with EBI approved data capture / monitoring tools. HJF and its partner sites will send reports on a monthly basis; these reports will be compiled into an overall report quarterly and submitted to DOD SRV.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	1,207,720	0

Narrative:

Target population:
HJF implements comprehensive HIV prevention services in Kericho, Bomet, Nandi and Narok (Transmara East and West Districts) counties of South Rift Valley Province.
Targeted as per KDHS, are youth and general population including discordant couples, couples, men in rural settings and those infected but unaware of their HIV status, and MARPs (Female sex workers and Truckers). HJF will expand the HTC scope and approach to minimize missed opportunities and accelerate HTC coverage to achieve the universal 80% knowledge of HIV status among individuals 15-64 years. HIV prevalence among the general population in Rift Valley is 6.3%. HTC coverage in the last year among men was 16% and 25% for women.
HTC approaches:
Client Initiated Counseling and Testing (CITC) and Provider Initiated Counseling and Testing (PITC) provided in health care facilities and community settings (mobile/outreach services, door-to-door, stand alone VCT, and targeted HTC campaigns) based on population density, HIV prevalence and HTC coverage.
Targets and achievements:
Last year, HJF provided HTC services to over 424,846 (vs target of 165,000) through: PITC 42%; campaigns and outreaches 20%; mobile HTC 30% and the rest (8%) through VCT and home based HTC approaches. The program supported capacity building of 230 HTC service providers including HTC refresher training (proficiency testing, national re-testing recommendations and data collection tools), CITC, PITC, and couple HTC. In FY 2012, the program will provide HTC services to 261,522 individuals, of whom 60% will be new testers, 20% couples, 15% MARPs and the rest will be through VMMC and other populations.
Proportion allocation of funding:
20% of the budget supports HTC among the MARPS and 6% for VMMC provided as part of the combination HIV prevention package.
For effective linkage and referrals, a directory of existing HIV care and treatment facilities is maintained; and referrals done using the NASCOP tool. Regular analysis of referral status between the HTC sites and care and treatment facilities is undertaken and necessary corrective measures taken. A follow up system is in place to track

clients tested at HTC sites; and HJF collaborates with Ministries of Health to ensure that all HIV infected individuals and their family's access care and support services in the community setting.HIV negative individuals will be referred for other prevention services such as VMMC.

Quality management:

HTC service providers are trained and certified by NASCOP. Quality Assurance systems are in place including counselor support supervision, proficiency testing and Dry Blood Spot (DBS) is taken for every 20th client. For service standardization, timers as well as job aids are used. Monthly HTC counselor supervision is done by program technical experts/managers in collaboration with the respective District Health Management Teams.

Monitoring and evaluation:

The program uses national tools for data recording and reporting. The Indicators collected include individuals receiving HIV testing disaggregated by age, sex, MARPs and couples.

Sensitization and mobilization is done through the use of Peer led networks among MARPs who motivate the peers to access the range of HIV prevention services. The community gatekeepers are also involved to give information on availability of HIV prevention services to the other community members.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1,410,390	0

Narrative:

HJF implements MARPs services in Kericho, Bomet, Nandi and 10% of Narok (i.e. Transmara East and West Districts) counties of south Rift Valley.

The total target population in FY12 is 98,960 which include: Female Sex Workers (3,328), truckers (150), general population (27,668), youth 15-19 (10,015), youth aged 20-24 (38,213), and PWP clinical (19,586), each sub-population to be reached with minimum package. The activities will target high risk sexual behavior prevalent among these populations such as incorrect and inconsistent condom use particularly with regular sex partners and concurrent partners.

HJF and its partners will work with FSWs and truckers to select, recruit and train them as peer educators. A sub-population identified as peer leaders will be further trained on peer education and facilitation skills, and will help cascade the peer education. They will train Small groups of 25 individuals identified by the peer educators based on gender and age to enhance active participations. During the peer sessions, mobilization and linkage/referrals for other services like STI treatment, HIV care and treatment services, HTC and VMMC will be offered. All the groups of peer educators will undergo 5 sessions on various SRH topical issues, with follow up sessions after 6 months for each group. Gender based violence, poor ARV drug adherence issues, excessive alcohol, drug and substance abuse, among other behavioral risk factors will be included as part of the elements of the sessions.

HJF will support implementation of the HIV Combination Prevention Interventions for FSWs as per National Guidelines for the package of services for SWs which captures evidence-informed behavioral, biomedical and

structural interventions. Some of the behavioral interventions include condom and lubricant demonstration and distribution, peer education and outreaches, risk assessment, risk reduction counseling and skills building. The specific EBIs for this group will be RESPECT, Sister-to-Sister and Safe in the City. Biomedical interventions include STI screening and treatment, HTC, Pre-exposure prophylaxis, TB screening and linkage/referral for treatment, HIV care and treatment, RH services, and Emergency contraception.

HJF will implement EBAN, which is an EBIs for discordant couples. It's aimed at lowering the rate of risky behavior and promoting safe sex through increased condom uptake among HIV-discordant couples; and provided as part of the integrated services.

The in and out of school Youth aged 15 – 19 years and 20-24 will be reached with Healthy Choices II (HCII) which aims at delaying sexual debut, promote secondary abstinence or have protected sexual intercourse. It helps in handling peer pressure, learning one's HIV status, and give knowledge and skills on correct and consistent condom use.

To facilitate Quality Assurance HJF and its partners will provide mentorships, learning on the job, Continuous Medical Education (CMEs), exchange visits for best practices and bench marking. In areas where knowledge or skill gaps are identified, they will be addressed through mentorship and refresher courses. Quarterly support supervision with NASCOP and DOD SRV technical managers will be done to promote quality of services offered.

For M&E purposes, HJF will ensure that all the data collected by service providers/facilitators will be entered into standard database and periodically analyzed and sent to DOD SRV

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	2,389,216	0

Narrative:

•The SRV program has scaled-up PMTCT services to 15 districts in south and north Rift Valley region. In COP 11: 84,200 pregnant women presented for their first antenatal visit; 99% were tested and received results. 80% of the 2,737 women who tested positive, and 67% of the exposed infants received ARV prophylaxis. In COP 12 and COP 13, the program aims to test a total of 92,984 and 97,633 expectant women respectively. 2,735 and 3,322 positive women are expected to be identified and put on ARVs, while 2,052 and 2,857 exposed infants are expected to be put on prophylaxis for the two years respectively. The KEMRI/WRP CRC laboratory in Kericho will provide HIV PCR EID services to the whole of Rift Valley province and Kisumu West district in Nyanza.

•The cost per target for FY10 was $22. This amount included support for the Kericho EID lab which is a National activity and the actual cost per patient is considerably lower. This cost will come down further as the program limits expansion and reaps from prior infrastructural investments.

•The SRV program will train 300 and retrain 400 health workers on the more efficacious regimens as well as other courses aimed at improved service delivery in the MCH clinic and maternity. In addition, technical assistance and on job training will be provided by HJF Technical staff.

•Monitoring: The program will continue to work with Provincial and District Health Management Teams

(P/DHMTs) to ensure that all the facilities are able to offer the minimum package of PMTCT. Coordination with GoK will ensure sustainability and ownership. Program data will be reviewed quarterly with the service providers, and identified weaknesses improved. The program has planned various program evaluations to assess effectiveness of the PMTCT and EID programs.

•Best practices: The SRV program will offer testing and counseling to all women attending ANC clinics, through task shifting including use of lay counselors to offer counseling services. All service providers will be trained on the new PMTCT guidelines. Continuous mentorship and on job training will be offered through the district mentors and the DHMTs. All sites will have access to CD4 testing by use of various strategies including a CD4 networker. Follow up will be reinforced through the use of support groups, CHWs and cough monitors as appropriate to assist with defaulter tracing. All exposed infants will be entered into a data base by the clinical mentor, followed up, and those positive started on care.

•Demand creation: The program will participate in community meetings to sensitize the community on ANC and PMTCT Specifically, Male involvement will been encouraged through the roll out of Saturday male clinics in selected health facilities in the region. The women will be given cards with their ANC number to be used by their partner when testing, to enable the health worker to link the results for the couple.

•Linkages: The SRV PMTCT activities will be implemented in the setting of a comprehensive HIV/AIDS prevention, care and treatment program. PMTCT clients will be linked directly to Treatment for ARVs; ; CT will be conducted on male partners and children of women in the MCH clinics. The women will also be screened for TB and linked to TB/HIV services. Linkages between PMTCT service and care outlets will be strengthened to improve utilization of care opportunities created through PEPFAR funding, including support for food and nutrition among other services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	5,392,025	0

Narrative:

HJF SRV will continue to provide treatment to all male and female adolescents and adults aged 15 years and above in the general population and MARPs such as sex workers, prisoners to reach a target of 21,190 and 22,315 currently on ART in FY 12 and FY 13 respectively.

As more PLHIV are initiated on ART due to adoption of new guidelines at a cut off of 350 and other eligibility criteria, COP 12 funds will be used to improve efficiencies by putting measures such as continued decentralization of ART services, task shifting, mentorship, support supervision and program review meetings.

A comprehensive treatment package will be offered to these PLHIV which will include: psychosocial support, clinical monitoring, PwP package, universal Cotrimoxazole prophylaxis, nutritional counseling assessment and supplementation and Laboratory monitoring. The current clinical outcome measures are: Improved health outcomes defined by viral suppression, improvements in immunological status (increase in CD4 cell count); clinical parameters (stable or decrease in WHO stage, increase in weight/body mass index, stable or improved hemoglobin,

and stable renal and liver function tests); and participant-reported improvement in health status. Selected level 4 facilities will be supported to be referral centers of excellence.
Strategies will be put in place to improve patient retention and adherence through: Continued patient education (group and individual education), proper documentation of the patients social history for effective follow up and defaulter tracing, encouraging PLHIV to have treatment partners, linkage to support groups and the community through the existing community units and community health care workers. The outcomes of such strategies are: improved health outcomes, reduced morbidity and mortality and reduced chances of developing resistance. The retention rate in SRV is currently >80% which reflects the retention at the national level.
Integration of services will be emphasized in all facilities: TB/HIV services including TB screening and Isoniazid prophylaxis; ART in MCH; counseling and /or provision or referral to Family planning services ; and cervical cancer screening in the HIV clinics.
The funds will be used to support: in-service ART trainings using the national approved curricula and Mentorship programs. Health care workers (HCWs) will be encouraged to hold CMEs, on job trainings and regular clinical review meetings to discuss challenging cases. Treatment failure retreats will be held in a forum where HCWs drawn from different hospitals meet to discuss treatment failure cases.
Support supervision to the facilities will be done jointly with MoH and in each visit; provision of quality treatment will be emphasized.
Accurate documentation of patient information in the files, MoH data collection and reporting tools will be supported for improved patient follow up and management. Facilities will be supported to hold regular data review meetings to improve data utilization for decision making. The new generation indicators will be collected and reviewed at least quarterly with the Strategic information, monitoring and evaluation team.
To promote local ownership and program sustainability, facility Health Management Teams develop their own work plans and scope of work with Technical Assistance from HJF staff. Performance is monitored and evaluated quarterly using in-house tools; this is done jointly with the HJF SRV technical staff.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	670,815	0

Narrative:

HJF SRV will support all male and female HIV-Infected children below 15 years of age, targeting 2, 673 and 2,982 children currently on ART in FY 12 & FY 13 respectively. Strategies to scale up pediatric treatment include: Offering PITC to all children presenting to facilities for whatever reason, both in in-patient and out-patient clinics; encouraging the mother or care giver to bring all the other siblings to be tested for HIV; and decentralization of pediatric ART services to all clinics offering ART services.
The capacity of HCWs to offer pediatric treatment will be strengthened through in-service training using nationally approved curricula, mentorship, encouraging the facilities to hold clinical review meetings and on-job training.
Technical Assistance (TA) will be offered through telephone and e-mail follow up where clinics are encouraged to

do case summaries and share with SRV program team. Treatment failure retreats are organized by the Technical Staff in the SRV program for facilities to share challenging cases with colleagues, including expert clinicians; such forums have instilled confidence in HCWs as regards pediatric treatment. *HCWs will be supported to improve documentation on patient files and other tools, for effective follow up and linkage. Support supervision will be carried out jointly with the DHMT and HMT.* *Adherence in pediatric population remains a challenge due to frequent change of caregivers, lack of social support etc. Efforts will be made to address these challenges through: Having dedicated pediatric clinic days, child friendly clinics, formation of age appropriate pediatric support groups; empowering care givers through trainings on disclosure and Families Matter Program under AB program on prevention messages; leveraging on the AB program in schools to sensitize teachers on HIV issues; male involvement in PMTCT, using family centered approach in pediatric treatment; linking the children to OVC programs and Youth Friendly Centers for the adolescents.* *Integrated pediatric services will be supported e.g. integration of ART in the MCH clinics, pediatric TB screening in all clinics including HIV clinics, treatment of those co-infected with TB in the TB clinic with each child accessing a comprehensive treatment package.* *A robust EID network to collect and transport DBS specimens from all facilities offering PMTCT to KEMRI/WRP CRC- Kericho lab is in place, and will be further supported to ensure that the results also get back to the facility on time to inform and improve clinical outcomes of the infants. A lab network system is in place where all specimens for CD4%, Viral Load ,other monitoring tests and where necessary, resistance testing are sent to various labs and results get back to the facilities in a short turn-around time. These labs are enrolled in EQA, personnel trained and mentored to assure of quality lab results.* *Efforts are made to address issues affecting adolescent treatment e.g. formation of adolescent support groups to sensitize them on life skills by leveraging on AB program curriculum, training of care givers to be able to handle adolescent issues, establish adolescent friendly clinics having been successfully modeled at Kericho District Hospital and also early preparations and counseling of adolescents for transition into adult treatment service.* *HCWs are encouraged to document best practices and submit abstracts to conferences including national treatment conferences.*

Implementing Mechanism Details

Mechanism ID: 10826	**Mechanism Name: Umbrella**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Elizabeth Glaser Pediatric AIDS Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No

Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 6,486,238	
Funding Source	**Funding Amount**
GHP-State	6,486,238

Sub Partner Name(s)

Beacon of Hope	Center for AIDS Awareness, Youth & Environment	Community Action for Rural Development (CARD)
Development Knowledge Link Africa (DEVLINK)	Diocese of Lodwar	Food for the Hungry
Gethsemane Garden of Hope for Africa (GGCHA)	Kakuma Mission Hospital	Kenya Association for the Prevention of Tuberculosis & Lung Diseases
KURIA District Diability Network (KDDN)	Mwafarikia Institute of Development	National Empowerment Network of people living with HIV/AIDS
North Star Alliance	Nyarami VCT Center	OleMila VCT
Our Lady of Perpetual Support for People Living with AIDS & Orphans, Kenya	Program for Appropriate Technology in Health	Rongai Social Economic Women's Organization (ROSEWO)
Siaya Peasant Community Outreach Project	SOI AIDS	SOS Villages
Upendo Widows Group	Victoria Agricultural & Environmental Conservation Organization	Xposha Self Help Theatre Group

Overview Narrative

Goals and objectives: The project's goal is to expand access of high quality HIV prevention, care, and treatment services through building technical and institutional capacity of 31 local non-governmental organizations (NGOs). The project also supports Ministry of Public Health and Sanitation (MoPHS) to formulate policies and develop guidelines to implement HIV Prevention evidence-informed behavioral interventions (EBI). Capacity building of local NGOs is aligned to the Kenya Partnership Framework and PEPFAR guidance so as to ensure sustainability. 2. Cost-efficiency strategy: This mechanism funds 31 local NGOs directly, with increasing levels over 5 yrs. In COP

2012, 88% of funding will be allocated to sub-grantees. Technical capacity for EBI service delivery fidelity will be done, and delivered through combination prevention for efficiency and effectiveness. At prime partner level, staffing will be streamlined and technical assistance will be targeted.

3. Transition to country partners:

The project is supporting the MoPHS to adapt more effective interventions, formulate policies and guideline on HIV Prevention and as such ensures country ownership. In addition, it supports 32 local NGOs to build their technical and institutional capacity for continued HIV prevention, care and treatment service delivery. Sub-grantees are thus expected to compete and secure funding on their own in future.

4. Vehicle information: 2 vehicles were procured in FY10 and 1 vehicle in FY11 for a total of 3 project vehicles. These vehicles are used by project staff to support sub-grantees in technical assistance and mentoring to the project's sub-grantees and local MOH partners. No vehicle will be procured with FY12 funds.

This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	50,000
Education	150,000
Food and Nutrition: Commodities	100,000
Food and Nutrition: Policy, Tools, and Service Delivery	10,000
Gender: GBV	110,000
Human Resources for Health	3,800,000
Key Populations: FSW	120,000
Key Populations: MSM and TG	100,000
Water	30,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**10826**
Mechanism Name:	**Umbrella**
Prime Partner Name:	**Elizabeth Glaser Pediatric AIDS Foundation**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	390,000	0

Narrative:

Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) TUNAWEZA project builds capacity for indigenous organizations to ensure sustainability of HIV/AIDS interventions. They will work with sub-grantees namely; Catholic Diocese of Lodwar, African Inland Church, Lodwar District Hospital, Beacon of Hope, Tumaini Medical center, Share our Sorrows children's home, and Our Lady of Perpetual Support to provide technical assistance through mentorship, supportive supervision and direct implementation of adult care and support activities in Rift Valley, Nyanza, Nairobi and Eastern regions.TUNAWEZA will work with the MOH at all levels to jointly plan, coordinate, implement and ensure provision of quality HIV care and support to 3816 current adult patients in FY12 and 4045 in FY13. TUNAWEZA will offer comprehensive care and support package of services including HIV testing to partner and family members of index patient and enrolling or referring/linking those that test HIV positive to care and support; provision of Basic Care Kit (safe water vessel, multivitamins, insecticide-treated mosquito nets, condoms, chlorine for water treatment and educational materials); therapeutic nutrition (FBP) to all enrolled HIV positive patients; prevention with positives(PwP), and cervical cancer screening to all enrolled women.TUNAWEZA will support targeted capacity building (training and mentorship) for health care workers and additionally offer continuous medical education on care and support e.g. OI diagnosis and treatment. TUNAWEZA will identify areas with staff shortages, and support recruitment of additional staff; support good commodities

management practices to ensure uninterrupted supply of commodities. TUNAWEZA will support ongoing community interventions for HIV infected individuals, including education by peer educators and use of support groups to provide adherence messaging, effective and efficient defaulter tracing and follow up will continue to be supported and strengthened to improve retention in all facilities; referral and linkages to community based psychosocial support groups; Water, sanitation and hygiene programs; Economic empowerment - Income generating activities (IGAs); Home Based Care services; Gender based violence support programs; vocational training; social and legal protection; food and nutrition or/and food security programs. They will adopt strategies to ensure access and provision of friendly services to youth, elderly and disabled populations. Strategies to increase access of care services by men will be employed, including supporting male peer educators, mentors and support groups, and supporting women to disclose and bring their male partners for testing and care. TUNAWEZA will continue to strengthen data collection and reporting at all levels to improve reporting to NASCOP and PEPFAR. Cohort analysis will be done and report retention rates as required by the NASCOP. TUNAWEZA will adopt the new generation indicators support the development and use of electronic medical records system in accordance with NASCOP's guidelines. TUNAWEZA will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV care and support services and integrate them into routinely collected data and use the results to evaluate and improve clinical outcomes. TUNAWEZA will support joint Annual Operation Plan (AOP) development, implementation, monitoring and evaluation and health system strengthening to facilitate sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	675,000	0

Narrative:

Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) through its local partners will support 2,000 OVC in FY12 and 5,000 OVC in FY13 with access to essential services. EGPAF will train 200 caregivers, and build the capacity of local, community and faith-based organizations, to meet the needs of OVC in their communities. EGPAF will continue to work in Nyanza, Rift Valley and Nairobi Provinces and will support the partners to provide critical services to OVC which include providing a comprehensive package that includes education, shelter, nutritional support, psychosocial support, support to OVC caretakers; which provides education and clothing, while linking OVC to other critical services and economic strengthening activities. EGPAF will target all OVC aged between 0 and 18 years and will provide "6 plus 1" services and report on at least 3 services which they provide to the OVC based on individual need. By March 2011, EGPAF had achieved the following: 1914 OVC served; 916 of OVC received primary direct support (PDS); 998 of OVC were provided with Supplemental Direct Support (SDS) and 84 providers/caretakers trained in caring for OVC. EGPAF continues to experience challenges in capacity building, partner linkages and networking to the local partners. In the next two years EGPAF will focus on strengthening HIV prevention education among OVC to equip them with life skills that would reduce their vulnerability to the risk of HIV infection. EGPAF will start to implement OVC interventions that are evidence-based in order to achieve

their two year goals. They will also train local organizations to strengthen the family support system and help to establish strong linkages between PLWHAs, HIV-infected children and health care services, including ensuring those children and their caregivers and other family members affected access appropriate care and treatment. EGPAF will work closely and link OVC with care and treatment partners to ensure that HIV-infected children receive appropriate psychosocial support and that they have a consistent caregiver to assure adherence to treatment. EGPAF will continue to work closely with District Children's Department and follow guidelines provided by the Ministry of Gender, Children and Social Development, as well as PEPFAR guidelines. EGPAF will support the local partners to establish partnerships and networks among other NGOs to strengthen their collective voice, build a unified approach, improve coordination, and share knowledge. EGPAF will embrace community and family centered approaches (such as the cash transfer program) that are preferred to institutional approaches and that they should explore OVC programming opportunities from a livelihoods approaches to OVC. There is limited information regarding current OVC programming in the EGPAF supported partners. EGPAF will undertake an OVC situation and gap analysis for its CBOs to document best practices and lessons learned for OVC and help the CBOs to explore new program approaches. EGPAF will also develop an OVC advocacy curriculum and provide training to CBOs and other OVC stakeholders. EGPAF will work with the local organizations to engage and advocate for OVC issues with key stakeholders in the Kenyan HIV/AIDS response, including donors. EGPAF will improve M&E systems based on rapid capacity and gaps analysis of the OVC activities they support. The program will also capture age specific services that are offered to OVC aged between 0 and 18 years.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	305,000	0

Narrative:

Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) TUNAWEZA builds capacity for indigenous organizations to ensure sustainability of HIV/AIDS interventions. They will work with sub-grantees; Catholic Diocese of Lodwar, African Inland Church, Lodwar District Hospital, Beacon of Hope, Tumaini Medical center, Share our Sorrows children's home, Our Lady of Perpetual Support and the Kenya Association for Prevention of Tuberculosis and Lung Diseases (KAPTLD), to support TB/HIV activities in Rift Valley, Nyanza, Nairobi, and Eastern Provinces by providing technical assistance through mentorship and supportive supervision, and by direct implementation of TB/HIV activities. By March 2011, 118 TB/HIV co-infected patients were on ART and 633 TB patients had received HIV testing. In FY 12 and FY 13, TUNAWEZA will intensify efforts to detect TB cases through clinical exams, laboratory investigations and ensure successful TB treatment through provision of appropriate treatment. Facilities providing TB/HIV services will have adequate and well trained clinical staff supported by well equipped and staffed laboratory, including sputum specimen transport where laboratory services are unavailable. All TB patients on treatment will be monitored both clinically and through periodic sputum examination. To reduce the burden of HIV in TB patients, TUNAWEZA will ensure that at least 95% of TB patients are screened for HIV and 95%TB-HIV co-infected patients are put on cotrimoxazole and ARVs regardless of the CD4 count as per the national guidelines.

TUNAWEZA will support the "one stop" model that provides integrated TB and HIV services in all TB clinics. All TB clinics will be stocked with cotrimoxazole and ARVs. 80 HCWs in FY12 and 60 in FY13 will be trained.
To reduce the burden of TB in HIV infected patients, TUNAWEZA will support intensified TB screening for 3392 in FY12 and 3596 in FY13 in their HIV care settings. 170 co-infected patients identified in FY12 and 180 co-infected patients identified in FY13 will be put on TB treatment and those without active TB will be provided with Isoniazid Preventive Therapy (IPT) as per national IPT protocol. To strengthen TB infection control in HIV settings, TUNAWEZA will ensure that adherence to the national IC guidelines at all sites and training of staff on IC is done. TUNAWEZA will support scaling up of at least 2 components of the national TB infection control strategy in HIV care settings, one of which should be fast tracking of patients with cough for expedited diagnostic work up and treatment. To improve surveillance and management of drug-resistant TB, TUNAWEZA will support timely transport of sputum specimens of TB retreatment cases from health facilities to the central reference laboratory for drug susceptibility testing and ensure return of the results to those facilities. They will also support scaling up of drug-resistant treatment sites thus expanding access to MDRTB treatment. TUNAWEZA will support expansion of prevention with positive (PwP) services in TB clinics, strengthen linkages of facility and community-based services, and improve patient referrals and tracking systems. TUNAWEZA will continue supporting Kenya Association for prevention of Tuberculosis and Lung Diseases (KAPTLD) to finalize an ongoing survey to assess current TB diagnostic practices, current TB and TB/HIV management practices, service provision practices, and policy application/implementation among private health providers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	62,000	0

Narrative:

Elizabeth Glaser Pediatric AIDS Foundation-TUNAWEZA project will work with sub-grantees; Catholic Diocese of Lodwar, African Inland Church, Lodwar District Hospital, Beacon of Hope, Tumaini Medical center, Share our Sorrows children's home and Our Lady of Perpetual Support to implement pediatric HIV care and support services in Rift Valley, Nyanza, Nairobi, and Eastern Provinces and also they will directly implement pediatric care and support services. Since 2009,
TUNAWEZA has been supporting PDCS activities in these regions and by March 2011 TUNAWEZA had 668 children enrolled in care of whom 487 are on cotrimoxazole prophylaxis. They will provide care and support services to 399 and 430 children currently on care in FY 12 and 13 respectively and also provide comprehensive, integrated quality services, and scale up to ensure 325 HIV infected infants are put on ARV prophylaxis and all HIV exposed children access pediatric care services. The focus of pediatric care services will be provision of comprehensive, integrated quality services including strengthening the use of the Mother-baby booklet, early infant diagnosis, provider initiated testing and counseling, and ensure those identified HIV infected are linked to care .

TUNAWEZA will ensure children enrolled in care receive quality clinical care services, including clinical history

and physical examination, WHO staging, CD4 tests, and other basic tests; opportunistic infection diagnosis, prophylaxis and management, TB screening, pain and symptom relief and management; and psychosocial support. Additional key care services will include nutritional assessment, counseling and support based on the WHO and IYCF guidelines (including provision of therapeutic or supplementary feeding, support to children with growth faltering, provision of vitamin A, zinc, and de-worming); provision of safe water, sanitation and hygiene interventions (WASH) in the community and in health facilities, malaria screening, treatment and provision of long lasting insecticide treated nets in malaria endemic areas.

TUNAWEZA will support integration of HIV services into routine child health care and survival services in the MCH department, including growth and development monitoring, immunization as per the Kenya Expanded Program on Immunization guidelines, case management of diarrhea, pneumonia, and other childhood illnesses, and community outreach efforts. They will also support the care of the newborn by supporting hospital delivery and ensuring that there is provision for newborn resuscitation and care (thermal care, hygiene cord care), and prophylactic eye care. Exposed children management and follow up will continue to be supported, and will include enrollment, HIV testing (PCR-DNA and antibody testing) as per the national guidelines, provision of Nevirapine throughout the breastfeeding period, follow up and retention, and linkages of those positive to care and ART services.
TUNAWEZA will support hospital and community activities to meet the needs of the HIV infected adolescents: support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, support for transitioning into adult services and teaching life skills.

Commodity access and infrastructure development will continue to be supported as will relevant trainings. TUNAWEZA will strengthen pediatric data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	270,396	0

Narrative:

EGPAF's activities focus on strengthening institutional capacity building for 31 indigenous organizations to improve HIV treatment, care and support services in Kenya. Overall, the mechanism seeks to build the capacity of Sub-grantees financial and human resource management structure. Specific system barriers to be addressed will include conducting a final review of their human resource regulations, code of ethics and finance policies. These barriers will be addressed through Providing training updates for all 31 sub-grantee Boards, reviewing human resource and finance policies as appropriate, Infrastructure improvement policies and developing sub-partners HIS system.

The mechanism envisage developing linkages with the MoH community strategy, Global fund and TOWA's reporting system as most of the organizations are community based. They will also be supported make applications for the current Global fund to Kenya Principal recipient, the Kenya Red Cross Society. Other linkages will be to identify and collaborate with on-going sustainable social programs to ensure the programs are more effective.

The target populations for service provision include Youth, MCH clients, PLHIV, fisher folk, sex workers and truckers. Those targeted for training include service providers, supervisors from implementing partners including members of the Turkana county District Health Management Team, members of the EBI TWG and Ministry of Health key staff at headquarters level.

Monitoring and evaluation are conducted through regular site visits for each sub-grantee. Overall monitoring will be through reports to CDC Kenya and the KePMS. In addition, EGPAF will be required to make progress presentations to CDC Kenya, Prevention branch. CDC Kenya staff will also conduct at least two visits per sub-grantee in a 12 month period.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	724,816	0

Narrative:

EGPAF supports HVAB activities by providing technical support to the Government of Kenya in the development, packaging, and roll-out of a portfolio of evidence-informed behavioral interventions (EBIs) for HIV prevention, including interventions designed to delay sexual debut, reduce the number of sexual partners, and promote monogamy in relationships; by strengthening the organizational capacity of local agencies implementing HVAB programs; and by providing grants to local partners for implementation of evidence-based HVAB programming. For 2012/13, EGPAF and its partners will provide HVAB services in the following provinces and counties: Rift Valley (Baringo, Nakuru, Laikipia, and Narok counties), Nyanza (Migori, Kisumu, and Homa Bay counties), Western (Kakamega county), and Northeastern (Marsabit county). Within these jurisdictions, EGPAF will reach 81,098 (of 246,555) 10-14-year-olds, 22,189 (of 290,155) and 15-19-year-olds.

EGPAF and its partners will serve youth aged 10-14 with two EBIs—Healthy Choices I (HC1) and Families Matter! Program (FMP). Older adolescents aged 15-19 will receive Healthy Choices 2 (HC2).

FMP is an EBI for parents of preadolescents and promotes positive parenting practices, positive reinforcement, parental monitoring, and effective parent-child communication on sexual topics and sexual risk reduction. FMP seeks to delay onset of sexual debut by training parents to deliver primary prevention messages to their children. HC1 targets in-school youth and aims to delay sexual debut by providing knowledge and skills to negotiate

abstinence, avoid negative peer pressure, avoid or handle risky situations, and to improve communication with a trusted adult. HC2 provides older adolescents with the knowledge, confidence, and skills necessary to reduce their risk of STDs, HIV, and pregnancy by abstaining from sex or using other risk reduction strategies.

Monitoring, evaluation, and quality assurance of these EBIs is promoted through rigorous training and certification of facilitators, ongoing process monitoring with standardized tools, and quality assurance site visits by a CDC activity manager or other technical experts. EGPAF has put in place for all sites the following: use of approved national curricula; emphasis of importance of fidelity to the curricula; use of trained and certified facilitators; observation of practice implementation; use of standardized, national data tools at every stage of EBI implementation; and regular field visits by trained program staff to check on delivery of EBIs and offer support supervision.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	958,681	0

Narrative:

Target population: The EGPAF mechanism provides technical assistance to 23 FBOs and CBOs to provide HTC services as part of the HIV combination prevention package targeting the general population with emphasis on couples in Nyanza, Rift Valley, Eastern and Nairobi Provinces. The respective regional HIV prevalence and HTC coverage rates vary. Eastern province has the lowest prevalence of 4.6% with testing coverage of 53% among women and 31% in men. Nyanza province with the highest HIV prevalence of 14.9% has testing coverage of 63.5% among women and 34.3 % among men. EGPAF will increase the number of CBOs/FBOs supporting HTC to a total of 32 and in target populations namely youth out of school, fisher folk, couples and the general population. The program will focus on increasing knowledge of HIV status among individuals who have never received HIV test and those with increased HIV acquisition risk.

Approaches: Services are primarily delivered through client initiated approaches at the community level. Settings include stand alone VCT, outreach/mobile HTC and door-to door HTC services.

Targets and achievements: During the first 9 months of 2010 COP, the program provided HTC services to 62,427 individuals surpassing the annual target of 50,000 and supported refresher training of 53 counselors on re-testing recommendation, QA and use of registers. In 2012 COP EGPAF will provide HTC services to 132,107 individuals with a target of 60% new testers and 30 % couples. Testing algorithm: The national testing algorithm is used.

Referrals and linkages: To ensure successful referral and linkage to ongoing care, the program has mapped out the respective Government and faith based HIV care and treatment sites and the community psychosocial support groups. The national (NASCOP) referral tool is used to refer clients from the HTC to care sites. Using structures

within the national community health strategy, the program has trained the community health workers (CHWs) in working with HIV positive clients to facilitate linkage to care and treatment services. In collaboration with the HTC service providers and HIV care and treatment sites, the CHWs actively track the linkage of HIV positive client and follow up those who have not accessed. The CBOs also participate in respective district level forums that analyze and review the status of referral and linkage networks within the HIV prevention, care and treatment sites to ensure continuum of care.

Quality management: HTC service providers are trained and certified in line with the national guidelines. Service delivery including testing procedures, job aids and room set up to ensure confidentiality in counseling is in line with national standards. The sites participate in the national quality assurance strategy in proficiency testing and supervision.

Monitoring and evaluation: The program uses national tools for data recording and reporting. Data collected includes national and PEPFAR indicators such as individuals receiving HIV testing services disaggregated by age, sex, and couple.

Promotional activities: Since these are community groups, mobilization and demand creation for HTC services is undertaken through their existing peer led networks and structures in addition to mass media through a different mechanism. The groups use IEC material with key messages on the importance of accessing HIV prevention, care and treatment services, with the emphasis that HIV testing is the entry point.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1,277,012	0

Narrative:

EGPAF HVOP activities include: 1) providing technical support to the Government of Kenya (GOK) in the packaging and roll-out of HIV prevention evidence-informed behavioral interventions (EBIs), 2) strengthening the technical capacity of local organizations that are implementing HIV prevention programs, and 3) providing grants to local partners for implementation of evidence-based HIV prevention programming. The first of these efforts is a national initiative whereas the latter two support capacity development and prevention activities among 32 local partners. EGPAF's target populations are Youth aged 15-24, MCH clients, PLHIV, fisher folk, sex workers and truckers. EGPAF and its partners will provide HVOP services in the following provinces and counties: Rift Valley (Baringo, Nakuru, Laikipia, and Narok counties), Nyanza (Migori, Kisumu, and Homa Bay), Western (Kakamega), and Eastern (Marsabit). EGPAF will expand HIV prevention services to include EBIs in clinical settings at comprehensive care centers (CCC), TB and Maternal Child Health (MCH) clinics as part of combination prevention.

This mechanism supports efforts to adapt, package, and roll-out the following EBIs: Positive Health, Dignity, and Prevention (PHDP), Healthy Choices 2 (HC2), Sister to Sister (S2S), Respect, Eban and START. EGPAF will also support its partners to implement EBIs. PHDP is a 5-10 minute, group and individual level EBI for HIV infected persons in clinical and community settings, focusing on partner testing, risk reduction, condom use, disclosure, adherence, STI reduction, and family planning. HC2 has 8 one-hour modules and targets out of school youth aged 13-17 and focuses on safer sex, condom use, negotiation, and communication skills. S2S is a 20-minute individual level EBI that targets women of reproductive age and focuses on self efficacy, safer sex negotiation skills, and condom use. START is an individual level EBI targeting incarcerated men and men leaving correctional facilities. Eban is a couple and group level EBI targeting sero-discordant couples. It has 8 weekly 2-hour sessions that focus on risk assessment, enhancing couple communication, and shared health responsibility. RESPECT has 2 brief individual sessions and focuses on risk reduction, condom use, and clients' understanding of personal risk. With guidance from the GOK, EGPAF will also support roll out of other EBIs including those targeting MSM and safe in the city

EGPAF will recruit and support peer educators (PE) to reinforce prevention messages delivered by health providers as a task shifting model in clinical PHDP. It will support placement of 5 PE at MCH, TB and CCC Clinics in hospitals and 2 PE at health centers and provide appropriate counseling space procuring 316 tents for hospitals and renovating 60 health centres. One PE within the hospital setting and another within the health centre will do regular client home follow up to strengthen ART adherence.

Monitoring of EBIs is promoted through rigorous training and certification of facilitators, routine KePMS, use of standardized MoH tools and quarterly reports. Quality assurance will be conducted through site visits, standardized MoH tools and support supervision.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	380,000	0

Narrative:

Elizabeth Glazier Pediatric Foundation (EGPAF) - TUNAWEZA project builds capacity for indigenous organizations to ensure sustainability of HIV/AIDS interventions. In FY 12 and 13, they will work with sub-grantees; Diocese of Lodwar, Share our Sorrows, Beacon of Hope, Feed the Hungry, AIC Lodwar and Our Lady of Perpetual Support supporting PMTCT activities in Rift Valley, Nyanza, Nairobi and Eastern Provinces by providing tailor-made technical assistance through mentorship and supportive supervision as well as direct implementation of PMTCT activities. In FY12, EGPAF TUNAWEZA will offer HIV counseling and testing to 7,749 pregnant women at ANC and give ARV prophylaxis to 311 HIV infected pregnant women. The HIV infected women will receive a CD4 test after undergoing a WHO clinical staging. EGPAF TUNAWEZA will give HAART to all eligible HIV positive pregnant women in line with the revised PMTCT national guidelines. In FY13, EGPAF

TUNAWEZA will increase the number of pregnant women counseled to 8,136, offer ARV prophylaxis to 378 pregnant women and 325 infants, and do EID for 325 infants. EGPAF TUNAWEZA will focus on 4 prongs of PMTCT: primary prevention; prevention of unwanted pregnancies, ARV prophylaxis to all HIV positive pregnant mothers and exposed infants, care and treatment to eligible HIV positive mothers, partners and children. The Minimum care package will include health and HIV education, individual/ family HIVCT, clinical/laboratory monitoring and assessment, OI screening and /or treatment, ARV prophylaxis and treatment for both mother and baby, nutritional support, psychosocial support, PWP, follow up, retention, referral and linkages. TB screening will be incorporated into routine antenatal care. Efforts will be made to reach 2,441 of 1st ANC attendees with couple CT to identify discordant and concordant couples to improve primary prevention and facilitate linkage to HIV care and treatment for the eligible. Integration of ART in MCH clinics and access to FP/RH services will be supported. Partner will establish or strengthen infection control and waste management activities. EGPAF TUNAWEZA will support hospital delivery through provision of delivery beds and sterile delivery packs, training, working with CHWs and TBAs to promote community-facility referral mechanism, health education and community services providing skilled birth attendance. EGPAF TUNAWEZA will support safe infant feeding practices as per national guidelines and support enrollment and follow up of 325 of babies born to HIV infected mothers to access CTX, ARV prophylaxis and EID services using the HIV exposed infant register till 18 months. EGPAF TUNAWEZA will facilitate ART initiation for those who test positive before 2 years. They will adapt efficient retention strategies for mothers and babies by supporting use of diaries and registers for tracking defaulters, having a structured mentorship and supervision plan, enhancing data quality, streamlining M&E gaps (new MOH ANC/maternity registers) and utility of data at facility level for program improvement and quarterly progress reports to CDC. Program quality and proficiency testing will be emphasized to validate PMTCT results. 60 Health Care Workers will be trained in FY12 and equal number in FY13 on PMTCT and orientation on the revised PMTCT, infant feeding guidelines, and community activities to increase demand creation for health services such as male involvement with couple CT services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,363,333	0

Narrative:

Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) TUNAWEZA project builds capacity for indigenous organizations to ensure sustainability of HIV/AIDS interventions. They will work with sub-grantees namely; Catholic Diocese of Lodwar, African Inland Church, Lodwar District Hospital, Beacon of Hope, Tumaini Medical center, Share our Sorrows children's home, and Our Lady of Perpetual Support to provide technical assistance through mentorship, supportive supervision and direct implementation of adult care and support activities in Rift Valley, Nyanza, Nairobi and Eastern regions. By March 2011 SAPR, they had enrolled 3,689 adult patients on ART, and 2,908 were active on ARTand 605 newly initiated on ART.

In FY12, TUNAWEZA will jointly work with the Ministry of Health (MoH) to continue supporting expansion and provision of quality adult HIV treatment services as per MoH guidelines to 3,780 patients currently receiving ART and 973 new adults resulting to cumulative 4,536 adults who have ever been initiated on ART. In FY13, this number will increase to 4,511 currently receiving ART and 984 new adults resulting to 5,520 adults who have ever been initiated on ART.

TUNAWEZA will support in-service training of 80 and 60 HCWs; continuous mentorship of trained health care workers on specialized treatment, including management of patients with ARV treatment failure and complicated drug adverse reactions; identify human resources and infrastructure gaps and support in line with MoH guidelines; and support good commodities management practices to ensure uninterrupted availability of commodities.

TUNAWEZA will support provision of a comprehensive package of services to all PLHIV including ART initiation for those eligible; laboratory monitoring including biannual CD4 testing, viral load testing for suspected treatment failure (through strengthened laboratory network); cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH; improved OI diagnosis and treatment including TB screening, diagnosis and treatment. Ongoing community interventions for PLHIV including peer education and use of support groups to provide adherence messaging, defaulter tracing and follow up will continue to be supported to improve retention in all sites. TUNAWEZA will also support strategies to ensure access and provision of friendly HIV treatment services to all, including supporting peer educators, mentors, support groups, and supporting patients to disclose and bring their partners for testing and care and treatment.

TUNAWEZA will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. TUNAWEZA will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services integrate them into routinely collected data and use the results to evaluate and improve clinical outcomes. TUNAWEZA will do cohort analysis and report retention as required by MoH. Additionally, TUNAWEZA will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. TUNAWEZA will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	80,000	0

Narrative:

Elizabeth Glaser Pediatric Foundation TUNAWEZA project builds capacity for indigenous organizations implementing HIV services to ensure sustainability of these services. They will work with sub-grantees namely;

Catholic Diocese of Lodwar, African Inland Church, Our Lady of Perpetual Support, Lodwar District Hospital, Beacon of Hope, Tumaini Medical center and Share our Sorrows children's home to support pediatric ART services as part of integrated comprehensive HIV clinical services in Rift Valley, Nyanza, Nairobi and Eastern provinces and they will directly implement pediatric ART activities. By March 2011 SAPR, they had enrolled 569 children patients on ART and 276 were currently on ARTand 90 newly initiated on ART.

In FY12, TUNAWEZA will jointly work with the MoH at all levels to continue supporting, expanding and ensuring provision of quality pediatric HIV treatment services as per MoH guidelines to 264 pediatrics currently receiving ART and 200 new pediatrics resulting to cumulative 240 pediatrics ever initiated on ART. In FY 13, this number will increase to 338 pediatrics currently receiving ART and new 180 resulting to cumulative 420 pediatrics ever initiated on ART.

TUNAWEZA will support comprehensive pediatric ART services including growth and development monitoring, immunization as per the Kenya Expanded Program on Immunization, management of childhood illnesses OI screening and diagnosis; WHO staging; ART eligibility assessment; laboratory monitoring including 6 monthly CD4, hematology and chemistry (through strengthening of lab networks); Pre-ART adherence and psychosocial counseling; initiation of ART as per MoH guidelines; Toxicity monitoring, treatment failure assessment through targeted viral load testing; Adherence strengthening; enhanced follow up and retention; support EID as per MoH guidelines and PITC to all children and their care givers attending Child welfare clinics; support family focused approach; community outreach efforts and integration of HIV services in other MNCH services.

TUNAWEZA will support hospital and community activities to support the needs of the HIV infected adolescents: support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services and support their transition into adult services.

TUNAWEZA will support in-service training of 80 and 60 HCWs in FY 12 and 13 respectively, continuous mentorship and capacity building of trained health care workers on specialized pediatric treatment including management of ARV treatment failure and complicated drug adverse reactions; identify human resources and infrastructure gaps and support in line with MoH guidelines; support good commodities management practices to ensure uninterrupted availability of commodities. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will additionally be optimized.

TUNAWEZA will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, TUNAWEZA will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. TUNAWEZA will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.

Implementing Mechanism Details

Mechanism ID: 11406	**Mechanism Name: Community Grants Program**
Funding Agency: U.S. Department of State/Bureau of African Affairs	Procurement Type: Grant
Prime Partner Name: U.S. Department of State	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 97,505	
Funding Source	**Funding Amount**
GHP-State	97,505

Sub Partner Name(s)

Andeka Men Fighting HIV/AIDS SHG	Bidii Women Group	City of God Center
Faith Rays of Hope	Friends Women Group Koruma	Jireh Community Based HIV/AIDS
Kinoru Mwiteria PLWAs Support Group	Mukwano Support Group	Okoa Community Project
Ring Road Church of Christ Youth Group	St. Teresa's Community Health Services	Tharu Mwendwa PLHIV SHG
Ukambani Christian CBO	Welinde Omwoyo Women Group	

Overview Narrative

Established in 2008, the Community Grants Program aims to better meet the needs of small, grassroots organizations in Kenya seeking support for HIV/AIDS affected communities. These grants are designed to provide one-year assistance to grassroots, community-run projects that work toward HIV prevention and provide care and support to adults and children affected by AIDS. The program aims to strengthen community level responses to HIV and contributes to broadening support for basic health care and support in HBHC and OVC program areas. CGP provides opportunity to develop local organizational capacity to handle future funding from USG and other donors, and transfers more responsibility to manage resources and project activities to local organizations, most of

which are led by women. The program aims at enhancing the quality of life of OVC and to reach as many people as possible with HIV prevention or effective home and community-based care through local organizations and rural communities that can sustain these projects after the grant period.

In 2012, CGP will continue to focus on projects that seek to improve and expand community awareness about, and referrals to health facilities and that focus on reduction of barriers that prevent communities from accessing health care and living healthy lives through education, improved food security, economic empowerment and information. CGP will enhance linkages with relevant host government departments from national to community level and other players in the area of care and support in order to identify the best organizations. This program has not and will not use PEPFAR funds for vehicle purchase. Target populations, geographic coverage, and M&E plans are included in budget code narratives. This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	10,000
Education	10,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources

Budget Code Information

Mechanism ID:	**11406**
Mechanism Name:	**Community Grants Program**
Prime Partner Name:	**U.S. Department of State**

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HBHC	47,505	0

Narrative:

The PEPFAR Community Grants Program will award one-year grants to community-level groups designed to provide a minimum package for home and community based care at the grassroots, in line with NASCOP guidelines. Awarded projects must be designed to promote care and support for persons living with HIV/AIDS to include men, women, adolescents, children and MARPS; and those who provide care and support to PLHIV. The services will include community-level nursing and palliative care with an emphasis on treatment literacy and sustainability; family care and support (including psychosocial support, access to reproductive health services, and initiatives to strengthen food security and/or proper nutrition); trainings for CHWs and peer educators; and establishing proper linkages and referrals to ensure clients access additional services as necessary. The program will fund projects in all provinces in line with PEPFAR's country ownership strategy. Funded projects must demonstrate strong community involvement and commitment and also demonstrate prior experience implementing and sustaining community-run activities that benefit people living with HIV and/or promote HIV prevention programming. The project activities should be geared towards strengthening the referral system from community to health facility and back again, outreaches for treatment literacy and HIV prevention. The projects must also show evidence of sustainability plans through the initiation of viable IGAs that will support their activities beyond the one-year PCGP funding, provide food security and basic nutritional support to their beneficiaries and build the household economic base. Groups that provide training for community health workers and peer educators will be expected to work with the relevant health departments at the community level – DASCOs/DMOH/CACC. The trainings should emphasize on key interventions including PWP, treatment literacy, elimination of mother to child transmission, adherence to ART, stigma reduction skills, disclosure and behavior change communication, palliative care, defaulter tracing and basic nutrition. These trainings should ensure that clients and care givers understand the treatment plans and the care that is expected at home and when to return to the health facility for follow up. Funded projects will also be expected to have linkages with other host government departments – Agriculture/Livestock/Fisheries, as well as micro-enterprises and other relevant experts in order to receive technical support for the IGAs. The program will support data collection and reporting using standard tools as per NASCOP/ NACC guidelines. Funded projects should describe a Monitoring and Evaluation plan based on the NACC that includes definable, measurable objectives that contribute to HIV care and/or support using set indicators.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	50,000	0

Narrative:

PEPFAR Community Grants Program awards one-year grants to eligible local organizations including community-based organizations (CBOs), faith-based organizations (FBOs), and registered self-help groups

providing support to AIDS orphans and vulnerable children under the HKID program area. These grants are designed to provide one-time assistance to communities with small-scale projects that put into place family strengthening strategies to give care and/or economic support to children affected by AIDS at the grassroots level. These grants may include support for developing microcredit enterprises for caregivers or older youth, school fees program, and youth-friendly centers that offer a safe place to learn about HIV and AIDS prevention and treatment, encourage healthy parent-child relationships, among others. The program funds eligible projects working with the local District Social Development Officers in all provinces in line with PEPFAR's country ownership strategy. In FY 2012, we will support approximately 2,500 OVC below 18 to include out-of-school youth, and 950 OVC care givers. Funded groups will be expected to provide support to OVC in education, age-appropriate health care and support, psychosocial support, child protection/rights issues and boost the household economic and food security. Funded projects must demonstrate strong community and family involvement and commitment and also demonstrate prior experience implementing and sustaining community-run activities that benefit OVC and/or promote HIV prevention programming. The project activities should be geared towards broadening support for basic health care and support in both the palliative care and orphans and vulnerable children program areas.

The projects must also show evidence of sustainability plans through the initiation of viable IGAs that will support their activities beyond the one-year PCGP funding, provide food security and basic nutritional support to their beneficiaries and build the OVC household economic base. Groups will be expected to work with the relevant host government departments at the community level – DASCOs/DMOH/CACC/Children's Officers. Funded projects will also be expected to have linkages with other host government departments – Agriculture/Livestock/Fisheries, as well as micro-enterprises and other relevant experts in order to receive technical support for the IGAs.

One of PCGP's successes is that all the funded groups have initiated an IGA and/or used appropriate technology for the benefit of OVC. The major challenge experienced is lack of consistent and highly qualified technical assistance from host government departments because some of the government departments at the community level are not very reliable. PCGP is encouraging groups to have linkages with other stakeholders from private sectors so as to benefit from other experts beside the government.

The program will support data collection and reporting using standard tools as per NACC guidelines. Funded projects should describe a Monitoring and Evaluation plan based on the NACC that includes definable, measurable objectives that contribute to HIV care and/or support using set indicators.

Implementing Mechanism Details

Mechanism ID: 12054	**Mechanism Name: Healthy Outcomes through Prevention Education (HOPE)**
Funding Agency: U.S. Agency for International	Procurement Type: Cooperative Agreement

Development	
Prime Partner Name: CHF International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

Kenya Girl Guides Association	National Organisation for Peer Educators (NOPE)	SAPTA
St. Johns Community Centre (SJCC)		

Overview Narrative

Healthy Outcomes through Prevention Education project (HOPE) plans to carry out school and community-based HIV/AIDS prevention activities in approximately 400 primary and secondary schools in the informal urban settlements (slums) within Nairobi Province and its surrounding areas. The target population includes boys and girls aged 10-18 and their families. The project will also support the Ministry of Education to revise the Education Sector Policy on HIV/AIDS and equip personnel in the MOE and the 47 new County Offices for its effective implementation. The overall goal of the project is to improve students' HIV/AIDS knowledge, attitudes and practices through evidence-based small group peer, school and community-based interventions. This will be achieved through peer-to-peer support and mentoring, equipping schools with the capacity to provide HIV/AIDS-related knowledge, classroom instruction and extracurricular activities, and parents and community members promoting healthy living through increased school involvement. The intervention will pull elements from the "Families Matter" program. Particular emphasis will be placed on gender issues, promoting healthy gender attitudes and practices, discouraging harmful male norms, and addressing the effect of gender disparity on the spread of HIV/AIDS. An M&E component will be put in place to ensure that the training experiences translate into learner outcomes in the classroom and ultimately a decrease in HIV transmission, and quality assurance and standard offices will monitor the process of teaching and learning. This project will support the national prevention policies on HIV and AIDS. This activity supports GHI/LLC and is completely funded through pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	12054		
Mechanism Name:	Healthy Outcomes through Prevention Education (HOPE)		
Prime Partner Name:	CHF International		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	0	0

Narrative:

Healthy Outcomes through Prevention Education project (HOPE), plans to carry out school and community-based HIV/AIDS prevention activities in approximately 400 primary and secondary schools in the informal urban settlements (slums) within Nairobi Province and its surrounding areas. The target population includes boys and girls aged 10-18 and their families. The project will also support the Ministry of Education to revise the Education Sector Policy on HIV/AIDS and equip personnel in the MOE and the 47 new County Offices for its effective implementation. The overall goal of the project is to improve students' HIV/AIDS knowledge, attitudes and practices through evidence-based small group peer, school and community-based interventions. This will be achieved through peer-to-peer support and mentoring, equipping schools with the capacity to provide HIV/AIDS-related knowledge, classroom instruction and extracurricular activities, and parents and community

members promoting healthy living through increased school involvement. The intervention will pull elements from the "Families Matter" program. Particular emphasis will be placed on gender issues, promoting healthy gender attitudes and practices, discouraging harmful male norms, and addressing the effect of gender disparity on the spread of HIV/AIDS. An M&E component will be put in place to ensure that the training experiences translate into learner outcomes in the classroom and ultimately a decrease in HIV transmission, and quality assurance and standard offices will monitor the process of teaching and learning. This project will support the national prevention policies on HIV and AIDS.

Implementing Mechanism Details

Mechanism ID: 12082	**Mechanism Name: Refugee Health**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: United Nations High Commissioner for Refugees	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 631,956	
Funding Source	**Funding Amount**
GHP-State	631,956

Sub Partner Name(s)

International Rescue Committee	Lutheran World Foundation	National Council of Churches of Kenya (NCCK)
Save the Children UK		

Overview Narrative

Goals and objectives: The UNHCR co-operative agreement aims to increase access and utilization of comprehensive HIV prevention, care and treatment and strengthen the public health systems serving refugees in Daadab and Kakuma refugee camps. Specific objectives in FY12 include:

- *Scale up evidence-based HIV prevention interventions for youth, general population and most at risk groups.1.Enhance knowledge of HIV status and foster effective linkages to care and treatment services.*

• *Scale up comprehensive adult and pediatric HIV care and treatment services including prevention of mother to child transmission (PMTCT), TB/HIV diagnosis and treatment, care and support for persons living with HIV and orphans and vulnerable children. 2. Cost-efficiency strategy: UNHCR will invest more resources in the promotion and scale up of provider initiated HIV testing and counseling (PITC) due to the low HIV prevalence among*

refugees (< 1%). This approach is cost effective and fosters better linkages of PLHIV to care, treatment and support services. UNHCR will also enhance engagement and training of incentive staff (refugees and host community) to provide services. This is cost effective and will address language barriers due to the varied nationalities in the camps, high turn-over of staff and build local capacity to implement the program. 3. Transition to country partners: UNHCR will build the capacity of local non-governmental and other organizations among them the National Council of Churches in Kenya, to offer comprehensive HIV care and treatment services to refugees. 4. Vehicle information: UNHCR has not used PEPFAR funds for vehicle purchase in the past and is not requesting funds in FY12.This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	30,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	12082		
Mechanism Name:	Refugee Health		
Prime Partner Name:	United Nations High Commissioner for Refugees		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	10,000	0

Narrative:

United Nations High Commission for Refugees (UNHCR) has two sub grantees offering adult care and support, IRC and ADEO, who will continue to support comprehensive HIV care and support in health facilities in Dadaab and Kakuma refugee camps. By March 2011, UNHCR had cumulatively enrolled 1,233 patients in HIV care of whom 1,118 were active and on cotrimoxazole prophylaxis.

UNHCR will work with the Ministry of Health (MoH) at the provincial, district and health facility level to jointly plan, coordinate, implement and ensure provision of quality HIV care and support to 466 current adult patients in FY12 and current patients in FY13.

UNHCR will offer a package of services including HIV testing to partner and the family members of index patient and enrolling or referring/linking those that test HIV positive to care and support; provision of Basic Care Kit (safe water vessel, multivitamins, insecticide-treated mosquito nets, chlorine for water treatment and educational materials); supplemental and therapeutic nutrition (FBP) to all eligible HIV positive patients; prevention with positives(PwP); and cervical cancer screening to all enrolled women.

UNHCR in collaboration with MoH will support targeted capacity building (training and mentorship) for health care workers and additionally offer continuous medical education on care and support such as OI diagnosis and treatment. UNHCR will identify areas with staff shortages, support recruitment of additional staff, and support good commodities management practices to ensure uninterrupted supply of commodities.

UNHCR will also support ongoing community interventions for HIV infected individuals, including peer education and support groups to provide adherence messaging; effective and efficient defaulter tracing and follow up to improve retention in all facilities; referral and linkages to community based psychosocial support groups; Water, sanitation, and hygiene programs; Economic empowerment - Income generating activities; Home Based Care services; Gender based violence support programs; vocational training; social and legal protection; and food and nutrition programs.

UNHCR will adopt strategies to ensure access and provision of friendly services to youth, elderly and disabled populations. Strategies to increase access of care services by men will be employed, including supporting male peer educators, mentors and support groups, and supporting women to disclose and bring their male partners for testing and care and treatment.

UNHCR will continue to strengthen data collection and reporting at all levels to improve reporting to NASCOP and PEPFAR. UNHCR will adopt the new generation indicators and support the development and use of electronic medical records system in accordance with NASCOP guidelines. UNHCR will continue using quality of care indicators (CQI) for monitoring the quality of HIV care and support services, integrate them into routinely collected data, and use the results to evaluate and improve clinical outcomes. UNHCR will do cohort analysis and report retention rates as required by NASCOP. UNHCR will support joint Annual Operation Plan (AOP) development, implementation, monitoring and evaluation, and health system strengthening to facilitate sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	50,000	0

Narrative:

United Nations High Commission for Refugees (UNHCR) currently has 4 partners providing OVC services: Save the Children, SCUK in Dadaab and LWF/FAI in Kakuma. By March 2011, UNHCR had achieved the following: 150 OVC served, 120 of OVC received primary direct support (PDS), 30 of OVC were provided with Supplemental Direct Support (SDS), and none of the providers/caretakers trained in caring for OVC.

In FY12 and FY13, UNHCR will reach 200 and 250 OVCs respectively with OVC care, 80% of which will be PDS and 20% SDS. UNHCR will provide critical services to OVC including providing a comprehensive package of education, shelter, nutritional support, psychosocial care and support, and support to OVC caretakers while linking OVC to other critical services and economic strengthening activities.

UNHCR will target all OVC aged between 0 and 18 years and will provide "6 plus 1" services and report on at least 3 services that they provide to the OVC based on individual need. UNHCR continues to experience challenges in areas of capacity building, partner linkages, and networking to the local partners. In the next two years, UNHCR will focus on strengthening HIV prevention education among OVC to equip them with life skills that will reduce their vulnerability to the risk of HIV infection.

UNHCR will start to implement OVC interventions that are evidence based in order to achieve their two year goals. They will also train the local organizations to strengthen the family support system and help them to establish strong linkages between PLWHAs, HIV-infected children, and health care services. UNHCR will ensure that

children and their parents or caregivers and other family members affected access appropriate care and treatment. UNHCR will work closely and link OVC with care and treatment partners to ensure that HIV-infected children receive appropriate psychosocial support and that they have a consistent caregiver to assure adherence to treatment.

UNHCR will continue to work closely with District Children's Department and will follow guidelines provided by the Ministry of Gender, Children and Social Development, alongside PEPFAR guidelines. UNHCR will support the local partners to establish partnerships and networks among other NGOs in order to strengthen their collective voice, build a unified approach, improve coordination, and share knowledge.

UNHCR will embrace community and family centered approaches (such as the cash transfer program) that are preferred to institutional approaches as well as explore livelihoods approaches to OVC programming.

There is limited information regarding current OVC programming in the UNHCR supported partners. UNHCR will undertake an OVC situation and gap analysis for its CBOs to document best practices and lessons learned for OVC and help the CBOs to explore new program approaches. UNHCR will also develop an OVC advocacy curriculum and provide training to CBOs and other OVC stakeholders. UNHCR will work with the local organizations to engage and advocate for OVC issues with key stakeholders in the Kenyan HIV/AIDS response, including donors.

UNHCR will work with the local partners to improve M&E systems based on rapid capacity and gaps analysis of the OVC activities they support. The program will also capture age specific services that are offered to OVC aged between 0 and 18 years.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	45,000	0

Narrative:

United Nations Higher Commission for Refugees (UNHCR) will support TB/HIV services for refugee populations. UNHCR has two sub-partners providing HVTB services: IRC and ADEO. UNHCR will support the sub-grantees in capacity building to provide quality HIV/TB services in three health facilities in Dadaab and Kakuma. UNHCR has been supporting TB/HIV services in these sites since October 2010 in line with the MOH Division of Leprosy, Tuberculosis and Lung Disease (DLTLD) and the National AIDS and STI Control Program (NASCOP).

Between October 2010 and March 2011, 49 TB patients received HIV testing, 13 TB/HIV coinfected patients were identified, and 126 HIV positive patients were screened for TB. In FY 2012 and 2013, UNHCR will intensify efforts to detect TB cases through clinical exams and laboratory investigations and ensure successful TB treatment

through provision of appropriate treatment. UNHCR will ensure that each facility providing TB/HIV services has adequate and well trained clinical staff supported by well equipped and staffed laboratory, including sputum specimen transport where laboratory services are unavailable. UNHCR will ensure that adequate supplies of anti-TB drugs are available and that the national TB treatment guidelines are followed. All TB patients on treatment will be monitored both clinically and through periodic sputum examination.

To reduce the burden of HIV in TB patients, UNHCR will ensure that at least 95% of TB patients are screened for HIV and 80%TB-HIV co-infected patients are put on cotrimoxazole and ARVs as early as possible regardless of the CD4 count as per the national guidelines. UNHCR will support the "one stop" model that provides integrated TB and HIV services in all TB clinics. All TB clinics will be stocked with cotrimoxazole and ARVs and staffed with 60 trained HCW as needed.

To reduce the burden of TB in HIV infected patients, UNHCR will support intensified TB screening for 291 in FY12 and 419 in FY13 at each clinical encounter using the national screening tool. 15 co-infected patients identified in FY12 and 21 in FY13 will be put on TB treatment and those without active TB will be provided with Isoniazid Preventive Therapy (IPT) as per national IPT protocol.

To strengthen TB infection control in HIV settings, UNHCR will ensure that the national IC guidelines are available at all sites and training of staff on IC is done. UNHCR will support scaling up of at least 2 components of the national TB infection control strategy in HIV care settings, one of which should be fast tracking of patients with cough for expedited diagnostic work up and treatment.

To improve surveillance and management of drug-resistant TB, UNHCR will support timely transport of sputum specimens of TB retreatment cases from health facilities to the central reference laboratory for drug susceptibility testing and ensure return of the results to those facilities. UNHCR will also support scaling up of drug-resistant treatment sites thus expanding access to MDRTB treatment.

UNHCR will also support expansion of prevention with positive (PwP) services in TB clinics, TB/HIV control activities in the prisons, strengthening linkages between facility and community-based services, and improving patient referrals and tracking systems. To strengthen HVTB program monitoring, UNHCR will support reporting of selected custom indicators to assist with program management and evaluation and monitoring of new activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	8,000	0

Narrative:

United Nations High Commission of Refugees (UNHCR) has two sub-grantees (IRC and ADEO) who have been

supporting ART provision as part of integrated comprehensive HIV clinical services in 3 health facilities in Dadaab and Kakuma refugee camps. As of September 2010 (APR), UNHCR had trained 63 HCWs in providing ART, 41 adults were newly initiated on ART, 335 adults were ever initiated on ART, and 294 adults and 27 children were currently on ART. The overall patient retention was 91%.

In FY12, UNHCR will jointly work with the Ministry of Health (MoH) to continue supporting expansion and provision of quality adult HIV treatment services as per MoH guidelines to 340 patients currently receiving ART and 217 new adults resulting to cumulative 408 adults who have ever been initiated on ART. In FY13, this number will increase to 502 currently receiving ART and 219 new adults resulting to 627 adults who have ever been initiated on ART.

UNHCR will support in-service training of 30 and 20 HCWs and continuous mentorship of trained health care workers on specialized treatment, including management of patients with ARV treatment failure and complicated drug adverse reactions. UNHCR will identify human resources and infrastructure gaps and support in line with MoH guidelines as well as support good commodities management practices to ensure uninterrupted availability of commodities.

UNHCR will support provision of comprehensive package of services to all PLHIV including ART initiation for those eligible; laboratory monitoring including biannual CD4 testing, viral load testing for suspected treatment failure (through strengthened laboratory network); cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH; and improved OI diagnosis and treatment including TB screening, diagnosis and treatment.
Ongoing community interventions for PLHIV including peer education and support groups to provide adherence messaging, defaulter tracing, and follow up will continue to be supported to improve retention in all sites. UNHCR will do cohort analysis and report retention as required by MoH.
UNHCR will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services, integrate them into routinely collected data, and use the results to evaluate and improve clinical outcomes. UNHCR will also support strategies to ensure access and provision of friendly HIV treatment services to all including supporting peer educators, mentors, support groups, and supporting patients to disclose and bring their partners for testing and care and treatment.

UNHCR will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, UNHCR will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. UNHCR will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVAB	113,956	0

Narrative:

The UNHCR co-operative agreement aims to increase access and utilization of comprehensive HIV prevention, care and treatment for refugees and strengthening the public health systems serving refugees in the Daadab and Kakuma refugee camps. PEPFAR support to the United Nations High Commission for Refugee (UNHCR) will support provision and scale up of comprehensive and evidence-based HIV prevention interventions targeting youth aged 10-24years and adults living in the Daadab and Kakuma refugee camps in Kenya.

An estimated 12,190 youth (10-14 years) in school will be reached with Healthy Choices I (HCI). HCI targets in-school youth aged 10-14 years and aims to delay sexual debut by providing knowledge and skills to negotiate abstinence, avoid negative peer pressure, avoid or handle risky situations and to improve communication with a trusted adult. HCI has 8 modules of approximately one hour each. It is delivered in 4 two hour sessions or in 8 one-hour sessions. To address gender-based violence, low levels of knowledge about HIV/AIDS and HIV-related stigma levels in the camps, the HCI intervention will be complimented by targeted HIV stigma reduction messages targeting youth in school as well as the broader community. HIV prevention messages and stigma reduction messages will be translated in local languages to address the needs of various nationalities living in the two camps.

Quality assurance of HCI will be promoted through rigorous training and certification of facilitators, ongoing process monitoring with standardized tools, and quality assurance site visits by a capacity building agency. The routine behavioral surveillance survey conducted by UNHCR will provide impact data on median age at sexual debut among youth over time and proportion of youth who have had sex by age 15.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	200,000	0

Narrative:

Target population: The primary target population for UNHCR is all the Refugees residing in Kenya's two main Refugee camps namely, Kakuma and Daadab. The total population served is 505,481 (UNHCR September 2011). This number continues to rise as more Somali refugees flee in to Kenya to escape war and famine in the Horn of Africa. HIV prevalence in the refugee population ranges from 1.4-1.91%. Currently, coverage of HTC is approximately 30-36% in both camps. For HTC, UNHCR will specifically target pregnant women, Most at Risk Populations (FSW, MSM/ MSW, Clients of sex workers), Couples, Youth in and out of School, OVC's, inpatient and outpatient clients including TB/STI clients in all health facilities.

HTC Approaches: HTC approaches are primarily PITC and CITC. For PITC, all sections in the health facilities

including TB clinics, STI clinics, and outpatient and inpatient departments are utilized to provide CT services. At the community level, mobile and outreach VCT is used especially targeting groups and settings with potential high HIV risk.

Targets and achievements: In the past one year, UNHCR had a target to test a total 20,000 but they managed to test 33,700 (167%). 37 HCW/Counselors were trained on PITC, 36 on Couple Counseling. For COP 2012, UNHCR will target to provide HTC services to 80,000 refugees of which 20% will be tested as couples, and 10% will be children below the age of 15.

Testing algorithm: National algorithm is being used

Referrals and linkages: A referral system is in place to ensure newly diagnosed HIV positive clients are linked to appropriate care and treatment services. Community health promoters follow up all the HIV positive clients to ensure access to services. At the community level, HIV positive clients are linked to post test clubs and are provided with prevention with positive (PWP) interventions. Systems to measure proportion of effective referrals against the number of all referrals from HTC to other services and vice versa are being strengthened. Use and record keeping of referral forms allows for comparison of total number of clients referred for services against the total number who accessed the referred services. Frequent monitoring of effectiveness is conducted.

Quality management: In order to improve and monitor quality of HTC services, UNHCR will put in place the following strategies: Training and continuing education of HTC providers; strict adherence to the standard operating procedures outlined in the national HTC guidelines; proper handling of HIV rapid kits as per the guidelines; putting in place a functional QA systems as provided for in the national HTC guidelines; participation in EQA- proficiency testing and finally conducting support supervisory visits.

Monitoring and evaluation: UNHCR uses all ministry of health' tools to capture HTC data, both for couples and individual patients. These include HTC lab Register and Monthly summary tool (MOH 711). MOH approved HTC lab registers have been introduced at all HIV testing points except PMTCT.

Promotional activities for HTC: Health talks at the facility level targeting inpatient and outpatient clients; Community awareness and demand creation facilitated by Community Health Workers/Promoters ; Mass Media campaigns (HTC video screening, IEC materials) targeting the general population; Peer leaders supported to reach out to MARPS to encourage access to comprehensive services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	24,286	0

Narrative:

The UNHCR Refugee Health Program provides comprehensive HIV prevention services in Daadab and Kakuma refugee camps, home to over 500,000 refugees. With PEPFAR support, , UNHCR will scale up evidence-based behavioral (EBI) interventions for youth, adults, female sex workers (FSW) and persons living with HIV/AIDS (PLHIV). An estimated 4090 out of school youth in Daadab and Kakuma will be reached with Healthy Choices II (HCII). HCII targets youth 13–17 years and aims to delay sexual debut, promote secondary abstinence and condom use, skills for handling peer pressure, and learning one's HIV status. HCII has 8 one-hour modules delivered either in 4 two-hour or 8 one-hour sessions. HCII will be complimented by provision of HIV testing and counseling services, referral for voluntary medical male circumcision, and condom promotion and provision.

UNHCR will target 3030 adults with RESPECT, a 2-session individual level EBI that focuses on reduction of sexually transmitted diseases (STD), fostering client understanding of personal HIV/STD risk and risk reduction steps. UNHCR will train 30 RESPECT facilitators to integrate RESPECT in HIV testing and counseling services targeting the general population and FSW. UNHCR will recruit 5 Positive Health and Dignity Prevention (PHDP) peer educators to work in comprehensive care centers, maternal child health and TB clinics, 2 peer educators for health centers and provide counseling space. One peer educator will strengthen ART adherence through home follow ups. 300 PLHA will receive PHDP intervention in clinical and community settings. PHDP is a 5-10min group or individual level EBI that targets PLHIV in clinical and community settings and focuses on knowledge of HIV status, partner testing, risk reduction counseling including condom use and partner reduction, supportive disclosure, adherence counseling, STI assessment and treatment and family planning counseling.

An estimated 250 female sex workers (FSW) will receive HIV/STI screening, STI treatment and referral, economic empowerment interventions, information and referrals to reproductive health, drug and alcohol reduction services and gender based violence services.

To address gender-based-violence (GBV), low levels of HIV/AIDS knowledge and HIV stigma, targeted behavior change communication will be disseminated in community meetings, strategic locations and media. In FY12, PEPFAR will support access to a comprehensive GBV package of services including post-exposure prophylaxis and linking young GBV victims to services targeting vulnerable children.

Quality assurance of EBIs and related interventions will be achieved through rigorous selection, training and certification of facilitators, process monitoring with standardized tools for each EBI and routine site visits. Routine behavioral surveys by UNHCR will provide outcome data on sexual behaviors over time and inform effective targeting of the interventions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	120,000	0

Narrative:

United Nations High Commission for Refugees (UNHCR) will support PMTCT activities targeting refugee populations in Dadaab and Kakuma camps through two sub-grantees (IRC and ADEO) working in 3 health facilities with approximately 14,000 expected pregnancies. The HIV prevalence is low at 2%. As of APR 2010, UNHCR had counseled and tested 8,953 pregnant women and given ARV prophylaxis to 16 out of 18 (89%) HIV positive pregnant women and 16 infants (88%). UNHCR trained 78 HCW in PMTCT, gave food supplements to 18 HIV positive pregnant women, and tested 7 HIV exposed infant for HIV of whom all tested negative.

In FY12, UNHCR will offer HIV counseling and testing to 12,784 pregnant women at ANC and give ARV prophylaxis to 227 HIV infected pregnant women. The HIV infected women will receive a CD4 test after undergoing WHO clinical staging. UNHCR will give HAART to all eligible HIV positive pregnant women in line with the revised PMTCT national guidelines. In FY13, UNHCR will increase the number of pregnant women counseled to 13,423, offer ARV prophylaxis to 276 pregnant women and 237 infants, and do EID for 237 infants.

UNHCR will focus on the 4 prongs of PMTCT: primary prevention; family planning; ARV prophylaxis to all HIV positive pregnant mothers and exposed infants; and care and treatment to eligible HIV positive mothers, partners, and children. The minimum care package will include health and HIV education, individual/family HIVCT, clinical/laboratory monitoring and assessment, OI screening and treatment, ARV prophylaxis and treatment for both mother and baby, nutritional support, psychosocial support, PWP, follow up, retention, and referral and linkages. UNHCR will incorporate TB screening into routine antenatal care.

UNHCR will support integration of ART in MCH clinics, access to FP/RH services, and establish or strengthen infection control and waste management activities. UNHCR will support hospital delivery through provision of delivery beds and sterile delivery packs, training, working with CHWs and TBAs to promote community-facility referral mechanism, health education, and community services providing skilled birth attendance.

UNHCR will support safe infant feeding practices as per national guidelines and support enrollment and follow up of 237 HIV exposed infants to access CTX, ARV prophylaxis, and EID services using the HIV exposed infant register till 18 months. UNHCR will facilitate ART initiation for those who test positive before 2 years.

UNHCR will adopt efficient retention strategies for mothers and babies by supporting use of diaries and registers for tracking defaulters, having a structured mentorship and supervision plan, enhancing data quality and streamlining M&E gaps including orientation of new MOH ANC/maternity registers, and utilization of data at facility level for program improvement and quarterly progress reports to CDC. UNHCR spends $18 per woman for PMTCT which will now stretch to cover all PMTCT prongs and wrap around like malaria prevention in line with GHI principles. Program quality and proficiency testing will be emphasized to validate PMTCT results

UNHCR will train 30 HCWs in FY 12 and equal number in FY13 on PMTCT and provide orientation to the revised

PMTCT and infant feeding guidelines. They will also engage in community activities for demand creation for health services such as male involvement with couple CT services, referral and linkages, and reach non clinic attendants.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	55,714	0

Narrative:

United Nations High Commission of Refugees (UNHCR) has two sub-grantees (IRC and ADEO) who have been supporting ART provision as part of integrated comprehensive HIV clinical services in 3 health facilities in Dadaab and Kakuma refugee camps. As of September 2010 (APR), UNHCR had trained 63 HCWs in providing ART, 41 adults were newly initiated on ART, 335 adults were ever initiated on ART, and 294 adults and 27 children were currently on ART. The overall patient retention was 91%.

In FY12, UNHCR will jointly work with the Ministry of Health (MoH) to continue supporting expansion and provision of quality adult HIV treatment services as per MoH guidelines to 340 patients currently receiving ART and 217 new adults resulting to cumulative 408 adults who have ever been initiated on ART. In FY13, this number will increase to 502 currently receiving ART and 219 new adults resulting to 627 adults who have ever been initiated on ART.

UNHCR will support in-service training of 30 and 20 HCWs and continuous mentorship of trained health care workers on specialized treatment, including management of patients with ARV treatment failure and complicated drug adverse reactions. UNHCR will identify human resources and infrastructure gaps and support in line with MoH guidelines as well as support good commodities management practices to ensure uninterrupted availability of commodities.

UNHCR will support provision of comprehensive package of services to all PLHIV including ART initiation for those eligible; laboratory monitoring including biannual CD4 testing, viral load testing for suspected treatment failure (through strengthened laboratory network); cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH; and improved OI diagnosis and treatment including TB screening, diagnosis and treatment. Ongoing community interventions for PLHIV including peer education and support groups to provide adherence messaging, defaulter tracing, and follow up will continue to be supported to improve retention in all sites. UNHCR will do cohort analysis and report retention as required by MoH.
UNHCR will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services, integrate them into routinely collected data, and use the results to evaluate and improve clinical outcomes. UNHCR will also support strategies to ensure access and provision of friendly HIV treatment services to all

including supporting peer educators, mentors, support groups, and supporting patients to disclose and bring their partners for testing and care and treatment.

UNHCR will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, UNHCR will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. UNHCR will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	5,000	0

Narrative:

United Nations High Commission for Refugees (UNHCR) has two sub-grantees (IRC and ADEO) who have been supporting pediatric ART services as part of integrated, comprehensive HIV clinical services in 3 health facilities in Dadaab and Kakuma refugee camps.

In FY12, UNHCR will jointly work with the Ministry of Health (MoH) at all levels to continue supporting, expanding and ensuring provision of quality pediatric HIV treatment services as per MoH guidelines to 53 pediatrics currently receiving ART and 11 new pediatrics resulting to cumulative 64 pediatrics ever initiated on ART. In FY13, this number will increase to 68 pediatrics currently receiving ART and 9 new resulting to a cumulative 73 pediatrics ever initiated on ART.

UNHCR will support comprehensive pediatric ART services including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization; management of childhood illnesses; OI screening and diagnosis; WHO staging; ART eligibility assessment; laboratory monitoring including 6 monthly CD4, hematology and chemistry (through strengthening of lab networks); Pre-ART adherence and psychosocial counseling; initiation of ART as per MoH guidelines; Toxicity monitoring; treatment failure assessment through targeted viral load testing; Adherence strengthening; and enhanced follow up and retention. UNHCR will support EID as per MoH guidelines and PITC to all children and their care givers attending Child welfare clinics, support family focused approach, community outreach efforts, and integration of HIV services in other MNCH services.

UNHCR will support hospital and community activities to meet the needs of the HIV infected adolescents such as support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services, and support their transition into adult services.

UNHCR will support in-service training of 30 and 20 HCWs in FY 12 and 13 respectively as well as continuous

mentorship and capacity building of trained HCWs on specialized pediatric treatment including management of ARV treatment failure and complicated drug adverse reactions. UNHCR will identify human resources and infrastructure gaps and support in line with MoH guidelines and support good commodities management practices to ensure uninterrupted availability of commodities. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will additionally be optimized. *UNHCR will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, UNHCR will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. UNHCR will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.*

Implementing Mechanism Details

Mechanism ID: 12083	**Mechanism Name: Community HTC**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Liverpool VCT and Care	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: PR/SR	
G2G: No	Managing Agency:

Total Funding: 1,795,627	
Funding Source	**Funding Amount**
GHP-State	1,795,627

Sub Partner Name(s)

Family Health Options Kenya-Nairobi		

Overview Narrative

Goals and objectives: 1)To contribute to Kenya's goal of 80% knowledge of HIV status by 2013 through innovative quality assured HTC service delivery using multiple approaches targeting couples, first time testers, MARPS and

vulnerable populations including people with disabilities. 2)To increase uptake and delivery of combination prevention interventions for general and special needs populations and strengthen referrals and linkages to other services. 3) Support Ministries of Gender and Health and other stakeholders to define and roll out a comprehensive gender-based violence package to train providers and law enforcement personnel. Cost-efficiency strategy: The mechanism targets areas of high burden and greatest risk of HIV transmission by mapping, mobilizing and taking services to the target populations. Couples, rural populations and MARPs are reached. The National testing guidelines and algorithm are strictly followed. The HTC approaches are carefully chosen based on the population. To enhance cost effectiveness combination prevention services are offered. Transition to country partners: LVCT is an indigenous organization. The program works closely with the Ministry of Health at national, provincial and district level health facilities and community levels, utilizing the country's community health strategy. Innovative ideas generated are shared at the National technical working group at NASCOP for replication and scale up. The program uses the national M&E framework and tools for reporting. Vehicle Information: In FY 2010 LVCT purchased a Land cruiser for program monitoring and support and HTC campaigns.This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Motor Vehicles: Purchased	50,880

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	12083		
Mechanism Name:	Community HTC		
Prime Partner Name:	Liverpool VCT and Care		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	142,500	0

Narrative:

In 2012, the HTC mechanism will implement a wide range of EBIs which will have been adopted by the country and integrated into combination prevention. This budget code will target general population with special emphasis on enhancing parent child communication, delaying sexual debut among the youth and adolescents. The populations that will be targeted in this mechanism are the youth in school and parents with adolescents age 9-12 years of both sexes.

People with disability will be a special category targeted as programs have tended to ignore them. The populations will be mapped and appropriate EBI implemented for specific groups. Both Families Matter Program- (FMP) and HC1 - have been adopted in the country and will be expanded to cover the whole of lower Eastern region covering the counties of Machakos, Kitui and Makueni. The program will work with churches, schools and the local county health departments and local administration to identify the specific groups for interventions.

Families Matter Program (FMP) is a 5 weekly session intervention targeting parents with children age 9-12 years. The goal of FMP is to reduce sexual risk behavior among adolescents, including delaying onset of sexual debut, by training parents to deliver primary prevention messages to their children. More effective parental communication can help to delay their children's sexual behavior and increase protective behaviors as their children get older. The intervention also links parents to other critical evidence-based interventions including HTC and VMMC. A target of 3500 youths will be reached in 2012.

Quality assurance of FMP is promoted through rigorous training and certification of facilitators, ongoing process monitoring with standardized tools, and quality assurance site visits by a capacity building agency.

Healthy Choices I (HCI) targets in-school youth aged 10-14 years and aims to delay sexual debut by providing knowledge and skills to negotiate abstinence, avoid negative peer pressure, avoid or handle risky situations and to improve communication with a trusted adult. HC I consists of 8 modules of approximately one hour each. It can be delivered in 4 sessions of 2 hours each or in 8 sessions of 1 hour each. A target of 3634 youths will be reached in 2012.

Quality assurance of HC is promoted through rigorous training and certification of facilitators, ongoing process monitoring with standardized tools, and quality assurance site visits by a capacity building agency.

Monitoring and evaluation is built up in the program implementation. Process evaluation will be done as determined and developed by the technical working group and the national program and the impact evaluation will be done in larger surveys like the Demographic health survey incorporating HIV markers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	1,333,388	0

Narrative:

The Community HTC mechanism targets general population with special emphasis on identifying discordant couples, key populations, rural men and people with disability. The area of coverage includes the counties in Eastern province with a prevalence of 3.5% and Nairobi County with a prevalence of 7.0%. Coverage for couples has remained poor at paltry 16% and yet data show that the driver of the epidemic in Kenya is infection in marriages and unions. The disability program has a national coverage (the prevalence among this group is not known) and will aim at developing and dissemination of national standardized training curriculum and development of operational guidelines. The mechanism will work with young people especially in Universities and colleges and provide comprehensive HIV prevention services targeting first time testers whose coverage now stand at 40%. Other services integrated include TB screening, FP screening and alcohol consumption screening followed by appropriate referrals. Innovative strategies like self testing and point of care CD4 will be integrated in HTC to assess its impact on referral uptake.

The mechanism uses the national guideless for HTC service provision and employs both provider- initiated and client initiated HTC both in facilities and in the community settings. Approaches which have been successfully used are workplace, moonlight and celebrity testing and accelerated testing campaigns, the later being organized by the national program. Celebrity testing is key in creating demand for workplace testing and counseling. Home based approach is used in areas of high population density. The total number of targets achieved in the past year is 83,000 clients offered HTC services. A total of 146 providers were offered refresher training in HTC following the of new guidelines and also in including quality management and integration of services. Training and technical updates will be key in provision of quality services. In 2012, 210,929 clients will receive HTC provided through multiple approaches; HBTC- 63,299; VCT- 63,300; mobile -78,000 and workplace services -6,350.

The national testing algorithm is used in all the program work. Referral uptake among clients remain a challenge and the strategies used to improve this are updated comprehensive referral directories available in all sites, PLHIV CHWs are used to make follow up, they make visits where possible, use phone calls and send short messages (sms) to clients to ensure referral uptake. The clients are followed up and tracked for 3 months and a register is maintained to ensure service uptake. These services will be integrated in the government's community strategy for sustainability.

The program follows in the national quality management guidelines and participates in the national quarterly proficiency testing, and observed practice for new providers

The program develops work plans and conducts biannual data quality audits and monthly data supervision is carried out and this informs the program implementation.

The national M&E framework is used including use of national registers and data collection tools. New indicators like couples tested, discordant couples, MARPs and people with disability have been incorporated in the national tools.

Promotional activities for demand creation include the print and electronic media, social media is used and materials are posted in face book for the youth. A hot line is operated that has a national reach.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	319,739	0

Narrative:

The Community HTC mechanism targets general population with special emphasis on identifying the high risk group. These will include women especially in the reproductive age, older men especially the rural folk and young people in and out of school. Those especially in marriages or unions will be targeted with prevention messages especially the discordant couples. People with disability will be a special category targeted as programs have tended to ignore them. The populations will be mapped and appropriate EBI implemented for specific groups.

RESPECT targets ages 20-24 females and 30-44 males with STI. It has 2 brief individual sessions targeting general population and youth, originally for heterosexual negative persons. It focuses on reduction of STDs/HIV, risk reduction, condom use and clients understanding of personal risk.
Healthy Choices II (HCII) targets both in and out of school youth aged 13 – 17 years and aims to delay sexual debut, promote secondary abstinence or have protected sexual intercourse, by providing knowledge and skills on correct and consistent condom use, handling peer pressure, and learning one's HIV status. HC II consists of 8 modules of approximately one hour each. It can be delivered in 4 sessions of 2 hours each or in 8 sessions of 1 hour each.
Eban/Connect is a six session, relationship-based intervention that teaches couples including those discordant, techniques and skills to enhance the quality of their relationship, communication, and shared commitment to safer sexual behaviors and will allow couples to work together to solve shared problems.
Sister to Sister is a brief (20-minute), one-on-one, skill-based HIV/sexually transmitted disease (STD) risk-reduction behavioral intervention for sexually active women 18 to 45 years old. The purpose of Sister to Sister is to: provide intensive, culturally sensitive health information to empower and educate and help women understand the various behaviors that put them at risk for HIV and other STDs; and enhance women's knowledge, beliefs, motivation, confidence, and skills to help them make behavioral changes that will reduce their risk for STIs, especially HIV.
PwP is an individual intervention promoting positive living and strategies to reduce HIV transmission and re-infection, promotes enrolment to care and treatment, drug adherence, family planning, continued counseling and promotes partner testing and disclosure of status as well as proper and consistent condom use.

All the interventions will have integrated condom demonstration and distribution. Comprehensive gender based sexual violence service package will be integrated in the prevention interventions targeting adolescents and adults.

These populations are most at risk of HIV infection and have the prevalence higher than the national average. Sex

is not discussed in family relationships, couples do not know each other's HIV status and HIV discordance is high in the country about 45% of HIVinfected persons and partner testing is low. *Quality assurance of all these interventions is promoted through rigorous training and certification of facilitators, ongoing process monitoring with standardized tools, and quality assurance site visits by a capacity building agency. Appropriate evaluation modalities will be developed by the Technical working group to assess the impact.*

Implementing Mechanism Details

Mechanism ID: 12530	**Mechanism Name: Provision of VMMC**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Nyanza Reproductive Health Society	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,000,000	
Funding Source	**Funding Amount**
GHP-State	1,000,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The mechanism goal is provision of voluntary medical male circumcision (VMMC) for HIV prevention in Kenya. The objectives are in line with Kenya's Partnership Framework and GHI. They are 1. Support to government of Kenya in strengthening capacity of systems and services for VMMC implementation; 2. Implement and scale up quality and safe VMMC; 3. Ensure VMMC services are integrated with comprehensive HIV prevention, care and treatment services; 4. Create and sustain informed demand for VMMC in the target communities; 5. Support scale up of evidence based interventions targeting MSM in Kisumu city and its environs.

NRHS has been implementing VMMC for HIV prevention and also services targeting MSM. With PEPFAR funding, they have successfully met their VMMC targets (Has done 75,000 circumcisions using COP 2010 funds), adopting cost efficient approaches like task-shifting, task-sharing and use of electrocultery. Capacity building by training HCW on VMMC has also been undertaken and will make program more cost efficient. Other efficient approaches

include undertaking VMMC in outreach and mobile sites.
VMMC is done in MOH facilities, minor theatres are refurbished/renovated, equipped with surgical instruments and training HCW for sustainability purposes. At the conclusion of the award, trained HCW will be able to continue providing VMMC services.
Geographical coverage of NRHS CoAg is wide (Nyanza, Nairobi, Teso and Turkana). Distances between facilities are long, and all service provision teams require moving nearly every day. NRHS has been using 16 vehicles (15 vehicles purchased by IRDO in FY07 and FY08. One vehicle purchased in FY10). During Rapid Results Initiative (RRI) periods they hire other vehicles. This will continue in COP 2012. This activity support GHI/LLC.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12530**		
Mechanism Name:	**Provision of VMMC**		
Prime Partner Name:	**Nyanza Reproductive Health Society**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	CIRC	1,000,000	0
Narrative:			
The Kenya Government/MOH recognized MC as an additional HIV prevention intervention in 2007 and PEPFAR supported developed of MC policy guidance, MC strategy and communication strategy, and adapted/adopted other relevant documents (VMMC clinical Manual, M&E indicators/tools to guide service delivery and demand creation			

and tracking. The program's objective is to circumcise men aged 15 – 49 years by 2013 and reach 80% coverage. Four regions (Nyanza, Western, Turkana and Nairobi) with low MC rates and high HIV prevalence have been identified by for priority scale up. Nyanza Province has MC rates of 48% and HIV prevalence of 14.9%. HIV prevalence among the uncircumcised Luo is 17%, and MC rates is estimated to be 22% (KDHS 2008/9). Nairobi Province has MC rates of 83% and HIV prevalence of 8.8%. The Turkana region in also has high HIV prevalence rate and low MC rates, estimated to be 16%. Since 2008, VMMC services have been provided through PEPFAR implementing partners working at Ministry of Health (MoH) facilities, to over 300,000 males. However, huge gaps still exist, and while coverage is nearly 50% in some Nyanza districts, it is very low in other regions like Nairobi, Turkana and Teso. In 2012, NRHS will contribute to addressing the gaps existing in Nyanza, Western, Nairobi and Turkana areas

•NRHS will provide MC services to 115,885 boys and men aged 15 years and above in all 4 regions (53,267 men in Greater Siaya,20,487 men in Nairobi, 21,643 men in Teso/Busia,20,488 men in Turkana)

•Current coverage of VMMC services in Siaya County is nearly 50%, while it is still below 5% in other regions

•NRHS (clinical & M&E) staff and the district M&E subcommittee will conduct quarterly support supervision visits to VMMC sites to ensure quality assurance, using the adapted QA tools and ensure reporting is done through the MOH M&E reporting system.

•NRHS will ensure requisite demand for services in generated among males and females in and around the catchment area of each facility where VMMC services are available, and explore other approaches for efficiency including conducting outreaches and mobiles, use of electrocultery, as well as moonlight services where applicable.

•As part of comprehensive prevention package, all clients will be provided with the minimum package of services at site according to national guidelines, which include opt out HTC for VMMC clients and their partners, age appropriate sexual risk reduction counseling, counseling on abstinence during 6 week healing period, and promotion of correct and consistent condom use

•Where necessary, HCW teams to provide VMMC services will be trained to build their capacity, using the MOH training guidelines

•Linkage with other services within facilities and within districts/counties will ensure VMMC is part of comprehensive package of prevention package. Identified men with HIV will be appropriately linked to Care and treatment sites, giving preference of referral to the sites of their choice to reduce Loss To Follow up. Active linkages with other programs has been established, with cross referrals to care and treatment for HIV positive men, as well as referral of uncircumcised men from routine HTC sites and discordant couples to VMMC services

•Regular EQA from WHO and PEPFAR teams has ensured VMMC activities adhere to international standards. Service provision will be monitored using the standardized VMMC reports and evaluated regularly through the MOH M&E reporting

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

NRHS will continue to expand access to a high quality comprehensive package of services targeting mainly MSM, majority of will be men engaged in sex work in Kisumu city and its environs. High risk sexual behavior prevalent among male sex workers including incorrect and inconsistent condom use, low knowledge of HIV status, multiple sex partners, excessive alcohol and drug use, transactional sex and low adherence to treatment will be addressed. This mechanism will support implementation of the Combination Prevention Interventions for MSM as defined in the National Guidelines for the package of services for SWs. These comprise evidence-informed behavioral, biomedical and structural interventions. The program will support the adaptation and implementation of an evidence-informed behavioral intervention (EBI) that has a sufficient 'goodness of fit' with the local context. EBIs may include Mpowerment or Many Men Many Voices. This will be an EBI that targets sexual risk behaviors among MSM including involvement in sex work as a main occupation, higher risk among receptive partners, low condom use, multiple sexual partners and sexual acts, bisexual partnerships etc. Biomedical interventions include HTC, STI screening and treatment, TB screening and referral to treatment, HIV care and treatment and pre-exposure prophylaxis (PrEP). There is also a strong consideration for initiating Treatment as Prevention for these MARPS groups and initiating PrEP where feasible. Other important service components include screening for drug and alcohol abuse and referral for treatment and provision of psychosocial support. Structural interventions will focus on enhancing a 100% Condom Use Program (CUP) nationally, mitigation of sexual violence and support to expand choices beyond sex work as a risk-reduction strategy.

The existing site/drop-in-center will be supported to intensify coverage and increase access to services for MSMs in Kisumu, closely collaborating with the other implementing partners, particularly the Liverpool VCT clinic in Kisumu City to improve their capacity in serving high-risk populations. Though estimated size of MSM in Kisumu is estimated to be nearly 1870, the HIV prevalence is high. From a recent respondent-driven sampling survey among 415 MSM in Kisumu, the overall HIV prevalence was 12%, but among those older than 30 years had HIV prevalence o f 34%. Quality assurance will be enhanced through close project monitoring, use of standardized national tools and program improvement through regular staff and peer review forums. Program staff will receive regular training and orientation on current practices. Services provided through this mechanism are closely linked to other public and non-government services e.g., the clinics/drop in centers are registered to receive some drug supplies from central drug procurement mechanisms and report to their local district and provincial health authorities. These include other supplies e.g., condoms, IEC materials and training opportunities, that are organized for service providers in the Kisumu region.

This mechanism has a well-established M&E plan, with a data officer on site who collates data, analyzes and shares it with program staff to help inform the project better.

Implementing Mechanism Details

Mechanism ID: 12540	Mechanism Name: MEASURE Evaluation

Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: University of North Carolina	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 3,100,000	
Funding Source	**Funding Amount**
GHP-State	3,100,000

Sub Partner Name(s)

Futures International	ICF Macro	John Snow Inc (JSI)
Management Sciences for Health	Tulane University	

Overview Narrative

In line with USG's objective of promoting rigorous country-led M&E and GHI's learning agenda, the goal of MEASURE Evaluation's work in Kenya is to build the capacity of MOH to increase the availability and use of health information. The project will build the capacity of the MOH (at sub national levels) in outcomes monitoring using Lot Quality Assurance Sampling (LQAS), scale up and institutionalize referrals monitoring, intensify efforts to improve the availability and use of community health data for decision making and program improvement (at community, sub-national and national levels), and conduct a facility Maternal /Child Mortality Survey that will provide cause-specific, facility-related, maternal and child death data. Additionally, in an effort to expand in-country M&E human resource capacity, the project will further strengthen M&E training programs at Kenyatta University by providing technical assistance in M&E and conducting evaluation studies. The project will work at the national level with the MOH and other GOK stakeholders on activities that require national consensus.
For LLC, this activity will strengthen part of host country health information system in Nyanza, Western and Coast through procurement of an IT infrastructure (internet connectivity and networking equipment) that connects central and 16 counties in the three provinces. It will also support the procurement of 16 county servers, 2 national servers, 200 computers, netbooks, smartphones, PDAs, and printers for use at national and county levels, but has not procured and will not procure vehicles. The procured equipment will help in strengthening the GoK's capacity to collect and report complete and accurate data. This activity is funded primarily with pipeilne funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Malaria (PMI)

Budget Code Information

Mechanism ID:	**12540**
Mechanism Name:	**MEASURE Evaluation**
Prime Partner Name:	**University of North Carolina**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	3,100,000	0

Narrative:

According to COP 2013 guidance, 10 % of total OVC project funding should be allocated to OVC program monitoring and evaluation. This fund will be used to strengthen OVC M&E systems with the aim of improving effectiveness of OVC programs. Strengthened quality monitoring and evaluations will enable OVC programs establish if they are achieving desired results and if results can be attributed to the services provided to orphans and vulnerable children.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	0	0

Narrative:

SI has five components, which include: 1) Build the capacity of the MOH (at sub national levels) in outcomes monitoring using LQAS, which is a cost and time efficient approach to tracking the performance of health programs; 2) Scale up and institutionalize referrals monitoring. This will include correctly incorporating referral indicators in the data capturing tools and monitoring referral indicators nationally (i.e. including referrals indicators in AOP). In addition, MEASURE Evaluation will develop and implement health workers referral training protocols and guidelines; 3) Support to community level M&E and CHIS. MEASURE Evaluation will aim to intensify efforts to improve the availability and use of community health data for decision making and program improvement (at community, sub-national and national levels). This will be done through systematic institutional capacity building for the division of community health services, targeted direct support to districts and community units through trainings, printing of data collection tools, support to supervision staff, and operationalization of data quality improvement and data use forums; 4) Maternal/child mortality surveillance. Conduct a facility Maternal /Child Mortality Survey that will provide cause-specific, facility-related, and maternal and child death data in 300 facilities. An initial assessment of selected facilities will look at the quality (e.g. completeness and cause of death accuracy) of mortality data. Based on that assessment, the survey methodology will be established and a program of capacity building (e.g. training in ICD-10 coding) will be established to remediate deficiencies in specific areas of data collection; 5) Capacity Building on pre-service M&E training with Kenyatta University. The activity centers on collaborative linkages with KU and long-term training to foster country ownership and sustainability of M&E training. The project will strengthen the capacity of Kenyatta University to offer sustainable M&E training programs, provide technical assistance in M&E, and conduct evaluation studies.

Implementing Mechanism Details

Mechanism ID: 12551	**Mechanism Name: Clinical Services**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of California at San Francisco	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 8,100,574	
Funding Source	**Funding Amount**
GHP-State	8,100,574

Sub Partner Name(s)

Kenya Medical Research Institute		

Overview Narrative

University of California at San Francisco (UCSF) Family AIDS Care and Education Services (FACES) supports implementation of comprehensive HIV prevention, care and treatment services in five districts in Nyanza and two sites in Nairobi. Services are targeted at individuals and families of all ages who are at risk of HIV, infected by HIV, or affected by HIV. The program goal and objectives are linked to Kenya's Partnership Framework (PF) and Global Health Initiative (GHI) strategies and are directly aligned to PF pillars 1-3: prevention, care and mitigation, treatment, and systems strengthening. Strategies to reduce maternal and child mortality and eliminate MTCT include supporting family planning integration into HIV clinics. Monitoring and evaluation (M&E) plans align with PEPFAR and country PF. Training on and use of Ministry of Health (MOH) HMIS systems will be supported to eliminate parallel M&E.

Cost efficiency is being addressed through integration of services, reduction of the technical teams by increased capacity building of the MOH staff, use of existing evidence-based efficient strategies, task shifting, implementing more facility-based training and mentorship as opposed to offsite training, evaluating cost effective strategies for defaulter management, laboratory networking, and mobilization.

Capacity-building strategies are aimed at strengthening sustainable local systems for effective transition of technical support from FACES to KEMRI and HIV care management and implementation from FACES to MOH.

FACES has procured 11 vehicles between FY04 and FY10. In FY12, FACES will procure an additional motor vehicle and four motorcycles for supportive supervision and tracking of defaulters to improve retention.

This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	81,006
Gender: GBV	8,000
Gender: Gender Equality	13,000
Human Resources for Health	3,684,776

Motor Vehicles: Purchased	91,667
Renovation	88,285

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**12551**
Mechanism Name:	**Clinical Services**
Prime Partner Name:	**University of California at San Francisco**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	900,000	0

Narrative:

University of California at San Francisco (UCSF)- Family AIDS Care and Education Services (FACES) will continue to support comprehensive HIV care and support in Nyanza and Nairobi Provinces. By SAPR 2011, FACES had a total of 101,617 patients ever enrolled in HIV care of which 85,499 individuals were provided with HIV-related palliative care including 64,431 patients on cotrimoxazole prophylaxis. The overall retention for patients in care stood at 74%.

FACES will continue working with the Ministry of Health (MoH) at the provincial, district and health facility level to jointly plan, coordinate, implement and ensure provision of quality HIV care and support to 63,270 adult patients

in FY12 and 76,500 patients in FY13. FACES will offer a package of services that includes HIV testing to partner and other family members of index patient and either enrolling or referring those that test HIV positive to care and support; provision of Basic Care Kit (safe water vessel, multivitamins, insecticide-treated mosquito nets, chlorine for water treatment and educational materials); supplemental and therapeutic nutrition (FBP) to all eligible HIV positive patients; prevention with positives(PwP); and cervical cancer screening to all enrolled women.

FACES in collaboration with MoH will support targeted capacity building of health care providers through recruitment, deployment, training, and mentorship and additionally offer continuous medical education on HIV care and support. In FY 12, 200 health providers will be targeted for training and another 150 in FY 13. FACES will support good commodity management systems and practices to ensure uninterrupted supply of commodities.

FACES will also support ongoing community interventions for HIV infected individuals through peer education and support groups to provide adherence messaging. Additional activities that will continue to be supported include effective and efficient defaulter tracing system to improve retention in all facilities; referral and linkages to community based psychosocial support groups; water, sanitation and hygiene programs; economic empowerment and income generating activities; Home Based Care services; gender based violence support programs; vocational training; social and legal protection; and food and nutrition programs.

FACES will adopt strategies to ensure access and provision of friendly services to youth, elderly and disabled populations. Strategies to increase men accessing care services will be employed such as male peer educators, mentors and support groups, disclosure and partners testing and care and treatment.

FACES will continue to strengthen data collection and reporting at all levels to improve reporting to NASCOP and PEPFAR, including adoption of new generation indicators. FACES will support the development and scale up of electronic medical records system in accordance with NASCOP guidelines. Quality of care indicators (CQI, HIVQUAL) will be integrated into routine data collection and results will be used to evaluate and improve clinical outcomes. FACES will also support cohort analysis and report retention rates as required by NASCOP. FACES will support joint Annual Operation Plan (AOP) development, implementation, monitoring and evaluation, and health system strengthening to facilitate sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	500,000	0

Narrative:

University of California at San Francisco Family AIDS Care and Education Services (FACES) program will support five districts in Nyanza and Nairobi Province. Since 2005, FACES has been supporting TB/HIV activities in

5 districts in Nyanza province. As of SAPR 2011, 96,076 HIV clients were screened for TB of which 1,132 were diagnosed and managed for TB.

In FY 12 and 13, FACES will continue supporting TB/HIV activities through collaboration with the Ministry of Health (MoH) in line with TB/HIV collaborative mechanisms. FACES will support intensified efforts to detect TB cases through clinical assessments and physical exams, sputum AFB follow up investigations, and provision of appropriate TB treatments to facilitate good treatment outcomes. FACES will ensure that each facility providing TB/HIV services has adequate and well trained clinical staff and well equipped and staffed laboratory or support sputum specimen transport where laboratory services are unavailable. FACES will ensure that adequate supplies of anti-TB drugs are available and that the national TB treatment guidelines are followed. All TB patients on treatment will be monitored both clinically and through periodic sputum examination.

To reduce the burden of HIV in TB patients, FACES will ensure that all TB patients are screened for HIV and co-infected patients put on cotrimoxazole and ARVs as early as possible regardless of the CD4 count as per the national guidelines. FACES will support the "one stop" model that provides integrated TB and HIV services in all TB clinics. All TB clinics will be stocked with cotrimoxazole and ARVs and 100 HCW will be trained in FY12 and 80 HCW trained in FY13.

To reduce the burden of TB in HIV infected patients, FACES will support intensified TB screening for 56,240 in FY12 and 68,000 in FY13 at each clinical encounter using the national screening tool. 2,812 co-infected patients identified in FY12 and 3,400 in FY13 will be put on TB treatment and those without active TB will be provided with Isoniazid Preventive Therapy (IPT) as per national IPT protocol. To strengthen TB infection control in HIV settings, FACES will ensure that the national IC guidelines are available at all sites and training of staff on IC is done. FACES will support scaling up of at least 2 components of the national TB infection control strategy in HIV care settings, one of which should be fast tracking of patients with cough for expedited diagnostic work up and treatment.

To improve surveillance and management of drug-resistant TB, FACES will support timely transport of sputum specimens of TB retreatment cases from health facilities to the central reference laboratory for drug susceptibility testing and ensure return of the results to those facilities. FACES will also support scaling up of drug-resistant treatment sites thus expanding access to MDRTB treatment.

FACES will also support expansion of prevention with positive (PwP) services in TB clinics, TB/HIV control activities in the prisons, strengthening linkages between facility and community-based services, and improving patient referrals and tracking systems. To strengthen HVTB program monitoring, FACES will support reporting of selected custom indicators to assist with program management and evaluation and monitoring of new activities in all levels.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	200,000	0

Narrative:

University of California at San Francisco Family AIDS Care and Education Services (FACES) program is a family-focused, comprehensive HIV prevention, care, and treatment program working collaboratively with the Government of Kenya in Nyanza and Nairobi Provinces since 2005. FACES will continue supporting HIV services including pediatric services in Nyanza and Nairobi Provinces.

By SAPR 2011, FACES had 16,127 children enrolled in care with 4,107 on ART, 10,739 on cotrimoxazole prophylaxis, and 3,100 HIV exposed children on ARV prophylaxis. In FY12, FACES will provide care and support services to 6,611 children on care. The number of children currently on care will increase to 8,138 during FY13. FACES will provide comprehensive, integrated quality services and scale up to ensure 6,231 HIV infected infants are enrolled and followed up for care and support.

FACES will improve access to TB and cryptococcal screening and management, pain/symptom relief and management, psychosocial support (including disclosure counseling and support) provided through education, counseling, and linkages to facility or community based support groups.

FACES will strengthen growth and development monitoring including nutritional (provision of vitamin A, zinc, and de-worming); support linkages for safe water, sanitation and hygiene interventions (WASH) in the community to prevent communicable disease among children; and malaria screening, treatment and provision of long lasting insecticide treated nets in malaria endemic areas. Emphasis will be on enhanced follow up and retention of all identified HIV infected and exposed children.

FACES will support the integration of HIV services into routine child health care and survival services in the MCH department and through wrap around of non-HIV services such as strengthening routine growth and development monitoring; immunization coverage; and management of diarrhea including oral rehydration therapy, pneumonia, and other childhood illnesses. The support will also include community outreach efforts. FACES will expand support to include care of the newborn by supporting hospital delivery and ensuring that there is provision for newborn resuscitation and care (thermal care, appropriate feeding options and hygiene including cord care and prophylactic eye care).

FACES will support the needs of HIV infected adolescents such as clinical and psychosocial support disclosure, PwP, substance abuse counseling, support for transitioning into adult services, and teaching life skills. FACES will also ensure optimized linkages of children to various programs including TB/HIV, education, OVC support, legal and social services, and other community based programs.

FACES will also support improved health care provider knowledge and skills through in-service and on-job trainings as well as continuous medical education. In FY 12, 200 health care providers will be targeted for training and 150 in 2013.

FACES will strengthen pediatric data collection and reporting at all levels to improve reporting to NASCOP and PEPFAR. With guidance from the national PEPFAR office, the new generation indicators will be adopted. To improve the quality of care and strengthen pediatric services, FACES will support supervision and mentorship activities and integrate the quality of care indicators (CQI and HIVQuaL) into routinely collected data to monitor the quality of pediatric HIV services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	752,304	0

Narrative:

GoK/MOH recognized MC as an additional HIV prevention intervention in 2007 and with PEPFAR support developed a MC policy guidance, MC strategy and communication strategy, and adapted/adopted other relevant documents (VMMC clinical Manual, VMMC M&E indicators/tools to guide service delivery and demand creation and tracking. The program's objective is to circumcise men aged 15 – 49 years by 2013 and reach 80% coverage. Four regions (Nyanza, Western, Turkana and Nairobi) have been identified for priority scale up. Nyanza Province has MC rates of 48% and HIV prevalence of 14.9%. HIV prevalence among the uncircumcised Luo is 17%, and MC rates is estimated to be 22% (KDHS 2008/9). Nairobi Province has MC rates of 83% and HIV prevalence of 8.8%. Since 2008, VMMC services have been provided through PEPFAR implementing partners working at MoH facilities, to over 300,000 males. However, huge gaps still exist, and while coverage is nearly 50% in some Nyanza districts, it is very low in other regions like Nairobi, Turkana and Teso. In 2012, FACES will contribute to addressing the VMMC gaps existing in Nyanza, and other pockets with significant populations of uncircumcised men in Kenya as advised by National Taskforce on VMMC.

- *FACES will provide VMMC services to 7,000 boys and men aged 15 years and above in all these areas (Kisumu county, Homabay County, Migori County,and in other identified areas by MOH)*
- *Current coverage of VMMC services in Counties ranges between 5% in some, and reaching 50% in others, and FACES will contribute to covering these gaps.*
- *FACES (clinical & M&E) staff and the district M&E subcommittee will conduct quarterly support supervision visits to VMMC sites to ensure quality assurance, using the adapted VMMC QA tools and ensure reporting is done through the MOH M&E reporting system.*
- *FACES will ensure requisite demand for VMMC services in generated among males and females in and around the catchment area of each facility where VMMC services are available, and explore other approaches for efficiency including conducting outreaches and mobiles, use of electrocultery, as well as moonlight services where*

applicable.

- *As part of comprehensive prevention package, all VMMC clients will be provided with the minimum package of services at site according to national guidelines, which include opt out HTC for VMMC clients and their partners, age appropriate sexual risk reduction counseling, counseling on abstinence during 6 week healing period, and promotion of correct and consistent condom use*
- *Where necessary, HCW teams to provide VMMC services will be trained to build their capacity, using the MOH VMMC training guidelines*
- *Linkage with other services within facilities and within districts/counties will ensure VMMC is part of comprehensive package of prevention package. Identified men with HIV will be appropriately linked to Care and treatment sites, giving preference of referral to the sites of their choice to reduce LossTo Follow up. Active linkages with other programs has been established, with cross referrals to care and treatment for HIV positive men, as well as referral of uncircumcised men from routine HTC sites and discordant couples to VMMC services*
- *Regular EQA from WHO and PEPFAR teams has ensured VMMC activities adhere to international standards. Service provision will be monitored using the standardized VMMC reports and evaluated regularly through the MOH M&E reporting system.*

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	229,198	0

Narrative:

Target population: FACES supports HIV testing and counseling services in all health facilities in five districts in three counties in Nyanza Province. The counties are Migori, Homabay and Kisumu. The districts of support in include Migori, Rongo, Nyatike, Kisumu East (from 15th August 2011) and Suba (from October 1st 2011). Target population includes all patients, their families and caretakers who access out and in patient services at all the health facilities in the 5 districts.

HTC Approaches: The program utilizes provider initiated opt out approach and the services are offered within all out patient departments, TB clinics, VMMC clinics, FP, ANCs, special clinics, HIV clinics (targeting family members) and in patient departments. The counseling and /or testing is either done within the consultation rooms by trained clinicians, counseling rooms by lay counselors within the outpatient if space is available or the in laboratories. Occasionally testing is offered during community action days, world Aids days and when the facilities conduct camps then community and home based counseling and testing is conducted.

Targets and achievements: HTC targets for FACES from July 2010 to June 2011 were 59,140 out of which it achieved 80,411 (139%). 15% of the total tested was HIV positive. In COP 2012, FACES will target to provide HTC services to a total of 115,000 persons of which 20% will be tested as couples and 10% will be children below the age of 15.

Testing algorithm: National algorithm is being used.

Referrals and linkages: In order to strengthen referrals, FACES continues to sensitize counselors on need for

proper referral. Counselors continue to educate clients on importance of being enrolled into HIV care and treatment programs if positive. Counselors also capture locator details for patients counseled and tested who turn positive; use of MOH referral tools and use of escorts/peer educators in different departments has also been strengthened. In order to monitor linkages from HTC to appropriate services FACES uses tracking tools/registers for the positive patients to verify whether they have reached the referral points.

Quality management: In order to improve and maintain high quality HTC services, FACES will put in place the following strategies: formation of District and facility HTC quality committees; recruitment of qualified and certified counselors; strict adherence to the standard operating procedures outlined in the national HTC guidelines; proper handling of HIV rapid kits as per the guidelines; putting in place a functional QA systems as provided for in the national HTC guidelines; participation in EQA- proficiency testing and finally conducting support supervisory visits.

Monitoring and evaluation: FACES will use all ministry of health' tools to capture HTC data, both for couples and individual patients. These include HTC lab Register and Monthly summary tool (MOH 711). MOH approved HTC lab registers will be introduced at all HIV testing points except PMTCT.

Promotional activities for HTC: All patients attending the supported facilities will be given health talks including the need for HIV counseling and testing and the importance of couple testing. Couples are given priority services. Sexual partners of HIV positive clients will be given individualized invitations though the index clients and available avenues for testing including individualized home testing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

UCSF implements comprehensive prevention, care and treatment programs in Nyanza province. In FY 2012/13, UCSF will expand HIV prevention services to include evidence based behavioral interventions (EBIs) for specific target populations in clinical settings at comprehensive care center (CCC), TB and Maternal Child Health (MCH) clinics as part of HIV combination prevention programs. The EBIs will include Positive Health and Dignity Prevention (PHDP) targeting adult male and female and adolescents living with HIV (PLHIV); and Sister to Sister EBI (S2S) targeting sexually active HIV negative women attending the MCH clinics.

PHDP is an ongoing 5-10min group and individual level intervention that targets PLHIV in clinical and community settings. This mechanism will support this intervention which constitutes of ART adherence counseling and support; partner and family testing; provision of PEP to the discordant spouse; treatment for prevention once approved; safer pregnancy counseling and provision of modern contraception; sexual risk reduction counseling including reduction of sexual partners, alcohol counseling, promoting of consistent and correct condom use; Sexually Transmitted Infections (STI) screening and treatment and using meaningful involvement of people living with HIV/AIDS (MIPA). The efficacy of PHDP has been shown to be 68% in preventing transmission of HIV, and 96%

in treatment for prevention.

S2S is a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use. Condoms are 80% effective in heterosexual relationships when used correctly and consistently.

UCSF will use HVOP funding to recruit and support appropriate peer educators/counselors to reinforce prevention messages delivered by health providers as a feasible model for task-shifting in the provision of PHDP in clinical settings, and specifically promote MIPA. It will support placement of 5 Peer Educators at the MCH, TB and CCC Clinics in hospitals, and 2 Peer educators at health centres and provide appropriate counseling space. One of the peer educators will do regular client home follow up to strengthen ART adherence.

Approximately 1.6 million Kenyans are PLHIV. The Kenya AIDS Indicator Survey 2007 showed 6% of couples to be in discordant relationships. Nyanza province has the highest HIV Prevalence (14.9). UCSF will reach 35639 (60%) PLHIV in FY2012 and 30360 (70%) in FY 2013 with a minimum package of PHDP. It will implement S2S EBI on a pilot basis.

Quality assurance for EBIs will be promoted through appropriate training and certification of peer educators using approved national curricula, standard job-aids and guidelines and regular supervision.

UCSF will work with appropriate national Technical Working Groups (TWG) to support integration of HIV prevention into care and treatment programs in clinical settings. These programs will also be linked to other HIV community programs. PLHIV will be specifically linked to STI and FP services, as necessary, through patient escorts.

Monitoring of PHDP and S2S will be done through the review/input of UCSF implementation plan, analysis of KePMS data, quarterly reviews, semiannual and annual reports. Evaluation will be conducted through operation research of combination HIV prevention and periodic surveys (Kenya Demographic and health survey, Kenya Indicator AIDS Survey, Kenya Service Provision Assessment).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	900,000	0

Narrative:

University of California at San Francisco Family AIDS Care and Education Services (FACES) has been implementing PMTCT services in 127 sites in 5 Districts in Nyanza region since 2005. The region has about 244,416 expected pregnancies annually and HIV prevalence of 15.1%.

As of 2010 APR, FACES had counseled and tested 18,349 women in ANC at 117 sites, 19 of which are fully integrated with Antenatal Care (ANC)/ART. Among 2,614 HIV positive women in ANC and Maternity (MAT), 2,352 women (90%) and 2,399 of their exposed infants (92%) received ARV prophylaxis. 309 out of 2,399 women who received ARV prophylaxis were initiated on HAART. Post natally, 371 HIV positive women were identified and received ARV prophylaxis (17 received HAART). A total of 1,125 partners across ANC, MAT, and postpartum were tested for HIV.

In FY12, FACES will offer HIV counseling and testing to 40,108 pregnant women at ANC and give ARV prophylaxis to 5,964 infected pregnant women. HIV infected women will receive a CD4 test after undergoing a WHO clinical staging. FACES will give HAART to all eligible pregnant women in line with the revised PMTCT national guidelines. In FY13, FACES will increase the number of pregnant women counseled to 42,113 and offer ARV prophylaxis to 7,243 pregnant women and 6,321 infants, and do EID for 6,321 infants.

FACES will focus on 4 prongs of PMTCT: primary prevention; family planning; ARV prophylaxis to all HIV positive pregnant mothers and exposed infants; and care and treatment to eligible HIV positive mothers, partners and children. The minimum care package will include health and HIV education, individual/family HIVCT, clinical/laboratory monitoring and assessment, OI screening and treatment, ARV prophylaxis and treatment for both mother and baby, nutritional support, psychosocial support, PWP, follow up, retention, referral, and linkages. FACES will incorporate TB screening into routine antenatal care.

FACES will support integration of ART in MCH clinics, access to FP/RH services, and establish or strengthen infection control and waste management activities. FACES will support hospital delivery through provision of delivery beds and sterile delivery packs, training, working with CHWs and TBAs to promote community-facility referral mechanisms, health education, and community services providing skilled birth attendance.

FACES will support safe infant feeding practices as per national guidelines and support enrollment and follow up of 6,321 of babies born to HIV infected mothers to access CTX, ARV prophylaxis, and EID services using the HIV exposed infant register till 18 months. FACES will facilitate ART initiation for those who test positive before 2 years.

FACES will adopt efficient retention strategies for mothers and babies by supporting use of diaries and registers for tracking defaulters, having a structured mentorship and supervision plan, enhancing data quality, streamlining M&E gaps including orientation of new MOH ANC/maternity registers, and utilizing data at facility level for program improvement and quarterly progress reports to CDC.

Program quality and proficiency testing will be emphasized to validate PMTCT results. FACES will train 90 HCWs in FY12 and equal number in FY13 on PMTCT and provide orientation on the revised PMTCT and infant feeding guidelines. FACES will also engage in community activities for demand creation for health services such as male involvement with couple CT services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	4,219,072	0

Narrative:

University of California at San Francisco Family AIDS Care and Education Services (FACES) will continue supporting treatment in Nyanza and Nairobi regions. Nyanza has a population of about 5.4 million with an estimated adult HIV prevalence of 14.9% compared to the national 7.1% and about 500,000 people are living with HIV (PLHIV). As of 2011 SAPR, 30,923 adults were on ART in 67 health facilities supported by FACES. 60 health care workers (HCWs) were trained on adult ART through both in-service training and continuous medical education at the facilities. Translation of knowledge to practice was enhanced through mentorship and Uliza clinician consultation hotline services contributing to improved quality of care. Cohort analysis revealed that 86% of adults were still on ART 12 months after initiation. Patient support groups, peer educators, and community health workers were engaged in supporting patient retention. Clinical Quality assessments and clinical mentorship activities were ongoing in most of the sites.

In FY12, FACES will jointly work with the Ministry of Health (MoH) to continue supporting expansion and provision of quality adult HIV treatment services as per MoH guidelines to 46,117 patients currently receiving ART and 12,832 new adults resulting to a total of 55,341. In FY13, a total of 55,753 will be receiving ART while 12,982 new adults will be initiated resulting to 68,323 cumulative number on ART.

FACES will support in-service training of 200 and 150 HCWs in FY 12 and FY 13 respectively and continuous mentorship of trained HCWs on advanced HIV management including management of patients with ARV treatment failure and complicated drug adverse reactions. FACES will identify and support human resource and infrastructure gaps as well as support good commodity management systems to ensure uninterrupted availability of commodities.
FACES will support provision of a comprehensive package of services to all PLHIV including ART initiation for those eligible; laboratory monitoring including biannual CD4 testing, viral load testing for suspected treatment failure (through strengthened laboratory network); cotrimoxazole prophylaxis; adherence and psychosocial counseling; referral to support groups; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH; and improved OI diagnosis and treatment including TB screening, diagnosis, and treatment.
Ongoing community interventions for PLHIV including peer education and support groups to provide adherence messaging and defaulter tracing and follow up will continue to be supported to improve retention in all sites.
FACES will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services, integrate them into routinely collected data, and use the results to evaluate and improve clinical outcomes.
FACES will also support short term activities to improve impact and patient outcomes.
FACES will continue to strengthen data collection and reporting at all levels to improve reporting to NASCOP and PEPFAR. FACES will also do cohort analysis and report retention as required by MoH and support program data review and evaluation in all facilities to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. FACES will strengthen local capacity as part of the transition plan to MoH for sustainable long-term HIV patient management in Kenya.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Treatment	PDTX	400,000	0

Narrative:

University of California at San Francisco Family AIDS Care and Education Services (FACES) has been supporting and will continue to support pediatric treatment services in five districts in Nyanza and Nairobi Provinces. Nyanza has an HIV prevalence of 14.9% and approximately 12,440 paediatrics ever initiated on ART as of May 2011. FACES has been supporting pediatric HIV treatment since 2005 and as of SAPR 2011, 3,360 paediatrics were active on ART and 120 health care workers (HCWs) were trained on pediatric ART and another 51 as Mentors, which contributed to improved quality of care. Strategies like engagement of peer educators and community health workers are ongoing to improve quality of services and retention. Clinical Quality Assessments and mentorships were implemented in all the sites.

In FY12, FACES will work with the Ministry of Health (MoH) at all levels to continue supporting expansion and provision of quality pediatric HIV treatment services as per MoH guidelines to 5,120 pediatrics currently on ART and 1,024 new pediatrics resulting to cumulative 6,144 pediatrics ever initiated on ART. In FY 13, this number will increase to 5,639 pediatrics on ART and 922 new resulting to 7,066 ever initiated on ART.

FACES will support comprehensive pediatric ART services including growth and development monitoring, immunization schedules as per the Kenya Expanded Program on Immunization, management of childhood illnesses, clinical and laboratory assessments including WHO staging and CD4 (through strengthening of lab networks), OI screening and management, ART eligibility assessment and initiation as per MoH guidelines, Adherence (ART), psychosocial counseling, ART toxicity and treatment failure monitoring. FACES will promote strengthened follow up and retention strategies, EID as per MoH guidelines and PITC to all children and their care givers attending Child welfare clinics, family focused approaches, community outreach efforts, and integration of HIV services in other MNCH services.

FACES will support hospital and community activities to meet the needs of the HIV infected adolescents such as support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services, and support their transition into adult services.

FACES will support in-service training of 200 and 150 HCWs in FY 12 and 13 respectively as well as continuous mentorship and capacity building of trained HCWs on specialized pediatric treatment including management of ARV treatment failure and complicated drug adverse reactions. FACES will identify human resources and infrastructure gaps, support in line with MoH guidelines, and support good commodities management practices to ensure uninterrupted availability of commodities. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will additionally be optimized.

FACES will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, FACES will support facility program data review and evaluation to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. FACES will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.

Implementing Mechanism Details

Mechanism ID: 12555	**Mechanism Name: Clinical Services/Centers of Excellence**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Nairobi	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 3,985,723	
Funding Source	**Funding Amount**
GHP-State	3,985,723

Sub Partner Name(s)

(No data provided.)

Overview Narrative

UON Partnership for Advanced Care and Treatment – Centers of Excellence (COE) project goal is to enhance the technical capacity of staff and faculty to provide high quality, evidence-based, comprehensive and integrated HIV prevention, care and treatment services at Kenyatta National Hospital (KNH) and Pumwani Maternity Hospital (PMH). They will support Kenya's HIV programs by establishing networks and capacity building HCW to ensure provision of quality HIV care and treatment services as well as by supporting policy, guidelines and curriculum development. COE will strengthen the capacity of KNH and PMH to ensure data quality, analysis, reporting, and use for evidence-based programming. Electronic medical records systems will be supported to ensure quality and sustainable M&E systems to inform program implementation and improvement. Periodic patient level outcome studies will be carried out to assess quality of interventions.

Cost efficiency is being addressed through integration of services, staff, use of existing evidence-based efficient strategies, task shifting, implementing more facility-based training and mentorship as opposed to offsite training, evaluating cost effective strategies for defaulter management, laboratory networking, and mobilization.
UON is a locally based university. To ensure transition and sustainability, COE will transfer administrative and program responsibility to PMH and KNH. Financial reporting systems will be established and integrated quality management teams in the facilities will be supported so that skills are transferred to staff in the two institutions.
COE acquired 1 van in 2011 to strengthen community based treatment prevention and defaulter tracing. No vehicle will be required in FY 12.
This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	37,857
Gender: GBV	4,000
Gender: Gender Equality	10,000
Human Resources for Health	1,564,169
Motor Vehicles: Purchased	95,000
Renovation	500,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**12555**
Mechanism Name:	**Clinical Services/Centers of Excellence**
Prime Partner Name:	**University of Nairobi**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	300,000	0

Narrative:

The University of Nairobi, Partnership for Advanced Care and Treatment, Centers of Excellence (COE) will continue to support pediatric ART services as part of integrated, comprehensive HIV clinical services in Kenyatta National Hospital (KNH) in Nairobi province. By March 2011, COE had cumulatively enrolled 14,946 patients in HIV care including 4,219 active patients on cotrimoxazole prophylaxis.

COE will work with the Ministry of Health (MoH) at the provincial, district and health facility levels, to jointly plan, coordinate, implement and ensure provision of quality HIV care and support to 4,773 current adult patients in FY12 and 9,251 current patients in FY13. A package of care services will be offered including HIV testing to partner and family members of index patient and enrolling or referring/linking those that test HIV positive to care and support; provision of Basic Care Kit (safe water vessel, multivitamins, insecticide-treated mosquito nets, chlorine for water treatment and educational materials); supplemental and therapeutic nutrition (FBP) to all eligible HIV positive patients; prevention with positives(PwP); and cervical cancer screening to all enrolled women.

In collaboration with MoH, COE will support targeted capacity building (training and mentorship) for health care workers and additionally offer continuous medical education on care and support e.g. OI diagnosis and treatment. Areas with staff shortages will be identified and additional staff recruited. COE will also support good commodities management practices to ensure uninterrupted supply of commodities will be supported.

Ongoing community interventions for HIV infected individuals will be supported including peer education and support groups to provide adherence messaging; effective and efficient defaulter tracing and follow up to improve retention in all facilities; referral and linkages to community based psychosocial support groups; Water, sanitation and hygiene programs; Economic empowerment - income generating activities; Home Based Care services; Gender based violence support programs; vocational training; social and legal protection; and food and nutrition programs.

COE will adopt strategies to ensure access and provision of friendly services to youth, elderly and disabled populations. Strategies to increase access of care services by men will be adopted including supporting male peer educators, mentors and support groups, and supporting women to disclose and bring their male partners for testing and care and treatment.

COE will continue to strengthen data collection and reporting at all levels to improve reporting to NASCOP and PEPFAR. COE will adopt the new generation indicators support the development and use of electronic medical records system in accordance with NASCOP guidelines. COE will continue using the quality of care indicators (CQI) for monitoring the quality of HIV care and support services, integrate them into routinely collected data, and use the results to evaluate and improve clinical outcomes. COE will do cohort analysis and report retention rates as required by the NASCOP. COE will support joint Annual Operation Plan (AOP) development, implementation, monitoring and evaluation, and health system strengthening to facilitate sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	150,000	0

Narrative:

The University of Nairobi, Partnership for Advanced Care and Treatment, Centers of Excellence (COE) has been supporting pediatric ART services as part of integrated comprehensive HIV clinical services in Kenyatta National Hospital (KNH) in Nairobi province since October 2010. Nairobi province reported 17,444 TB patients in 2010. By the end of June 2011, 1,337 TB patients received HIV testing and 703 TB/HIV co-infected patients were identified and 33% of these were put on ART.

In FY12 and FY13, COE will work with the Ministry of Health (MoH) to intensify efforts to detect TB cases through clinical exams and laboratory investigations and ensure successful TB treatment through provision of appropriate treatment. They will ensure that KNH has adequate and well trained clinical staff supported by well equipped and staffed laboratory to carry out tests. Adequate supplies of anti-TB drugs will be available and strategies to ensure that the national TB treatment guidelines are followed will be employed. All TB patients on treatment will be monitored both clinically and through periodic sputum examination.

To reduce the burden of HIV in TB patients, COE will ensure that all TB patients are screened for HIV and 95% TB-HIV co-infected patients are put on cotrimoxazole and ARVs as early as possible regardless of the CD4 count as per the national guidelines. A "one stop" model which provides integrated TB and HIV services in all TB clinics will be supported. All TB clinics will be stocked with cotrimoxazole and ARVs. COE will train 300 HCWs in FY12 and 200 in FY13 on TB/HIV, 5Is and data management.

To reduce the burden of TB in HIV infected patients, COE will support intensified TB screening for 4,243 in FY12

and 8,222 in FY13 for HIV infected patients in HIV care settings using the national screening tool. 212 active TB patients in FY12 and 411 in FY13 will be put on TB treatment and those without active TB will be provided with Isoniazid Preventive Therapy (IPT) as per national IPT protocol. To strengthen TB infection control in HIV settings, COE will ensure that the national IC guidelines are available at all sites and training of staff on IC is done. Scaling up of at least 2 components of the national TB infection control strategy in HIV care settings, one of which should be fast tracking of patients with cough for expedited diagnostic work up and treatment will be supported.

To improve surveillance and management of drug-resistant TB, the KNH lab will be equipped to support drug susceptibility testing for the retreatment cases both from KNH and other facilities and ensure return of the results to those facilities. They will also support scaling up of drug-resistant treatment thus expanding access to MDRTB treatment.

COE will also support expansion of prevention with positive (PwP) services in TB clinics, strengthening linkages between facility and community-based services, and improving patient referrals and tracking systems. To strengthen HVTB program monitoring, COE will support reporting of selected custom indicators to assist with program management and evaluation and monitoring of new activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	70,000	0

Narrative:

The University of Nairobi, Partnership for Advanced Care and Treatment, Centers of Excellence (COE) has been supporting pediatric care and support as part of integrated, comprehensive HIV clinical services in Kenyatta National Hospital (KNH) and Nairobi Province. By March 2011, COE had 1,547 children enrolled in care with 1,273 receiving HIV care, 914 on ARV prophylaxis, and 582 on cotrimoxazole prophylaxis.

In FY12 and FY13, COE will provide care and support services to 498 and 984 children currently on care respectively. COE will provide comprehensive, integrated quality services and scale up to ensure 1,053 HIV infected infants are put on ARV prophylaxis and all HIV exposed children access pediatric care services.

COE will continue to work with the Ministry of Health (MoH) at all levels to coordinate scale up and strengthening of pediatric care and support services. To improve the quality of care, they will support supervision and mentorship activities, adapt quality of care indicators, integrate the indicators into routinely collected data, and use the data to assess quality of pediatric HIV services.

Child survival interventions including growth and development monitoring; immunization; nutritional assessment,

counseling, and support (including provision of therapeutic or supplementary feeding for the malnourished and vulnerable children, vitamin A supplementation, zinc, and de-worming); safe water, sanitation and hygiene interventions; and malaria screening, treatment, and provision of insecticide treated nets in malaria endemic areas will be provided. HIV palliative care services including specialist pediatric clinics, TB/HIV care, psychosocial care, and Prevention with Positive (PwP) activities will be provided.

COE will prioritize the identification of HIV exposed children < 24 months of age by provision of EID (PCR-DNA) for < 18 months of age and antibody testing for those > 18 months at the MCH, PITC, family-testing through clinical and community HTC strategies, and by use of the mother-baby booklet at MCH. Cotrimoxazole prophylaxis will be provided to all HIV exposed infants and ART provided for all the HIV infected. Follow up and retention of all identified HIV exposed children, HIV testing per the national guidelines, and provision of Nevirapine throughout the breastfeeding period will be strengthened.

Priority will be to ensure children enrolled in care are promptly evaluated for ART using CD4 and WHO staging; have access to diagnostic tests for opportunistic infection including cryptococcal antigen testing; are managed for opportunistic infections; and are provided with basic HIV care package including cotrimoxazole prophylaxis, multivitamins, safe water systems, TB screening, and pain and symptom relief and management. COE will support strengthening of the regional system of samples/results transfer and quality control to optimize the utilization diagnostic tests including CD4 counts, DNA PCR for Early Infant Diagnosis, viral load, and resistance testing.

Community activities will be strengthened to meet the needs of adolescents including support groups to enhance disclosure, adherence messaging, defaulter training, PwP, provision of reproductive health services, substance abuse counseling, support for transitioning into adult service, and teaching life skills. Linkages of children to various community programs including OVCs, education, and legal and social services will be provided.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	260,000	0

Narrative:

The University of Nairobi (UON) in collaboration with their co-partner, University of Maryland through the Department of Medical Microbiology, Kenya AIDS Vaccine initiative (KAVI) Laboratory will support the national laboratory accreditation initiative through WHO–Stepwise process by giving on-site mentorship and training in Good Clinical Laboratory Practice (GCLP) and Laboratory Quality Management Systems (LQMS) in accordance with SLMTA task-based training principles to three Ministry of Health laboratories – National HIV Reference laboratory (NHRL), Mbagathi DH. Such training will be designed to impact all the staff at the two labs without taking them away from their routine work. Both MOH and CDC have resolved to steer away from hotel trainings

for technical personnel. Specifically, KAVI staff experienced in laboratory quality systems will work shoulder-shoulder with MOH laboratory quality officers and managers to implement ISO 15189 standards at each laboratory. Regular internal audits based on the WHO step-wise accreditation checklist will be conducted and corrective measures supported. UON-KAVI will also support preparations for external audits towards accreditation. To support facility based improvement projects AGHPF will procure stationery items and minor essential laboratory supplies such as thermometers, timers, safety boxes, diamond pencils, signage and safety devices.

Through this cooperative agreement UON- KAVI lab will give expert technical assistance to MOH, National AIDS and STD Control Program (NASCOP) and NHRL in matters related to testing for HIV diagnosis and management. This will include evidence based selection of test kits, kit evaluation, post-market surveillance, determination of testing algorithms, equipment/method validation and use of program data for decision making. This efforts will enable Kenya to successfully implement the ten steps for quality of rapid HIV/Tb/malaria testing as prescribed by CDC; Internal DGHA laboratory.

In line with GHI principles improved laboratory systems will benefit all testing areas including TB, malaria, HIV related opportunistic infections and neglected tropical diseases. These activities are in line with the Kenya/USG partnership framework which seeks to enhance laboratory quality systems. Additionally this activity strengthens local organizations and fosters sustainability and country ownership.

This cooperative agreement will be monitored by CDC Kenya through regular quarterly meeting to review progress on the work plan, compliance to the Notice of Award and USG regulations. MOH- National Laboratory Accreditation Committee guidelines will be followed to ensure country ownership and sustainability.

This activity, implemented by a local partner, will contribute directly to three accredited laboratories in Kenya and training of at least 60 health care workers. The exact cost of improving laboratory quality through the WHO Step-wise accreditation process and of running a quality HIV management laboratory support service are not yet known. This activity will provide critical information for more accurate forecasting, planning and budgeting for laboratory support for program activities. MOH laboratory managers will acquire skills in developing facility budgets and advocating for a fair share of resources both centrally and at facility level.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	389,236	0

Narrative:

Target population: UON -COE will support all HIV testing and counseling services at Kenyatta National Hospital located in Nairobi City. Target population will include all patients, their family members and caretakers who access out and in patient services in all the supported facilities.

HTC Approaches: The program will utilize provider initiated opt out approach and the services are offered within all out patient departments, TB clinics, FP, ANCs, special clinics, HIV clinics (targeting family members) and in patient departments. The counseling and testing is either done within the consultation rooms by trained clinicians

or in counseling rooms by lay counselors within the outpatient departments if space is available or at the laboratories.
Targets and achievements: In COP 2012, UON-COE will target to provide HTC services to a total of 79,000 persons of which 20% will be tested as couples and 10% will be children below the age of 15.
Testing algorithm: National algorithm is being used.
Referrals and linkages: In order to strengthen referrals, UON-COE will put in place several important strategies. They include: use of peer educators as patient escorts from one hospital department to the CC; same day enrollment of clients to CCC; use of an integrated defaulter tracing system for tracing patients who default on care or ART upon enrollment; introduction of documented referral system by use of the NASCOP referral booklet; use of mobile phones to follow up whether the client was actually enrolled.
Quality management: In order to improve and monitor quality of HTC services, UON-COE will put in place the following strategies: Training and continuing education of HTC providers; strict adherence to the standard operating procedures outlined in the national HTC guidelines; management of HIV rapid kits as per the guidelines; putting in place a functional QA systems as provided for in the national HTC guidelines; participation in EQA-proficiency testing and finally by conducting support supervisory visits.

Monitoring and evaluation: UON-COE will use all ministry of health' tools to capture HTC data, both for couples and individual patients. These include HTC lab Register and Monthly summary tool (MOH 711). MOH approved HTC lab registers will be introduced at all HIV testing points except PMTCT.

Promotional activities for HTC: All patients attending the supported facilities will be given health talks including the need for HIV counseling and testing and the importance of couple testing. Couples are given priority services. Sexual partners of HIV positive clients will be given individualized invitations though the index clients and available avenues for testing including individualized home testing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	184,798	0

Narrative:

UON COE implements comprehensive prevention, care and treatment programs in Nairobi province. In FY 2012/13, UON COE will expand HIV prevention services to include evidence based behavioral interventions (EBI) for specific target populations in clinical settings at comprehensive care center (CCC), TB and Maternal Child Health (MCH) clinics as part of HIV combination prevention programs. The EBI will include Positive Health and Dignity Prevention (PHDP) targeting adult male and female and adolescents living with HIV (PLHIV); and Sister to Sister EBI (S2S) targeting sexually active HIV negative women attending the MCH clinics.
PHDP is an ongoing 5-10min group and individual level intervention that targets PLHIV in clinical and community settings. This mechanism will support this intervention which constitutes of ART adherence counseling and support;

partner and family testing; provision of PEP to the discordant spouse; treatment for prevention once approved; safer pregnancy counseling and provision of modern contraception; sexual risk reduction counseling including reduction of sexual partners, alcohol counseling, promoting of consistent and correct condom use; STI screening and treatment and using meaningful involvement of people living with HIV/AIDS (MIPA). The efficacy of PHDP has been shown to be 68% in preventing transmission of HIV, and 96% in treatment for prevention.

S2S is a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use. Condoms are 80% effective in heterosexual relationships when used correctly and consistently.

UON COE will use HVOP funding to recruit and support appropriate peer educators/counselors to reinforce prevention messages delivered by health providers as a feasible model for task-shifting in the provision of PHDP in clinical settings, and specifically promote MIPA. It will support placement of 5 Peer Educators at the MCH, TB and CCC Clinics in hospitals, and 2 Peer educators at health centres and provide appropriate counseling space. One of the peer educators will do regular client home follow up to strengthen ART adherence.

Approximately 1.6 million Kenyans are PLHIV. The Kenya AIDS Indicator Survey 2007 showed 6% of couples to be in discordant relationships. Nairobi province HIV Prevalence is high (8.8%). UON COE will reach 2689 (60%) PLHIV in FY2012 and 6090 (70%) in FY 2013 with a minimum package of PHDP. It will implement S2S EBI on a pilot basis.

Quality assurance for EBIs will be promoted through appropriate training and certification of peer educators using approved national curricula, standard job-aids and guidelines and regular supervision.

UON COE will work with appropriate national Technical Working Groups (TWG) to support integration of HIV prevention into care and treatment programs in clinical settings. These programs will also be linked to other HIV community programs. PLHIV will be specifically linked to STI and FP services, as necessary, through patient escorts.

Monitoring of PHDP and S2S will be done through the review/input of UON COE implementation plan, analysis of KePMS data, quarterly reviews, semiannual and annual reports. Evaluation will be conducted through operation research of combination HIV prevention and periodic surveys (Kenya Demographic and health survey, Kenya Indicator AIDS Survey, Kenya Service Provision Assessment)

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	400,000	0

Narrative:

The University of Nairobi, Partnership for Advanced Care and Treatment, Centers of Excellence (COE) has been supporting PMTCT services as part of integrated, comprehensive HIV clinical services in Kenyatta National Hospital (KNH) and Pumwani Maternity Hospital in Nairobi Province since October 2010. Nairobi has an estimated 114,920 pregnancies per year and a HIV prevalence of 7%.

By June 2011, 6,866 (55% of annual target) pregnant women were tested and counseled for HIV of whom 461 were HIV positive, ARV prophylaxis given to 739 women in the ANCs and delivery units, and DNA-PCR tests were carried out for 673 infants of which 9 (1.6%) were positive among the 542 received. 63 HCW have been trained on PMTCT.

In FY12, COE will offer HIV counseling and testing to 11,415 pregnant women at ANC and give ARV prophylaxis to 1,008 HIV infected pregnant women. The HIV infected women will receive a CD4 test after undergoing WHO clinical staging. COE will give HAART to all eligible HIV positive pregnant women in line with the revised PMTCT national guidelines. In FY13, COE will increase the number of pregnant women counseled to 11,986, offer ARV prophylaxis to 1,225 pregnant women and 1,053 infants, and do EID for 1,053 infants.

COE will focus on 4 prongs of PMTCT: primary prevention; prevention of unwanted pregnancies; ARV prophylaxis to all HIV positive pregnant mothers and exposed infants; and care and treatment to eligible HIV positive mothers, partners, and children. The Minimum care package will include health and HIV education, individual/ family HIVCT, clinical/laboratory monitoring and assessment, OI screening and treatment, ARV prophylaxis and treatment for both mother and baby, nutritional support, psychosocial support, PWP, follow up, retention, and referral and linkages. COE will incorporate TB screening into routine antenatal care.

COE will reach 3,596 of 1st visit ANC attendees with couple CT to identify discordant and concordant couples to improve primary prevention and facilitate linkage to HIV care and treatment for the eligible. COE will support integration of ART in MCH clinics, access to FP/RH services, and establish or strengthen infection control and waste management activities. COE will support hospital delivery through provision of delivery beds and sterile delivery packs, training, working with CHWs and TBAs to promote community-facility referral mechanism, health education, and community services providing skilled birth attendance.

COE will adapt efficient retention strategies for mothers and babies by supporting use of diaries and registers for tracking defaulters, having a structured mentorship and supervision plan, enhancing data quality and streamlining M&E gaps including orientation of new MOH ANC/maternity registers, and utilization of data at facility level for program improvement and quarterly progress reports to CDC.

Program quality and proficiency testing will be emphasized to validate PMTCT results.
COE will train 100 HCWs in FY 12 and an equal number in FY13 on PMTCT and provide orientation to the revised PMTCT and infant feeding guidelines. COE will engage in community activities for demand creation for health services such as male involvement with couple CT services and referral and linkages.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	2,031,689	0

Narrative:

The University of Nairobi Partnership for Advanced Care and Treatment and Centers of Excellence (COE) will support treatment services at Kenyatta National Hospital (KNH). KNH is the national referral hospital in Kenya. COE has been supporting the development of sustainable technical leadership in HIV prevention, care and treatment in Nairobi province since October 2010 to ensure provision of evidence-based, high quality, comprehensive and integrated HIV services that meet national quality standards including adult care and treatment. As of March 2011 SAPR, 8,788 patients had been initiated on ART and 4,634 were active.

In FY12, COE will jointly work with the Ministry of Health (MoH) to continue supporting expansion and provision of quality adult HIV treatment services as per MoH guidelines to 6,300 patients currently receiving ART and 918 new adults resulting to cumulative 7,560 adults who have ever been initiated on ART. In FY13, this number will increase to 6,990 currently receiving ART and 929 new adults resulting to 8,489 adults who have ever been initiated on ART.

COE will support in-service training of 300 and 200 HCWs; continuous mentorship of trained health care workers on specialized treatment, including management of patients with ARV treatment failure and complicated drug adverse reactions; identify human resources and infrastructure gaps and support in line with MoH guidelines; and support good commodities management practices to ensure uninterrupted availability of commodities.

COE will support provision of a comprehensive package of services to all PLHIV including ART initiation for those eligible; laboratory monitoring including biannual CD4 testing, viral load testing for suspected treatment failure (through strengthened laboratory network); cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH; and improved OI diagnosis and treatment including TB screening, diagnosis, and treatment. Ongoing community interventions for PLHIV including peer education and use of support groups to provide adherence messaging and defaulter tracing and follow up will continue to be supported to improve retention in all sites. COE will do cohort analysis and report retention as required by MoH.
COE will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services, integrate them into routinely collected data, and use the results to evaluate and improve clinical outcomes. COE will also support strategies to ensure access and provision of friendly HIV treatment services to all including supporting peer educators, mentors, support groups, and supporting patients to disclose and bring their partners for testing and care and treatment.

COE will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, COE will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. COE will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management

in Kenya.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	200,000	0

Narrative:

The University of Nairobi, Partnership for Advanced Care and Treatment, Centers of Excellence (COE) has been supporting pediatric treatment in Kenyatta National Hospital (KNH) since October 2010. Nairobi province has an estimated population of 3.1 million people respectively with an estimated adult HIV prevalence of 8.8% compared to the national 7.1%. As of June 2011, 1,292 children (83% of annual targets) had been initiated on ART and 651 were active.

In FY12, COE will work with the Ministry of Health (MoH) at all levels to continue supporting, expanding and ensuring provision of quality pediatric HIV treatment services as per MoH guidelines to 1,109 pediatrics currently receiving ART and 222 new pediatrics resulting to cumulative 1,331 pediatrics ever initiated on ART. In FY 13, this number will increase to 1,256 pediatrics currently receiving ART and new 200 resulting to cumulative 1,531 pediatrics ever initiated on ART.

COE will support comprehensive pediatric ART services including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization; management of childhood illnesses; OI screening and diagnosis; WHO staging; ART eligibility assessment; laboratory monitoring including 6 monthly CD4, hematology and chemistry (through strengthening of lab networks); Pre-ART adherence and psychosocial counseling; initiation of ART as per MoH guidelines; Toxicity monitoring; treatment failure assessment through targeted viral load testing; and adherence strengthening. COE will support enhanced follow up and retention, EID as per MoH guidelines and PITC to all children and their care givers attending Child welfare clinics, family focused approach, community outreach efforts, and integration of HIV services in other MNCH services.

COE will support hospital and community activities to meet the needs of the HIV infected adolescents such as support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services, and support their transition into adult services.

COE will support in-service training of 300 and 200 HCWs in FY12 and 13 respectively as well as continuous mentorship and capacity building of trained health care workers on specialized pediatric treatment including management of ARV treatment failure and complicated drug adverse reactions; identify human resources and infrastructure gaps and support in line with MoH guidelines; and support good commodities management practices to ensure uninterrupted availability of commodities. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will additionally be optimized.

COE will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, COE will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. COE will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.

Implementing Mechanism Details

Mechanism ID: 12585	**Mechanism Name: Eastern Province**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Columbia University Mailman School of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 16,323,854	
Funding Source	**Funding Amount**
GHP-State	16,323,854

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Columbia University's International Centre for AIDS Care and Treatment (CU-ICAP) - Eastern supports implementation of high quality HIV prevention, care and treatment services in the southern districts of Eastern province. ICAP ensures availability of high quality, comprehensive HIV prevention, care and treatment services including PMTCT, TB/HIV, adult and pediatric HIV care and treatment and PITC. The projects goals are aligned with the GHI principles and include decentralization and integration of HIV services into existing clinics including maternal and child health and TB clinics. ICAP supports the national M&E system and will continue to build the capacity of Health Records Information Officers and also scale-up electronic medical records at facilities to allow for efficient reporting both to PEPFAR and NASCOP and support patient outcomes analysis to inform program improvement. Strategies to reduce cost will include support for government-led programs to avoid duplication,

decentralization of trainings to the districts, and support for an integrated district mentorship program in order to capacity build district teams to conduct mentorship and promote ownership and sustainability of the program.ICAP is building the capacity of local NGOs as a strategy for transitioning the program. ICAP supports the Provincial and District Health Management Teams and carries out joint planning to promote ownership and sustainability. ICAP has procured 3 vehicles between FY 08-11. ICAP wishes to purchase an additional vehicle for transportation of program officers and supplies to supported facilities since the program has expanded to new regions. This activity supports GHI/LLC

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	163,239
Gender: GBV	5,000
Gender: Gender Equality	12,000
Human Resources for Health	7,706,201
Motor Vehicles: Purchased	325,638
Renovation	938,768

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**12585**
Mechanism Name:	**Eastern Province**
Prime Partner Name:	**Columbia University Mailman School of Public Health**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	1,800,000	0

Narrative:

Columbia University's International Centre for AIDS Care and Treatment (CU/ICAP) supports adult HIV care in 58 facilities in the southern region of the Eastern Province of Kenya. As of March 2011 SAPR, CU/ICAP had cumulatively enrolled 53,967 patients into care with 30,743 active at end of the period.

CU/ICAP will work with the Ministry of Health (MoH) at the provincial, district and health facilities levels, to jointly plan, coordinate, and implement quality HIV care and support to 36,091 current adult patients in FY12 and 41,680 patients in FY13.

CU/ICAP will offer comprehensive care and support package of services including: HIV testing to partners and family members of index patients and enrolling or referring/linking those that test HIV positive to care and support; provision of Basic Care Kit (safe water vessel, multivitamins, insecticide-treated mosquito nets, condoms, chlorine for water treatment and educational materials); therapeutic nutrition (FBP) to all enrolled HIV positive patients; prevention with positives(PwP), family planning and reproductive health services including cervical cancer screening to all enrolled women.

CU/ICAP in collaboration with MoH will support targeted capacity building (training and mentorship) for health care workers and offer continuous medical education on care and support, e.g. OI diagnosis and treatment. CU/ICAP will identify areas with staff shortages, support recruitment of additional staff, and support good commodities management practices to ensure uninterrupted supply of commodities. CU/ICAP will also support ongoing community interventions for HIV infected individuals including peer education and use of support groups to provide adherence messaging; effective and efficient defaulter tracing and follow up to improve retention in all facilities; referral and linkages to community based psychosocial support groups; water, sanitation, and hygiene programs; economic empowerment and income generating activities (IGAs); home based care services; gender based violence support programs; vocational training; social and legal protection; and food and nutrition and/or food security programs.

CU/ICAP will adopt strategies to ensure access and provision of friendly services to youth, elderly, and disabled populations. Strategies to increase access of care services by men will be employed, including supporting male peer

educators, mentors and support groups, and supporting women to disclose and bring their male partners for testing and care and treatment.

CU/ICAP will do a cohort analysis and report retention rates as required by NASCOP.
CU/ICAP will continue to strengthen data collection and reporting at all levels to improve reporting to National AIDS & STI Control Programme (NASCOP) and PEPFAR. CU/ICAP will adopt the new generation indicators and support the development and use of electronic medical records system in accordance with NASCOP guidelines. CU/ICAP will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV care and support services. Indicators will be integrated into routinely collected data and results used to evaluate and improve clinical outcomes. CU/ICAP will support joint Annual Operation Plan (AOP) development, implementation, monitoring and evaluation, and health system strengthening to facilitate sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	1,550,000	0

Narrative:

Columbia University's International Centre for AIDS Care and Treatment (CU/ICAP) will support TB/HIV services in southern region of Eastern Province which reported 12,446 TB patients in 2010. Over 12,000 TB patients received HIV testing and 3,720 TB/HIV co-infected patients were identified. 97% and 47% received cotrimoxazole prophylaxis and ART respectively.

In FY 2012 and 2013, CU/ICAP will intensify efforts to detect TB cases through clinical exams and laboratory investigations and ensure successful TB treatment through provision of appropriate treatment. CU/ICAP will ensure that each facility providing TB/HIV services has adequate and well trained clinical staff supported by well equipped and staffed laboratory, including sputum specimen transport where laboratory services are unavailable. CU/ICAP will ensure that adequate supplies of anti-TB drugs are available and that the national TB treatment guidelines are followed. All TB patients on treatment will be monitored both clinically and through periodic sputum examination.

To reduce the burden of HIV in TB patients, CU/ICAP will ensure that at least 95% of TB patients are screened for HIV and 95% TB-HIV co-infected patients are put on cotrimoxazole and ARVs as early as possible regardless of the CD4 count as per the national guidelines. CU/ICAP will support the "one stop" model that provides integrated TB and HIV services in all TB clinics. All TB clinics will be stocked with cotrimoxazole and ARVs. 150 HCW in FY12 and 100 in FY13 will be trained.

To reduce the burden of TB in HIV infected patients, CU/ICAP will support intensified TB screening for 32,081 in FY12 and 37,049 in FY13. HIV infected persons identified in their HIV care settings will be screened at each

clinical encounter using the national screening tool. 1,604 co-infected patients identified in FY12 and 1,852 co-infected patients identified in FY13 will be put on TB treatment and those without active TB will be provided with Isoniazid Preventive Therapy (IPT) as per national IPT protocol.

To strengthen TB infection control in HIV settings, CU/ICAP will ensure that the national IC guidelines are available at all sites and IC training of staff is done. CU/ICAP will support scaling up of at least 2 components of the national TB infection control strategy in HIV care settings, one of which will be fast tracking of patients with cough for expedited diagnostic work up and treatment.

To improve surveillance and management of drug-resistant TB, CU/ICAP will support timely transport of sputum specimens of TB retreatment cases from health facilities to the central reference laboratory for drug susceptibility testing and ensure return of results to the facilities. CU/ICAP will also support scaling up of drug-resistant treatment sites thus expanding access to MDRTB treatment.

CU/ICAP will also support expansion of prevention with positive (PwP) services in TB clinics, TB/HIV control activities in the prisons, strengthening linkages between facility and community-based services, and improving patient referrals and tracking systems. To strengthen HVTB program monitoring, CU/ICAP will support reporting of selected custom indicators to assist with program management and monitoring and evaluation of new activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	230,000	0

Narrative:

Columbia University's International Centre for AIDS Care and Treatment (CU/ICAP) supports pediatric HIV care in 58 facilities in southern Eastern Province of Kenya. By March 2011, CU/ICAP had 6,634 children enrolled in care with 5,113 receiving HIV care.

In FY 12 period, CU/ICAP will provide care and support services to 3,771 children currently on care. The number of children on care will increase to 4,434 in FY 13. CU/ICAP will provide comprehensive, integrated quality services and scale up to ensure 3,764 HIV infected infants are put on ARV prophylaxis and all HIV exposed children access pediatric care services.

The focus of pediatric care services will continue to be provision of comprehensive, integrated quality services including strengthening the use of the Mother-baby booklet, early infant diagnosis, universal provider initiated testing and counseling, and ensure those identified HIV infected are linked to care and ART services.

CU/ICAP will ensure children enrolled in care receive quality clinical care services, including clinical history and

physical examination; WHO staging, CD4 tests, and other basic tests; opportunistic infection diagnosis, prophylaxis and management; TB screening; pain and symptom relief and management; and psychosocial support. Additional key care services will include nutritional assessment, counseling and support based on the WHO and IYCF guidelines (including provision of therapeutic or supplementary feeding; support to children with growth faltering; and provision of vitamin A, zinc, and de-worming); provision of safe water, sanitation and hygiene interventions (WASH) in the community and in health facilities; and malaria screening, treatment and provision of long lasting insecticide treated nets in malaria endemic areas.

CU/ICAP will support integration of HIV services into routine child health care and survival services in the maternal child health department including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization guidelines; case management of diarrhea, pneumonia, and other childhood illnesses; and community outreach efforts. They will also support the care of the newborn by supporting hospital delivery and ensuring that there is provision for newborn resuscitation and care (thermal care, hygiene cord care) and prophylactic eye care. Exposed children management and follow up will continue to be supported and will include enrollment, HIV testing (PCR-DNA and antibody testing) as per the national guidelines, provision of Nevirapine throughout the breastfeeding period, follow up and retention, and linkages of those positive to care and ART services.

CU/ICAP will support hospital and community activities to support the needs of the HIV infected adolescents including support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, support for transitioning into adult services, and teaching life skills. Commodity access and infrastructure development will continue to be supported, including relevant trainings.

CU/ICAP will strengthen pediatric data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	889,510	0

Narrative:

The circumcision resources will support the Government of Kenya in ensuring provision of safe voluntary medical male circumcision (VMMC) services in Siaya District, which has low MC rates and high HIV prevalence. In particular, the funds will support implementation of VMMC for HIV prevention activities, in Health facilities and within community settings in Siaya District. VMMC for HIV prevention is a priority HIV intervention for both the Government of Kenya and US Government through PEPFAR, as both Governments and World Health organization (WHO) have recommended scale up of high quality voluntary and safe male circumcision services in Kenya as an added HIV prevention intervention in districts with low circumcision rates. CDC has been providing technical and

financial assistance for the scale up of VMMC services in Kenya since 2008, in support of the Kenya MOH strategy of circumcising 80% of uncircumcised males aged 15- 49 years by 2013. Through implementing partners, over 450,000 VMMCs for HIV prevention have been done in Kenya. Although a lot has been done, a significant proportion of uncircumcised males in need of VMMC remains in Siaya District. Continuity of VMMC services in Siaya district is critical in serving the many men in need. Having started providing VMMC services in Nov 2012, ICAP's work in ensuring VMMC services in Siaya are available, safe, of high quality and provided as a package of comprehensive HIV prevention, care and treatment will contribute to reduction of new HIV infections in Siaya District.

Specific activities by ICAP include support to the provision of VMMC services according to MOH guidelines. ICAP will continue to work closely with MOH structures in Nyanza Province and Siaya District in particular to expand access to VMMC services in all health facilities in Siaya District. ICAP teams will consider providing services and optimize delivery using a combination of facility-based and community based approaches, consistent with the national standards. ICAP will also work collaboratively with other VMMC stakeholders to avoid duplication, following national policies and guidelines on VMMC. Other activities include intensifying efforts to find and recruit men aged 15 years and above (who are most likely sexually active) and provide safe VMMC services to most of them within the shortest time possible, so as to result to greatest impact of preventing new HIV infections. ICAP in collaboration with HHS/CDC Kenya , MOH and other stakeholders will continue to develop and implement and support the Rapid Results Initiative that yields many men coming for circumcision in the months of November and December, ensuring that VMMC minimum package is provided (Opt out HTC, risk reduction counseling, promotion of consistent condom use, address male norms and behaviors that promote gender-sensitive and safer sexual behaviors), recruit and support VMMC teams to provide outreach and mobile VMMC services to increase access in remote areas, support the development of long-term sustainable and integrated VMMC capacity in health facilities, including the provision of neonatal VMMC services in PMTCT and MCH settings in line with developed MOH policy/guidelines, undertake advocacy, community sensitization and education to create informed demand for VMMC services, and closely collaborate with partners providing HIV CT to ensure linkage and referral of HIV negative males to VMMC services, Work with the relevant government ministry.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	43,167	0

Narrative:

Target population: ICAP Nyanza and Eastern supports HIV testing and counseling services in all health facilities in Siaya, Bondo, Rarieda and Nyando districts in Nyanza Province. Target population includes all patients, their families and caretakers who access out and in patient services at all the health facilities in the 4 districts.
HTC Approaches: The program utilizes provider initiated opt out approach and the services are offered within all out patient departments, TB clinics, VMMC clinics, FP, ANCs, special clinics, HIV clinics (targeting family

members) and in patient departments. The counseling and /or testing is either done within the consultation rooms by trained clinicians, or in counseling rooms by lay counselors within the outpatient departments if space is available or the in laboratories.
Targets and achievements: In COP 2013, ICAP Nyanza/Eastern will target to provide HTC services to a total of 133,000 persons of which 20% will be tested as couples and 10% will be children below the age of 15.
Testing algorithm: National algorithm is being used.
Referrals and linkages: In order to strengthen referrals, ICAP Nyanza has put in place several important strategies. They include: use of peer educators as patient escorts from one hospital department to the PSC; same day enrollment of clients to PSCs; use of an integrated defaulter tracing system for tracing patients who default on care or ART upon enrollment; use of the NASCOP referral booklets; use of mobile phones to follow up whether the client was actually enrolled.
Quality management: In order to improve and monitor quality of HTC services, ICAP Nyanza will put in place the following strategies: Training and continuing education of HTC providers; strict adherence to the standard operating procedures outlined in the national HTC guidelines; proper handling (storage and transportation) of HIV rapid kits as per the guidelines; putting in place a functional QA systems as provided for in the national HTC guidelines; participation in EQA- proficiency testing and finally conducting support supervisory visits.
Monitoring and evaluation: ICAP will use all ministry of health' tools to capture HTC data, both for couples and individual patients. These include HTC lab Register and Monthly summary tool (MOH 711 and MOH 731). MOH approved HTC lab registers have been introduced at all HIV testing points except PMTCT.
Promotional activities for HTC: All patients attending the supported facilities will be given health talks including the need for HIV counseling and testing and the importance of couple testing. Couples are given priority services. Sexual partners of HIV positive clients will be given individualized invitations though the index clients and available avenues for testing including individualized home testing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

ICAP implements comprehensive prevention, care and treatment programs in Eastern province. In FY 2012/13, ICAP will expand HIV prevention services to include evidence based behavioral interventions (EBIs) for specific target populations in clinical settings at comprehensive care center (CCC), TB and Maternal Child Health (MCH) clinics as part of HIV combination prevention programs. The EBIs will include Positive Health and Dignity Prevention (PHDP) targeting adult male and female and adolescents living with HIV (PLHIV); and Sister to Sister EBI (S2S) targeting sexually active HIV negative women attending the MCH clinics.

PHDP is an ongoing 5-10min group and individual level intervention that targets PLHIV in clinical and community settings. This mechanism will support this intervention which constitutes of ART adherence counseling and support;

partner and family testing; provision of PEP to the discordant spouse; treatment for prevention once approved; safer pregnancy counseling and provision of modern contraception; sexual risk reduction counseling including reduction of sexual partners, alcohol counseling, promoting of consistent and correct condom use; Sexually Transmitted Infections (STI) screening and treatment and using meaningful involvement of people living with HIV/AIDS (MIPA). The efficacy of PHDP has been shown to be 68% in preventing transmission of HIV, and 96% in treatment for prevention.

S2S is a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use. Condoms are 80% effective in heterosexual relationships when used correctly and consistently.

ICAP will use HVOP funding to recruit and support appropriate peer educators/counselors to reinforce prevention messages delivered by health providers as a feasible model for task-shifting in the provision of PHDP in clinical settings, and specifically promote MIPA. It will support placement of 5 Peer Educators at the MCH, TB and CCC Clinics in hospitals, and 2 Peer educators at health centres and provide appropriate counseling space. One of the peer educators will do regular client home follow up to strengthen ART adherence.

Approximately 1.6 million Kenyans are PLHIV. The Kenya AIDS Indicator Survey 2007 showed 6% of couples to be in discordant relationships. HIV prevalence in Eastern province is (4.6%).ICAP will reach 20330 (60%) PLHIV in FY2012 and 27437 (70%) in FY 2013 with a minimum package of PHDP. It will implement S2S EBI on a pilot basis.

Quality assurance for EBIs will be promoted through appropriate training and certification of peer educators using approved national curricula, standard job-aids and guidelines and regular supervision.

ICAP will work with appropriate national Technical Working Groups (TWG) to support integration of HIV prevention into care and treatment programs in clinical settings. These programs will also be linked to other HIV community programs. PLHIV will be specifically linked to STI and FP services, as necessary, through patient escorts.

Monitoring of PHDP and S2S will be done through the review/input of ICAP implementation plan, analysis of KePMS data, quarterly reviews, semiannual and annual reports. Evaluation will be conducted through operation research of combination HIV prevention and periodic surveys (Kenya Demographic and health survey, Kenya Indicator AIDS Survey, Kenya Service Provision Assessment)

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	2,700,000	0

Narrative:

Columbia University (CU/ICAP) will support implementation of PMTCT services in Eastern Province. Since January 2011, CU/ICAP has been implementing PMTCT services in 246 sites in southern Eastern Province with about 141,080 expected pregnancies annually and HIV prevalence of 4.1%. Between January and March 2011, CU/ICAP had tested 18,792and given ARV prophylaxis to 555 HIV positive pregnant women.

In FY12, CU/ICAP will offer HIV counseling and testing to 105,980 pregnant women at the ANC and give ARV prophylaxis to 3,604 HIV infected pregnant women. The HIV infected women will receive a CD4 test after undergoing a WHO clinical staging. CU/ICAP will give HAART to all eligible HIV positive pregnant women per the revised PMTCT national guidelines. In FY13, CU/ICAP will increase the number of pregnant women counseled to 111,279, offer ARV prophylaxis to 4,377 pregnant women and 3,765 infants, and do EID for 3,765 infants.

CU/ICAP will focus on 4 prongs of PMTCT: primary prevention; family planning; ARV prophylaxis to all HIV positive pregnant mothers and exposed infants; and care and treatment to eligible HIV positive mothers, partners, and children. The Minimum care package will include health and HIV education, individual/ family HIVCT, clinical/laboratory monitoring and assessment, OI screening and treatment, ARV prophylaxis and treatment for both mother and baby, nutritional support, psychosocial support, PWP, follow up, retention, and referral and linkages. CU/ICAP will also incorporate TB screening into routine antenatal care.

Efforts will be made to reach 33,384 of 1st visit ANC attendees with couple CT to identify discordant and concordant couples to improve primary prevention and facilitate linkage to HIV care and treatment for the eligible.

CU/ICAP will support integration of ART in MCH clinics, access to FP/RH services, and establish or strengthen infection control and waste management activities.

CU/ICAP will support hospital delivery through provision of delivery beds and sterile delivery packs, training, working with CHWs and TBAs to promote community- facility referral mechanism, health education, and community services providing skilled birth attendance.

CU/ICAP will support safe infant feeding practices as per national guidelines and support enrollment and follow up of 3,765 of babies born to HIV infected mothers to access CTX, ARV prophylaxis, and EID services using the HIV exposed infant register till 18 months. CU/ICAP will facilitate ART initiation for those who test positive before 2 years.

CU/ICAP will adopt efficient retention strategies for mothers and babies by supporting use of diaries and registers for tracking defaulters, having a structured mentorship and supervision plan, and enhancing data quality and streamlining M&E gaps. HCWs will be orientated on the new MOH ANC/maternity registers and data will be

utilized at facility level for program improvement and quarterly progress reports to CDC.

Program quality and proficiency testing will be emphasized to validate PMTCT results.
CU/ICAP will train 120 HCWs in FY12 and equal number in FY13 on PMTCT and provide orientation to the revised PMTCT and infant feeding guidelines. CU/ICAP will engage in community activities for demand creation for health services such as male involvement with couple CT services, referral and linkages.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	8,306,177	0

Narrative:

Columbia University's International Centre for AIDS Care and Treatment Program (ICAP) will support treatment in Eastern Province. Eastern Province has an estimated population of 3 million people with an estimated adult HIV prevalence of 4.2% compared to the national 7.1%. Since 2007, ICAP has supported HIV treatment in 58 facilities and as of March 2011 SAPR, a cumulative 29,737 patients were started ART with 16,990 active.

In FY12, ICAP will jointly work with MoH to continue supporting expansion and provision of quality adult HIV treatment services in the southern region of Eastern Province as per MoH guidelines to 18,749 patients currently receiving ART and 1,417 new adults resulting to cumulative 22,499 adults who have ever been initiated on ART. In FY13, this number will increase to 19,813 currently receiving ART and 1,433 new adults resulting to 23,932 adults who have ever been initiated on ART.

ICAP in collaboration with MoH will support in-service training of 200 and 150 health care workers in FY 12 and FY 13 respectively, identify human resources and infrastructure gaps and support in line with MoH guidelines, and support good commodities management practices to ensure uninterrupted availability of commodities.

ICAP will support provision of comprehensive package of services to all PLHIV including ART initiation for those eligible; laboratory monitoring including biannual CD4 testing and viral load testing for suspected treatment failure (through strengthened laboratory network); cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH; and improved OI diagnosis and treatment including TB screening, diagnosis and treatment. Ongoing community interventions for PLHIV including peer education and support groups to provide adherence messaging and defaulter tracing and follow up will continue to be supported to improve retention in all sites. ICAP will adopt strategies to ensure access and provision of friendly HIV treatment services including supporting peer educators, support groups, disclosure, partner testing and family focused care and treatment.

ICAP will continue to support ongoing community activities and support for HIV infected individuals including peer

education and use of support groups to strengthen adherence, effective and efficient retention strategies; referral and linkages to psychosocial support groups, economic empowerment projects, Home Based Care, and food and nutrition programs. ICAP will support provision of friendly services to youth and special populations.

ICAP will do cohort analysis and report retention as required by MoH and discuss the analysis results with facility staff in order to improve program performance. ICAP will adopt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services, integrate them into routinely collected data, use the results to evaluate and improve clinical outcomes, and support short term activities to increase impact and improve patient outcomes.

ICAP will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Use of an electronic medical records system will be supported and strengthened.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	805,000	0

Narrative:

Columbia University's International Centre for AIDS Care and Treatment (CU/ICAP) will support Pediatric treatment in Eastern Province. Eastern Province has an estimated population of 4.3 million people with an estimated adult HIV prevalence of 3.6% compared to the national 7.1%. CU/ICAP will support pediatric treatment services in 58 facilities in southern Eastern Province in the next two years. As of March 2011 SAPR, CU/ICAP had enrolled 6,634 patients on ART with 3,975 active on treatment.

In FY12, CU/ICAP will jointly work with the Ministry of Health (MoH) at all levels to continue supporting, expanding and ensuring provision of quality pediatric HIV treatment services as per MoH guidelines to 2,139 pediatrics currently receiving ART and 428 new pediatrics for a cumulative 2,567 pediatrics ever initiated on ART. In FY 13, an additional 385 pediatrics will be initiated on ART, for a total 2,223 pediatrics currently receiving ART, and a cumulative 2,952 pediatrics ever initiated on ART.

CU/ICAP will support comprehensive pediatric ART services including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization; management of childhood illnesses OI screening and diagnosis; WHO staging; ART eligibility assessment; laboratory monitoring including 6 monthly CD4, hematology and chemistry (through strengthening of lab networks); Pre-ART adherence and psychosocial counseling; initiation of ART as per MoH guidelines; Toxicity monitoring; treatment failure assessment through targeted viral load testing; Adherence strengthening; enhanced follow up and retention; support EID as per MoH guidelines and PITC to all children and their care givers attending Child welfare clinics; support family focused approach; community outreach efforts; and integration of HIV services in other MNCH services.

CU/ICAP will support hospital and community activities to support the needs of the HIV infected adolescents: support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services, and support their transition into adult services. *CU/ICAP will support in-service training of 150 and 100 HCWs in FY 12 and 13 respectively, continuous mentorship and capacity building of trained health care workers on specialized pediatric treatment including management of ARV treatment failure and complicated drug adverse reactions, identify human resources and infrastructure gaps and support in line with MoH guidelines, and support good commodities management practices to ensure uninterrupted availability of commodities. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will additionally be optimized.* *CU/ICAP will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, CU/ICAP will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. CU/ICAP will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.*

Implementing Mechanism Details

Mechanism ID: 12598	**Mechanism Name: HIV Prevention in the General Population and Youth**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: International Rescue Committee	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 990,120	
Funding Source	**Funding Amount**
GHP-State	990,120

Sub Partner Name(s)

(No data provided.)

Overview Narrative

1.Goals and objectives:

Project Goal: To reduce the number of new HIV infections through a combination HIV/AIDS prevention services for general populations and youth using evidence-based, cost-effective approaches in Turkana County of the Republic of Kenya. Project Objectives: i)Implement targeted interventions aimed at decreasing HIV risk behaviors and increasing protective behaviors among young people and the general population. ii)Increase access to confidential HIV testing and counseling services.2.Cost-efficiency strategy: In order to reduce costs, IRC will work with local partners, using local resources and structures and ensure that community participation remains a valued element in the project. In addition, IRC will use its existing operational structures with already established field offices and other existing long term health interventions in Turkana for integrated programming.3.Transition to country partners: IRC is working with two indigenous partners with an aim of building their capacity to be able to in future carry on with the activities. IRC is also working closely with the Government of Kenya to build its capacity at the regional level to be able to implement HIV prevention activities.4.Vehicle information: A total of three vehicles have bought in the previous and current mechanism. Two vehicles were bought under Cooperative Agreement number U62PS224875 in Year 1 (2005/06) and Year 3 (2007/08) and one vehicle under Co-Ag number U2GPS002866 in Year 1 (2010/11). All vehicles bought were field-oriented four wheel drives bought to facilitate mobile outreach program activities in the hard terrain and are all based in Turkana. This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	30,000
Motor Vehicles: Leased	38,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms

Budget Code Information

Mechanism ID:	12598		
Mechanism Name:	HIV Prevention in the General Population and Youth		
Prime Partner Name:	International Rescue Committee		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	120,000	0

Narrative:

IRC works exclusively in Turkana County targeting youth in and out of school with two HIV-prevention, abstinence and being faithful evidence-informed behavioral interventions (EBIs), Healthy Choices I (HC1) and Families! Program (FMP).

The two interventions are implemented in 7 administrative divisions of the Turkana County; Turkana Central, Loima, Kakuma, Lokichar, Kalokol, Lokichoggio. The population of adolescents in the county between the ages of 10 – 17 as per 2009 Census is estimated at 219,191. The targets to be reached will be 5000 throgh HCI and 5000 through FMP.

FMP is an evidence-based, parent-focused EBI for parents, guardians, and other primary caregivers (hereafter referred to as "parents") of preadolescents ages 9–12 years. Delivered in 5 weekly sessions to give parents time to internalize new information and practice skills, the program promotes positive parenting practices such as positive reinforcement and parental monitoring and effective parent-child communication on sexual topics and sexual risk reduction. The goal of FMP is to reduce sexual risk behavior among adolescents, including delaying onset of sexual debut, by training parents to deliver primary prevention messages to their children. More effective parental communication can help to delay their children's sexual behavior and increase protective behaviors as their children get older. The intervention also links parents to other critical evidence-based interventions including HTC and VMMC. Quality assurance of FMP is promoted through rigorous training and certification of facilitators, ongoing process monitoring with standardized tools, and quality assurance site visits by a CDC activity managers and technical experts.

HCI targets in-school youth aged 10-14 years and aims to delay sexual debut by providing knowledge and skills to negotiate abstinence, avoid negative peer pressure, avoid or handle risky situations and to improve communication with a trusted adult. HC I consists of 8 modules of approximately one hour each. It can be delivered in 4 sessions of 2 hours each or in 8 sessions of 1 hour each. Quality assurance of HC is promoted through rigorous training and certification of facilitators, ongoing process monitoring with standardized tools, and quality assurance site visits by a capacity building agency.

For further quality assurance, IRC has put in place for all sites the following: use of approved national curricula;

emphasis of importance of fidelity to the respective curricula; use of trained and certified pair of gender balanced facilitators; trainings on EBIs are conducted by certified national trainers; observed practice of implementation is done soon after training; use of standardized, national data tools at every stage of EBI implementation; and regular field visits by trained program staff to check on delivery of EBIs and offer support supervision.

The proposed activities and EBIs are guided by the goal and objectives of the project. Targets for each of the interventions are laid out at the start of the project year which is tracked on a monthly basis through respective field reports. Results are analyzed on a quarterly basis. The targets are in line with the PEPFAR NGI's. Monitoring and evaluation will be conducted with EBI approved data capture / monitoring tools. Field staff will send reports on a monthly basis; these reports will be compiled into an overall report quarterly which will be submitted to CDC.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	597,445	0

Narrative:

Target population: IRC targets to provide HIV testing and counseling services to youth and general population residing in Turkana County. Currently, IRC is working in four (4) Districts in Turkana County. These are: Turkana Central District (Lodwar and Kalokol), Loima District (Turkwel and Loima), Turkana West District (Kakuma, Lokichoggio and Oropoi) and Turkana South (Lokichar). HIV prevalence in Turkana county is estimated to be 6.7% in rural areas and 8 -14% in Urban areas. HTC
Approaches: Main approaches are home based HTC and Static HTC.
Targets and achievements: In the past one year, IRC had a target to test a total 20,000 but they managed to test 21,095 (105%). There were no HTC trainings. For COP 2012, IRC will target to provide HTC services to 64,000 persons of which 20% will be tested as couples, and 10% will be children below the age of 15.

Testing algorithm: National testing algorithm is used.

Referrals and linkages: At point of testing, detailed contact details of client are obtained to enable easy follow up. Use of new MOH 362 HTC register also captures name of client enabling easy follow up. In addition, clients are counseled on their positive result extensively and made to understand the need to seek early treatment, care and support. Referral is then given to local preferred facility for care and treatment and recorded using MOH Community Referral form. Beginning July 2011, monthly reports are prepared on tracking of referral of HIV positive persons by the counselors using the referral tracking form developed by IRC. Strong linkages exist between HTC counselors with the health facilities in catchment areas. PWP facilitators and the health center are notified by HTC counselors on a new HIV Positive person identified and advised to follow-up the cases through visitation to the client. For proper monitoring of the referrals, field visitation of client by counselors, monthly reporting on status of referral, cross checking data from health centers. Beginning July 2011, monthly reports are prepared on

tracking of referral of HIV positive persons by the counselors using the referral tracking form developed by IRC. Data obtained from the form is used for continuous follow-up on clients not linked to care & treatment.
Quality management: Activities for quality assurance in both testing and counseling include: use of qualified counselors applying core principles of HTC; obtaining kits from approved and nationally recognized health centers; ensuring the proper and hygienic storage of kits and other cold chain commodities; application of nationally approved algorithm; proper data capture and management using approved and standardized MOH tools; conduction of client exit interviews as well as administration of provider self assessment; field supervision by MOH officials and POA project team; implementation of monthly counselor support supervision; Proficiency testing & Dry Blood sample (DBS) collection for EQA.
Monitoring and evaluation: IRC uses all ministry of health' tools to capture HTC data, both for couples and individual patients. These include HTC lab Register and Monthly summary tool (MOH 711). MOH approved HTC lab registers have been introduced at all HIV testing points except PMTCT.
Promotional activities for HTC: Community awareness and demand creation facilitated by community health workers/promoters ; Mass media campaigns (HTC video screening, IEC materials) targeting the general population.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	272,675	0

Narrative:

IRC works exclusively in Turkana County implementing evidence-informed behavioral interventions (EBIs; see below) with the following priority populations: youth 15-19 (119,187), people living with HIV/AIDS (Positive Health and Dignity Prevention; PHDP) (~5,307); sero-discordant couples (~6,000), males 20-24 (43,110), females 20-24 (37,149), males 30-44 (53,459), persons with STIs (~4,804), and female sex workers (get number from Mercy). EBIs will be implemented in 7 administrative divisions of the Turkana County; Turkana Central, Loima, Kakuma, Lokichar, Kalokol, Lokichoggio. All EBIs are linked to other HIV services such as HIV testing and counseling, provision of condoms, care and treatment.

HCII targets both in and out of school youth aged 13 – 17 years and aims to delay sexual debut, promote secondary abstinence or have protected sexual intercourse, by providing knowledge and skills on correct and consistent condom use, handling peer pressure, and learning one's HIV status. HC II consists of 8 modules of approximately one hour each. It can be delivered in 4 sessions of 2 hours each or in 8 sessions of 1 hour each. Quality assurance of HC II is promoted through rigorous training and certification of facilitators, ongoing process monitoring with standardized tools, and quality assurance site visits by a capacity building agency.

Prevention with Positives is an ongoing 5-10min group and individual level intervention that targets HIV infected persons in clinical and community settings, focusing on partner testing, risk reduction, condom use, disclosure,

adherence, STI reduction and family planning.

RESPECT will be implemented along with HTC and provision of condoms for males and females ages 20 – 24, males ages 30 -44, and persons with STIs. Respect has 2 brief individual sessions targeting general population and youth, originally for heterosexual negative persons. It focuses on reduction of STDs/HIV, risk reduction, condom use and clients understanding of personal risk.

Comprehensive HIV prevention interventions will be implemented for female sex workers. These interventions will include Sister to Sister, a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use.

For further quality assurance, IRC has put in place for all sites the following: use of approved national curricula; emphasis of importance of fidelity to the respective curricula; use of trained and certified pair of gender balanced facilitators; trainings on EBIs are conducted by certified national trainers; observed practice of implementation is done soon after training; use of standardized, national data tools at every stage of EBI implementation; and regular field visits by trained program staff to check on delivery of EBIs and offer support supervision.

The proposed activities and EBIs are guided by the goal and objectives of the project. Targets for each of the interventions are laid out at the start of the project year which is tracked on a monthly basis through respective field reports. Results are analyzed on a quarterly basis. The targets are in line with the PEPFAR Next Generation Indicators (NGI's). Monitoring and evaluation will be conducted with EBI approved data capture / monitoring tools. Field staff will send reports on a monthly basis; these reports will be compiled into an overall report quarterly which will be submitted to CDC.

Implementing Mechanism Details

Mechanism ID: 12605	**Mechanism Name: Clinical Services**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Care International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 4,537,159	
Funding Source	**Funding Amount**
GHP-State	4,537,159

Sub Partner Name(s)

Merlin		

Overview Narrative

CARE International (CI) supports the Ministry of Health (MOH) in implementing HIV activities in 6 districts of Nyanza province namely: Kisii Central & South, Marani, Gucha South, and Nyamira North & South. They will support provision of high quality, comprehensive HIV prevention, care and treatment services including PMTCT, adult and pediatric HIV care and treatment, and TB/HIV. They will also strengthen the capacity of the MOH and indigenous institutions in line with the GHI principles. CI will support decentralization as well as integration of HIV services into existing clinics including MCH and TB clinics.

To increase cost efficiency, CI will continue to work with the MOH through a sub-grant and jointly prepare work plans with the DHMT and PHMT to avoid duplication of services. Integration of services into MOH service delivery systems will be strengthened.

CI has adopted strategies to transition programs to government and strengthens systems through integration of HIV services and referrals. Additionally, they will support staff training, improvement of data management and setting up Electronic Medical Records. CI will support development of harmonized program structures for community-facility linkages and reporting.

The program coverage will be decentralized to more facilities, to improve access to HIV services. Two vehicles will be required to support the additional transport logistics. The program is in the process of procuring 5 vehicles using FY10 funding and had 1 vehicle carried forward from their previous cooperative agreement with CDC. This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	45,372
Gender: GBV	6,000

Gender: Gender Equality	12,000
Human Resources for Health	2,246,330
Renovation	305,161

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**12605**		
Mechanism Name:	**Clinical Services**		
Prime Partner Name:	**Care International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	300,000	0

Narrative:

CARE International (CI) has been supporting comprehensive adult care and support services in 37 public health facilities in Nyanza province since April 2011.

In FY12/13 they will continue to support comprehensive clinical services in the current 37 sites and scale up services to new sites.

CI will work with the Ministry of Health (MoH) at Provincial and District levels to jointly plan, coordinate,

implement and ensure provision of quality HIV care and support services to 10,321 and 11,911 patients in FY 12 and FY13, respectively.

They will offer comprehensive care and support package of services including HIV testing to the partner and family members of index patient and enrolling or referring those that test HIV positive to care and support; provision of Basic Care Kit with safe water vessel, multivitamins, insecticide-treated mosquito nets, condoms, chlorine for water treatment and educational materials; Food By Prescription (FBP) to all enrolled HIV positive patients; prevention with positives (PwP); and cervical cancer screening to all enrolled women.

CI will collaborate with the MoH to support targeted capacity building (training and mentorship) for health care workers and offer continuous medical education on care and support, such as OI diagnosis and treatment. CI will identify areas with staff shortages, support recruitment of additional staff, and support good commodities management practices to ensure uninterrupted supply of commodities.

CI will continue to support ongoing psychosocial and community activities including peer education; referral and linkages to community based psychosocial support groups to strengthen adherence; effective and efficient retention strategies of patients on follow up; water, sanitation and hygiene programs; income generating activities; Home Based Care; vocational training; social and legal protection; and food and nutrition programs. CI will adopt strategies to ensure access to friendly services for youth, elderly and physically or mentally challenged populations.

Strategies to increase access of care services by men will be employed such as supporting male peer educators, mentors and support groups, and supporting women to disclose and bring their male partners for testing and care and treatment.

CI will strengthen data collection and reporting at all levels to improve reporting to NASCOP and PEPFAR. The New Generation Indicators will be adopted and the development and use of electronic medical records system in accordance with NASCOP's guidelines will be supported. CIwill adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV care and support services and integrate them into routinely collected data. The results will be used to evaluate and improve clinical outcomes.

CI will support formulation and implementation of MOH-coordinated District Annual Operation Plans (AOP) within which health systems will be strengthened to facilitate sustainability. The partner will also support establishment of a strong M&E system.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	250,000	0

Narrative:

CARE International has been supporting integration of TB/HIV services, hiring of additional staff and commodity support in 37 sites in Kisii Central, Marani, Gucha South and Kisii South Districts since April 2011. CARE International is implementing the first of a 5 year co-operative agreement with CDC and will continue to support TB/HIV services in the current 37 sites and scale up services to additional 12 sites.

In FY12 and 13, CARE International will support the Ministry of Health (MoH) Provincial and District Health Management Teams to plan, coordinate, and implement quality comprehensive collaborative TB/HIV services prioritized in Kenya's 5-Year National AIDS and TB Strategic Plans. Efforts to detect TB cases and ensure delivery of appropriate treatment will be intensified.

To reduce the HIV burden for TB patients, routine HIV screening for all TB patients will be supported, and efforts to ensure at least 95% TB-HIV co-infected patients are provided with comprehensive HIV care and treatment services in line with MoH guidelines will be optimized.

To reduce the burden of TB in HIV infected patients, support of intensified TB screening will continue, for 9,174 in FY12 and 10,588 in FY13, patients in HIV care settings and put 459 and 529 patients on TB treatment respectively. Patients without active TB will be put on isoniazid preventive therapy (IPT) according to the national protocol. To strengthen TB infection control (IC) in HIV settings, national IC guidelines will be made available and implemented including expedited diagnosis of patients with a cough and staff training on infection control.

To improve diagnosis, surveillance and management of both new and drug-resistant TB, CARE International will support a sputum network to facilitate timely shipment of specimens from health facilities to testing centres within the districts and to the central reference laboratory for drug susceptibility testing for TB retreatment cases and ensure return of results. Additional support will be provided for the ambulatory model of DR-TB treatment in Nyanza South by providing additional support to Kisii Level 5 hospital.

CARE International will continue to strengthen overall TB/HIV data management to ensure data of high quality are summarized and reported quarterly using custom MOH and new generation PEPFAR indicators. The partner will also support the development and use of electronic medical records system in accordance with MoH guidelines, and adapt cohort analysis and quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV care and support services. Indicators will be integrated into routinely collected data and use the results to evaluate and improve program activities. Finally, CARE International will support appropriate operations research designed to strengthen program performance.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	50,000	0

Narrative:

CARE International has been supporting comprehensive pediatric care and support services in 37 public health facilities in Kisii Central, Marani, Gucha South and Kisii South Districts in Nyanza Province. The partner is implementing the first year activities of a 5 year co-operative agreement with CDC and will continue to support comprehensive clinical services in the current 37 sites and scale up services to 12 new sites.

In FY 12, CARE International will continue to provide care and support services to 1,079 children currently on care and increase to a cumulative total of 1,267 children in FY 13. The focus of pediatric care services will continue to be provision of comprehensive, integrated quality services including strengthening the use of the Mother-baby booklet, early infant diagnosis, universal provider initiated testing and counseling, and linking those testing HIV positive to care and treatment services.

The program will be strengthened to ensure children enrolled in care receive quality clinical care services, including clinical evaluation; WHO staging; CD4 and other basic tests; opportunistic infection diagnosis, prophylaxis, and management; TB screening; pain and symptom relief and management; and psychosocial support. Additional services will include nutritional assessment, counseling and support based on the WHO and IYCF guidelines (including provision of therapeutic or supplementary feeding, support to children with growth faltering, provision of vitamin A, zinc, and de-worming); provision of safe water, sanitation and hygiene interventions (WASH) in the community and in health facilities; and malaria screening, treatment and provision of long lasting insecticide treated nets in malaria endemic areas.

CARE International will support integration of HIV services into routine child health and survival services in the maternal child health department, including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization guidelines; case management of diarrhea, pneumonia, and other childhood illnesses; and community outreach efforts. CARE International will also support the care of the newborn by supporting hospital delivery and provision of newborn resuscitation and care (thermal care, hygiene cord care, and prophylactic eye care). HIV exposed children management and follow up will continue to be supported, including enrollment, HIV testing (PCR-DNA and antibody testing) per the national guidelines, provision of Nevirapine throughout the breastfeeding period, follow up and retention, and linkages of positive children to care and ART service. Hospital and community activities will be strengthened to support the needs of the HIV infected adolescents: support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, support for transitioning into adult services, and teaching life skills.

Commodity access and infrastructure development will continue to be supported. Relevant trainings will continue to be supported. CARE International will strengthen pediatric data collection and reporting at all levels to increase and improve reporting to NASCOP/PEPFAR and conduct cohort analysis to inform programming.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVCT	225,387	0

Narrative:

The goal of the country as reflected in Kenya National Aids strategic plan (KNASP III) is to reach 80% knowledge of HIV status in the country by 2013. Nyanza Province, which has a population of about 5.1 million people, carries the highest HIV burden in Kenya. With an estimated adult HIV prevalence of 14.9% compared to the national 7.1%, ~500,000 people are living with HIV.

CARE – Clinical services supports direct implementation of comprehensive prevention, care and treatment activities in four districts in Nyanza Province that include: Kisii Central, Kisii South, Gucha South and Nyamira Districts. It covers several program areas and activities that include HIV Testing and Counseling in health care settings. The overall goal of this mechanism is to increase use of high quality, comprehensive HIV services in four districts of Nyanza Province, Kenya.

In FY 10, CARE supported Provider Initiated Testing and Counseling services in the four districts with emphasis in the Outpatient department, Inpatient and Child welfare Clinics. Between October 2010 and June 2011, a total of 57,732 people were offered comprehensive HTC services. A total of 2,578 (4.5%) individuals were identified as HIV infected and were linked to care and treatment services.

Guided by gaps identified in KAIS, KDHS 2009 and program data, CARE will continue to support HTC service implementation in the four districts with specific area of focus being facility-based Provider Initiated Testing and Counseling (PITC) approach. CARE will work with the Ministry of Health (MOH) at the county, District and health facility levels to jointly plan, coordinate and implement HTC services for both adults and children in support of the KNASP III and the District and Provincial level MOH annual operation plans.

CARE will target clients at the out-patient, in-patient and child welfare clinics with emphasis on enhancing diagnosis of HIV status among individuals with unknown HIV infection status, enhanced knowledge of HIV status with emphasis of identifying HIV infected individuals and HIV sero-discordant couples and strengthened linkage to appropriate HIV prevention, care and treatment services. CARE will target a total of 110,000 individuals with HTC of whom 10% will be pediatrics. These will contribute 1.7% of the national targets which aims at increasing knowledge of HIV status to at least 80% of the Kenyan adult population. These targets have been sub-divided to county and district level targets to guide implementation and program monitoring.

CARE will work to identify areas with training and mentorship needs, staff shortages and support appropriately through a MOH driven mechanism which ensures ownership and program sustainability.

All HIV-infected persons will be linked to care, treatment and other HIV prevention services at the facility and community level. Referrals will be strengthened by working together with SI team in implementing an effective referral strategy. HIV-negative individuals will be referred to PEPFAR supported prevention services. CARE will strengthen the WHO recommended multistep approach to Quality Assurance in counseling and testing. QA audit teams will be strengthened at the counties. CARE will continue to strengthen data collection, analysis, utilization and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVOP	0	0

Narrative:

CARE implements comprehensive prevention, care and treatment programs in Nyanza province. In FY 2012/13, CARE will expand HIV prevention services to include evidence based behavioral interventions (EBIs) for specific target populations in clinical settings at comprehensive care center (CCC), TB and Maternal Child Health (MCH) clinics as part of HIV combination prevention programs. The EBIs will include Positive Health and Dignity Prevention (PHDP) targeting adult male and female and adolescents living with HIV (PLHIV); and Sister to Sister EBI (S2S) targeting sexually active HIV negative women attending the MCH clinics.

PHDP is an ongoing 5-10min group and individual level intervention that targets PLHIV in clinical and community settings. This mechanism will support this intervention which constitutes of ART adherence counseling and support; partner and family testing; provision of PEP to the discordant spouse; treatment for prevention once approved; safer pregnancy counseling and provision of modern contraception; sexual risk reduction counseling including reduction of sexual partners, alcohol counseling, promoting of consistent and correct condom use; Sexually Transmitted Infections (STI) screening and treatment and using meaningful involvement of people living with HIV/AIDS (MIPA). The efficacy of PHDP has been shown to be 68% in preventing transmission of HIV, and 96% in treatment for prevention.

S2S is a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use. Condoms are 80% effective in heterosexual relationships when used correctly and consistently.

CARE will use HVOP funding to recruit and support appropriate peer educators/counselors to reinforce prevention messages delivered by health providers as a feasible model for task-shifting in the provision of PHDP in clinical settings, and specifically promote MIPA. It will support placement of 5 Peer Educators at the MCH, TB and CCC Clinics in hospitals, and 2 Peer educators at health centers and provide appropriate counseling space. One of the peer educators will do regular client home follow up to strengthen ART adherence.

Approximately 1.6 million Kenyans are PLHIV. The Kenya AIDS Indicator Survey 2007 showed 6% of couples to be in discordant relationships. Nyanza province has the highest HIV Prevalence (14.9%). CARE will reach 5814 (60%) PLHIV in FY2012 and 7841 (70%) in FY 2013 with a minimum package of PHDP. It will implement S2S EBI on a pilot basis.

Quality assurance for EBIs will be promoted through appropriate training and certification of peer educators using approved national curricula, standard job-aids and guidelines and regular supervision.

CARE will work with appropriate national Technical Working Groups (TWG) to support integration of HIV

prevention into care and treatment programs in clinical settings. These programs will also be linked to other HIV community programs. PLHIV will be specifically linked to STI and FP services, as necessary, through patient escorts.

Monitoring of PHDP and S2S will be done through the review/input of CARE implementation plan, analysis of KePMS data, quarterly reviews, semiannual and annual reports. Evaluation will be conducted through operation research of combination HIV prevention and periodic surveys (Kenya Demographic and health survey, Kenya Indicator AIDS Survey, Kenya Service Provision Assessment).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,252,243	0

Narrative:

CARE International (CI) has been supporting PMTCT services in 80 facilities in Kisii, Central, Kisii South, Marani, Gucha South, Nyamira North and Nyamira South Districts in Nyanza Province since 2010. As of March 2011 (SAPR), these districts had counseled and tested 13,807 pregnant women, provided ARV prophylaxis to 641 HIV positive pregnant women, provided ARVs prophylaxis to 300 infants, supported early infant diagnosis and follow up of HIV exposed infants, provided nutritional supplements to eligible pregnant women, and trained 416 HCWs on PMTCT revised guidelines.

In FY12, CI will support provision of HIV counseling and testing to 45,706 pregnant women at the ANCs and ARV prophylaxis to 2,306 HIV infected pregnant women. The HIV infected women will receive a CD4 test after undergoing WHO clinical staging and provision of HAART to all eligible HIV positive pregnant women according to revised PMTCT national guidelines will be supported. In FY13 CI will supported an increase in the number of pregnant women counseled and tested for HIV to 47,991, offer ARV prophylaxis to 2,801 pregnant women and 2,409 infants, and provide EID for 2,409 infants.

CI will focus on the 4 prongs of PMTCT: primary prevention; family planning, ARV prophylaxis to all HIV positive pregnant mothers and exposed infants, and care and treatment to eligible HIV positive mothers, partners and children. The minimum care package will include health and HIV education, individual/family HIVCT, clinical/laboratory monitoring and assessment, OI screening and/or treatment, TB screening, ARV prophylaxis and treatment for both mother and baby, nutritional support, psychosocial support, PWP, follow up, retention, referral, and linkages.

A total of 14,397 of 1st visit ANC attendees will be reached with couple CT to identify discordant and concordant couples to improve primary prevention and facilitate linkage to HIV care and treatment for the eligible. CI will support integration of ART in MCH clinics, access to FP/RH services, and establish or strengthen infection control

and waste management activities.

Hospital delivery will be supported through provision of delivery beds and sterile delivery packs, training, working with CHWs and TBAs to promote community-facility referral mechanisms, health education, and community services providing skilled birth attendance.

CI will support safe infant feeding practices as per national guidelines; enrollment and follow up of 2,409 of babies born to HIV infected mothers to access CTX, ARV prophylaxis, and EID services using the HIV exposed infant register to 18 months. ART initiation for those who test positive before 2 years will be facilitated.

CI will adopt efficient retention strategies for mothers and babies by supporting use of diaries and registers for tracking defaulters and having a structured mentorship and supervision plan. Training of 100 HCWs in FY12 and equal number FY13 will be supported. Enhancing data quality and streamlining M&E gaps will continue, including orientation of new MOH ANC/maternity registers and utility of data at facility level for program improvement and quarterly progress reports to CDC.

Program quality and proficiency testing will be emphasized to validate PMTCT results.
CI will support orientation of health care workers on the revised PMTCT and infant feeding guidelines and engage the community in activities for demand creation for health services such as male involvement with

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	2,309,529	0

Narrative:

Care International (CI) has been supporting comprehensive adult HIV treatment services since 2011 in government health facilities in Kisii Central, Marani, Gucha South and Kisii South Districts.

In FY12, CI will jointly work with the Ministries of Health (MoH) at all levels to continue supporting, expanding and ensuring provision of quality adult HIV treatment services as per MoH guidelines to 9,249 adults receiving ART and 2,257 new adults resulting to cumulative 11,099 adults ever initiated on ART.
In FY 13, this number will increase to 10,944 adults receiving ART and 2,283 new adults for a cumulative 13,382 adults ever initiated on ART.

CI will support in-service training of 50 and 40 HCWs in FY 12 and FY 13 respectively, support continuous mentorship and capacity building of trained HCWs, identify human resources and infrastructure gaps and support in line with MoH guidelines, and support good commodities management practices to ensure uninterrupted availability of commodities.

CI will support provision of a comprehensive package of services to all PLHIV including ART initiation for those eligible; laboratory monitoring including biannual CD4 testing and viral load testing for suspected treatment failure (through strengthened laboratory networks); cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH; improved OI diagnosis and treatment including TB screening, diagnosis, and treatment.

Support for ongoing community activities and for PLHIV will continue, including strengthened peer education and support groups to improve adherence, effective and efficient retention strategies, referral and linkages to psychosocial support groups, economic empowerment projects, Home Based care, and food and nutrition programs. Provision of friendly services to youth and special populations will be supported. Additionally,
CI will do cohort analysis and report retention rates as required by the national program and discuss the analysis results with facility staff in order to improve program performance
CI will adopt quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services and integrate them into routinely collected data. The results will be used to evaluate and support short term activities to increase impact and improve clinical outcomes.
CI will adopt strategies to ensure access and provision of friendly HIV treatment services to all including peer educators, support groups, partner testing and family focused care and treatment. CI will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Use of an electronic medical record system will be supported and strengthened.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	150,000	0

Narrative:

CARE International (CI) has been supporting comprehensive pediatric treatment services in public health facilities in Kisii Central, Marani, Gucha South and Kisii South districts since 2011.

In FY12, CI will jointly work with the Ministry of Health (MoH) at all levels to continue supporting, expanding and ensuring provision of quality pediatric HIV treatment services as per MoH guidelines to 949 patients currently receiving ART and 190 new ones resulting to a cumulative 1,139 patients ever initiated on ART.
In FY 13, this number will increase to 1,063 pediatric patients currently receiving ART and 171 new ones for a cumulative 1,310 pediatrics ever initiated on ART.

Provision of comprehensive pediatric ART services will be supported, including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization; management of childhood illnesses OI screening and diagnosis; WHO staging; ART eligibility assessment; laboratory monitoring including 6

monthly CD4, hematology and chemistry (through strengthening of lab networks); Pre-ART adherence and psychosocial counseling; initiation of ART as per MoH guidelines; Toxicity monitoring; treatment failure assessment through targeted viral load testing; Adherence strengthening; enhanced follow up and retention; support EID as per MoH guidelines and PITC to all children and their care givers attending Child welfare clinics; support family focused approach; and community outreach efforts and integration of HIV services in other MNCH services.

CI will support hospital and community activities to support the needs of HIV infected adolescents: support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services, and support their transition into adult services.

Support will be provided for in-service training of 100 and 80 HCWs in FY 12 and 13 respectively, continuous mentorship and capacity building of trained health care workers on specialized pediatric treatment including management of ARV treatment failure and complicated drug adverse reactions, identification of human resources and infrastructure gaps and support in line with MoH guidelines, and support of good commodities management practices to ensure uninterrupted availability of commodities. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will be optimized. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will be optimized.

CI will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, support will be given for data review and program evaluation to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. CI will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.

Implementing Mechanism Details

Mechanism ID: 12612	**Mechanism Name: HIVQUAL**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: New York AIDS Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	

G2G: No	Managing Agency:

Total Funding: 100,000	
Funding Source	**Funding Amount**
GHP-State	100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Goals/Objectives: This program seeks to systematically assess and improve the quality of care and treatment provided to PLWHA. Specific objectives are to:

• systematically improve the quality of HIV care provided at ART & PMTCT sites using continuous quality improvement methodologies;

• develop and implement facility-specific quality improvement measures to address identified weak areas;

• promote regular measurement of HIV performance data at the facility level and build capacity for sustainable quality improvement measures through human and systems infrastructure development; and

• build the capacity of the Kenya's MOH staff to lead national quality assessments and improvement activities.

Cost-efficiency strategy: HIVQual success has necessitated engagement of other USG partners to provide support for training of HCWs on HIVQual implementation in unsupported provinces.In FY11, Center for Health Solutions & EGPAF provided support for implementation in 2 new provinces. Entrenching HIVQual as part of routine M&E will yield wider participation & improve efficiencies.

Transition to country partners:NASCOP leads implementation and will coordinate, supervise, and entrench HIVQual activities into health facilities. In FY12, HIVQual will be rolled out to all district level facilities. All DHMTs from all regions will be trained to supervise & support HIVQual implementation. Nutrition & HIV, TB and health systems indicators will be incorporated. TA is provided by HEALTHQUAL and CDC. A NASCOP coordinator & data manager have been trained to support HIVQual rollout, supervision and engagement of new partners. A stakeholders TWG meets quarterly to guide HIVQual implementation & roll-out through support by USG IP & health facilities. This activity will support GHI/LLC.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	20,000

TBD Details

(No data provided.)

Key Issues

TB

Family Planning

Budget Code Information

Mechanism ID:	12612		
Mechanism Name:	HIVQUAL		
Prime Partner Name:	New York AIDS Institute		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	0	0

Narrative:

This program seeks to systematically assess and improve the quality of care and treatment provided to People Living with HIV/AIDS in Kenya.

Specific objectives are:

i.To systematically improve the quality of HIV care provided at ART and PMTCT sites using continuous quality improvement methodologies;

ii.To develop and implement facility-specific quality improvement measures to address identified weak areas;

iii.To promote regular measurement of HIV performance data at the facility level and build capacity for sustainable quality improvement measures through human and systems infrastructure development; and

iv.To build the capacity of the Kenya's Ministry of Health (MOH) staff to lead national quality assessments and improvement activities.

The objectives listed above will translate into activities that will lead into better utilization of data to support patients/clients management at facility level. Involvement of health care managers at District level to provide

support and supervision of HIVQual activities will enhance overall quality of care for patients living with HIV. Entrenching HIVQual as part of routine monitoring and evaluation will yield wider participation and improve efficiencies.

Through data abstraction process, weaknesses in data recording and filing systems will be identified hence leading to an overall improvement of data quality and electronic and manual data capture and reporting systems.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	100,000	0

Narrative:

This program seeks to systematically assess and improve the quality of care and treatment provided to People Living with HIV/AIDS in Kenya through supporting Kenya's Ministry of Health to develop a harmonized HIV quality improvement system.

Specific objectives are:
i. To build the capacity of the Kenya's Ministry of Health (MOH) staff to lead national quality and improvement activities.
ii. With the MOH, systematically review existing HIV quality improvement tools, indicators, and systems currently being used by facilities and implementing partners.
iii. With the MOH, develop a harmonized HIV quality tools, indicators, and system.
iv. With the MOH, disseminate the harmonized HIV quality improvement system to provincial, district, and facility levels
v. With MOH, promote regular measurement of HIV performance data at the facility level and build capacity for sustainable quality improvement measures through human and systems infrastructure development

The objectives listed above will translate into activities that will lead into better utilization of data to support patients/clients management at facility level. Involvement of health care managers at District level to provide support and supervision of HIV quality improvement activities will enhance overall quality of care for patients living with HIV. Entrenching HIV quality improvement as part of routine monitoring and evaluation will yield wider participation and improve efficiencies. Through data abstraction process, weaknesses in data recording and filing systems will be identified hence leading to an overall improvement of data quality and electronic and manual data capture and reporting systems.

Implementing Mechanism Details

Mechanism ID: 12637	Mechanism Name: Strengthening Strategic Information in Kenya
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Futures Group	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,400,000	
Funding Source	**Funding Amount**
GHP-State	2,400,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Goals: To seek to strengthen health information systems and data use in health service delivery. This project will deploy an upgraded EMR at 25% of health facilities offering HIV treatment. Future's will install the IQCare and one other nationally recognized EMR at approximately 300 ART sites. They will migrate data from the existing systems to the supported EMRs. The upgraded EMRs will implement SDMX standards to enable data exchange with the DHIS. Futures will work with the MOH to establish a continuing training program for the 600 health workers including doctors & nurses, to enter data into the system, use its decision support function for patient management & generate routine M&E reports. Futures will also work the MOH to establish regional or county based support mechanism for maintaining installed systems. Support will include hardware, software and Internet connectivity. They will establish a national health data warehouse that is aligned to the health enterprise architecture and linked to the DHIS. Futures will work with the MOH departments to develop policies around data privacy & confidentiality. Working with the Min of Gender, MoH, & IMs, Futures will support the design and implementation of a national gender-based violence (GBV) information system. Futures is working closely with other partners including UW-ITECH and USAID funded AfyaInfo to implement standards-based electronic systems to eliminate duplication through interoperable systems.Futures implements and support IQCare – an electronic medical records systems that complies with international standards but is maintained by Kenyan staff working closely with the MoH.This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12637**
Mechanism Name:	**Strengthening Strategic Information in Kenya**
Prime Partner Name:	**Futures Group**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	2,400,000	0

Narrative:

This mechanism primarily focuses on strengthening HMIS capacity in Kenya with the main goal of supporting the MOH to address challenges of data collection, transmission, storage, retrieval and exchange through a standards based approach. This will be achieve through development of interoperable health information systems that support patient care, routine M&E/reporting and disease surveillance.

Futures Group International will provide technical assistance to the GOK to support key health information systems activities implemented under NASCOP and the division of HIS within the Ministries of Health. The following priority work will be conducted as ongoing or new activities over the next two years (2012-2014):

- *Deploying an upgraded EMR at 25% of health facilities offering HIV treatment. Under this activity,*

Futures Group will install the IQCare and one other nationally recognized EMR at approximately 300 ART sites. They will migrate data from the existing systems to the supported EMRs. The upgraded EMRs will implement SDMX standards to enable data exchange with the District Health Information System (DHIS). Futures will work with the MOH to establish a continuing training program for the 600 health workers, including doctors and nurses, to enter data into the system, use its decision support function for patient management and generate routine M&E reports. The partner will also work the MOH to establish regional or county based support mechanism for maintaining installed systems. Such support will include hardware, software and Internet connectivity.

- *Establishing the national health data warehouse that is aligned to the health enterprise architecture and linked to the DHIS. This will be a repository of key health data including routine HMIS, vital registration and census data among others. Futures Group will work with other partners to ensure that the conceptual design, data needs and use policies are in place. Depending on the needs of the MOH, the data warehouse may contain individual patient level data or aggregate data or a combination. Futures will mainly focus on the database development and the application as the hardware and Internet connectivity will be supported through other partners. Relevant MOH staff including high level leadership as well as key stakeholders will be trained on accessing data from the national data warehouse.*

- *Working with the MOH departments (HIS and NASCOP) to develop policies around data privacy and confidentiality. There is a large body of data at the MOH but for access and use are either non-existent or outdated.*

- *Working in collaboration with Ministry of Gender, Ministry of Health, and implementing partners, Futures Group will support the design and implementation of a national gender-based violence (GBV) information system. Futures will work with Liverpool VCT to assess gaps in the current M&E system and tools, support harmonization of GBV data collection tools and set up an electronic data base for program and national level reporting.*

The EMRs, although originally intended to collect data for HIV, can be used for any chronic or acute illness and will help collect data for the US ambassador's Health Task Force (HTF). The EMRs, DHIS and national data warehouse will greatly strengthen the country's capacity to perform disease surveillance, reporting, M&E and operational research.

Implementing Mechanism Details

Mechanism ID: 12656	**Mechanism Name: Clinical Services**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement

Prime Partner Name: Eastern Deanery AIDS Relief Program	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 7,544,223	
Funding Source	**Funding Amount**
GHP-State	7,544,223

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Eastern Deanery AIDS Relief Program (EDARP) is a local Faith Based Organization (FBO) based in the Eastern slums of Nairobi whose goal is to reduce the incidence of HIV and TB and improve the quality of life through effective care, treatment, and prevention interventions. The program goal & objectives are linked to Kenya's Partnership Framework (PF) and Global Health Initiative (GHI) strategies and are directly aligned to PF pillars 1-3, prevention, care and mitigation, treatment, and systems strengthening. Strategies to reduce maternal and child mortality and eliminate MTCT include supporting family planning integration into HIV clinics. (M&E) plans will align with PEPFAR and country PF. Training on and use of MOH HMIS systems will be supported to eliminate parallel M&E

EDARP will ensure cost efficiency through integration of services, use of existing evidence-based efficient strategies, task shifting, implementing more facility-based training and mentorship as opposed to offsite training, evaluating cost effective strategies for defaulter management, laboratory networking, and mobilization.

EDARP is a local FBO and is partnering with the MOH in various aspects of the HIV program. Capacity-building strategies are aimed at strengthening sustainable local systems for effective transition of technical support from EDARP to MOH. EDARP will continue to build its capacity in monitoring and evaluation of the program by sending its key staff for training and courses in grants management and administration.

EDARP procured 4 vehicles between 2004 and 2008. EDARP requests purchase of 1 vehicle for efficient commodity distribution between their central site and the 14 satellite facilities, as well as during community outreach.This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	75,442
Gender: GBV	6,000
Gender: Gender Equality	15,000
Human Resources for Health	3,132,396
Renovation	74,960

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**12656**		
Mechanism Name:	**Clinical Services**		
Prime Partner Name:	**Eastern Deanery AIDS Relief Program**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	600,000	0
Narrative:			

Eastern Deanery AIDS Relief (EDARP) will support 12 sites in the Eastern slums of Nairobi with an estimated adult HIV prevalence of 7% compared to the national 7.1%. By March 2011, EDARP had cumulatively enrolled 37,722 patients in HIV care of whom 16,226 patients are active.

EDARP will work with the Ministry of Health (MoH) at the provincial, district and health facility level to jointly plan, coordinate, implement and ensure provision of quality HIV care and support to 22,883 current adult patients in FY12 and 27,266 current patients in FY13.

EDARP will offer comprehensive care and support package of services including: HIV testing to partners and family members of index patients and enrolling or referring/linking those that test HIV positive to care and support; provision of Basic Care Kit (safe water vessel, multivitamins, insecticide-treated mosquito nets, condoms, chlorine for water treatment and educational materials); therapeutic nutrition (FBP) to all enrolled HIV positive patients; prevention with positives(PwP), family planning and reproductive health services including cervical cancer screening to all enrolled women.

EDARP in collaboration with MoH will support targeted capacity building (training and mentorship) for health care workers and additionally offer continuous medical education on care and support, e.g. OI diagnosis and treatment. EDARP will identify areas with staff shortages, support recruitment of additional staff, and support good commodities management practices to ensure uninterrupted supply of commodities.

EDARP will also support ongoing community interventions for HIV infected individuals, including: peer education and use of support groups to provide adherence messaging, effective and efficient defaulter tracing and follow up to improve retention in all facilities; referral and linkages to community based psychosocial support groups; water, sanitation and hygiene programs; economic empowerment - income generating activities (IGAs); home based care services; gender based violence support programs; vocational training; social and legal protection; and food and nutrition or/and food security programs. EDARP will adopt strategies to ensure access and provision of friendly services to youth, elderly and disabled populations. Strategies to increase access of care services by men will be employed, including supporting male peer educators, mentors and support groups, and supporting women to disclose and bring their male partners for testing and care and treatment.

EDARP will continue to strengthen data collection and reporting at all levels to improve reporting to NASCOP and PEPFAR. They will do a cohort analysis and report retention rates as required by the NASCOP. EDARP will adopt the new generation indicators and support the development and use of electronic medical records system in accordance with NASCOP guidelines. EDARP will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV care and support services and integrate them into routinely collected data and use the results to evaluate and improve clinical outcomes. EDARP will to support joint Annual Operation Plan (AOP) planning, implementation, monitoring and evaluation and health system strengthening to facilitate sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	900,000	0

Narrative:

Eastern Deanery AIDS Relief (EDARP) will support TB/HIV activities in the Eastern Slums of Nairobi. Nairobi province has HIV prevalence of 7% and reported 17,444 cases of TB. The HIV prevalence in TB infected patients is 45.5%. EDARP has been supporting TB/HIV services in 12 sites since 1993 in line with the Ministry of Health Division of Leprosy, Tuberculosis and Lung Disease (DLTLD) and the National AIDS and STI Control Program (NASCOP).
Between October 2010 and March 2011, 1,530TB patients received HIV counseling and testing and all the 893 (100%) TB HIV confected patients identified received cotrimoxazole prophylaxis while 773 received ART.

In FY 2012 and 2013, EDARP will intensify efforts to detect TB cases through clinical exams, laboratory investigations and ensure successful TB treatment through provision of appropriate treatment. EDARP will ensure that each facility providing TB/HIV services has adequate and well trained clinical staff supported by well equipped and staffed laboratory, including sputum specimen transport where laboratory services are unavailable. All TB patients on treatment will be monitored both clinically and through periodic sputum examination.

To reduce the burden of HIV in TB patients, EDARP will ensure that at least 95% of TB patients are screened for HIV and 95%TB-HIV co-infected patients are put on cotrimoxazole and ARVs as early as possible regardless of the CD4 count as per the national guidelines. EDARP will support the "one stop" model that provides integrated TB and HIV services in all TB clinics. All TB clinics will be stocked with cotrimoxazole and ARVs. 80 HCWs in FY12 and 40 HCWs in FY13 will be trained.

To reduce the burden of TB in HIV infected patients, EDARP will support intensified TB screening for 20,341 in FY12 and 24,238 in FY13 HIV infected persons identified in their HIV care settings. 1,017 co-infected patients identified in FY12 and 1,212 co-infected patients identified in FY13 will be put on TB treatment and those without active TB will be provided with Isoniazid Preventive Therapy (IPT) as per national IPT protocol.

To strengthen TB infection control in HIV settings, EDARP will ensure that the national IC guidelines are available at all sites and training of staff on IC is done. EDARP will support scaling up of at least 2 components of the national TB infection control strategy in HIV care settings, one of which should be fast tracking of patients with cough for expedited diagnostic work up and treatment.

To improve surveillance and management of drug-resistant TB, EDARP will support timely transport of sputum specimens of TB retreatment cases from health facilities to the central reference laboratory for drug susceptibility testing and ensure return of the results to those facilities. EDARP will also support scaling up of drug-resistant

treatment sites thus expanding access to MDRTB treatment.

EDARP will also support expansion of prevention with positive (PwP) services in TB clinics, TB/HIV control activities in the prisons, strengthening linkages between facility and community-based services, and improving patient referrals and tracking systems. To strengthen HVTB program monitoring, EDARP will support reporting of selected custom indicators to assist with program management and evaluation and monitoring of new activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	100,000	0

Narrative:

Eastern Deanery AIDS Relief (EDARP) will continue to support pediatric care services in 12 sites located in Eastern slums of Nairobi province. By March 2011, EDARP had 5,473 children enrolled in care with 2,297 active and on cotrimoxazole prophylaxis. In FY 12, EDARP will provide care and support services to 2,391 children currently on care. The number of children currently on care will increase to 2,901during FY 13.

EDARP will provide comprehensive, integrated quality services, and scale up to ensure 180 HIV infected infants are put on ARV prophylaxis and all HIV exposed children access pediatric care services. The focus of pediatric care services will continue to be provision of comprehensive, integrated quality services including strengthening the use of the Mother-baby booklet, early infant diagnosis, universal provider initiated testing and counseling, and ensure those identified HIV infected are linked to care and ART services.

EDARP will ensure children enrolled in care receive quality clinical care services, including clinical history and physical examination, WHO staging, CD4 tests, and other basic tests; opportunistic infection diagnosis, prophylaxis and management, TB screening, pain and symptom relief and management; and psychosocial support. Additional key care services will include nutritional assessment, counseling and support based on the WHO and IYCF guidelines (including provision of therapeutic or supplementary feeding, support to children with growth faltering, provision of vitamin A, zinc, and de-worming); provision of safe water, sanitation and hygiene interventions (WASH) in the community and in health facilities, malaria screening, treatment and provision of long lasting insecticide treated nets in malaria endemic areas.

EDARP will support integration of HIV services into routine child health care and survival services in the maternal child health department, including growth and development monitoring, immunization as per the Kenya Expanded Program on Immunization guidelines, case management of diarrhea, pneumonia, and other childhood illnesses, and community outreach efforts. They will also support the care of the newborn by supporting hospital delivery and ensuring that there is provision for newborn resuscitation and care (thermal care, hygiene cord care), and prophylactic eye care. Exposed children management and follow up will continue to be supported, and will include

enrollment, HIV testing (PCR-DNA and antibody testing) as per the national guidelines, provision of Nevirapine throughout the breastfeeding period, follow up and retention, and linkages of those positive to care and ART services.

EDARP will support hospital and community activities to meet the needs of the HIV infected adolescents: support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, support for transitioning into adult services and teaching life skills. Commodity access, infrastructure development, and relevant trainings will continue to be supported.

EDARP will strengthen pediatric data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	1,008,833	0

Narrative:

The Kenya Government/MOH recognized MC as an additional HIV prevention intervention in 2007 and with PEPFAR support developed a MC policy guidance, MC strategy and communication strategy, and adapted/adopted other relevant documents (VMMC clinical Manual, VMMC M&E indicators/tools to guide service delivery and demand creation and tracking. The program's objective is to circumcise men aged 15 – 49 years by 2013 and reach 80% coverage. Four regions (Nyanza, Western, Turkana and Nairobi) have been identified for priority scale up. Nyanza Province has MC rates of 48% and HIV prevalence of 14.9%. HIV prevalence among the uncircumcised Luo is 17%, and MC rates is estimated to be 22% (KDHS 2008/9). Nairobi Province has MC rates of 83% and HIV prevalence of 8.8%. Since 2008, VMMC services have been provided through PEPFAR implementing partners working at Ministry of Health (MoH) facilities, to over 300,000 males. However, huge gaps still exist, and while coverage is nearly 50% in some Nyanza districts, it is very low in other regions like Nairobi and EDARP will contribute to addressing the existing gaps

- *EDARP will provide VMMC services to 6,977 boys and men aged 15 years and above in Eastlands region of Nairobi County to increase VMMC coverage.*
- *EDARP will partner with various church groups in ensuring that Adolescent circumcision camps incorporate safer surgical practices and HIV prevention counseling into the traditional rite of passage in line with the phased approach as outlined in the Kenya National Strategy for Voluntary Medical male Circumcision.*
- *EDARP clinical staff and district M&E subcommittee will conduct quarterly support supervision visits to VMMC sites to ensure quality assurance, using the adapted VMMC QA tools and ensure reporting is done through the MOH M&E reporting system.*
- *EDARP will ensure requisite demand for VMMC services in generated among males and females in and around the catchment area of each facility where VMMC services are available, and explore other approaches for*

efficiency including conducting outreaches and mobiles, use of electrocultery, as well as off hour services (Monday to Saturday up to 10 pm in the evening) where applicable.

- *As part of comprehensive prevention package, all VMMC clients will be provided with the minimum package of services at site according to national guidelines, which include opt out HTC for VMMC clients and their partners, age appropriate sexual risk reduction counseling, counseling on abstinence during 6 week healing period.*
- *Where necessary, HCW teams to provide VMMC services will be trained to build their capacity, using the MOH VMMC training guidelines.*
- *Linkage with other services within facilities and within districts/counties will ensure VMMC is part of comprehensive package of prevention package. Identified men with HIV will be appropriately linked to Care and treatment sites, giving preference of referral to the sites of their choice to reduce Loss to follow up. Active linkages with other programs has been established, with cross referrals to care and treatment for HIV positive men, as well as referral of uncircumcised men from routine HTC sites and discordant couples to VMMC services.*
- *Regular EQA from WHO and PEPFAR teams has ensured VMMC activities adhere to international standards. Service provision will be monitored using the standardized VMMC reports and evaluated regularly through the MOH M&E reporting system.*

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	807,195	0

Narrative:

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Target population: Eastern Deanery AIDS Relief Program (EDARP) is a local Roman Catholic Faith Based organization that is located in the Eastern slums of Nairobi, covering half a million households and a population of 1.7 million people. EDARP has a community based service delivery model offering integrated HIV/TB care and prevention at 13 sites. EDARP targets the general population with special emphasis on couples, pregnant women, people with TB, and adolescents/youth. In the past 12 months, 93,148 people were tested in the region. The average HIV prevalence for those tested is 9.6%.

HTC Approaches: EDARP provides client and provider initiated HIV testing and counseling. Client initiated testing is offered in the VCTs and during mobile HTC, youth friendly camps at churches and visits to workplaces. Provider initiated testing is offered in home based testing targeting specific geographical areas and households of index clients/patients. EDARP's 13 integrated facilities offer PITC as routine for ANC, TB screening and treatment, voluntary male medical circumcision, cervical cancer screening, and STI screening.

Targets and achievements: For last 12 months up to July 2011, EDARP tested 55,460 people in VCT versus a target of 40,000. In PITC, 21,099 people tested against a target of 30,000.The HBCT target is 70,000, and 19,865 people have been tested. EDARP also trained 114 staff on the following areas; Couples HTC - 15, HBTC- 78, and HIV

testing and counseling -21. For COP 2012, EDARP will target to reach 117,000 persons of which 20% will be tested as couples and 10% will be children below the age of 15.

Testing algorithm: National algorithm

Referrals and linkages: Strengthening of linkages and successful referrals is aided by an integrated model where HTC is linked to all services offered ensuring that clients who have positive tests are smoothly transitioned into care in the same setting. In outreach settings, involvement of community health workers for community mobilization and as a link for those tested to ensure successful referrals.

Promotional activities for HTC: Promotional activities around HTC for demand creation includes community mobilization. EDARP also uses of IEC materials and media campaigns. EDARP also leverage on other integrated services like TB screening and treatment, VMMC and Cervical cancer screening.

Quality management: Activities for Quality Assurance for both testing and counseling include support supervision to all HTC staff, continuous skill building by regular HTC updates and trainings, participation in Proficiency testing (PT) and Human Quality Assessment Services (HUQAS) in every quarter. For home based testing, HTC counselors submit a DBS for every 20th client per counselor which is sent to the National Reference laboratory. All HTC counselors undergo Observed Practice every quarter.

Monitoring and evaluation: This will involve collection of data using routine HTC indicators as defined in the revised MOH HIV/AIDS HMIS guidelines and PEPFAR NGI. EDARP will apply appropriate technology in Health Information Management including Electronic medical records system. EDARP submits monthly reports using the national system. The facilities review the HTC indicators monthly

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

EDARP implements comprehensive prevention, care and treatment programs in Nairobi province. In FY 2012/13, EDARP will expand HIV prevention services to include evidence based behavioral interventions (EBI) for specific target populations in clinical settings at comprehensive care center (CCC), TB and Maternal Child Health (MCH) clinics as part of HIV combination prevention programs. The EBI will include Positive Health and Dignity Prevention (PHDP) targeting adult male and female and adolescents living with HIV (PLHIV); and Sister to Sister EBI (S2S) targeting sexually active HIV negative women attending the MCH clinics.

PHDP is an ongoing 5-10min group and individual level intervention that targets PLHIV in clinical and community settings. This mechanism will support this intervention which constitutes of ART adherence counseling and support; partner and family testing; provision of PEP to the discordant spouse; treatment for prevention once approved; safer pregnancy counseling and provision of modern contraception; sexual risk reduction counseling including reduction of sexual partners, alcohol counseling, promoting of consistent and correct condom use; Sexually Transmitted Infections (STI) screening and treatment and using meaningful involvement of people living with HIV/AIDS (MIPA). The efficacy of PHDP has been shown to be 68% in preventing transmission of HIV, and 96% in treatment for prevention.

S2S is a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use. Condoms are 80% effective in heterosexual relationships when used correctly and consistently.

EDARP will use HVOP funding to recruit and support appropriate peer educators/counselors to reinforce prevention messages delivered by health providers as a feasible model for task-shifting in the provision of PHDP in clinical settings, and specifically promote MIPA. It will support placement of 5 Peer Educators at the MCH, TB and CCC Clinics in hospitals, and 2 Peer educators at health centres and provide appropriate counseling space. One of the peer educators will do regular client home follow up to strengthen ART adherence.

Approximately 1.6 million Kenyans are PLHIV. The Kenya AIDS Indicator Survey 2007 showed 6% of couples to be in discordant relationships. Nairobi province HIV Prevalence is high (8.8%). EDARP will reach 12890 (60%) PLHIV in FY2012 and 17949 (70%) in FY 2013 with a minimum package of PHDP. It will implement S2S EBI on a pilot basis.

Quality assurance for EBIs will be promoted through appropriate training and certification of peer educators using approved national curricula, standard job-aids and guidelines and regular supervision.

EDARP will work with appropriate national Technical Working Groups (TWG) to support integration of HIV prevention into care and treatment programs in clinical settings. These programs will also be linked to other HIV community programs. PLHIV will be specifically linked to STI and FP services, as necessary, through patient escorts.

Monitoring of PHDP and S2S will be done through the review/input of EDARP implementation plan, analysis of KePMS data, quarterly reviews, semiannual and annual reports. Evaluation will be conducted through operation research of combination HIV prevention and periodic surveys (Kenya Demographic and health survey, Kenya Indicator AIDS Survey, Kenya Service Provision Assessment)

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	MTCT	50,000	0

Narrative:

Eastern Deanery AIDS Relief Program (EDARP) will support implementation of PMTCT in the Eastland slums in Nairobi. Since 2004, EDARP has been implementing a PMTCT program in 12 health facilities in these informal settlements with a HIV prevalence of 11%. By end of March 2011, EDARP had counseled and tested 1,495 pregnant women and given ARV prophylaxis to 955 HIV positive pregnant women.

In FY12, EDARP will offer HIV counseling and testing to 1,952 pregnant women at the ANC and give ARV prophylaxis to 172 HIV infected pregnant women. The HIV infected women will receive a CD4 test after undergoing a WHO clinical staging. EDARP will give HAART to all eligible HIV positive pregnant women in line with the revised PMTCT national guidelines. In FY13, EDARP will increase the number of pregnant women counseled to 2,050, offer ARV prophylaxis to 209 pregnant women and 180 infants, and do EID for 180 infants.

EDARP will focus on 4 prongs of PMTCT: primary prevention; family planning, ARV prophylaxis to all HIV positive pregnant mothers and exposed infants, and care and treatment to eligible HIV positive mothers, partners and children. The Minimum care package will include health and HIV education, individual/ family HIVCT, clinical/laboratory monitoring and assessment, OI screening and treatment, ARV prophylaxis and treatment for both mother and baby, nutritional support, psychosocial support, PWP, follow up, retention, referral and linkages. EDARP will incorporate TB screening into routine antenatal care.

EDARP will reach 615 couples with couple CT to identify discordant and concordant couples to improve primary prevention and facilitate linkage to HIV care and treatment for the eligible.
EDARP will support integration of ART in MCH clinics, access to FP/RH services, establish or strengthen infection control and waste management activities. EDARP will support hospital delivery through provision of delivery beds and sterile delivery packs, training, working with CHWs and TBAs to promote community- facility referral mechanism, health education and community services providing skilled birth attendance.

EDARP will support safe infant feeding practices as per national guidelines and support enrollment and follow up of 180 HIV exposed infants to access CTX, ARV prophylaxis and EID services using the HIV exposed infant register till 18 months. EDARP will facilitate ART initiation for those who test positive before 2 years.

EDARP will adopt efficient retention strategies for mothers and babies by supporting use of diaries and registers for tracking defaulters, having a structured mentorship and supervision plan, enhancing data quality and streamlining M&E gaps including orientation of new MOH ANC/maternity registers and utility of data at facility level for program improvement and quarterly progress reports to CDC.

Program quality and proficiency testing will be emphasized to validate PMTCT results.
EDARP will train 30 HCWs in FY12 and 30 in FY13 on PMTCT and provide orientation to the revised PMTCT and infant feeding guidelines and engage in community activities for demand creation for health services such as male involvement with couple CT services, referral and linkages and reach non clinic attendants.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	3,778,195	0

Narrative:

Eastern Deanery AIDS Relief (EDARP) will support treatment in Eastern slums of Nairobi province which has a population of about half a million people and an estimated adult HIV prevalence of 9% compared to the national 7.1%. Since 2003, EDARP has been supporting HIV treatment activities in 12 sites within the informal settlements in Eastern Nairobi. As of March 2011, EDARP had enrolled 21,497 adults on ART with 14,560 active on treatment. As per the 2009 treatment cohort, 80% of patients were still on ART at 1 year, 14% lost to follow up, and the rest reported dead.

In FY12, EDARP will jointly work with the Ministry of Health (MoH) to continue supporting expansion and provision of quality adult HIV treatment services as per MoH guidelines to 14,593 patients currently receiving ART and 3,377 new adults resulting to cumulative 17,512 adults who have ever been initiated on ART. In FY13, this number will increase to 17,129 currently receiving ART and 3,417 new adults resulting to 20,546 adults who have ever been initiated on ART.

EDARP will support in-service training of 80 and 60 HCWs in FY 12 and FY 13 respectively, continuous mentorship of trained health care workers on specialized treatment, including management of patients with ARV treatment failure and complicated drug adverse reactions; identify human resources and infrastructure gaps and support in line with MoH guidelines; and support good commodities management practices to ensure uninterrupted availability of commodities.
EDARP will support provision of comprehensive package of services to all PLHIV including ART initiation for those eligible; laboratory monitoring including biannual CD4 testing, viral load testing for suspected treatment failure (through strengthened laboratory network); cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH; and improved OI diagnosis and treatment including TB screening, diagnosis and treatment.
Ongoing community interventions for PLHIV including peer education and use of support groups to provide adherence messaging, defaulter tracing and follow up will continue to be supported to improve retention in all sites. EDARP will do cohort analysis and report retention as required by MoH. EDARP will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services integrate them into routinely collected data and use the results to evaluate and improve clinical outcomes. EDARP will also support strategies to

ensure access and provision of friendly HIV treatment services to all, including supporting peer educators, mentors, support groups, and supporting patients to disclose and bring their partners for testing and care and treatment. EDARP will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, EDARP will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. EDARP will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	300,000	0

Narrative:

Eastern Deanery AIDS Relief (EDARP) will support Nairobi province which has a population of about 3.1 million people and an estimated adult HIV prevalence of 9% compared to the national 7.1%. Since 2003, EDARP has been supporting HIV treatment activities in 12 sites within the informal settlements in Eastern Nairobi. As of March 2011, EDARP had enrolled 1,337 children on ART with 945 active on treatment. As per the 2009 treatment cohort, 85% of patients were still on ART at 1 year, and 15% lost to follow up or dead.

In FY12, EDARP will jointly work with the Ministry of Health (MoH) at all levels to continue supporting, expanding and ensuring provision of quality pediatric HIV treatment services as per MoH guidelines to 1,451 pediatrics currently receiving ART and 290 new pediatrics resulting to cumulative 1,741 pediatrics ever initiated on ART. In FY 13, this number will increase to 1,546 pediatrics currently receiving ART and new 261 resulting to cumulative 2002 pediatrics ever initiated on ART.

EDARP will support comprehensive pediatric ART services including growth and development monitoring, immunization as per the Kenya Expanded Program on Immunization, management of childhood illnesses OI screening and diagnosis; WHO staging; ART eligibility assessment; laboratory monitoring including 6 monthly CD4, hematology and chemistry (through strengthening of lab networks); Pre-ART adherence and psychosocial counseling; initiation of ART as per MoH guidelines; Toxicity monitoring, treatment failure assessment through targeted viral load testing; Adherence strengthening; enhanced follow up and retention; support EID as per MoH guidelines and PITC to all children and their care givers attending Child welfare clinics; support family focused approach; community outreach efforts and integration of HIV services in other MNCH services.

EDARP will support hospital and community activities to support the needs of the HIV infected adolescents: support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services and support their transition into adult services

EDARP will support in-service training of 80 and 60 HCWs in FY 12 and 13 respectively, continuous mentorship and capacity building of trained health care workers on specialized pediatric treatment including management of ARV treatment failure and complicated drug adverse reactions; identify human resources and infrastructure gaps and support in line with MoH guidelines; and support good commodities management practices to ensure uninterrupted availability of commodities. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will additionally be optimized.

EDARP will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, EDARP will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. EDARP will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.

Implementing Mechanism Details

Mechanism ID: 12658	**Mechanism Name: Clinical Services**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Mkomani Society Clinic	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 3,512,972	
Funding Source	**Funding Amount**
GHP-State	3,512,972

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Mkomani Clinic Society (MCS) supports the implementation and expansion of high quality HIV Prevention, Care and Treatment Activities at the facility and community level at the Bomu Clinic and affiliated sites. The program goal and objectives are linked to Kenya's Partnership Framework (PF) and Global Health Initiative (GHI)

strategies and are directly aligned to PF pillars 1-3: prevention, care and mitigation, treatment, and systems strengthening. Strategies to reduce maternal and child mortality and eliminate MTCT include supporting family planning integration into HIV clinics. Monitoring and evaluation (M&E) plans will align with PEPFAR and country PF. Training on and use of MOH HMIS systems will be supported to eliminate parallel M&E.

MCS has developed a strategy of partnering with corporate organizations to provide capital investment. In this manner, they reduce capital expenditure and the program becomes cost effective. MCS also runs other clinical departments that generate income and provide a point of entry to the HIV program.

MCS is already partnering with the MOH in various aspects of the HIV program to provide training for MOH and affiliated facilities. Capacity-building strategies are aimed at strengthening sustainable local systems for effective transition of technical support from MCS to MOH and the community. MCS will continue to build its capacity in monitoring and evaluation of the program by sending its key staff for training and courses in grants management and administration.

Since 2010, MCS has procured 1 vehicle. MCS intends to purchase a vehicle for the implementation of the program and extension of services beyond the normal working hours.This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	35,130
Gender: GBV	6,000
Gender: Gender Equality	10,000
Human Resources for Health	1,802,999

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**12658**
Mechanism Name:	**Clinical Services**
Prime Partner Name:	**Mkomani Society Clinic**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	400,000	0

Narrative:

Mkomani Clinic Society (MCS) will support 4 facilities in Coast Province, which they have been supporting HBHC activities since 2010. By March 2011, MCS had cumulatively enrolled 21,642 patients in HIV care and of these 14,329 were active and on Cotrimoxazole prophylaxis.

MCS will work with the Ministry of Health (MoH) at provincial, district and health facility level, to jointly plan, coordinate, implement and ensure provision of quality HIV care and support to 14,484 current adult patients in FY12 and 18,022 current patients in FY13.

MCS will offer comprehensive care and support package of services including: HIV testing to partners and family members of index patients and enrolling or referring/linking those that test HIV positive to care and support; provision of Basic Care Kit (safe water vessel, multivitamins, insecticide-treated mosquito nets, condoms, chlorine for water treatment and educational materials); therapeutic nutrition (FBP) to all enrolled HIV positive patients; prevention with positives(PwP), and cervical cancer screening to all enrolled women.

MCS in collaboration with MoH will support targeted capacity building (training and mentorship) for health care workers and additionally offer continuous medical education on care and support, e.g. OI diagnosis and treatment. MCS will identify areas with staff shortages, support recruitment of additional staff, and support good commodities management practices to ensure uninterrupted supply of commodities.

MCS will also support ongoing community interventions for HIV infected individuals, including: peer education

and use of support groups to provide adherence messaging; effective and efficient defaulter tracing and follow up to improve retention in all facilities; referral and linkages to community based psychosocial support groups; Water, sanitation and hygiene programs; economic empowerment/income generating activities (IGAs) projects; home based care services; gender based violence support programs; vocational training; social and legal protection; and food and nutrition programs. MCS will adopt strategies to ensure access and provision of friendly services to youth, elderly and disabled populations. Strategies to increase access of care services by men will be employed, including supporting male peer educators, mentors and support groups, and supporting women to disclose and bring their male partners for testing and care and treatment.

MCS will continue to strengthen data collection and reporting at all levels to improve reporting to NASCOP and PEPFAR. MCS will do cohort analysis and report retention rates as required by NASCOP. MCS will adopt the new generation indicators and support the development and use of electronic medical records system in accordance with NASCOP guidelines. MCS will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV care and support services, integrate them into routinely collected data, and use the results to evaluate and improve clinical outcomes. MCS will support joint Annual Operation Plan (AOP) development, implementation, monitoring and evaluation, and health system strengthening to facilitate sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	100,000	0

Narrative:

Mkomani clinic Society (MCS) is a local, not-for-profit, non-governmental partner that will provide 1500 OVC in FY12 and 2000 OVC in FY13 with access to essential services in the Coast region. MCS will train 100 caregivers, to meet the needs of OVC in their communities. MCS will provide critical services to OVC which include providing a comprehensive package that includes education, shelter, nutritional support, psychosocial care and support, support to OVC caretakers; while linking OVC to other critical services and economic strengthening activities. MCS will target all OVC aged between 0 and 18 years and will provide "6 plus 1" services and report on at least 3 services which they provide to the OVC based on individual need. By March 2011, MCS had achieved the following: 1500 OVC served; 850 of OVC received primary direct support (PDS); 650 of OVC were provided with Supplemental Direct Support (SDS) and 70 providers/caretakers trained in caring for OVC.
In the next two years MCS will focus on strengthening HIV prevention education among OVC to equip them with life skills that would reduce their vulnerability to the risk of HIV infection. MCS will start to implement OVC interventions that are evidence-based in order to achieve their two year goals They will also train the local organizations to strengthen the family support system and help them to establish strong linkages between PLWHAs and HIV-infected children and health care services, including ensuring that children and their parents or caregivers and other family members affected access appropriate care and treatment. MCS will work closely and link with care and treatment partners to ensure that HIV-infected children receive appropriate psychosocial support

and that they have a consistent caregiver to assure adherence to treatment. MCS will continue to work closely with the District Children's Department and will follow guidelines provided by the Ministry of Gender, Children and Social Development, as well as PEPFAR guidelines. MCS will support the local partners to establish partnerships and networks among other NGOs in order to strengthen their collective voice, build a unified approach, improve coordination, and share knowledge.

MCS will embrace community and family centered approaches (such as the cash transfer program) that are preferred to institutional approaches and that they should explore OVC programming opportunities from a livelihoods approach to OVC. There is scanty information regarding current OVC programming in the MCS supported partners. MCS will undertake an OVC situation and gap analysis for its CBOs to document best practices and lessons learned for OVC and help the CBOs to explore new program approaches. MCS will also develop an OVC advocacy curriculum and provide training to CBOs and other OVC stakeholders. MCS will work with the local organizations to engage and advocate for OVC issues with key stakeholders in the Kenyan HIV/AIDS response, including donors.

MCS will work with the local partners to improve M&E systems based on rapid capacity and gaps analysis of the OVC activities they support. The program will also capture age specific services that are offered to OVC aged between 0 and 18 years.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	200,000	0

Narrative:

Mkomani Clinic Society (MCS) will support 4 sites in Coast region, which has a population of about 4.4 million people and reported 10,623 TB patients in 2010. Over 10,000 TB patients received HIV testing and 3,531 TB/HIV co-infected patients were identified. 97% and 47% received cotrimoxazole prophylaxis and ART respectively. Since 2010, MCS has been supporting TB/HIV activities as a local transition partner from New York University in the Coast region.

In FY12 and FY13, MCS will intensify efforts to detect TB cases through clinical exams and laboratory investigations as well as ensure successful TB treatment through provision of appropriate treatment. MCS will ensure that each facility providing TB/HIV services has adequate and well trained clinical staff supported by well equipped and staffed laboratory, including sputum specimen transport where laboratory services are unavailable. MCS will ensure that adequate supplies of anti-TB drugs are available and that the national TB treatment guidelines are followed. All TB patients on treatment will be monitored both clinically and through periodic sputum examination.

To reduce the burden of HIV in TB patients, MCS will ensure that at least 95% of TB patients are screened for HIV and all TB-HIV co-infected patients are put on cotrimoxazole and ARVs as early as possible regardless of the CD4

count as per the national guidelines. MCS will support the "one stop" model that provides integrated TB and HIV services in all TB clinics. All TB clinics will be stocked with cotrimoxazole and ARVs and 50 HCW will be trained in FY12 and 30 HCW trained in FY13.

To reduce the burden of TB in HIV infected patients, MCS will support intensified TB screening using the national screening tool for 12,874 in FY12 and 16,020 in FY13 at each clinical encounter. 644 co-infected patients identified in FY12 and 801 in FY13 will be put on TB treatment and those without active TB will be provided with Isoniazid Preventive Therapy (IPT) as per national IPT protocol. To strengthen TB infection control in HIV settings, MCS will ensure that the national IC guidelines are available at all sites and training of staff on IC is done. MCS will support scaling up of at least 2 components of the national TB infection control strategy in HIV care settings, one of which should be fast tracking of patients with cough for expedited diagnostic work up and treatment.

To improve surveillance and management of drug-resistant TB, MCS will support timely transport of sputum specimens of TB retreatment cases from health facilities to the central reference laboratory for drug susceptibility testing and ensure return of the results to those facilities. MCS will also support scaling up of drug-resistant treatment sites thus expanding access to MDRTB treatment.

MCS will also support expansion of prevention with positive (PwP) services in TB clinics, TB/HIV control activities in the prisons, strengthening linkages between facility and community-based services, and improving patient referrals and tracking systems. To strengthen HVTB program monitoring, MCS will support reporting of selected custom indicators to assist with program management and evaluation and monitoring of new activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	80,000	0

Narrative:

Mkomani Clinic Society (MCS) will support pediatrics activities in Coast Province, which has an estimated population of 3.3 million people with an estimated HIV prevalence of 8.1% compared to the national 7.1%. MCS has been supporting HIV activities as a local transition partner from New York University in 4 treatment sites in Coast Province. By March 2011, MCS had enrolled 4,370 children in care, of whom 2645 were active and on cotrimoxazole.

In FY 12, MCS will provide care and support services to 1,513 children currently on care. The number of children currently on care will increase to 1,917 in FY13. MCS will provide comprehensive, integrated quality services and scale up to ensure 42 HIV infected infants are put on ARV prophylaxis and all HIV exposed children access pediatric care services.

The focus of pediatric care services will continue to be provision of comprehensive, integrated quality services including strengthening the use of the Mother-baby booklet, early infant diagnosis, universal provider initiated testing and counseling, and ensure those identified HIV infected are linked to care and ART services. MCS will ensure children enrolled in care receive quality clinical care services including clinical history and physical examination; WHO staging, CD4 tests, and other basic tests; opportunistic infection diagnosis, prophylaxis and management; TB screening; pain and symptom relief and management; and psychosocial support. Additional key care services will include nutritional assessment; counseling and support based on the WHO and IYCF guidelines (including provision of therapeutic or supplementary feeding, support to children with growth faltering, provision of vitamin A, zinc, and de-worming); provision of safe water, sanitation and hygiene interventions (WASH) in the community and in health facilities; and malaria screening, treatment, and provision of long lasting insecticide treated nets in malaria endemic areas.

MCS will support integration of HIV services into routine child health care and survival services in the maternal child health department, including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization guidelines; case management of diarrhea, pneumonia, and other childhood illnesses; and community outreach efforts. They will also support the care of the newborn by supporting hospital delivery and ensuring that there is provision for newborn resuscitation and care (thermal care, hygiene cord care) and prophylactic eye care. Exposed children management and follow up will continue to be supported and will include enrollment, HIV testing (PCR-DNA and antibody testing) as per the national guidelines, provision of Nevirapine throughout the breastfeeding period, follow up and retention, and linkages of those positive to care and ART services.

MCS will support hospital and community activities to meet the needs of the HIV infected adolescents: support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, support for transitioning into adult services, and teaching life skills. Commodity access and infrastructure development will continue to be supported. Relevant trainings will continue to be supported. MCS will strengthen pediatric data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	47,038	0

Narrative:

Target population: Mkomani Medical society will support HIV testing and counseling services in 4 health facilities in Mombasa county of Coast province. Target population will include all patients, their family members and caretakers who access out and in patient services a number of health facilities in the 4 counties.
HTC Approaches: The program will utilize provider initiated opt out approach and the services are offered within all out patient departments, TB clinics, FP, ANCs, special clinics, HIV clinics (targeting family members) and in

patient departments. The counseling and testing is either done within the consultation rooms by trained clinicians or in counseling rooms by lay counselors within the outpatient departments if space is available or at the laboratories.
Targets and achievements: MMS in the past 12 months had a target to provide HTC services to a total of 10,000 persons but managed to serve 23,489 (234%) out of which 4185 (17.8%) tested positive. In COP 2012, MMS will target to provide HTC services to a total of 27,000 persons of which 20% will be tested as couples and 10% will be children below the age of 15.
Testing algorithm: National algorithm is being used.
Referrals and linkages: In order to strengthen referrals, MMS will put in place several important strategies. They include: use of peer educators as patient escorts from one hospital department to the CC; same day enrollment of clients to CCC; use of an integrated defaulter tracing system for tracing patients who default on care or ART upon enrollment; introduction of documented referral system by use of the NASCOP referral booklet; use of mobile phones to follow up whether the client was actually enrolled.
Quality management: In order to improve and monitor quality of HTC services, MMS will put in place the following strategies: Training and continuing education of HTC providers; strict adherence to the standard operating procedures outlined in the national HTC guidelines; management of HIV rapid kits as per the guidelines; putting in place a functional QA systems as provided for in the national HTC guidelines; participation in EQA- proficiency testing and finally conducting support supervisory visits.

Monitoring and evaluation: MMS will use all ministry of health' tools to capture HTC data, both for couples and individual patients. These include HTC lab Register and Monthly summary tool (MOH 711). MOH approved HTC lab registers will be introduced at all HIV testing points except PMTCT.

Promotional activities for HTC: All patients attending the supported facilities will be given health talks including the need for HIV counseling and testing and the importance of couple testing. Couples are given priority services. Sexual partners of HIV positive clients will be given individualized invitations though the index clients and available avenues for testing including individualized home testing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

BOMU implements comprehensive prevention, care and treatment programs in Coast province. In FY 2012/13, BOMU will expand HIV prevention services to include evidence based behavioral interventions (EBIs) for specific target populations in clinical settings at comprehensive care center (CCC), TB and Maternal Child Health (MCH) clinics as part of HIV combination prevention programs. The EBIs will include Positive Health and Dignity Prevention (PHDP) targeting adult male and female and adolescents living with HIV (PLHIV); and Sister to Sister

EBI (S2S) targeting sexually active HIV negative women attending the MCH clinics.

PHDP is an ongoing 5-10min group and individual level intervention that targets PLHIV in clinical and community settings. This mechanism will support this intervention which constitutes of ART adherence counseling and support; partner and family testing; provision of PEP to the discordant spouse; treatment for prevention once approved; safer pregnancy counseling and provision of modern contraception; sexual risk reduction counseling including reduction of sexual partners, alcohol counseling, promoting of consistent and correct condom use; Sexually Transmitted Infections (STI) screening and treatment and using meaningful involvement of people living with HIV/AIDS (MIPA). The efficacy of PHDP has been shown to be 68% in preventing transmission of HIV, and 96% in treatment for prevention.

S2S is a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use. Condoms are 80% effective in heterosexual relationships when used correctly and consistently.

BOMU will use HVOP funding to recruit and support appropriate peer educators/counselors to reinforce prevention messages delivered by health providers as a feasible model for task-shifting in the provision of PHDP in clinical settings, and specifically promote MIPA. It will support placement of 5 Peer Educators at the MCH, TB and CCC Clinics in hospitals, and 2 Peer educators at health centres and provide appropriate counseling space. One of the peer educators will do regular client home follow up to strengthen ART adherence.

Approximately 1.6 million Kenyans are PLHIV. The Kenya AIDS Indicator Survey 2007 showed 6% of couples to be in discordant relationships. HIV Prevalence in Coast province is (8.1%). BOMU will reach 8159 (60%) PLHIV in FY2012 and 11864 (70%) in FY 2013 with a minimum package of PHDP. It will implement S2S EBI on a pilot basis.

Quality assurance for EBIs will be promoted through appropriate training and certification of peer educators using approved national curricula, standard job-aids and guidelines and regular supervision.

BOMU will work with appropriate national Technical Working Groups (TWG) to support integration of HIV prevention into care and treatment programs in clinical settings. These programs will also be linked to other HIV community programs. PLHIV will be specifically linked to STI and FP services, as necessary, through patient escorts.

Monitoring of PHDP and S2S will be done through the review/input of BOMU implementation plan, analysis of KePMS data, quarterly reviews, semiannual and annual reports. Evaluation will be conducted through operation research of combination HIV prevention and periodic surveys (Kenya Demographic and health survey, Kenya

Indicator AIDS Survey, Kenya Service Provision Assessment)

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	242,484	0

Narrative:

The Kenya drug use epidemic's prevalence is 18.3%, over two times more than that of the general population. HIV prevalence amongst PWID is 18.3% amongst needle-sharing sharing IDUs, prevalence is 30% while for non-needle sharing PWID, it is 5%. This mechanism will target the PWUD/PWID population with appropriate targeted responses to each of the sub-groups within the PWUD/PWID population to address their varied risk profiles. These will include social networks of drug-users, addressing high risk sexual practices such as multiple sexual partners and unprotected sex and drug injecting practices such as needle-sharing and flash-blood practices among users and their peers. Women who use or inject drugs face additional risks due to their engagement in sex work and in transacting sex for drugs. They also face additional stigma, which becomes exacerbated in the event of a pregnancy. These behaviors are reinforced by multiple determinants such as criminalization of injecting drug use, and poverty among majority of the self-identified PWUD/PWID. Children of female PWID will also be linked to appropriate wrap around services that address gender and the needs of continually abused children. This mechanism will support the set up and scale up of a comprehensive package of services targeting 1,000 PWID/PWUD in the Coast region where BOMU works. A 9-intervention package of services per the PEPFAR and UNAIDS/UNODC guidelines will be offered to include Medication-Assisted Treatment (MAT) for drug-dependence treatment, ART, HTC, STI prevention and treatment, Condom demonstration and distribution for PWID and their partners, targeted behavioral interventions and IEC materials, TB diagnosis and treatment and vaccination, diagnosis and treatment of viral hepatitis. Methadone and other MAT drugs and supplies will be centrally procured through a designated supply chain and therefore funds under this mechanism may not be used for drug procurement, unless under special circumstances. Per PEPFAR guidance, funds in this mechanism may not be used to procure Needle and Syringe Program (NSP) supplies but the program may work with other partners to support NSP. This program will work collaboratively with the public health sector/Coast Provincial Director of Medical Services, participate in national MARPS and PWUD/PWID forums careful planning with a broad range of community and local administration stakeholders with a view to enlisting the crucial buy-in and support for an enabling environment. Training will be conducted in collaboration with the national training program for use of national PWID guidelines and MAT treatment protocols. Out-patient treatment will be the desirable model of offering MAT, backed by a close follow-on addiction counseling therapy. PWID/PWUD and MAT treatment services will be integrated with the HIV comprehensive, care and treatment program that is currently implemented under this mechanism

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	50,000	0

Narrative:

Mkomani Clinic Society (MCS) will support implementation of PMTCT services in Coast Province, where they have been supporting 4 sites since 2010. Coast Province has an HIV prevalence of 3.4%. By March 2011 SAPR, MCS had counseled and tested 15,850 pregnant women and given ARV prophylaxis to 1,325 HIV positive pregnant women and 399 infants.

In FY12, MCS will offer HIV counseling and testing to 2,857 pregnant women at ANC and give ARV prophylaxis to 204 HIV infected pregnant women. HIV infected women will receive a CD4 test after undergoing WHO clinical staging. MCS will give HAART to all eligible HIV positive pregnant women in line with the revised PMTCT national guidelines. In FY13, MCS will increase the number of pregnant women counseled to 3,000, offer ARV prophylaxis to 247 pregnant women and infants, and offer EID for 213 infants.

MCS will focus on 4 prongs of PMTCT: primary prevention; family planning; ARV prophylaxis to all HIV positive pregnant mothers and exposed infants; and care and treatment to eligible HIV positive mothers, partners, and children. The minimum care package will include health and HIV education, individual/ family HIVCT, clinical/laboratory monitoring and assessment, OI screening and treatment, ARV prophylaxis and treatment for both mother and baby, nutritional support, psychosocial support, PWP, follow up, retention, referral, and linkages. MCS will incorporate TB screening into routine antenatal care.

Efforts will be made to reach 900 of 1st visit ANC attendees with couple CT to identify discordant and concordant couples to improve primary prevention and facilitate linkage to HIV care and treatment for the eligible. Integration of ART in MCH clinics and increased access to FP/RH services will be supported. MCS will establish or strengthen infection control and waste management activities.

MCS will support hospital delivery through provision of delivery beds and sterile delivery packs, training, working with CHWs and TBAs to promote community-facility referral mechanism, health education, and community services providing skilled birth attendance.

MCS will support safe infant feeding practices as per national guidelines and support enrollment and follow up of 213 of babies born to HIV infected mothers to access CTX, ARV prophylaxis and EID services using the HIV exposed infant register till 18 months. MCS will facilitate ART initiation for those who test positive before 2 years.

MCS will adopt efficient retention strategies for mothers and babies by supporting use of diaries and registers for tracking defaulters, having a structured mentorship and supervision plan (train 30 health workers in FY12 and equal number in FY13), enhancing data quality and streamlining M&E gaps including orientation of new MOH ANC/maternity registers, and utilizing data at facility level for program improvement and quarterly progress reports to CDC.

Program quality and proficiency testing will be emphasized to validate PMTCT results.
MCS will train HCWs on PMTCT and provide orientation to the revised PMTCT and infant feeding guidelines and engage in community activities for demand creation for health services such as male involvement with couple CT services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	2,263,450	0

Narrative:

Mkomani Clinic Society (MCS) will support treatment in 4 sites in Coast Province. Coast Province has an estimated population of 3.3 million people with an estimated adult HIV prevalence of 8.1% compared to the national 7.1%. Since 2010, MCS has been supporting treatment in 4 sites as a local transition partner from New York University in Coast Province. As of SAPR 2011, 11,099 adults had ever been initiated on ART and 8,793 were active.

In FY12, MCS will jointly work with the Ministry of Health (MoH) to continue supporting expansion and provision of quality adult HIV treatment services in line with MoH guidelines to 12,614 patients currently receiving ART and 2,995 new adults resulting to cumulative 15,137 adults who have ever been initiated on ART. In FY13, this number will increase to 14,864 currently receiving ART and 3,030 new adults resulting to 18,167 adults who have ever been initiated on ART.

MCS in collaboration with MoH will support in-service training of 50 and 30 health care workers (HCW) in FY12 and FY13 respectively, identify human resources and infrastructure gaps and support in line with MoH guidelines, and support good commodities management practices to ensure uninterrupted availability of commodities.

MCS will support provision of a comprehensive service package to all PLHIV including ART initiation for those eligible; laboratory monitoring including biannual CD4 testing, viral load testing for suspected treatment failure (through strengthened laboratory network); cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH; and improved OI diagnosis and treatment including TB screening, diagnosis and treatment.

MCS will continue to support ongoing community activities and support for HIV infected individuals including peer education and use of support groups to strengthen adherence; effective and efficient retention strategies; referral and linkages to psychosocial support groups; economic empowerment projects; Home Based Care; and food and nutrition programs. MCS will support provision of friendly services to youth and special populations. MCS will adopt strategies to ensure access and provision of friendly HIV treatment services to all including supporting peer educators, support groups, disclosure, partner testing, and family focused care and treatment.

MCS will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services, integrate them into routinely collected data, use the results to evaluate and improve clinical outcomes, and support short term activities that improve impact and patient outcomes. Additionally, MCS will do cohort analysis, report retention rates as required by the national program, and discuss the analysis results with facility staff in order to improve program performance
MCS will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Use of an electronic medical records system will be supported and strengthened.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	130,000	0

Narrative:

Mkomani Clinic Society (MCS) will support pediatrics activities in Coast Province, which has an estimated population of 3.3 million people with an estimated HIV prevalence of 8.1% compared to the national 7.1%. MCS has been supporting HIV treatment activities as a local transition partner from New York University in 4 treatment sites in Coast Province. As of SAPR 2011, 1,425 pediatrics were ever initiated on ART and 946 were active.

In FY12, MCS will jointly work with the Ministry of Health (MoH) at all levels to continue supporting, expanding and ensuring provision of quality pediatric HIV treatment services as per MoH guidelines to 1,531 pediatrics currently receiving ART and 306 new pediatrics resulting to cumulative 1,837 pediatrics ever initiated on ART. In FY13, this number will increase to 1,731 pediatrics currently receiving ART and 276 new resulting to a cumulative 2,113 pediatrics ever initiated on ART.

MCS will support comprehensive pediatric ART services including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization; management of childhood illnesses; OI screening and diagnosis; WHO staging; ART eligibility assessment; laboratory monitoring including 6 monthly CD4, hematology, and chemistry (through strengthening of lab networks); Pre-ART adherence and psychosocial counseling; initiation of ART as per MoH guidelines; Toxicity monitoring; treatment failure assessment through targeted viral load testing; Adherence strengthening; and enhanced follow up and retention. MCS will also support EID as per MoH guidelines and PITC to all children and their care givers attending Child welfare clinics; support family focused approach; and support community outreach efforts and integration of HIV services in other MNCH services.

MCS will support hospital and community activities to meet the needs of the HIV infected adolescents: support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services, and support their transition into adult services.

MCS will support in-service training of 50 and 40 HCWs in FY12 and 13 respectively and provide continuous mentorship and capacity building of trained health care workers on specialized pediatric treatment including management of ARV treatment failure and complicated drug adverse reactions. MCS will identify human resources and infrastructure gaps and support in line with MoH guidelines as well as support good commodities management practices to ensure uninterrupted availability of commodities. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will additionally be optimized. *MCS will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, MCS will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. MCS will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.*

Implementing Mechanism Details

Mechanism ID: 12664	**Mechanism Name: Clinical Services**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: African Medical and Research Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,283,499	
Funding Source	**Funding Amount**
GHP-State	1,283,499

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Africa Medical Research Foundation's (AMREF) goal is to implement high quality prevention, care, & treatment of HIV, sexually transmitted infections, and related opportunistic infections in the Kibera slums where the HIV

prevalence is almost twice the national. AMREF also has a Maternal, Newborn and Child Health and a School Health project in Kibera. The three projects work in an integrated manner with a strong focus on women and children, leveraging on each other's resources while providing different entry points to proving better health care for the people in Kibera.Cost efficiency is being addressed through integration of services, use of existing evidence-based efficient strategies, task shifting, implementing more facility-based training and mentorship as opposed to offsite training, evaluating cost effective strategies for defaulter management, LAB networking, and mobilization. AMREF is closely working with the government, local community based organizations and community members in project implementation by building their capacity & ensuring that project activities are well coordinated and in line with the governments priorities. AMREF is also supporting the implementation of the community strategy which enables better planning, coordination and the efficient use of resources. AMREF is working closely with the government through the MOH & the District Health Management Team. The community health centre in Kibera is run jointly by AMREF & the government. The government posts staff to the facility and the plan is to eventually hand over the facility to the government to run it while AMREF continues to offer technical support.
Since 2004 AMREF has procured 4 vehicles. No vehicle will be required in FY 12 and 13. This activity suppports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	12,835
Gender: GBV	5,000
Gender: Gender Equality	10,000
Human Resources for Health	573,863
Renovation	60,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**12664**
Mechanism Name:	**Clinical Services**
Prime Partner Name:	**African Medical and Research Foundation**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	300,000	0

Narrative:

AMREF will continue to support comprehensive HIV care and support in 4 health facilities in Langata District, Nairobi, namely: Kibera AMREF, Ushirika, Uhuru Camp and Langata health center. By March 2011 AMREF had cumulatively enrolled 6,398 in HIV care; of these 3106 patients were active and on cotrimoxazole prophylaxis. The overall patient retention stood at 67%.

AMREF will work with the Ministry of Health (MoH) at the provincial, district and health facility level, to jointly plan, coordinate, implement and ensure provision of quality HIV care and support to 3,604 adult patients in FY12 and 4,139 adult patients in FY13.

AMREF will offer a package of services including: HIV testing to partners and family members of index patients and enrolling or referring/linking those that test HIV positive to care and support; provision of Basic Care Kit (safe water vessel, multivitamins, insecticide-treated mosquito nets, chlorine for water treatment and educational materials); supplemental and therapeutic nutrition (FBP) to all eligible HIV positive patients; prevention with positives(PwP); and family planning and reproductive health services including cervical cancer screening to all enrolled women.

AMREF in collaboration with MoH will support targeted capacity building (training and mentorship) for health care workers and offer continuous medical education on care and support, such as OI diagnosis and treatment. AMREF will identify areas with staff shortages, support recruitment of additional staff, and support good commodities management practices to ensure uninterrupted supply of commodities. AMREF will also support

ongoing community interventions for HIV infected individuals, including peer education and support groups (for adherence messaging and psychosocial support), defaulter tracing and follow up to improve retention in all facilities; water, sanitation and hygiene programs; economic empowerment and income generating activities; home based care services; gender based violence support programs; vocational training; social and legal protection; and food and nutrition (food security) programs.

AMREF will adopt strategies to ensure access and provision of friendly services to youth, elderly and disabled populations. Strategies to increase access of care services by men will be employed, including supporting male peer educators, mentors and support groups, and supporting women to disclose and bring their male partners for testing, care and treatment. AMREF will continue to strengthen data collection and reporting at all levels to improve reporting to National AIDS and STI Control Programme (NASCOP) and PEPFAR. AMREF will adopt the New Generation Indicators and support the development and use of electronic medical records system in accordance with NASCOP's guidelines. AMREF will continue using the quality of care indicators (CQI) for monitoring the quality of HIV care and support services and integrate them into routinely collected data. The CQI results will be used to evaluate and improve clinical outcomes. AMREF will do cohort analysis and report retention rates as required by NASCOP. AMREF will support joint Annual Operation Plan (AOP) planning, implementation, monitoring and evaluation and health system strengthening to facilitate sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	100,000	0

Narrative:

African Medical Research Foundation (AMREF) will support TB/HIV activities in 4 health facilities in Nairobi: Kibera AMREF, Ushirika, Uhuru and Langata. Nairobi province has HIV prevalence of 8.8% and reported 2,974 HIV positive patients screened for TB between April and June 2011. The HIV prevalence in TB infected patients is 45.5%. AMREF has been supporting TB/HIV services in the 4 sites since 2003 in line with the Ministry of Health Division of Leprosy, Tuberculosis and Lung Disease (DLTLD) and the National AIDS and STI Control Program NASCOP. By the end of March 2011 (SAPR 11), 600 TB patients received HIV testing, 288 TB HIV confected patients were identified. A total of 5,480 HIV positive patients were screened for TB.

In the next two years covering FY 12 and FY 13, AMREF will intensify efforts to detect TB cases through clinical exams, laboratory investigations and ensure successful TB treatment through provision of appropriate treatment. AMREF will ensure that each facility providing TB/HIV services has adequate and well trained clinical staff supported by well equipped and staffed laboratory, including sputum specimen transport where laboratory services are unavailable.

To reduce the burden of TB in HIV infected patients, AMREF will support intensified TB screening at each clinical

encounter using the national screening tool for 3204 and 3679 HIV infected patients in FY12 and FY13 respectively. It is expected that 160 co-infected patients identified in FY12 and 184 co-infected patients in FY13 will be put on TB and HIV treatment. All patients without active TB will be provided with Isoniazid Preventive Therapy (IPT) as per national IPT protocol.

To reduce the burden of HIV in TB patients, AMREF will ensure that at least 95% of TB patients are screened for HIV and 80%TB-HIV co-infected patients are put on cotrimoxazole and ARVs as early as possible regardless of the CD4 count as per the national guidelines. AMREF will support the "one stop" model that provides integrated TB and HIV services in all TB clinics. All TB clinics will be stocked with cotrimoxazole and ARVs, and 60 HCW trained as needed.

To strengthen TB infection control in HIV settings, AMREF will ensure that the national IC guidelines are available at all sites and training of staff on IC is done. AMREF will support scaling up of at least 2 components of the national TB infection control strategy in HIV care settings, one of which should be fast tracking of patients with cough for expedited diagnostic work up and treatment

To improve surveillance and management of drug-resistant TB, AMREF will support timely transport of sputum specimens of TB retreatment cases from health facilities to the central reference laboratory for drug susceptibility testing and ensure return of the results to those facilities AMREF will also support scaling up of drug-resistant treatment sites thus expanding access to MDRTB treatment.

AMREF will also support expansion of prevention with positive (PwP) services in TB clinics, TB/HIV control activities in the prisons, strengthening linkages between facility and community-based services, and improving patient referrals and tracking systems. To strengthen HVTB program monitoring, AMREF will support reporting of selected custom indicators to assist with program management and evaluation and monitoring of new activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	30,000	0

Narrative:

AMREF is in year 2 of PEPFAR II, since October 2010. AMREF will support pediatric services in 4 health facilities in Nairobi's Langata District: Kibera AMREF, Ushirika, Uhuru Camp and Langata. By March 2011 AMREF had 296 children in care.

In FY 12 AMREF will provide care and support services to 376 children currently on care. The number of children currently on care will increase to 440 during the FY 13.

AMREF will provide comprehensive, integrated quality services, and scale up to ensure 352 HIV infected infants are put on ARV prophylaxis and all HIV exposed children access pediatric care services. AMREF will improve access to cryptococcal antigen testing, TB screening and management; pain and symptom relief and management; and psychosocial support (including disclosure counseling and support) provided through education, counseling and linkages to facility or community based support groups. AMREF will strengthen the provision of therapeutic or supplementary feeding support to children with growth faltering, provision of vitamin A, zinc, and de-worming); provision of safe water, sanitation and hygiene interventions (WASH) in the community and health facilities to prevent diarrhea and other illnesses among the HIV infected, exposed and other children in the community; and malaria screening, treatment and provision of long lasting insecticide treated nets in malaria endemic areas. Emphasis will be on enhanced follow up and retention of all identified HIV infected and exposed children.

AMREF will support the integration HIV services into routine child health care and survival services in the maternal child health department, including growth and development monitoring, immunization as per the Kenya Expanded Program on Immunization guidelines, case management of diarrhea, pneumonia, and other childhood illnesses, and community outreach efforts. They will also support the care of the newborn by supporting hospital delivery and ensuring that there is provision for newborn resuscitation and care (thermal care, hygiene cord care), and prophylactic eye care.

AMREF will support hospital and community activities to provide the needs of the HIV infected adolescents such as support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, support for transitioning into adult services and teaching life skills.
AMREF will ensure optimized linkages of children to various programs, including TB/HIV, PMTCT and OVC services, and other community based programs, including education, protection and legal and social services.

AMREF will also support relevant class-based and on-job trainings, including continuous medical education. AMREF will strengthen pediatric data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. With guidance from the national PEPFAR office, the new generation indicators will be adopted. To improve the quality of care and strengthen pediatric services AMREF will support supervision and mentorship activities and use the quality of care indicators (CQI and HIVQuaL) for monitoring the quality of pediatric HIV services that have been adopted by NASCOP and integrate them into routinely collected data.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	63,877	0

Narrative:

Target population: AMREF will continue to provide high quality HTC services to all patients and accompanying relatives and friends attending 4 health care facilities within Kibera and surrounding communities in Nairobi. They

include couples, pregnant women, post natal clients, family planning clients, TB patients, outpatient clients, maternity patients, child welfare clinics and in the in-patient wards. Current HIV prevalence in Kibera is estimated to be 15%. HTC Approaches: AMREF utilizes both client and provider initiated HIV testing and counseling (PITC) strategies. Family testing (facility based or targeted home testing) has been introduced in an effort to reach out to sexual partners and children of HIV infected index clients. HTC is provided everywhere in the facility where the patients come in contact with the health workers-ANC, TB clinic, outpatient clinic, pediatric clinic, MCH clinic, Social work, Nutrition etc. Achievements and targets: In the past one year, AMREF had a target to counsel and test 15,000 persons in health facilities (excluding PMTC settings) and they managed to reach a total of 16,903 (112%) with 1229 testing positive (7,3%). Out of this number, 351 were tested as couples. A total of 35 health care workers have been trained in PITC. For COP 2012, AMREF will targets to test 24,000 persons of which 20% of them will be tested as couples, 10% will be children below the age of 15. Testing algorithm: National HIV testing algorithm is used. Referrals and linkages: Clients who test HIV positive are escorted to CCC where their demographic details are taken including the patients' contact information. Client referral forms have been introduced and staffs have been trained on how to use them. In addition, introduction and use of Electronics Medical Records system has made it easier to follow up on individual patients. AMREF also uses a family form to ensure that it is able to track all the members of a family if one of them tests positive in the four supported facilities. Promotional activities for HTC: AMREF employs several strategies to promote HTC. These include the use of community radio to promote the importance of HTC including couple testing; production and distribution of IEC materials to promote HTC; Combination of HTC with outreaches to provide medical care; and Identification of strategies to promote male involvement in ANC. In addition to this, all patients are given health talks including the need for HIV counseling and testing and the importance of couple testing. Quality management: All AMREF supported health facilities are participating in Proficiency testing program as required. AMREF has also instituted the use of observed practice and counselor support supervision to ensure quality of counseling and testing. There is also the use of EQA at the National Referral Laboratory on every 20th client. Monitoring and evaluation: AMREF uses all ministry of health' tools to capture HTC data, both for couples and individual patients. These include HTC lab Register and Facility summary tool (MOH 711). MOH approved HTC lab registers have been introduced at all HIV testing points except PMTCT. The team is working in close collaboration with the facility management team to ensure timely and accurate reporting to Ministry of Health and to the Donor.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

AMREF implements comprehensive prevention, care and treatment programs in Nairobi province. In FY 2012/13, AMREF will expand HIV prevention services to include evidence based behavioral interventions (EBIs) for specific target populations in clinical settings at comprehensive care center (CCC), TB and Maternal Child Health (MCH) clinics as part of HIV combination prevention programs. The EBIs will include Positive Health and Dignity

Prevention (PHDP) targeting adult male and female and adolescents living with HIV (PLHIV); and Sister to Sister EBI (S2S) targeting sexually active HIV negative women attending the MCH clinics. PHDP is an ongoing 5-10min group and individual level intervention that targets PLHIV in clinical and community settings. This mechanism will support this intervention which constitutes of ART adherence counseling and support; partner and family testing; provision of PEP to the discordant spouse; treatment for prevention once approved; safer pregnancy counseling and provision of modern contraception; sexual risk reduction counseling including reduction of sexual partners, alcohol counseling, promoting of consistent and correct condom use; Sexually Transmitted Infections (STI) screening and treatment and using meaningful involvement of people living with HIV/AIDS (MIPA). The efficacy of PHDP has been shown to be 68% in preventing transmission of HIV, and 96% in treatment for prevention.

S2S is a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use. Condoms are 80% effective in heterosexual relationships when used correctly and consistently.

AMREF will use HVOP funding to recruit and support appropriate peer educators/counselors to reinforce prevention messages delivered by health providers as a feasible model for task-shifting in the provision of PHDP in clinical settings, and specifically promote MIPA. It will support placement of 5 Peer Educators at the MCH, TB and CCC Clinics in hospitals, and 2 Peer educators at health centers and provide appropriate counseling space. One of the peer educators will do regular client home follow up to strengthen ART adherence.

Approximately 1.6 million Kenyans are PLHIV. The Kenya AIDS Indicator Survey 2007 showed 6% of couples to be in discordant relationships. Nairobi province HIV Prevalence is high (8.8%). AMREF will reach 2030 (60%) PLHIV in FY2012 and 2725 (70%) in FY 2013 with a minimum package of PHDP. It will implement S2S EBI on a pilot basis.

Quality assurance for EBIs will be promoted through appropriate training and certification of peer educators using approved national curricula, standard job-aids and guidelines and regular supervision.

AMREF will work with appropriate national Technical Working Groups (TWG) to support integration of HIV prevention into care and treatment programs in clinical settings. These programs will also be linked to other HIV community programs. PLHIV will be specifically linked to STI and FP services, as necessary, through patient escorts.

Monitoring of PHDP and S2S will be done through the review/input of AMREF implementation plan, analysis of KePMS data, quarterly reviews, semiannual and annual reports. Evaluation will be conducted through operation research of combination HIV prevention and periodic surveys (Kenya Demographic and health survey, Kenya Indicator AIDS Survey, Kenya Service Provision Assessment).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	74,000	0

Narrative:

AMREF will support 4 PMTCT sites in Langata District with about 4000 expected pregnancies annually and HIV prevalence of 11%. By end of March 2011 SAPR, AMREF had counseled and tested 1763 pregnant women, given ARV prophylaxis to 163 HIV positive pregnant women and 91 infants, and trained 33 Health Care Workers in PMTCT.

In FY12, AMREF will offer HIV counseling and testing to 3,810 pregnant women attending ANC and give ARV prophylaxis to 336 HIV infected pregnant women. The HIV infected women will receive a CD4 test after undergoing WHO clinical staging. AMREF will give HAART to all eligible HIV positive pregnant women, in line with the revised PMTCT national guidelines. In FY13, AMREF will increase the number of pregnant women counseled to 4,000, offer ARV prophylaxis to 409 pregnant women and 352 infants, and offer EID to 352 infants.

AMREF will focus on 4 prongs of PMTCT: primary prevention; family planning; ARV prophylaxis to all HIV positive pregnant mothers and exposed infants; and care and treatment to eligible HIV positive mothers, partners and children. The minimum care package will include health and HIV education, individual/family HIVCT, clinical/laboratory monitoring and assessment, OI screening and treatment, ARV prophylaxis and treatment for both mother and baby, nutritional support, psychosocial support, PWP, follow up and retention, referral and linkages. AMREF will also incorporate TB screening into routine antenatal care.

AMREF will support ART integration into MCH clinics, access to FP/RH services, and establish or strengthen infection control and waste management activities. Hospital delivery will be supported through provision of delivery beds and sterile delivery packs, training, working with CHWs and TBAs to promote community-facility referral and health education.

AMREF will support enrollment and follow up of 352 HIV exposed infants to access CTX, ARV prophylaxis, safe infant feeding practices as per national guidelines and other EID services using the HIV exposed infant register until 18 months. AMREF will facilitate ART initiation for those who test positive before 2 years.

AMREF will adopt retention strategies for mothers and babies by supporting use of diaries and registers for tracking defaulters, having a structured mentorship and supervision plan, enhancing data quality and streamlining M&E gaps including orientation of new MOH ANC/maternity registers and utility of data at facility level for program improvement and quarterly progress reports to CDC.

AMREF spends $18 per woman for PMTCT, which will now stretch to cover all PMTCT prongs and wrap around

like malaria prevention in line with GHI principles. Program quality and proficiency testing will be emphasized to validate PMTCT results.

AMREF will train 30 HCWs in both FY12 and FY13 on the revised PMTCT and infant feeding guidelines. AMREF will conduct community engagement activities to strengthen referral linkages and also increase demand for ANC and other health services such as couple CT services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	675,622	0

Narrative:

African Medical Research Foundation (AMREF) will support treatment services in 4 sites within Langata district in Nairobi Province. Nairobi province has an estimated population of 3.1 million people with an estimated adult HIV prevalence of 8.8% compared to the national 7.1%. By the end of March 2011 SAPR results, AMREF had initiated 3,016 adults and children of ART of whom 2000 were active.

In FY12, AMREF will jointly work with the Ministry of Health (MoH) to continue supporting expansion and provision of quality adult HIV treatment services in line with MoH guidelines to 2,092 patients currently receiving ART and 313 new adults resulting to cumulative 2,511 adults who have ever been initiated on ART. In FY13, this number will increase to 2,327 currently receiving ART and 317 new adults resulting to 2,828 adults who have ever been initiated on ART.

AMREF will support in-service training of 50 and 40 HCWs in FY 12 and 13 respectively, continuous mentorship and capacity building of trained health care workers; identify human resources and infrastructure gaps and support in line with MoH guidelines; support good commodities management practices to ensure uninterrupted availability of commodities.

AMREF will support provision of comprehensive package of services to all PLHIV including ART initiation for those eligible; laboratory monitoring including biannual CD4 testing, viral load testing for suspected treatment failure (through strengthened laboratory networks); cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH; improved OI diagnosis and treatment including TB screening, diagnosis and treatment.

AMREF will continue to support ongoing community activities and support for HIV infected individuals including education by peer educators and use of support groups to strengthen adherence, effective and efficient retention strategies; referral and linkages to psychosocial support groups, economic empowerment projects, and Home Based Care, food and nutrition programs. AMREF will support provision of friendly services to youth and special

populations. Additionally, AMREF will do cohort analysis and report retention rates as required by the national program and discuss the analysis results with facility staff in order to improve program performance
AMREF will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services integrate them into routinely collected data; use the results to evaluate and improve clinical outcomes and additionally support short term activities with great impact and better patient outcomes.

AMREF will adopt strategies to ensure access and provision of friendly HIV treatment services to all including supporting peer educators, support groups, disclosure, partner testing and family focused care and treatment. AMREF will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Use of an electronic medical records system will be supported and strengthened.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	40,000	0

Narrative:

African Medical Research Foundation (AMREF) will support implementation of pediatrics services in Langata Districts in Nairobi Province. Nairobi province has an estimated population of 3.1 million people with an estimated adult HIV prevalence of 8.8% compared to the national 7.1%. AMREF has been supporting pediatric ART services in 4 sites (Kibera AMREF, Ushirika, Uhuru camp and Langata Health Center) in Nairobi's Langata district and by the end of March 2011 SAPR results 148 children had been initiated on ART of whom 84 were active. In FY12, AMREF will jointly work with the Ministry of Health (MoH) at all levels to continue supporting, expanding and ensuring provision of quality pediatric HIV treatment services as per MoH guidelines to 132 children currently receiving ART and 26 new children resulting to cumulative 159 children ever initiated on ART. In FY 13, this number will increase to 161 children currently receiving ART and 24 new resulting to cumulative 183 children ever initiated on ART. AMREF will support comprehensive pediatric ART services including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization; management of childhood illnesses; OI screening and diagnosis; WHO staging; ART eligibility assessment; laboratory monitoring including 6 monthly CD4, hematology and chemistry (through strengthening of lab networks); Pre-ART adherence and psychosocial counseling; initiation of ART as per MoH guidelines; Toxicity monitoring and treatment failure assessment through targeted viral load testing; Adherence strengthening; enhanced follow up and retention; support EID as per MoH guidelines and PITC to all children and their care givers attending Child Welfare clinics; support family focused approach; community outreach efforts and integration of HIV services in other MNCH services.

AMREF will support hospital and community activities to support the needs of HIV infected adolescents through support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services and support their transition into adult services.

AMREF will support in-service training of 50 and 40 HCWs in FY 12 and 13 respectively, continuous mentorship and capacity building of trained health care workers on specialized pediatric treatment including management of ARV treatment failure and complicated drug adverse reactions; identify human resources and infrastructure gaps and support in line with MoH guidelines; support good commodities management practices to ensure uninterrupted availability of commodities. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will additionally be optimized. *AMREF will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, AMREF will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. AMREF will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.*

Implementing Mechanism Details

Mechanism ID: 12970	**Mechanism Name: Pre-Service Training**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Johns Hopkins University Bloomberg School of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,030,522	
Funding Source	**Funding Amount**
GHP-State	2,030,522

Sub Partner Name(s)

Christian Health Association of Kenya	KMTC	

Overview Narrative

John Hopkins University supports pre-service training in mid level colleges in Kenya. The objective of the Pre-service HIV education program is to strengthen pre-service education with a focus on HIV/AIDS at all mid-level medical training colleges (MTCs) in Kenya. The ultimate goal of this project is to support the 53 public and private MTCs to ensure the graduating students from six classes of health professionals are competent to provide HIV/AIDS services without needing in-service training.

This program responds to the GHI principle of increasing impact through strategic efficiencies by using pre-service training to reduce in-service training needs. In turn, pre-service training strengthens health systems by supporting cadres of fully trained, new health care providers. The program is working with Academic Boards to make sure the HIV/AIDS teaching materials are integrated into their training programs. An effective and efficient pre-service program will significantly reduce in-service training needs thereby substantially reducing the cost to the programs. Activities under this program will include program evaluation and monitoring of the training programs. These assessments will measure whether students have attained the required competencies before they graduate.

The program is working closely with two local organizations: Kenya Medical Training College which runs 29 public MTCs, and Christian Health Association of Kenya . By building the capacity of these two institutions, the program is well suited to ensure the activities are continued long after the program ends.

The program has one vehicle purchased in 2010 and will require one more vehicle to effectively provide supportive supervision and other program activities.

This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Gender: GBV	10,000
Gender: Gender Equality	20,000
Human Resources for Health	1,500,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12970		
Mechanism Name:	Pre-Service Training		
Prime Partner Name:	Johns Hopkins University Bloomberg School of Public Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVTB	230,000	0

Narrative:

John Hopkins University (JHPIEGO), which is a lead in a consortium of Danya, Kenya Medical Training College (KMTC), Christian Health Association of Kenya (CHAK), supports training of tutors, strengthening of the Nursing, Clinical Medicine, Oral Health/Dental, Pharmaceutical Technology, Laboratory Technology and Technicians, Public Health, Nutrition, Social Work and other health professions curricula among other Departments. JHPIEGO also supports targeted infrastructure support to improve quality of training and support critically needed supplies/equipment for laboratories and skills laboratories. The goal of this award is to support midlevel medical training colleges (MTCs) to produce graduates who are ready and competent to provide comprehensive HIV/AIDS services without needing in-service training. In addition, the program will support scholarships to support human resource for the MTCs and production of cadre specific HIV/AIDS materials.

JHPIEGO will continue to support strengthening pre-service and in-service training nationally with focus on pre-service HIV Education and Training in public and faith-based MTCs. The students will be trained in all areas of HIV management including HIV diagnosis, prevention, treatment, care and support using integrated curricula and innovative training methods that incorporate TB-HIV materials into the mainstream HIV management training, in line with existing National standards for TB/HIV integration activities. To date, the project has built capacity of 200 tutors from all the 53 MTCs in Kenya on effective teaching skills or student performance assessment or IT skills while 50 tutors who have been identified as master trainers have received training on updated HIV content. Tutors now have the capacity to effectively deliver HIV/AIDS trainings to students in MTCs.

JHPIEGO will support training Adult HIV treatment and all aspects of HIV diagnosis, prevention, treatment, care and support by developing curricula that incorporate materials developed and approved by the National AIDS and STD Control Program (NASCOP), KMTCT, and other MTCs as well as respective professional and regulatory bodies and provide trainings for health care workers in all MTCs including private MTCs and will incorporate

components of post training follow up and quality assurance.

The trainings will use integrated, innovative and comprehensive curricula. For example the TB-HIV trainings will adopt and adapt the new NASCOP curriculum and Division of Leprosy, TB, and Lung Disease (DLTLD) guidelines/materials. The training will utilize expert patients to mount skills stations for skills training. The cadre specific materials being revised will ensure all relevant graduates have sufficient knowledge, attitude and skills to support TB-HIV services. Emphasis of the 3Is will be covered in the pre-service training programs. This activity links to other TB/HIV activities (HVTB) provided by comprehensive clinical services. Funds will support refresher training of faculty as well as well as basic laboratory microbiology capacity and link to the laboratory training in order to meet the increased needs of TB testing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	0	0

Narrative:

The child health training program will build knowledge and capacity of 6500 health workers in community case management of pneumonia, malaria and diarrheal diseases in the highest HIV prevalence areas of Western, Nyanza and Coast Provinces. The training curricula consist of community case management of uncomplicated pneumonia, diarrheal diseases, and malaria in areas with poor access to healthcare, and the ability to refer complicated cases to the facility level. Activities for the health workers include training targeted at increased diagnosis and management of pneumonia, diarrheal diseases, and malaria. These activities will be achieved through implementation and scale-up of the Integrated Management of Childhood illnesses (IMCI) and use of rapid diagnostic tests for HIV, malaria, and other diarrheal diseases. All of these activities are defined as Government of Kenya (GOK) priorities and are stipulated in the national health services strategic plan. The GOK and other partners will continue to support these activities either through the national or county governments in the event that PEPFAR funding is only provided for the initial implementation period.

The Government of Kenya has also developed a community health strategy that relies on community based health workers to reach mothers and their children within their households. Lifesaving interventions and messages will be scaled up to reach children living with HIV/AIDS and therefore enable prevention of opportunistic infections which will result in improvement of quality of life. Proposed activities include the development and deployment of eLearning materials and messages that can be deployed through a variety of different mobile technologies to include smartphones, SMS, DVD, and internet-based. The focus of these will concentrate mainly on promotion of prevention methods, healthy behaviors at household level including exclusive breastfeeding for children below 6 months, appropriate complementary feeding, dietary diversity targeting -9 to 24 months period, use of long-lasting insecticide-treated bed nets (LLINs), hand washing with soap, safe water storage and treatment and community-led total sanitation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	200,000	0

Narrative:

Since COP 2009, JHPIEGO, an affiliate of the Johns Hopkins University, has worked in partnership with KMTC, CHAK, Danya and NASCOP to strengthen pre-service HIV laboratory training at Kenya Medical Training College and other medical colleges. For the past two years, JHPIEGO has worked with the KMTC faculty to carry out a training needs assessment (TNA) at pre-service level, based on the national guidelines. Based on the TNA, JHPIEGO reviewed existing training curricula and methodologies, while establishing core competencies including HIV diagnosis, quality systems management, commodities management, leadership, biosafety, safe phlebotomy, basic laboratory equipment and step-wise improvement of laboratory quality systems. A product of this effort is a new a modular training curriculum on HIV/AIDS that will be implemented in the 10 diploma training colleges, including national polytechnics.

For the FY 2012, JHPIEGO will build on lessons learnt in 2011 to finalize the implementation of the revised curriculum at the diploma training colleges. This will entail training the faculty/academic members from the Medical Laboratory Sciences (MLS) Departments in Effective Teaching skills (ETS)/Clinical Teaching Skills (CTS) and Student Performance Assessment (SPA) programs. These programs are aimed at improving content delivery in the medical training colleges. In addition, JHPIEGO will partner with Safety Monitoring in International Laboratories (SMILE), a US based QA program specialized web based resources useful for monitoring and supplying lab quality systems such as monitoring results for EQA, preventive actions and web-based access to records and resources, to monitor and provide assistance technical to Kenya labs implementing accreditation. A budget of $300,000 is proposed for JHIEGO to deliver on the following specific activities:

•Finalize and implement the revised curriculum at the 10 diploma training colleges as well as national polytechnics
•Improve and standardize teaching in all the MLS departments of KMTC colleges
•Train 30 faculty/academic members from the MLS Departments in Effective Teaching skills (ETS)/Clinical Teaching Skills (CTS) and Student Performance Assessment (SPA) programs
•Through SMILE, assist 30 medical laboratories implementing accreditation with QA tools for monitoring laboratory improvements, EQA/IQA performance and mounting preventive actions

These activities will have strong linkages with the PEPFAR technical area on training and retention of laboratory professionals as it relates to sustaining pre-service training initiative and to ensure training adequately meets Kenya's needs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	50,000	0

Narrative:

John Hopkins University (JHU) will contribute to the prevention of HIV transmission through safe blood transfusion in Kenya. It will work with the National Blood Transfusion Service (NBTS), CHF, WHO and other relevant MOH structures and in-country partners to update Blood Safety training program at Kenya Medical Training College (KMTC) to be in line with the current international Blood Safety trends and as guided by WHO. It will review the training curriculum for the laboratory, clinical officers and nurses to ensure that any training related to blood safety is updated. Emphasis will be laid in the current methods and technologies of blood testing and processing and evidence based appropriate clinical use of blood and patient monitoring. One approach to strengthen transfusion services in the country is to have a pool of well trained and qualified staff in blood transfusion. Although a training course in higher national Diploma (HND) in Blood Transfusion exists enrollment in the course has been minimal and this has created a gap in qualified staff. JHU will address this challenge and try to popularize this course.

Integration with other activities

Blood safety training will be integrated into relevant trainings and will be viewed as one of the HIV prevention interventions.

Coverage and scope

This activity will specifically focus on pre-service KMTC training for health workers whose work may touch blood for transfusion either in the NBTS, in a clinical laboratory or in a transfusing health facility. JHU will work with KMTC to review and update the specialized HND course in blood transfusion. It will work with NBTS and CHF to identify interested candidates and potential leaders in blood

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	500,000	0

Narrative:

Goals and Objectives

John Hopkins University (JHU) will contribute to the prevention of medical transmission of HIV (and other blood borne pathogens) through sharps and other medical waste. It will do this by supporting training in infection prevention and control (IPC) and blood collection/phlebotomy training. Blood drawing has been recognized as a high risk procedure in the country that puts health workers at risk of acquiring HIV and other blood borne pathogens. CDC has worked in partnership with NASCOP and BD Company in a public-private partnership (PPP) to strengthen in-service phlebotomy training throughout the country. The next phase has been to establish a phlebotomy training center of excellence in Nairobi. This funding will scale up this activity to other regions.

Coverage and scope of activities

JHU will support setting up centers of excellence (CoE) for phlebotomy and other sample collection in 5 of its campuses that offer laboratory training in different counties. This will be done by renovating and equipping the current skills demonstration stations and installing the necessary ICT systems for possible e-learning. Dummies and other devices for practical lessons will be provided. All health workers who draw blood and other samples during their work will be expected to rotate in this center including laboratory staff, clinical officers and nurses. JHU will also support 100 in-service trainees to come for a two weeks specialized phlebotomy training in the Nairobi center. In addition JHU will lead the development of a specialized IPC training curriculum that will target those who wish to specialize in this area.

Integration into program

JHU will continue work started in the first year of ensuring integration of injection safety, waste management and infection prevention and control principles into all training curriculum. It will ensure that any HIV pre-service training course at KMTC advocates for IPC and timely access and uptake of post-exposure prophylaxis.

Country ownership and sustainability

By training staff at pre-service level JHU will ensure that they graduate when they are market-ready which will reduce the need for further in-service training. JHU will strengthen the capacity of KMTC which has a national presence spread across the country to offer the required training. Training skills of the tutors will be strengthened and necessary technology as well as infrastructure updated to current international standards. The CoE in phlebotomy will be set up in a flexible way so that other trainings can also be rolled out in the future in the same settings.

Partnerships and collaboration

JHU will work closely with CDC and BD through the existing public private partnerships (PPP) to support this activity. It will also work closely with any other partner that will lead to strengthening of KMTC training capacity.

Quality improvement and M&E

Quality assurance and improvements will be a key component of this program. JHU will ensure this by rolling out a strong monitoring and evaluation system with indicators for tracking along the lifespan of the project.

Commodity security

The training in safe phlebotomy and blood collection will have a component on commodity and logistics management. This will ensure that even as health workers join the working field they have the capacity to ensure appropriate forecasting, procurement and usage of various blood drawing devices.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	90,522	0

Narrative:

John Hopkins University (JHPIEGO), is a lead in a consortium of Danya, Kenya Medical Training College (KMTC), Christian Health Association of Kenya (CHAK). The consortium supports training of tutors, strengthening of the Nursing, Clinical Medicine, Oral Health/Dental, Pharmaceutical Technology, Laboratory Technology and Technicians, Public Health, Nutrition, Social Work and other health professions curricula; targeted infrastructure support to improve quality of training.

In line with the PEPFAR goal of capacity building, the goal of the award is to support midlevel medical training colleges (MTCs) to produce graduates who are ready and competent to provide comprehensive HIV/AIDS services without needing in-service training. In addition, the program will support scholarships to support human resource development for the MTCs and production of cadre specific HIV/AIDS materials.

The project had some delay in startup, however to date, the project has built capacity of 200 tutors from all the 53 MTCs in Kenya on effective teaching skills or student performance assessment or IT skills while 50 tutors who have been identified as master trainers have received training on updated HIV content. Tutors now have the capacity to effectively deliver HIV/AIDS trainings to students in MTCs.

JHPIEGO will continue to support strengthening pre-service and in-service training nationally with focus on pre-service HIV Education and Training in public and faith-based MTCs. The students will be trained across the broad range of HIV management including HIV diagnosis, prevention, treatment, care and support using integrated curricula and innovative training methods that incorporate the national HTC curriculum and guidelines. HTC training will cover all the key technical and operational components articulated in the national HTC guidelines (2007) namely testing approaches that is Client Initiated HTC (CITC) and Provider Initiated HTC (PITC); testing in facility and community settings; the key role of HTC in HIV Prevention and how to optimize this for maximum HIV prevention in the population; Couple HTC; Quality Assurance in HTC and issues surrounding testing of children and minors. The training will also focus on innovative approaches to strengthen linkage between HTC services and HIV Care and Treatment services for the HIV infected individuals.

JHPIEGO will continue to work with USG agencies in collaboration with MOH and regulatory and accrediting bodies and professional associations to address pre-service training. Strengthening of pre-service education with directly respond to government approach of reducing in-service training in Kenya thereby reducing service interruptions. JHPIEGO will contribute 3,300(400 in FY 12 and 13) new healthcare workers graduating competent to provide HIV/AIDS services in the next two years, thus contributing 2.4% of the PEPFAR II goal of 140,000 new pre-service graduates by 2014 and will support KNASP strategies and build the capacity of health care providers to provide quality HIV/AIDS services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	500,000	0

Narrative:

John Hopkins University (JHPIEGO), which is a lead in a consortium of Danya, Kenya Medical Training College (KMTC), Christian Health Association of Kenya (CHAK), supports training of tutors, strengthening of the Nursing, Clinical Medicine, Oral Health/Dental, Pharmaceutical Technology, Laboratory Technology and Technicians, Public Health, Nutrition, Social Work and other health professions curricula; targeted infrastructure support to improve quality of training; and critically needed supplies/equipment for laboratories and skills laboratories.

The goal of this award is to support midlevel medical training colleges (MTCs) to produce graduates who are ready and competent to provide comprehensive HIV/AIDS services without needing in-service training. In addition, the program will support scholarships to support human resource for the MTCs and production of cadre specific HIV/AIDS materials.

To date, the project has built capacity of 200 tutors from all the 53 MTCs in Kenya on effective teaching skills or student performance assessment or IT skills while 50 tutors who have been identified as master trainers have received training on updated HIV content. Tutors now have the capacity to effectively deliver HIV/AIDS trainings to students in MTCs. One key challenge was delay in start up of activities due to funding restrictions on the TNA, which was later lifted after necessary clarifications. Other challenges included unwillingness by institutions to embrace curriculum review especially as some departments had just concluded their curriculum review and staff shortages in the institutions making it difficult to withdraw some staff for capacity building or for important meetings.

JHPIEGO will continue to support strengthening pre-service and in-service training nationally with focus on pre-service HIV Education and Training in public and faith-based MTCs. The students will be trained in all areas of HIV management including HIV diagnosis, prevention, treatment, care and support using integrated curricula and innovative training methods that incorporate the PMTCT curriculum and guidelines. PMTCT training will focus on all the four prongs: primary prevention of HIV; prevention of unwanted pregnancy among HIV positive

women; interruption of MTCT among HIV positive pregnant women; and treatment, care and support of HIV positive women and their partners, children and other members of their families. PMTCT training will be comprehensive with emphasis on elimination of MTCT and integration of PMTCT in other services. Infant and young child feeding will also be included. Linkages to pediatric and adult HIV treatment will be emphasized.

JHPIEGO will continue to work with USG agencies in collaboration with MOH and regulatory and accrediting bodies and professional associations to address pre-service training. Strengthening of pre-service education with directly respond to government approach of reducing in-service training in Kenya thereby reducing service interruptions. JHPIEGO will contribute 3,300(400 in FY 12 and 13) new healthcare workers graduating competent to provide HIV/AIDS services in the next two years, thus contributing 2.4% of the PEPFAR II goal of 140,000 new pre-service graduates by 2014 and will support KNASP strategies and build the capacity of health care providers to provide quality HIV/AIDS services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	430,000	0

Narrative:

John Hopkins University (JHPIEGO) which is a lead in a consortium of Danya, Kenya Medical Training College (KMTC), and Christian Health Association of Kenya (CHAK) supports training of tutors, strengthening of the Nursing, Clinical Medicine, Oral Health/Dental, Pharmaceutical Technology, Laboratory Technology and Technicians, Public Health, Nutrition, Social Work and other health professions curricula among other Departments; targeted infrastructure support to improve quality of training; and support critically needed supplies/equipment for laboratories and skills laboratories. In addition, the program will support scholarships to support human resource for the MTCs and production of cadre specific HIV/AIDS materials.

As of SAPR 2011, JHPIEGO had supported capacity building of 200 tutors from the 53 Medical Training Colleges (MTCs) in Kenya on effective teaching skills or student performance assessment or IT skills while 50 tutors who have been identified as master trainers have received training on updated HIV content. Tutors now have the capacity to effectively deliver HIV/AIDS trainings to students in MTCs.

A total of 500 HCWs will graduate from pre-service training in FY12 and 400 in FY13; 150 HCWs will be provided with in-service training in FY12 and 100 in FY13. JHPIEGO will support training on Adult HIV treatment and all aspects of HIV diagnosis, prevention, treatment, care and support by integrating and design and develop curricula that incorporate materials developed and approved by the National AIDS and STD Control Program (NASCOP) and regulatory bodies. JHPIEGO will provide trainings for health care workers in all MTCs including private MTCs and will incorporate components of quality assurance and post training follow up. The trainings will use integrated, innovative and comprehensive curricula. For example, the adult antiretroviral treatment (ART)

trainings will adapt the new NASCOP curriculum on Integrated Management of Adolescent and Adult Illness (IMAI). The program will also use electronic learning platforms to deliver updated adult treatment materials. Specific materials to enhance skills of pharmaceutical students have been included. Linkages to pediatric and adult HIV treatment will be emphasized.

Activities will also include classroom and practical training of health care workers in antiretroviral (ARV) drug management as part of training on comprehensive care of people with HIV/AIDS. In collaboration with other partners, JHPIEGO will incorporate components of post training follow up and quality assurance. Faculty will also receive continuing medical education (CME) as well as accessing updated materials from resource centres the program will be supporting. JHPIEGO will also assist and collaborate with University of Maryland to support in-service and pre-service university HIV training and build their capacity to design, develop, and deliver quality training and mentorship as well as evaluate and monitor the training and its impact.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	30,000	0

Narrative:

John Hopkins University (JHPIEGO) which is a lead in a consortium of Danya, Kenya Medical Training College (KMTC), and Christian Health Association of Kenya (CHAK) supports training of tutors, strengthening of the Nursing, Clinical Medicine, Oral Health/Dental, Pharmaceutical Technology, Laboratory Technology and Technicians, Public Health, Nutrition, Social Work and other health professions curricula among other Departments; targeted infrastructure support to improve quality of training; and support critically needed supplies/equipment for laboratories and skills laboratories. In addition, the program will support scholarships to support human resource for the MTCs and production of cadre specific HIV/AIDS materials.

As of SAPR 2011, JHPIEGO had supported capacity building of 200 tutors from the 53 Medical Training Colleges (MTCs) in Kenya on effective teaching skills or student performance assessment or IT skills while 50 tutors who have been identified as master trainers have received training on updated HIV content. Tutors now have the capacity to effectively deliver HIV/AIDS trainings to students in MTCs.

A total of 500 HCWs will graduate from pre-service training in FY12 and 400 in FY13; 150 HCWs will be provided with in-service training in FY12 and 100 in FY13. JHPIEGO will support training in Pediatric HIV treatment and all aspects of HIV diagnosis including early infant diagnosis, prevention, treatment, care and support in infants, young children and older children by integrating and design and develop curricula that incorporate materials developed and approved by the National AIDS and STD Control Program (NASCOP) and respective professional and regulatory bodies and will incorporate components of quality assurance and post training follow up. Pediatric antiretroviral treatment (ART) trainings will adopt and adapt the curriculum on Integrated Management of

Childhood Illness (IMCI) and Comprehensive HIV care and treatment in Pediatrics. These activities will include classroom and practical training of health care workers in antiretroviral (ARV) drug management as part of training on comprehensive care of people with HIV/AIDS. Faculty will also receive continuing medical education (CME) as well as accessing updated materials from resource centers the program will be supporting. JHPIEGO will also assist and collaborate with University of Maryland to support training in in-service and pre-service university HIV training and build their capacity to design, develop, and deliver quality training and mentorship and evaluate and monitor the training and its impact.

Implementing Mechanism Details

Mechanism ID: 12979	**Mechanism Name: IDEA**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Reference Bureau	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Under the IDEA (Informing Decision makers to Act) project, the Population Reference Bureau (PRB) brings a fresh vision to providing information about HIV, family planning and reproductive health to policy audiences around the world. In Kenya the IDEA project supports the National Coordinating Agency for Population and Development (NCAPD) to build the capacity of program managers in public and private sector and policy makers in in the health sector and media to analyze health data and utilize it effectively for policy and advocacy efforts. A priority for NCAPD is to strengthen existing relationships and develop new partnerships with other organizations and institutions to expand policy communication and advocacy activities that will reach new decision makers in the years ahead for economic development and social progress. This activity supports GHI/LLC and is completely funded through pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Child Survival Activities
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	**12979**
Mechanism Name:	**IDEA**
Prime Partner Name:	**Population Reference Bureau**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	0	0

Narrative:

This activity budget code will contribute towards PRBs goal of supporting advocacy and policy efforts around HIV, family planning and reproductive health in Kenya with the aim of strengthening information use among policy and decision makers. IDEA project will work with NCAPD to conduct two workshops for public sector and private sector health managers and USG staff to address HIV prevention and care and integration with other services as an important component of development.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Governance and Systems	OHSS	0	0

Narrative:

In order to support advocacy efforts for increasing the health sector allocation towards health services in particular HIV, the project will work with the National Coordinating Agency for Population and Development (NCAPD) to improve data collation including financial information through the NCAPD website. The IDEA project implemented by PRB will continue to work with NCAPD to expand the NCAPD website into a development resource center for stakeholders, government officials, academics, civil society, and the media.

Implementing Mechanism Details

Mechanism ID: 12994	**Mechanism Name: FANIKISHA Institutional Strengthening**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 361,208	
Funding Source	**Funding Amount**
GHP-State	361,208

Sub Partner Name(s)

Danya International, Inc	Pact, Inc.	Regional AIDS Training Network (RATN)

Overview Narrative

The FANIKISHA Institutional Strengthening Project is a 5-year project implemented by Management Sciences for Health, Pact Inc., Danya International, and the Regional AIDS Training Network. This consortium brings together over 25 years of work in Kenya strengthening the institutional capacity of CSOs that improve health and well-being. FANIKISHA aims to improve the capacity of 4 to 8 national level CSOs to strengthen their financial, human resources, and management systems; monitoring and evaluation systems; strategic planning skills; leadership and

governance skills; and advocacy capacity to play a more strategic role in working with the GOK and other stakeholders to deliver effective health services at the community level. Through a competitive selection process, FANIKISHA will award mentored sub-grants to participating CSOs in 2012-13 and additional sub-grants for their affiliates in 2014-15.

Participating Kenyan CSOs must have a national mandate; have a presence in at least 7 counties or 2 provinces; provide or contribute to the GOK's community health response by building capacity of their institutions and that of their affiliates or members; provide sub-grants; and undertake advocacy for increased engagement in health policy issues at the community and national levels. It is anticipated that some CSOs will provide HIV services. The size, age distribution, and other characteristics of the populations reached through the CSOs will be determined upon selection.

Three vehicles will be purchased using pipeline funds. Technical Advisors will travel to sub-grantee project sites to provide support supervision/mentorship training. This activity supports GHI/LLC and is completely funded by pipeline in this budget cycle, including vehicle purchase.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	300,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12994**
Mechanism Name:	**FANIKISHA Institutional Strengthening**
Prime Partner Name:	**Management Sciences for Health**

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HBHC	0	0

Narrative:

The FANIKISHA project will partner with Kenyan CSOs and their affiliates through mentored grants to improve health and well-being. By supporting these CSOs in strengthening financial, human resources, and management systems, leadership and governance skills, and advocacy capacity, FANIKISHA is ensuring effective health services delivery, including home-based HIV care, at the community level. Among 10 CSOs currently pre-qualified to receive grants, five focus on HIV/AIDS interventions, with at least one specifically offering comprehensive social care and support to people living with HIV/AIDS (PLWHA), which includes home-based health care. The actual size, age distribution, and other characteristics of the populations reached through the 4-8 mentored CSOs will be determined after selection in March 2012.
Additionally, by partnering with the RATN and the AIDS, Population and Health Integrated Assistance (APHIAplus) Project, FANIKISHA is committed to strengthening the capacity of CSOs to provide home-based care for PLWHA.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	0	0

Narrative:

The FANIKISHA project will partner with Kenyan CSOs and their affiliates through mentored grants to improve health and well-being. By supporting these CSOs in strengthening financial, human resources, and management systems, leadership and governance skills, and advocacy capacity, FANIKISHA is ensuring effective health services delivery, including care for orphans and vulnerable children (OVC), at the community level. Among 10 CSOs currently pre-qualified to receive mentored grants, five focus on HIV/AIDS interventions, with at least one specifically offering comprehensive social care and support to OVCs. The actual size, age distribution, and other characteristics of the populations reached through the 4-8 mentored CSOs will be determined after selection in March 2012.
Additionally, by partnering with the RATN and APHIAplus, FANIKISHA is committed to strengthening the capacity of CSOs to provide OVC services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

Through collaborations among project partners and stakeholders, including the GoK and APHIAplus, FANIKISHA is strengthening health systems at all levels of society, including the community, provincial and regional levels. Through its mentored grants program with Kenyan CSOs strengthening financial, human resources, and management systems, leadership and governance skills, and advocacy capacity, FANIKISHA is strengthening

health systems for HIV/AIDS as well as other conditions. Among 10 CSOs currently pre-qualified to receive mentored grants, five specifically support health systems strengthening. The actual size, age distribution, and other characteristics of the populations reached through the 4-8 mentored CSOs will be determined after selection in March 2012.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

By working with the RATN and APHIAplus, FANIKISHA is committed to strengthening the institutional capacity of CSOs that implement HIV prevention interventions, including those focused on abstinence and fidelity. The FANIKISHA project will partner with CSOs and their affiliates through mentored grants to improve health and well-being. By supporting these CSOs in strengthening financial, human resources, and management systems, leadership and governance skills, and advocacy capacity, FANIKISHA is ensuring effective health services delivery, including abstinence-based HIV prevention interventions. Among 10 CSOs currently pre-qualified to receive mentored grants, five focus on HIV/AIDS interventions, with at least two of these organizations specifically working to prevent and mitigate HIV/AIDS through peer education and behavior change communication (BCC) among young people, including abstinence education. The actual size, age distribution, and other characteristics of the populations reached through the 4-8 mentored CSOs will be determined after selection in March 2012.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	108,672	0

Narrative:

The FANIKISHA project will partner with Kenyan CSOs and their affiliates through mentored grants to improve health and well-being. By supporting these CSOs in strengthening financial, human resources, and management systems, leadership and governance skills, and advocacy capacity, FANIKISHA is ensuring effective health services delivery, including HIV voluntary counseling and testing (VCT), at the community level. Among 10 CSOs currently pre-qualified to receive mentored grants, five focus on HIV/AIDS interventions, with four specifically supporting VCT. The actual size, age distribution, and other characteristics of the populations reached through the 4-8 mentored CSOs will be determined after selection in March 2012.
Additionally, by partnering with the RATN and APHIAplus, FANIKISHA is committed to strengthening the capacity of CSOs to provide VCT services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	252,536	0

Narrative:

The FANIKISHA project will partner with Kenyan CSOs and their affiliates through mentored grants to improve health and well-being. By supporting these CSOs in strengthening financial, human resources, and management systems, leadership and governance skills, and advocacy capacity, FANIKISHA is ensuring effective health services delivery, including the provision of HIV prevention services for high-risk populations. Among 10 CSOs currently pre-qualified to receive mentored grants, five focus on HIV/AIDS interventions, of which three specifically supporting HIV prevention for high-risk youth, truck drivers or female sex workers. The actual size, age distribution, and other characteristics of the populations reached through the 4-8 mentored CSOs will be determined after selection in March 2012. *Additionally, by partnering with the RATN and APHIAplus, FANIKISHA is committed to strengthening the capacity of CSOs to respond to the HIV prevention needs of high-risk populations.*

Implementing Mechanism Details

Mechanism ID: 13025	**Mechanism Name: Integrated HIV Prevention Interventions Including Male Circumcision**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Impact Research and Development Organization	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 6,473,097	
Funding Source	**Funding Amount**
GHP-State	6,473,097

Sub Partner Name(s)

(No data provided.)

Overview Narrative

IRDO is a Kenyan NGO based in Kisumu, Nyanza Province. Its principal mandate is to design, implement and evaluate public health programs and research. In October 2004, IRDO was funded by PEPFAR, through a CoAg with CDC, to design and implement a HIV prevention program that promotes abstinence and being faithful among the youth living in the informal (slum) settlements of Kisumu City. The program has expanded both in geographical

coverage (from 5 small slums to the entire Kisumu East, Suba, Kisumu West, Nyando, Siaya, Bondo and Rarieda districts) and in programmatic areas to cover more comprehensive preventions programs including male circumcision, evidence based behavioral interventions and biomedical interventions.
In COP 2012, the goals of this mechanism are to reach out to 11,972 members of the general population with individual or small group HIV prevention interventions that are evidence-based (Community PwP and RESPECT); circumcise 94,556 males as part of the minimum package of MC for HIV Prevention services per national standards and in accordance with the WHO/UNAIDS/Jhpiego Manual for Male Circumcision under Local anesthesia; provide 43,000 individuals with HIV testing and counseling services and to ensure effective linkage to care for those infected; and provide services to 600 injecting drug users as per PEPFAR guidelines.
IRDO is supporting MOH and building the capacity of local staff and organizations. To ensure good quality of services, IRDO will conduct regular supervisory visits using national or WHO/UNAIDS standard supervisory tools. Monitoring will done using SAPR and APR reports, KePMS, quarterly presentations to CDC staff, and regular documented site visits.
IRDO is not purchasing vehicles under this mechanism. this activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	2,589,238
Key Populations: FSW	10,000
Key Populations: MSM and TG	10,000
Motor Vehicles: Purchased	100,480
Renovation	25,266

TBD Details

(No data provided.)

Key Issues

Mobile Population
Workplace Programs

Budget Code Information

Mechanism ID:	13025		
Mechanism Name:	Integrated HIV Prevention Interventions Including Male Circumcision		
Prime Partner Name:	Impact Research and Development Organization		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	CIRC	6,122,433	0

Narrative:

The Kenya Government/MOH recognized MC as an additional HIV prevention intervention in 2007 and with PEPFAR support developed a MC policy guidance, MC strategy and communication strategy, and adapted/adopted relevant documents (VMMC clinical Manual, M&E indicators/tools) to guide service delivery and demand creation and tracking. The program's objective is to circumcise men aged 15 – 49 years by 2013 and reach 80% coverage. Four provinces (Nyanza, Western, Rift Valley and Nairobi) have been identified for priority scale up. Nyanza Province has MC rates of 48% and HIV prevalence of 14.9%. HIV prevalence among the uncircumcised Luo is 17%, and MC rates is estimated to be 22% (KDHS 2008/9). Nairobi Province has MC rates of 83% and HIV prevalence of 8.8%. Since 2008, VMMC services have been provided through PEPFAR implementing partners working at Ministry of Health (MoH) facilities, to over 300,000 males. However, gaps still exist, and while coverage is nearly 50% in some Nyanza districts, it is very low in Nairobi among members of non-circumcising communities, and in other urban centers. In 2012, IRDO will contribute to addressing the VMMC gaps existing in Nyanza, Nairobi and other pockets with significant populations of uncircumcised men in Kenya as advised by National Taskforce on VMMC

- *IRDO will provide VMMC services to 94,556 boys and men aged 15 years and above in these areas (18,717 men in Kisumu county,25,604 men in Homabay County, 28,075 men in Migori County,9,358 men in Nairobi and 12,802 in other identified areas*
- *Current coverage of VMMC services in counties ranges between 5% in some, and reaching 50% in others, and IRDO will contribute to covering these gaps*
- *IRDO (clinical & M&E) staff, the district and provincial M&E subcommittees will conduct quarterly support supervision visits to VMMC sites to ensure quality assurance, using the adapted VMMC QA tools and ensure reporting is done through the MOH M&E reporting system*
- *IRDO will ensure requisite demand for services in generated by males and females in and around the catchment area of each facility where VMMC services are available, and explore other efficiency approaches, including conducting outreaches/mobiles, electrocultery, and moonlight services where applicable*
- *As part of comprehensive package, clients will be provided with the minimum package of services at site according to national guidelines, which include opt out HTC for VMMC clients and their partners, age appropriate sexual risk reduction counseling, counseling on abstinence during 6 week healing period, and promotion of correct*

and consistent condom use

- *Where necessary, HCW teams to provide services will be trained to build their capacity, using the MOH VMMC training guidelines*
- *Linkage with other services within facilities and within districts/counties will ensure VMMC is part of comprehensive package of prevention package. Identified men infected with HIV will be effectively linked to Care and treatment sites. Active linkages with other programs has been established, with cross referrals to care and treatment for HIV positive men, as well as referral of uncircumcised men from routine HTC sites and discordant couples to VMMC services*
- *Regular EQA from WHO and PEPFAR teams has ensured VMMC activities adhere to international standards. Service provision will be monitored using the standardized VMMC reports and evaluated regularly through the MOH M&E reporting system*

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	272,471	0

Narrative:

The goal of the country as reflected in Kenya National Aids strategic plan KNASP III is to reach 80% knowledge of HIV status in the country by 2013. Nyanza Province, which has a population of about 5.1 million people, carries the highest HIV burden in Kenya. With an estimated adult HIV prevalence of 14.9% compared to the national 7.1%, ~500,000 people are living with HIV.

IRDO – The Pembe Tatu Project supports the Provision of Integrated HIV Prevention Interventions. This mechanism covers several program areas and activities that include HIV testing and Counseling in outreaches/mobiles and national Rapid Response Initiative (RRI) campaigns. Many of these activities build synergies between HIV testing and counseling, HIV Prevention, care and treatment services. The overall goal of HTC is to increase the proportion of individuals who know their correct HIV status in Migori and Homabay counties.

In FY10, this mechanism supported HTC in the two counties using various approaches including national RRI campaigns, mobile/outreach and moonlight HTC. Between October 2010 and August 2011, a total of 115,482 people were offered comprehensive HTC services. A total of 16,203 (14%) individuals were identified as HIV infected and were linked to care and treatment services.

Guided by gaps identified in KAIS 2007, KDHS 2009 and program data, this mechanism will continue to support HTC service implementation in the two counties with specific area of focus being outreach/mobile and targeted HTC approaches to most-at-risk populations. This mechanism will work with the Ministry of Health (MOH) at the county, District and community levels to jointly plan, coordinate and implement HTC services for both adults and children in support of the Kenya National Strategic Plan III, the Partnership framework and the District and Provincial level MOH annual operation plans.

This mechanism will target couples, sexually active youth, youth out of school and general population amongst

others with intent to enhancing diagnosis of HIV status among individuals with unknown HIV infection status, enhanced knowledge of HIV status with emphasis of identifying HIV infected individuals and HIV sero-discordant couples and strengthened linkage to appropriate HIV prevention, care and treatment services and ensuring disclosure as a key strategy of strengthening HIV prevention among sero-discordant couples. The program will target a total of 43,000 individuals with HTC of whom 10% will be pediatrics.
A significant effort will be directed towards building capacity of MOH staff to provide safe and quality services, as well as minor renovations in MOH facilities to ensure ownership for sustainability.
Working with other relevant stakeholders, the program will work to strengthen appropriate referral and linkages between Community HTC and other HIV/AIDS prevention, care and treatment services in the selected districts. The program will also work with the GoK system and in particular NASCOP to support the following activities at district level: Commodity management, Training of HIV service providers, Implementation of the WHO recommended multistep approach to Quality Assurance and National Quality Assurance Strategy on HIV Testing, Supervision and Implementation of the community PwP strategy. The program will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	78,193	

Narrative:

The drug use epidemic in Kenya has a HIV prevalence that is over two times more than that of the general population. HIV prevalence amongst PWID is 18.3%. Amongst needle-sharing sharing IDUs, prevalence is 30% while for non-needle sharing PWID, it is 5%. This mechanism will therefore target the PWUD/PWID population in general, and provide appropriate targeted responses to each of the sub-groups within this population to address their varied risk profiles. Among social networks drug-users, high risk sexual and injecting practices include multiple sexual partners, unprotected sex among injecting peers, needle-sharing and flash-blood sharing. Women who use or inject drugs face additional risks due to their engagement in sex work and in transacting sex for drugs. They also face additional stigma, which becomes exacerbated in the event of a pregnancy. These behaviors are reinforced by multiple determinants such as criminalization of injecting drug use, and poverty among majority of the self-identified IDUs.
This mechanism will support the set up and scale up of a comprehensive package of services targeting 600 PWID/PWUD who will receive a 8-intervention package of services per the PEPFAR and UNAIDS/UNODC guidelines. These services include Medication-Assisted Treatment (MAT) for drug-dependence treatment, ART, HTC, STI prevention and treatment, Condom demonstration and distribution for PWID and their partners, targeted behavioral interventions and IEC materials, TB diagnosis and treatment and vaccination, diagnosis and treatment of viral hepatitis. Some program interventions will be implemented for the first time in Kenya, and will involve careful planning with a broad range of stakeholders, including involvement of local administration with a view to enlisting the crucial buy-in and support for an enabling environment. This activity will be carefully rolled

out to assure efficiency in rolling out drug dependency treatment. Service providers in this program will receive training in addiction counseling and managing drug dependence treatment, in collaboration with the national Treatment II program. Close linkages will be established with the regional drug-dependence treatment. Out-patient treatment will be the desirable model of offering MAT, backed by a close follow-on addiction counseling therapy. *IRDO will participate in the IDU sub-Technical working group led by NASCOP, with participation from the Health Ministry's Mental Health Services to adapt and disseminate national PWID program guidelines, MAT treatment protocols and reporting tools to guide implementation. Training, supportive supervision and mentorship will be provided to this program. Other key players with who this program will work with include the UNODC, NACADAA and the HIV treatment and care programs. PWID/PWUD will be linked to collaborating HIV care and treatment centers to ensure a close follow-on to their treatment and adherence.*

Implementing Mechanism Details

Mechanism ID: 13028	**Mechanism Name: TA for Implementation and Expansion of Blood Safety Activities in Kenya**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Community Housing Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,233,429	
Funding Source	**Funding Amount**
GHP-State	1,233,429

Sub Partner Name(s)

African Society of Blood Transfusion - Kenya Chapter		

Overview Narrative

Goals/objectives:

CHF will contribute to prevention of HIV transmission through provision of safe and adequate blood in Kenya. This will be accomplished by giving TA to blood safety program for collection, testing, processing and distribution of blood at quality assured laboratories; establishment of a national quality system; and support for appropriate blood utilization. These objectives are in keeping with 3rd Kenya National AIDS Strategic Plan (KNASP-III) goal of eliminating HIV transmission in healthcare settings in next two years. This will contribute to GHI goals of reducing maternal, infant and malaria-related morbidity. The TA provided will also lead to systems strengthening.
Cost-efficiency:
CHF will support NBTS to align itself to the new Kenyan constitution by positioning itself as a national body but serving all counties in the country. It will support a sustainable health financing system that will tap into national resources, multilateral partners and public-private-partnerships. It will ensure cost-efficiency through improved financial management system, efficient automated blood testing and processing and use of blood components and pediatric packs. CHF will support NBTS to leverage PEPFAR HIV prevention programs to develop a pool of safe regular donors and will use modern technology such as SMS to communicate with them. A monitoring and evaluation system will be strengthened using an information management system and use of data to enhance program efficiency.
Transition to country
CHF will build capacity of AFSBT and other local implementing partners while gradually transitioning activities to them.
Vehicle info: Partner has not purchased vehicles in the past and will not procure vehicles.
This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	450,000

TBD Details

(No data provided.)

Key Issues

Malaria (PMI)
Child Survival Activities
Safe Motherhood
Custom

Budget Code Information

Mechanism ID:	**13028**
Mechanism Name:	**TA for Implementation and Expansion of Blood Safety Activities in Kenya**
Prime Partner Name:	**Community Housing Foundation**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	1,233,429	0

Narrative:

Objectives and approaches

CHF in consortium with the Africa Society for Blood Transfusion (AFSBT) will contribute to the prevention of HIV transmission by supporting the provision of safe and sufficient blood in Kenya. It will support National Blood Transfusion Service (NBTS) and other blood safety partners to update Blood Safety policies to be in line with the new Kenya constitution and current international Blood Safety trends as guided by WHO. It will give expert guidance to all technical sub-committees of the NBTS TWG to ensure that highest standards of blood safety are met. It will contract and coordinate blood mobilizing partners who will adopt newer approaches of donor recruitment and retention including use of SMS, internet, tele-recruitment, and use of regional blood donation buses. It will support scaling up mass media campaigns to develop a culture of regular blood donation in Kenya. It will ensure quality in blood testing laboratories for TTIs and compatibility testing by adopting standard operating procedures and enrollment of NBTS in external quality assurance schemes. It will support NBTS in the WHO-AFRO stepwise accreditation process for its key laboratories to achieve international certification. It will promote component processing while up scaling appropriate utilization in transfusing facilities through training, mentorship and establishment of hospital transfusion committees. The M&E program will be strengthened so as to ensure data analysis and usage for decision making while strengthening software for information management system. CHF will support a biannual national blood needs and utilization assessment. It will advise on infrastructure development that will support collection, equitable access and distribution of blood to the rural areas while supporting innovative cold chain systems that can serve the Northern and arid parts of Kenya.

Integration with other activities

CHF will support the blood safety program in Kenya to ensure integration within the broader HIV program and other health programs. This will include HIV prevention and healthy lifestyles as well as cross-referrals across testing and treatment programs. It will also advocate for support by facility partners such as treatment and PMTCT to support appropriate utilization of blood while training the health workers on the same.

Coverage and scope

The activities will cover all potential blood donors from 16 years to 65 years in line with NBTS policy guidelines. CHF activities will be national and will be cross-cutting across all blood safety partners. CHF will train 100 TOTs and 500 health workers on blood safety, support formation of 100 hospital transfusion committees and coordinate mobilization of 137,000 units of blood. *Country ownership and Sustainability* *CHF will build the capacity of AFSBT and other local partners including NBTS to ensure success of the blood safety project in Kenya beyond CHF's project period. It will use the training of trainer (TOT) model to ensure a pool of qualified trainers in-country; additionally it will support integration of blood safety training into pre-service curricula.*

Implementing Mechanism Details

Mechanism ID: 13040	**Mechanism Name: Kenya Mentor Mother Program**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Mothers 2 Mothers	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,100,000	
Funding Source	**Funding Amount**
GHP-State	1,100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of the M2M is to improve the quality of PMTCT service delivery in Kenya's health care facilities through the widespread integration of M2M model of peer-based psychosocial education and support for pregnant women, new mothers and caregivers living with HIV in Kenya. Ultimately this will contribute to minimizing vertical transmission, increase access to health care for HIV+ mothers and empower and enable mothers to live positively further contributing to a reduction in OVCs. The M2M uses a Prevention with Positives (PwP) approach to achieve each of these goals by training and employing HIV+ mothers to provide high quality support and education to their

peers in the health care setting. As former PMTCT clients themselves, M2M's Mentor Mothers link women to various services, promote skilled and hospital deliveries, and improve the continuum of care that so often breaks down across PMTCT service delivery. They will design a roll out strategy that will include building the skills of management teams and partners to conduct supportive supervision.

Two vehicles purchased under NPI for use by CMMB (former sub-partner) were transferred to M2M during FY11 and the official title transfer documents are currently in process. One vehicle purchased under NPI for use by M2M (programming start-up in Coast province) was purchased in FY11. One vehicle pending final purchase under this current award mechanism (KMMP) for use by M2M will be made during this budget cycle. In 2012, the four vehicles will be allocated across the regions where we operate. This activity supports GHI/LLC and is funded completely with pipeline funds in this budget cycle, including vehicle purchase.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	200,000

TBD Details

(No data provided.)

Key Issues

Safe Motherhood

Budget Code Information

Mechanism ID:	**13040**
Mechanism Name:	**Kenya Mentor Mother Program**
Prime Partner Name:	**Mothers 2 Mothers**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,100,000	0

Narrative:
M2M will undertake the activities using a two prong approach - a direct and an indirect form of implementation. In direct implementation, M2M will set up program sites that will serve as "centers of excellence". These centers will provide a reference for technical assistance activities against which implementing partners can benchmark efforts to replicate and scale-up the Kenya Mentor Mother Program (KMMP). In addition, they will conduct a Training of Trainers course for the National program. *In indirect implementation the partner will provide technical assistance. At the national level they will form a partnership with the National AIDS and STI Coordinating Program (NASCOP), Department of Reproductive Health (DRH) and the national PMTCT Technical Working Group to conceptualize a strategic plan for national scale-up. They will work with these teams to adapt and adopt of the M2M curriculum and other program tools to the national context through a consultative process. They will also continue to refine and adapt the KMMP model and begin to respond to the challenge to support rapid national scale–up of integrated and cost effective services to approximately 4,000 PMTCT facilities.* *At the level of implementing partner organizations, M2M will create partnerships with partner organizations to implement the M2M model of care throughout the country through accreditation or other similar approaches. A Quality Assurance/Quality Improvement system will be set up to facilitate this process.*

Implementing Mechanism Details

Mechanism ID: 13050	**Mechanism Name: Coptic Hospital / University of Washington Collaborative HIV Care Program**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Coptic Hospital	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 3,795,185	
Funding Source	**Funding Amount**
GHP-State	3,795,185

Sub Partner Name(s)

University of Washington		

Overview Narrative

Coptic Mission Hospital (CMH) provides high quality, family-oriented medical and psychosocial services for people infected with and affected by HIV in Nairobi and Nyanza. Objectives include: optimize treatment outcomes through support of psychosocial well-being; prevent HIV transmission; and establish the administrative, technical, and physical capacity of the CMH to deliver HIV care. The goal and objectives are linked to Kenya's Partnership Framework (PF) and GHI strategies and are directly aligned to PF pillars 1-3, prevention, care and mitigation, treatment, and systems strengthening. Strategies to reduce maternal and child mortality and eliminate MTCT include supporting family planning integration into HIV clinics.Cost efficiency efforts include: integration of services, use of existing evidence-based efficient strategies, task shifting, implementing facility-based training/mentorship as opposed to offsite training, evaluating cost effective strategies for defaulter management, lab networking, mobilization, strengthening and implementing IT systems to produce reports and provide timely access to information, and implementing accounting system to ensure accuracy and track expenses.CMH is a local FBO partnering with the MOH in various aspects of the HIV program. Capacity-building strategies are aimed at strengthening sustainable local systems for effective transition of technical support from CMH to MOH. CMH will continue to build its capacity in M&E of the program by sending its key staff for training and courses in grants management and administration.

CMH procured 7 vehicles in between FY 07-10. CMH program will procure 4 vehicles with FY12 funds to support service implementation and replace some which are grounded. This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	37,951
Gender: Gender Equality	6,000
Human Resources for Health	1,669,331
Motor Vehicles: Purchased	67,360
Renovation	119,825

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**13050**
Mechanism Name:	**Coptic Hospital / University of Washington Collaborative HIV Care Program**
Prime Partner Name:	**Coptic Hospital**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	400,000	0

Narrative:

Coptic Mission Hospital (CMH) will support two sites in Nairobi province (Ngong Hope Centre & Industrial Hope Centre) and one site in Nyanza province (Maseno Hope Centre). Nairobi Province has a HIV prevalence of 8.8% and 15.3% in Nyanza. By March 2011, CMH had cumulatively enrolled 17,212 in HIV care; of these 10,309 are active. Cotrimoxazole was provided to 9,550 patients, which is 93% of active patients.

CMH will work with the Ministry of Health (MoH) at the provincial, district, and health facility level, to plan, coordinate, implement and ensure provision of quality HIV care and support to 10,139 current adult patients in FY12 and 11,910 current patients in the FY13.

CMH will offer comprehensive care and support package of services including: HIV testing to partners and family members of index patients and enrolling or referring/linking those that test HIV positive to care and support; provision of Basic Care Kit (safe water vessel, multivitamins, insecticide-treated mosquito nets, condoms, chlorine for water treatment and educational materials); therapeutic nutrition (FBP) to all enrolled HIV positive patients; prevention with positives(PwP); and family planning and reproductive health services including cervical cancer screening for all enrolled women.

CMH in collaboration with MoH will support targeted capacity building (training and mentorship) for health care workers and offer continuous medical education on care and support, e.g. OI diagnosis and treatment. CMH will identify areas with staff shortages, support recruitment of additional staff, and support good commodities management practices to ensure uninterrupted supply of commodities.

CMH will also support ongoing community interventions for HIV infected individuals, including peer education and use of support groups to provide adherence messaging; effective and efficient defaulter tracing and follow up to improve retention in all facilities; referral and linkages to community based psychosocial support groups; water, sanitation and hygiene programs; economic empowerment and income generating activities (IGAs); home based care services; gender based violence support programs; vocational training; social and legal protection; and food and nutrition and/or food security programs.

CMH will adopt strategies to ensure access and provision of friendly services to youth, elderly and disabled populations. Strategies to increase access of care services by men will be employed, including supporting male peer educators, mentors and support groups, and supporting women to disclose and bring their male partners for testing and care and treatment.

CMH will do cohort analysis and report retention rates as required by the National AIDS & STI Control Programme (NASCOP). CMH will continue to strengthen data collection and reporting at all levels to improve reporting to NASCOP and PEPFAR. New generation indicators will be adopted and CMH will support the development and use of electronic medical records system in accordance with NASCOP guidelines. Quality of care indicators (CQI, HIVQUAL) will be used for monitoring the quality of HIV care and support services. Indicators will be integrated into routinely collected data and results used to evaluate and improve clinical outcomes. CMH will support joint Annual Operation Plan (AOP) planning, implementation, monitoring and evaluation, and health system strengthening to facilitate sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	130,000	0

Narrative:

Coptic Mission Hospital (CMH) will support two sites in Nairobi province (Ngong Hope Centre & Industrial Hope Centre) and one site Nyanza province (Maseno Hope Centre). CMH has been supporting TB/HIV services in the 3 sites in line with the Ministry of Health Division of Leprosy, Tuberculosis and Lung Disease (DLTLD) and the National AIDS and STI Control Program (NASCOP) since 2010.

Between October 2010 and March 2011, the 2,714 adult HIV patients received TB treatment. Patients who received HIV testing counseling were 3,627 and 2,714 TB HIV co-infected patients were identified.

In FY12 and FY 13, CMH will intensify efforts to detect TB cases through clinical exams and laboratory investigations as well as ensure successful TB treatment through provision of appropriate treatment. CMH will ensure that each facility providing TB/HIV services has adequate and well trained clinical staff supported by well

equipped and staffed laboratory, including sputum specimen transport where laboratory services are unavailable. CMH will ensure that adequate supplies of anti-TB drugs are available and that the national TB treatment guidelines are followed. All TB patients on treatment will be monitored both clinically and through periodic sputum examination.

To reduce the burden of HIV in TB patients, CMH will ensure that at least 95% of TB patients are screened for HIV and 95% TB-HIV co-infected patients are put on cotrimoxazole and ARVs as early as possible regardless of the CD4 count as per the national guidelines. CMH will support the "one stop" model that provides integrated TB and HIV services in all TB clinics. All TB clinics will be stocked with cotrimoxazole and ARVs. 50 and 40 HCWs will be trained in FY12 and FY13 respectively.

To reduce the burden of TB in HIV infected patients, CMH will support intensified TB screening for 9,012 in FY12 and 10,586 in FY13 HIV infected persons identified in their HIV care settings. 451 co-infected patients identified in FY12 and 551 co-infected patients identified in FY13 will be put on TB treatment and those without active TB will be provided with Isoniazid Preventive Therapy (IPT) as per national IPT protocol.

To strengthen TB infection control in HIV settings, CMH will ensure that the national IC guidelines are available at all sites and training of staff on IC is done. CMH will support scaling up of at least 2 components of the national TB infection control strategy in HIV care settings, one of which will be fast tracking of patients with cough for expedited diagnostic work up and treatment.

To improve surveillance and management of drug-resistant TB, CMH will support timely transport of sputum specimens of TB retreatment cases from health facilities to the central reference laboratory for drug susceptibility testing and ensure return of the results to those facilities. CMH will also support scaling up of drug-resistant treatment sites thus expanding access to MDRTB treatment.

CMH will support expansion of prevention with positive (PwP) services in TB clinics, TB/HIV control activities in the prisons, strengthening linkages between facility and community-based services, and improving patient referrals and tracking systems. To strengthen HVTB program monitoring, CMH will support reporting of selected custom indicators to assist with program management and evaluation and monitoring of new activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	80,000	0

Narrative:

Coptic Mission Hospital (CMH) is in year 2 of a 5-year cooperative agreement and will support two sites in Nairobi Province (Ngong Hope Centre & Industrial Hope Centre) and one site in Nyanza Province (Maseno Hope

Centre). Nairobi province has a HIV prevalence of 8.8% and 15.3% in Nyanza. CMH has been supporting pediatric care activities in the 3 sites since 2010. As of March 2011, CMH had enrolled 1,197 children into care of whom 695 were active and on cotrimoxazole prophylaxis.

In FY 12 and 13, CMH will provide care and support services to 1,060 and 1,267 children currently on care respectively. CMH will provide comprehensive, integrated quality services, and scale up to ensure 89 HIV infected infants are put on ARV prophylaxis and all HIV exposed children access pediatric care services.

The focus of pediatric care services will be provision of comprehensive, integrated quality services including strengthening the use of the Mother-baby booklet, early infant diagnosis, universal provider initiated testing and counseling, and ensure those identified HIV infected are linked to care and ART services.

CMH will ensure children enrolled in care receive quality clinical care services including clinical history and physical examination; WHO staging, CD4 tests, and other basic tests; opportunistic infection diagnosis, prophylaxis and management; TB screening; pain and symptom relief and management; and psychosocial support. Additional key care services will include nutritional assessment, counseling and support based on the WHO and IYCF guidelines (including provision of therapeutic or supplementary feeding, support to children with growth faltering, provision of vitamin A, zinc, and de-worming); provision of safe water, sanitation and hygiene interventions (WASH) in the community and in health facilities; and malaria screening, treatment and provision of long lasting insecticide treated nets in malaria endemic areas.

CMH will support integration of HIV services into routine child health care and survival services in the MCH including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization guidelines; case management of diarrhea, pneumonia, and other childhood illnesses; and community outreach efforts. CMH will a support newborn care by supporting hospital delivery, ensuring that there is provision for newborn resuscitation and care (thermal care, hygiene cord care), and prophylactic eye care. Exposed children management and follow up will continue to be supported and will include enrollment, HIV testing (PCR-DNA and antibody testing) as per the national guidelines, provision of Nevirapine throughout the breastfeeding period, follow up and retention, and linking HIV positive children to care and ART services.

CMH will support hospital and community activities to support the needs of adolescents including support groups to enhance disclosure, adherence messaging, PwP, substance abuse counseling, support for transitioning into adult services, and teaching life skills. Commodity access and infrastructure development will be supported. CMH will strengthen pediatric data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVCT	6,717	0

Narrative:

The Hope Centre for infectious Diseases (COPTIC) has three centers where they offer ART services and also provide testing and counseling both as VCT and PITC. Provider Initiated Testing and counseling approach is used in the outpatient clinics in their two sites in Nairobi and one in Maseno, Western Kenya. They also offer Home based testing and counseling during their outreach services. The total number of clients served in the past one year is 3,627 offered testing and counseling.
The program has had staff trained in PwP data management and quality management.

In 2012 Coptic hospital will be supported to integrate PITC fully into their clinical services and to expand PITC in outpatient services as well as serve communities around their static sites. This will start with a modest target of 5,000 which is based on their past performance. Out of this 20% will be couples and 60 % will be new testers. Coptic Hospital has well established ART service and this will be used as a platform for enhanced PwP.

The program will continue to use the national testing algorithm for testing and counseling.

The national M&E framework is used including use of national registers and data collection tools and reporting will be through the DHIS in future. Quality services is ensured by adherence to national guidelines, use of national certified kits and participation in the external quality assurance through proficiency testing run by the government.
Quarterly review meetings for the program will be conducted and improvements made as necessary for greater impact.

Promotional activities will be by IEC materials and community mobilization in the area of coverage. The national communication strategy will enhance mobilization.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

COPTIC implements comprehensive prevention, care and treatment programs in Nairobi province. In FY 2012/13, COPTIC will expand HIV prevention services to include evidence based behavioral interventions (EBIs) for specific target populations in clinical settings at comprehensive care center (CCC), TB and Maternal Child Health (MCH) clinics as part of HIV combination prevention programs. The EBIs will include Positive Health and Dignity Prevention (PHDP) targeting adult male and female and adolescents living with HIV (PLHIV); and Sister to Sister EBI (S2S) targeting sexually active HIV negative women attending the MCH clinics.

PHDP is an ongoing 5-10min group and individual level intervention that targets PLHIV in clinical and community settings. This mechanism will support this intervention which constitutes of ART adherence counseling and support; partner and family testing; provision of PEP to the discordant spouse; treatment for prevention once approved; safer pregnancy counseling and provision of modern contraception; sexual risk reduction counseling including reduction of sexual partners, alcohol counseling, promoting of consistent and correct condom use; Sexually Transmitted Infections (STI) screening and treatment and using meaningful involvement of people living with HIV/AIDS (MIPA). The efficacy of PHDP has been shown to be 68% in preventing transmission of HIV, and 96% in treatment for prevention.

S2S is a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use. Condoms are 80% effective in heterosexual relationships when used correctly and consistently.

COPTIC will use HVOP funding to recruit and support appropriate peer educators/counselors to reinforce prevention messages delivered by health providers as a feasible model for task-shifting in the provision of PHDP in clinical settings, and specifically promote MIPA. It will support placement of 5 Peer Educators at the MCH, TB and CCC Clinics in hospitals, and 2 Peer educators at health centres and provide appropriate counseling space. One of the peer educators will do regular client home follow up to strengthen ART adherence.

Approximately 1.6 million Kenyans are PLHIV. The Kenya AIDS Indicator Survey 2007 showed 6% of couples to be in discordant relationships. Nairobi province HIV Prevalence is high (8.8%). COPTIC will reach 5711 (60%) PLHIV in FY2012 and 7840 (70%) in FY 2013 with a minimum package of PHDP. It will implement S2S EBI on a pilot basis.

Quality assurance for EBIs will be promoted through appropriate training and certification of peer educators using approved national curricula, standard job-aids and guidelines and regular supervision.

COPTIC will work with appropriate national Technical Working Groups to support integration of HIV prevention into care and treatment programs in clinical settings. These programs will also be linked to other HIV community programs. PLHIV will be specifically linked to STI and FP services, as necessary, through patient escorts.

Monitoring of PHDP and S2S will be done through the review/input of COPTIC implementation plan, analysis of KePMS data, quarterly reviews, semiannual and annual reports. Evaluation will be conducted through operation research of combination HIV prevention and periodic surveys (Kenya Demographic and health survey, Kenya Indicator AIDS Survey, Kenya Service Provision Assessment).

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	MTCT	50,000	0

Narrative:

Coptic Mission Hospital (CMH) will support PMTCT in 3 sites. Since 2010, CMH has been implementing PMTCT services in two sites in Nairobi province (Ngong Hope Centre & Industrial Hope Centre) and one site in Nyanza Province (Maseno Hope Centre). By end of March 2011, CMH had counseled and tested 291 pregnant women and given ARV prophylaxis to 690 HIV positive pregnant women.

In FY12, CMH will offer HIV counseling and testing to 996 pregnant women at ANC and give ARV prophylaxis to 164 HIV infected pregnant women. The HIV infected women will receive a CD4 test after undergoing a WHO clinical staging. CMH will give HAART to all eligible HIV positive pregnant women in line with the revised PMTCT national guidelines. In FY13, CMH will increase the number of pregnant women counseled to 1,014, offer ARV prophylaxis to 104 pregnant women and 89 infants, and do EID for 89 infants.

CMH will focus on 4 prongs of PMTCT: primary prevention; family planning; ARV prophylaxis to all HIV positive pregnant mothers and exposed infants; and care and treatment to eligible HIV positive mothers, partners and children. The Minimum care package will include health and HIV education, individual/ family HIVCT, clinical/laboratory monitoring and assessment, OI screening and treatment, ARV prophylaxis and treatment for both mother and baby, nutritional support, psychosocial support, PWP, follow up, retention, and referral and linkages. CMH will incorporate TB screening into routine antenatal care.

CMH will reach 304 of 1st visit ANC attendees with couple CT to identify discordant and concordant couples to improve primary prevention and facilitate linkage to HIV care and treatment for the eligible. CMH will support integration of ART in MCH clinics, access to FP/RH services, and establish or strengthen infection control and waste management activities.

CMH will support hospital delivery through provision of delivery beds and sterile delivery packs, training, working with CHWs and TBAs to promote community- facility referral mechanism, health education, and community services providing skilled birth attendance.

CMH will support safe infant feeding practices as per national guidelines and support enrollment and follow up of 89 of babies born to HIV infected mothers to access CTX, ARV prophylaxis, and EID services using the HIV exposed infant register till 18 months. CMH will facilitate ART initiation for those who test positive before 2 years.

CMH will adopt efficient retention strategies for mothers and babies by supporting use of diaries and registers for tracking defaulters, having a structured mentorship and supervision plan (training 30 HCP in FY12 and FY13), enhancing data quality and streamlining M&E gaps including orientation of new MOH ANC/maternity registers, and utilization of data at facility level for program improvement and quarterly progress reports to CDC.

Program quality and proficiency testing will be emphasized to validate PMTCT results. CMH will train HCWs on PMTCT and provide orientation to the revised PMTCT and infant feeding guidelines and engage in community activities for demand creation for health services such as male involvement with couple CT services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	2,928,468	0

Narrative:

Coptic Mission Hospital (CMH) will support treatment in 3 sites located in Nairobi and Nyanza provinces. Nairobi and Nyanza provinces have an estimated population of 3.1 and 5.4 million people respectively with an estimated adult HIV prevalence of 8.8% and 14.9% respectively compared to the national 7.1%. Since 2004, CMH has been supporting adult treatment in 3 sites and had initiated 7,796 adults on ART with 7,700 active as of 2011 SAPR.

In FY12, CMH will jointly work with the Ministry of Health (MoH) to continue supporting provision of quality adult HIV treatment services in the 3 sites in line with MoH guidelines to 8,852 patients currently receiving ART and 1,579 new adults resulting to cumulative 10,622 adults who have ever been initiated on ART. In FY13, this number will increase to 10,038 currently receiving ART and 1,597 new adults resulting to 12,219 adults who have ever been initiated on ART.

CMH in collaboration with MoH will support in-service training of 50 and 40 health care workers in FY 12 and 13 respectively, identify human resources and infrastructure gaps and support in line with MoH guidelines, and support good commodities management practices to ensure uninterrupted availability of commodities.

CMH will support provision of comprehensive package of services to all PLHIV including ART initiation for those eligible; laboratory monitoring including biannual CD4 testing and viral load testing for suspected treatment failure (through strengthened laboratory network); cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH; and improved OI diagnosis and treatment including TB screening, diagnosis, and treatment.

CMH will continue to support ongoing community activities for HIV infected individuals including peer education and use of support groups to strengthen adherence, effective and efficient retention strategies, referral and linkages to psychosocial support groups, economic empowerment projects, Home Based Care, and food and nutrition programs. CMH will adopt strategies to ensure access and provision of friendly HIV treatment services to all, but in particular youth and special populations, through supporting peer educators, support groups, disclosure, partner testing and family focused care and treatment.

CMH will do cohort analysis and report retention rates as required by the national program and discuss the analysis results with facility staff in order to improve program performance. CMH will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services and integrate them into routinely collected data, use the results to evaluate and improve clinical outcomes, and support short term activities that increase impact and improve patient outcomes.

CMH will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Use of an electronic medical records system will be supported and strengthened.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	200,000	0

Narrative:

Coptic Mission Hospital (CMH) will support pediatric HIV treatment in Nairobi. Since 2004, CMH has been supporting pediatric treatment in Ngong Hope Centre, Industrial Hope Centre in Nairobi and Maseno Hope Centre in western Kenya and had initiated 590 children on ART and 576 were active as per 2011 SAPR.

In FY12, CMH will jointly work with the Ministry of Health (MoH) to continue supporting expansion and provision of quality pediatric HIV treatment services in the 3 sites in line with MoH guidelines to 775 children currently receiving ART and 155 new children resulting to cumulative 930 children who have ever been initiated on ART. In FY13, this number will increase to 870 currently receiving ART and 139 new children resulting to 1,069 children ever initiated on ART.

CMH will support comprehensive pediatric ART services including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization; management of childhood illnesses; OI screening and diagnosis; WHO staging; ART eligibility assessment; laboratory monitoring including 6 monthly CD4, hematology, and chemistry (through strengthening of lab networks); Pre-ART adherence and psychosocial counseling; initiation of ART as per MoH guidelines; Toxicity monitoring; treatment failure assessment through targeted viral load testing; Adherence strengthening; enhanced follow up and retention; support EID as per MoH guidelines; PITC to all children and their care givers attending child welfare clinics; support family focused approach; community outreach efforts; and integration of HIV services in other MNCH services.

CMH will support hospital and community activities to support the needs of HIV infected adolescents: support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services, and support their transition into adult services. CMH will additionally support short term activities to increase impact and improve patient outcomes.

CMH will support in-service training of 50 and 40 HCWs in FY 12 and 13 respectively, continuous mentorship and capacity building of trained health care workers on specialized pediatric treatment including management of ARV treatment failure and complicated drug adverse reactions. CMH will identify human resources and infrastructure gaps and support in line with MoH guidelines and support good commodities management practices to ensure uninterrupted availability of commodities. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will additionally be optimized. *CMH will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, CMH will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. CMH will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.*

Implementing Mechanism Details

Mechanism ID: 13061	**Mechanism Name: Advancement of Public Health Practices in Kenya**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: MINISTRY OF PUBLIC HEALTH AND SANITATION	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: Both	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 10,618,509	
Funding Source	**Funding Amount**
GHP-State	10,618,509

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Kenya Ministry of Public Health and Sanitation (KMOPHS) assures national service delivery through the dissemination of funding, technical support, and M&E. KMOPHS has contributed to reduced morbidity, mortality

and the improvement in a number of health indicators. Still many Kenyans are exposed to a broad, heavy disease burden including a high child mortality from malaria, HIV andTB. KMOPHS faces challenges in addressing these health burdens including inadequate financial and human resources, poor physical infrastructure, inefficient support systems, and poorly coordinated responses to public health problems. In accordance with the Kenya GHI Strategy, KMOPHS plans to address these challenges by coordinating and integrating a high impact national response to reduce disease burden particularly among women and children. To build sustainability and transition the program to country ownership, the program seeks to: a) strengthen the KMOPHS capacity to plan, implement, manage, and monitor programs that address critical public health needs; b) support the implementation of national public health programs; c) conduct public health surveillance and epidemiological assessments; d) incorporate surveillance, epidemiological, and evaluation data into operational public health programs, policies and guidelines; and e) disseminate the results of surveillance and program planning, execution and evaluation results. KMOPHS will work across Ministries to coordinate disease-specific and broader national public health programs to increase cost effectiveness. This partner has not used PEPFAR funds for vehicle purchase in the past and is not requesting funds for vehicle purchase in FY12. This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	200,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
TB

Budget Code Information

Mechanism ID:	**13061**
Mechanism Name:	**Advancement of Public Health Practices in Kenya**

Prime Partner Name:	MINISTRY OF PUBLIC HEALTH AND SANITATION		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	700,000	0

Narrative:

Ministry of Public Health and Sanitation (MOPHS) will use the funds to support, coordinate, and oversee the national implementation of all facility, community, and home based HIV care and support programs for people living with HIV/AIDS including health care workers and others providing services to people living with HIV in Kenya.

The funds will be channeled through the technical departments and divisions as appropriate. The Family Health Department will coordinate the nutrition and reproductive health issues (including cervical cancer screening and management) among all partners in the provision of care for people with HIV (through national level meetings such as the National TWG and stakeholders forums) and supervision of care and support services in Government of Kenya (GOK) and other facilities. The Technical Planning and Performance Monitoring Department roles include monitoring of quality of care and support services. This department will work with relevant MOPHS divisions to support and coordinate relevant research studies to advance evidence based interventions for care and support issues.

The Disease Control Department houses the National AIDS and STI Coordination (NASCOP) office, which has a system in place to supervise regional HIV/AIDS treatment activities and programs. NASCOP will establish care and treatment services at additional sites and conduct program evaluations and accreditation. The department also has specific divisions that provide national expertise and oversight on tuberculosis, leprosy and lung diseases, non-communicable diseases, and malaria control in accordance with the GHI Kenya Strategy. NASCOP will distribute HIV prevention materials for health care providers that incorporate consistent messages regarding HIV status disclosure, partner testing, and condom use to prevent sexual transmission. Specific guidelines for prevention and treatment of opportunistic infections, including sexually transmitted infections, HIV prevention in care settings, and management of nutrition interventions will be revised, updated, printed, distributed and disseminated as needed.

Other activities include improvement and strengthening of referral systems and care linkages between the community and facility based activities; support of strategies that address client retention in the HIV program including the use of community outreach, decentralization of care and treatment services to lower level health facilities to increase access and reduce waiting lists at provincial and district hospitals; and improved coordination with other sources of support such as the Global Fund for AIDS Tuberculosis, and Malaria.

The MOPHS activities coordinated and carried out by the various departments and divisions (such as the vaccine and immunization, child and adolescent) are linked to Counseling and Testing, PMTCT, Adult and Pediatric ARV Services, Strategic Information and TB/HIV activities in Kenya. These activities are also closely linked to the Management Systems of Health (MSH) supported logistics/systems strengthening, particularly for the Kenya Medical Supplies Agency for the procurement of OI drugs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	928,660	0

Narrative:

The Division of TB and Lung Disease (DLTLD) and National AIDS and STI Control Program (NASCOP), under the Ministry of Public Health and Sanitation (MOPHS), are responsible for establishing TB/HIV policy, development of TB/HIV training curriculum, and providing overall implementation of collaborative TB/HIV activities in Kenya, as prioritized in Kenya's 5-Year National AIDS and TB Strategic Plans

In 2010, DLTLD registered 105,781 TB cases. Of these, 34%, 31% and 17% constituted smear positive, smear negative, and extra-pulmonary disease, respectively. TB treatment success rate for patients registered was 86.4%. 90% of the registered TB patients were tested for HIV. The average national HIV prevalence among TB patients was 41%, although it was as high as 75% in some settings. In 2010, DLTLD identified 57,224 HIV co-infected TB patients, of whom 97% and 47% received cotrimoxazole and ARVs respectively. Integration of TB/HIV services in many settings and increased decentralization of ART points have prepared the ground for improved ART access for TB patients, regardless of CD4 counts. To initiate and expand TB screening in HIV care and treatment clinics, implementing partners supported widespread distribution and use of new MOH screening tools for both adults and children. Kenya has developed and adapted the new national IPT implementation guidelines/tools to kick-start implementation of IPT. Drug susceptibility testing (DST) for TB re-treatment cases reached 70% and 112 MDRTB patients were put on treatment.

In 2012, DLTLD's priorities include scaling up the Three I's, early initiation of HAART for HIV+ TB patients, integration of TB/HIV services, systems strengthening, and introduction of new technology to improve MDR-TB surveillance and diagnosis of HIV-driven TB. Efforts will be made to ensure GoK and Global Fund TB funding complement PEPFAR, GHI and other donor support. DLTLD will concentrate on getting more eligible TB/HIV co-infected patients onto ART and intensify, in collaboration with NASCOP and other partners, TB screening for HIV+ persons identified in HIV care settings. DLTLD will ensure widespread distribution/use of MOH TB infection control guidelines/tools to protect patients and health providers. DTLD plans to expand access to TB preventive treatment (IPT) in selected sites. Emphasis will be placed on developing regional trainers who will provide classroom training and mentorship of health care workers at the facility level in order to build the capacity and confidence of clinicians and ensure sustainability.

In 2011/12, Kenya will conduct a national anti-TB drug resistance survey, strengthen TB diagnostic services, support construction of a new central reference TB laboratory (CRTL), and decentralize TB culture capacity and improvement of bio-safety levels at the CRTL. Other priorities include: introduce geneXpert technology for more efficient detection of TB and DR TB; evaluate diagnosis and management of TB in children; develop regional laboratory centers of excellence in Nyanza, Eldoret, Kericho and Coast General Hospitals; and strengthen community TB strategy. In support of MDRTB diagnosis and management, DLTLD will develop 2 MDRTB treatment centers in Coast and Nyanza Provincial General Hospitals. DLTLD will improve patient referrals/tracking systems and expand support for establishment of electronic TB and HIV reporting systems to improve patient referrals, tracking, linkages, and program evaluation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	80,000	0

Narrative:

The Ministry of Public Health and Sanitation (MOPHS) will oversee the scale up, expansion and implementation of all pediatric HIV care and support programs for the under 15 year olds in Kenya. MOPHS will support the coordination of all partners in the area of pediatric antiretroviral treatment (ART) provision (through national level meetings such as the National ART task force), and supervision of pediatric treatment in Government of Kenya (GOK) supported and other facilities.

MOPHS, through NASCOP, is heading a technical group that has developed a psychosocial package of care for pediatrics and is currently developing an adolescent care package to include disclosure activities, adherence counseling, PWP, provision of reproductive health services, substance abuse counseling, and support for transitioning into adult services and teaching of life skills. Linkages of children to various community programs including OVCs, education, and legal and social services will be provided. Other activities will include development of referral systems and care linkages for HIV positive mothers identified through the PMTCT programs, decentralization of care services to lower level health facilities to increase access, and linkages to community activities to support the needs of the HIV infected children and adolescents.

MOPHS will work though the Division of Child Health and Division of Reproductive Health, which are currently working jointly to integrate pediatric HIV into child survival interventions including: growth and development monitoring; immunization; nutritional assessment, counseling and support; safe water, sanitation and hygiene interventions; and malaria screening, treatment and provision of insecticide-treated nets in malaria endemic areas. MOPHS will continue to coordinate the provision of and national scale up of nutritional assessment and counseling activities for all children including provision of food complement and supplements and preventive packages.

MOPHS will continue to improve the national system for tracking the number of children receiving care and support. The national supervisory structure includes a core staff at a national level that consists of a small technical and administrative staff, and an expanding staff responsible for monitoring and evaluation activities. The Provincial AIDS and STI coordinating officers (PASCO) coordinate and provide supportive supervision to regions and facilities. The PASCOs are responsible for assisting with establishment of services at additional sites, conducting site evaluations and accreditations, and supervising ART programs. MOPHS will oversee the linkage of HIV treatment and prevention activities to the Kenya Pharma/Chemonics supported logistics/systems strengthening and the Kenya Medical Supplies Association (KEMSA).

MOPHS will also support the development and strengthening of laboratory networks for Early Infant Diagnosis (EID), quality assurance, and staff training for health care workers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	750,000	0

Narrative:

The National Public Health Laboratory Services will coordinate laboratory services nationally including laboratory commodities management, equipment maintenance, policy formulation, technical guidance in quality management systems, laboratory information system and specimen referral systems with the KMOPH Laboratory services.

Continuing activities

- *Coordinate scale up of laboratory capacity for ART monitoring, OI diagnosis and TB smear microscopy and culture to match service demands and increase access*
- *Institutionalize specimen referral networks within MOPH to improve diagnostic efficiency for ART monitoring, Early Infant HIV diagnosis (EID), TB/HIV resistance testing, viral load and TB culture*
- *Support laboratory program coordination and support supervision at all levels*
- *Support development, review and dissemination of laboratory policies and guidelines for point of care diagnosis, monitoring and accreditation*
- *Support sustainability in technical capacity through staff training in Quality management systems (QMS), leadership skills, bio-safety, mentorship, FELTP, exchange programs among internal and external laboratories*
- *Support enrollment expansion of external quality assurance (EQA) programs for ART*
- *Support national scale up of laboratory stepwise accreditation program to ensure equity in all counties*
- *Support for the National reference laboratories to provide technical expertise and specialized testing services in HIV related diagnostic testing*
- *Strengthening of paper-based Laboratory Information Systems (LIS) and electronic LIS at public health laboratories to streamline data collection, storage, analysis, reporting and integration of Laboratory information*

management systems (LIMS) with Health Management information system (HMIS)

- *Strengthen the Central Data unit to manage laboratory strategic information and collect 80% of reportable indicators*
- *Strengthen data collection and reporting in commodity supply and consumption for accurate forecasting, planning and budgeting*
- *Coordinate implementation of bio-safety and bio-security activities within MOPH laboratories in each county*

New activities

- *Support standardization of testing methodology and laboratory equipment maintenance and service policy*
- *Support decentralization and coordination of laboratory services to county level in the devolved system of government*
- *Support implementation of quality assurance in rapid HIV testing to 5000+ sites through the multi-step saturation approach and develop guidelines and policies*
- *Support an integrated quality assurance program for HIV, TB, malaria and microbiology*
- *Support the laboratory accreditation steering committee and collaborate with Department of Standards Regulation and Kenya National Accreditation System (KENAS) to provide technical guidance and streamline laboratory accreditation within GOK structures and systems*
- *Coordinate implementation of point of care testing for CD4 and other diagnostic testing and monitor effectiveness*
- *Support sustainability in equipment maintainace by training of biomedical engineers to provide quality equipment maintenance including support for service contracts for specialized type of maintenance*
- *Indicators will be the number of clinical labs with capacity for HIV diagnosis and ART monitoring (135); number of staff trained in-service (40) number of labs accredited and; (2) activity implementation monitoring will be performed on quarterly basis.*

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	1,650,000	0

Narrative:

The main objective of this activity is to strengthen the MOH's capacity to collect, analyze, interpret and use data. Various capacity building initiatives are carried out through NASCOP and the division of Health Information Systems (HIS).

NASCOP

NASCOP supports coordination of partner activities, supervision and development of policy guidelines related to HIV/AIDS programs. Through this mechanism, CDC supports the strengthening of data collection, analysis and use

for routine M&E reporting, HIV and STI surveillance and program evaluation. MOH staff capacity building is a key component of this activity through CDC TA as part of the PF. The MOH deploys skilled epidemiologists, data managers and other cadres of staff as their commitment to the PF. NASCOP recently conducted an assessment of the country's readiness to use routine PMTCT data to monitor trends in the HIV epidemic. NASCOP, in collaboration with implementing partners, is currently rolling out revised M&E tools for HIV programs nationally. These include summary registers and individual patient data collection forms.

Working with the ADAM Consortium, NASCOP completed the development of M&E training curriculum and will train health workers to use it. NASCOP and implementing partners will conduct routine data QA at randomly selected sites to ensure high quality data. This will be done in collaboration with regional and county health and management teams.

In FY2012, NASCOP will, together with stakeholders, implement the recommendations of the assessment of PMTCT data to monitor HIV epidemic in Kenya. These include training nurses/counselors on HIV testing SOP and on data quality. NASCOP will also play a leading/coordination role in the implementation of the Kenya AIDS Indicator Survey (KAIS) and MARPs surveillance. The survey report will be launched in FY 2012, followed by dissemination workshops. NASCOP will continue to coordinate the HIV quality of care improvement work and together with HIV-Qual International roll out QA/QI activities in 3 additional provinces, bringing the total to 6.

NASCOP will oversee the scale up of EMR coverage to about 600 health facilities across the country in the next two years, supported by partners such as ITECH and Futures Group.

NASCOP will also conduct program evaluation and operational research to identify initiatives that work. In addition, they will analyze existing data and prepare abstracts and manuscripts for publication.

HIS Division

The division of Health Information Systems (HIS) is jointly hosted within the two MOHs. The HIS is responsible for collecting, storing, analyzing, and reporting data for the entire health sector. The HIS division also coordinates the development and review of all data collection tools (registers, forms, cards) for the health sector, in collaboration with the USG and partners.

In the FY 2012, the HIS division will undertake the following:

(i) Continue the national rollout of the District Health Information System – DHIS. This includes training of health workers as well as county, regional and national officers on the aggregate reporting tool.
(ii) Distribute the integrated reporting tools for the health sector. Health workers will be trained on the use of

these tools to ensure high quality of data.

(iii) Regular updating of the master facilities list, including geo-codes to enable mapping of facilities.

(iv) Overall coordination of HIS activities in Kenya.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	585,858	0

Narrative:

This mechanism aims to strengthen the Biomedical Engineering Department of Ministry of Health. PEPFAR has invested heavily in equipment but there has not been a matched investment in management of this health equipment. Technology in Healthcare is emerging as a real challenge due to rapid technological changes that impact Medical Equipment. Medical Engineering staffs are not able to manage most of modern technology due to lack of manpower development programs to keep abreast with technology. Over the years the ministry of health has received medical equipment of diverse technology through either direct procurement by the ministry or donations resulting in a lack of standardization and non availability of spare parts or skills to repair the equipment. In addition the skill development for Engineers has not kept in pace with new technology and as a result equipment is non functional throughout the system. Policies on management or disposal of obsolete equipment are weak or nonexistent and e waste is also becoming a problem. The existing MOPHS cooperative agreement will be used as the mechanism for strengthening the system. The Bio-Medical Engineering Division is a fully functional division within the ministry of health. The Division consists of a team at the Headquarters which provide technical and administrative support to Bio-Medical personnel deployed in provincial, district and sub-district hospitals across the country. Alongside this Division is a Unit for supply of Medical Spare parts. The spare part unit has four branches situated in Nairobi, Nyeri, Mombasa and Kisumu. Ensuring availability of appropriate, functional, safe and effective Medical equipment and plant through selection of appropriate technology during purchase of new equipment, carrying out preventive maintenance and repair as well as function and safety tests on existing equipment is the core mandate of the biomedical engineering department with an overall objective of promoting proper diagnosis, treatment and care for the patient. Activities supported through this mechanism will include: Development of policy and guidelines on management of medical equipment.

? Establishment of inventories by developing web based inventory management systems

? Upgrading of skills of biomedical engineers

? Supervision, monitoring and evaluation of biomedical engineering departments at county level

? National assessment of equipment at all levels

? Equipping of Medical engineering with appropriate test and calibration equipment.

Strengthening the biomedical engineering departments will have positive spillover effects on all service delivery areas and the coverage will be national.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	CIRC	86,451	0

Narrative:

The Ministry of Public Health and Sanitation (MOPHS) objective, to reduce HIV incidence through appropriate policy guidance and implementation of interventions, includes the intervention of Voluntary Medical Male Circumcision (VMMC). MOPHS technical staff, stationed at National AIDS and STI Coordination Program (NASCOP), will oversee the VMMC program implementation. The VMMC program began in 2008, with an objective of circumcising and reaching 80% of uncircumcised men aged 15 – 49 years by 2013. NASCOP provides leadership, coordination, and policy direction to all HIV intervention programs in Kenya, including the VMMC program. Since 2008, VMMC services have been provided, through PEPFAR implementing partners working at the Ministry of Health (MoH) facilities, to over 300,000 males.

NASCOP roles are to provide policy direction, coordination, advocacy and implementation oversight of the VMMC program. The continuing activities under this planning period include supporting both National and sub-national VMMC TWGs and sub-committees for technical oversight and coordination. Regular support supervision visits for the VMMC program will be conducted quarterly by the VMMC technical team in collaboration with CDC prevention technical advisors to ensure safety and adherence to quality and standards in the delivery of services in 4 priority regions of Nyanza, Western, Turkana and Nairobi, these regions have low male circumcision rates and high HIV prevalence. MOPHS will undertake sensitization and mobilization and advocacy campaigns targeting religious, cultural, provincial administration and leaders in order to increase demand for MC in line with the VMMC communication strategy. Additionally, MOPHS will review/update/develop guidelines, protocols, curriculums and IEC materials that will result in a strengthened and sustained VMMC program in Kenya.

NASCOP will host annual planning meetings and with the collaboration of CDC and schedule verification visits by NASCOP VMMC team to assess the accomplishments toward the program objectives.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	550,000	0

Narrative:

Objectives/Approaches
The MOPHS Injection Safety program through NASCOP will contribute to the prevention of medical transmission of HIV (and other blood borne pathogens) through sharps and other medical waste. This will contribute in achieving the third Kenya National AIDS Strategic Plan (KNASP-III) goal of eliminating HIV transmission in healthcare settings in the next two years. NASCOP will coordinate and monitor the implementation of all national policies, standards, guidelines and strategic plans for injection safety and health care waste management in the country. It will support the scale up of injection safety and safety of other related procedures such as phlebotomy

by various partners country-wide. It will lead the development and implementation of post-exposure prophylaxis (PEP) and occupational safety policies and guidelines for health workers. It will support universal access to PEP services and commodity security for IPC and injection safety commodities. It will also support integration of Injection Safety and Infection Prevention and Control (IPC) as well as bio-safety and safe medical waste management practices into HIV services and other existing health programs. This is in line with the Global Health Initiative core principle of health systems strengthening.

Scope of activities and targets

NASCOP will implement a national injection safety program targeting health workers with some support to community interventions. KMOPHS will support:

- *Development of a post-exposure prophylaxis (PEP) and health workers occupational safety policy and guidelines (4 documents); roll out of IPC/Biosafety coordination committees in 25 counties; roll out of post exposure prophylaxis to all health facilities; sharps injury and PEP surveillance systems leading to 50% reportage rates; supervision for IPC and healthcare waste management nationally and provide 4 reports annually.*
- *Coordinate 4 quarterly meetings on technical working group (TWG) on prevention of HIV in health care settings.*
- *Support a community communication campaign to reduce injection demand and ensure safe injection safety and medical waste disposal practices.*
- *Advocacy for IPC and injection safety at national and other forums.*
- *Support medical training colleges and universities to integrate IPC practices into all their pre-service and in-service training curricula.*

NASCOP will work closely with the Biosafety Program to harmonize their approach and strategies. In addition to the above, the following activities will be supported:

Strengthening of a national Biosafety office; Facilitate 4 meetings of Biosafety TWG; Establish an M&E system for Biosafety in Kenya; Support implementation of policy guidelines on Biosafety; Ensure support supervision of biosafety activities 4 times annually and coordinate biosafety trainings nationally by other partners.

Country ownership, M&E, partnerships

NASCOP is led by Kenyan staff and will support training of local training of trainers (TOT) to develop country owned sustainable programs. Additionally it will leverage on current public-private partnership (PPP) and explore others that will contribute to improved safety in health programs. It will strengthen M&E for injection safety activities and use data obtained to make better programmatic decisions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	190,000	0

Narrative:

This mechanism supports, supervises and monitors national abstinence programs targeting youth 10-19 and

faithfulness programs targeting discordant couples and men 30-44 at risk of having multiple partners. It will take the lead in developing national policies, guidelines, and packaged evidence-informed behavioral interventions (EBIs). The mechanism will enable MoPHS to take leadership through coordinating the EBI Technical Working Group (TWG). The mechanism will lead a four pronged approach to ensure standardized abstinence and faithfulness EBIs throughout the country through: (1) systematically assessing interventions currently in use to determine if they include characteristics found in effective programs; (2) identifying behavioral interventions developed and rigorously evaluated with demonstrated efficacy for translation into packages for scale up; (3) systematically adapting EBIs developed in other countries to ensure they are appropriate for Kenyan priority populations and repackaging for scale-up; (4) developing operational research to improve the functioning and effectiveness of EBIs. All EBIs will be used to reinforce or compliment biomedical and structural interventions as part of combination prevention. This mechanism will coordinate the development and distribution of trainings and printed packages of abstinence and faithfulness EBIs.

The mechanism will support the scale up of Families Matter Program (FMP) and Healthy Choices 1 (HC1). FMP is a parent-focused EBI for parents, guardians, and other primary caregivers (hereafter referred to as "parents") of preadolescents ages 9–12 years. Delivered in 5 weekly sessions to give parents time to internalize new information and practice skills, the program promotes parental monitoring and effective parent-child communication on sexual topics and sexual risk reduction. The goal of FMP is to reduce sexual risk behavior among adolescents, including delaying sexual debut, by training parents to deliver primary prevention messages to their children. More effective parental communication can help to delay their children's sexual behavior and increase protective behaviors as children age. FMP also links parents to other critical interventions including HTC and VMMC. HC1 targets in-school youth aged 10-14 years and aims to delay sexual debut by providing knowledge and skills to negotiate abstinence, avoid negative peer pressure, avoid or handle risky situations and to improve communication with a trusted adult. HC1 consists of 8 modules of approximately one hour each. The mechanism will also support for national scale up the adapted Stepping Stones for males aged 30-44 who are at risk for engaging in multiple partnerships. Stepping Stones includes 17 sessions male peer groups implemented over 3 to 12 weeks. Sessions will involve discussions on a variety of sexual health topics including gender-based violence and faithfulness. Peer groups build assertive communication skills by leading presentations on exercises from the Stepping Stones program. Quality assurance for EBIs will be promoted through appropriate training and certification of peer educators using approved national curricula, standard job-aids and guidelines and regular supervision.

Monitoring will be done through analysis of partner EBI TWG minutes and Kenya HIV/AIDS Program Monitoring System data analysis. Evaluation will be conducted through operation research of combination HIV prevention and periodic surveys.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	400,000	0

Narrative:

One of Kenya's goals by 2013 is to reach 80% of persons knowing their HIV status, as reflected in the Kenya National Aids Strategic Plan (KNASP III). This mechanism will be responsible for the formulation, dissemination and implementation of policies and guidelines regulating the practice of HIV testing and counseling (HTC) in the country. Special focus areas will be: strengthening couple testing and counseling and identification of discordant couples with subsequent linkage to treatment and care; provision of quality HTC services; and stronger and effective referral strategies for clients who receive testing and counseling. Policy and implementation guidelines for newer approaches like self testing will be developed and rolled out to targeted populations.

The Ministry of Public Health and Sanitation (MOPHS) will coordinate and lead the HTC technical working group (TWG) to share their expertise on HTC, policy formulation and guideline development. Training and certification of service providers will be conducted through development of appropriate training curricula and establishment of quality standards in HIV service provision. MoPHS will continue to identify and encourage innovative approaches in both client-initiated and provider-initiated HTC settings. The reach and coverage for PITC will be increased to 80% of inpatients and 50% of outpatients. Community approaches will be strengthened and rural men specifically targeted. HTC will be integrated as part of combination prevention for greater efficiency and effectiveness in HIV prevention. Home based HTC will be done in areas with high population density and high HIV prevalence. Quality services are key in the implementation of HTC services. MoPHS will monitor quality assurance (QA) through the implementation of quality assurance management guidelines and the implementation of the WHO multistep approach. Through the WHO multistep approach, QA will be strengthened through the development of standardized curriculum, new and refresher trainings, supervision, use of approved kits, using correct algorithm and certification of service providers. A database of all service providers will be developed and training tracked in a timely manner to ensure all service providers are well trained and receive updates. QA audit teams will be strengthened in all counties. Strategies for effective referrals and linkage of clients to prevention, care and treatment services will be prioritized, and guidelines for integration with other community services will be developed. This mechanism will give guidance on the use of shorter acting rapid test kits so as to reduce client workload experienced by service providers. Strong collaboration will be established with laboratory services for quality assurance in HIV testing. A comprehensive communication strategy will be developed for wider coverage and to improve the demand for HTC services. This mechanism will support MoPHS devolved services to the county level of administration in line with Kenya's new constitution.

Monitoring will be done through analysis of partner HTC TWG minutes and Kenya HIV/AIDS Program Monitoring System (KePMS) data analysis. Evaluation will be conducted through periodic surveys including Kenya AIDS Indicator Survey, Kenya Service Provision Assessment and Kenya Demographic and Health Survey.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	175,996	0

Narrative:

The Ministry of Public Health and Sanitation (MOPHS) supports, supervises and monitors national prevention programs toward reducing HIV incidence through appropriate policy guidance and implementation of combination prevention interventions. Populations include discordant couples, youth 15-24 years, males 30-44 years, women attending Maternal Child Health clinics, individuals with STIs, PLHIV, widows/widowers and most-at-risk populations (MARPs).

MoPHS will lead development of national policies, guidelines, and packaged evidence-informed behavioral interventions (EBI). All EBI will reinforce biomedical and structural interventions as part of combination prevention. It will lead a multi-sectoral technical working groups (TWG), constituting of all stakeholders. It will provide technical leadership in the scale up of HIV combination prevention interventions including treatment for prevention and Pre-exposure Prophylaxis. MoPHS will lead scaling up of Positive Health and Dignity Prevention (PHDP) EBI, size estimation and mapping for MARPs.

MoPHS will lead a four pronged approach to ensure national standardized prevention EBIs: 1) systematically assess interventions currently in use to determine if they include characteristics found in effective programs; 2) identify EBI developed and rigorously evaluated with demonstrated efficacy for translation into packages for scale up; 3) adapt EBIs developed in other countries to ensure they are appropriate for Kenya and repackaging for scale-up; 4) operational research to improve EBIs.

This mechanism supports EBI for above priority populations. Specific EBI include PHDP, Healthy Choices 2 (HC2), Sister to Sister (S2S), Respect, Eban, and START. PHDP is an ongoing group and individual level EBI for PLHIV in clinical and community settings, focusing on partner testing, risk reduction, condom use, disclosure, adherence, STI reduction and family planning. HC2 targets in and out of school youth 13-17 yrs and focuses on safer sex, condom use, negotiation and communication skills. S2S is a 20 minute individual level EBI targeting sexually active women focusing on self efficacy, negotiation skills and condom use. START targets incarcerated males delivered at 6 pre and post release sessions. It focuses on HIV/STI education, safe sex/condom provision at post release, assessment of personal risk and linkage to services. Eban is a couple and group level EBI targeting sero-discordant couples. It is 8 weekly 2 hour sessions focusing on risk assessment, enhancing couple communication and shared health responsibility. Respect has 2 brief individual sessions targeting general population. It focuses on reduction of STDs/HIV, risk reduction, condom use and clients understanding of personal risk. MoPHS will also support roll out of other EBIs identified for MSM and video-led EBI such as Safe in the City.

Quality assurance of all EBI is promoted through rigorous training and certification of facilitators, support supervision, and site visits. MoPHS will provide technical support across regions including joint stakeholder meetings and regular visits to assure quality implementation of programs.

Monitoring of EBI will be done through partner reporting, Kenya HIV/AIDS Program Monitoring System data analysis, TWG and stakeholder meetings. Evaluation will be conducted through periodic surveys in Kenya demographic and health survey, Kenya Indicator AIDS Survey, and Kenya Service Provision Assessment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	100,000	0

Narrative:

This mechanism will support a national-level leadership, coordination and monitoring of comprehensive programs for people who inject and use drugs (PWID). The HIV burden among people who inject drugs in Kenya is 2-4 times that of the general population. Overall HIV prevalence among PWID is 18.3% and 30% among the needle sharing subpopulation. Beyond the risk of transmission through needle sharing, PWID also have sexual relationship with non-PWID. The Government of Kenya is implementing both syringe exchange programs (NSP) and medicated assistance therapy (MAT) as evidence-informed interventions to reducing injecting drug use and HIV incidence. The Ministry of Public Health and Sanitation (MOPHS) in collaboration with UNODC, the Ministry of Medical Services, Division of Mental Health Services and the National Coordinating authority against drug and alcohol Abuse (NACADAA) is leading policy formulation, introduction and scaling up of NSP and MAT. Policy formulation and development of guidelines for drug-addiction treatment, roll-out plan and quality standards will be put in place. MoPHS will centrally procure Needles and syringes and MAT and carefully control supply to health facilities and identified community service organizations (CSOs) serving PWID.

This mechanism will support strengthening access to comprehensive services for PWID and PWUD as per the country's and PEPFAR's guidelines. MoPHS will provide national technical oversight, through the Most-at-risk (MARPs) Technical working group (TWG). Specific interventions include (1) NSP (2) MAT and other drug dependence treatment (3) ARVs (4) HTC (5) Prevention and treatment of STIs (6) Condoms for drug users and their partners (7) targeted prevention education and IEC materials (8) vaccination, diagnosis and treatment of viral hepatitis (9) prevention, diagnosis and treatment of TB. These services will target drug users and their injecting and sexual partners. Special attention will be paid to women who use drugs owing to their associated sexual risk behavior in sex work and transactional sex and the high burden of stigma they bear. Service providers will receive training on harm reduction approaches and MAT. This will build upon the current Treatment initiative of providing drug dependence treatment to health care providers. The priority geographic locations will be the Coastal province towns, Nairobi and Kisumu. Two national drug dependence treatment centers ie Mathare Hospital and Coast Provincial general hospital will be supported as key referral and treatment centers. NASCOP will support on-going capacity strengthening of health providers, CSOs and program personnel across the regions.

Quality assurance will be promoted through appropriate training and certification of peer educators and health workers using approved national curricula, standard job-aids and guidelines and regular supervision.

Monitoring will be done through analysis of partners Kenya HIV/AIDS Program Monitoring System (KePMS) data analysis, MARPs TWG updates, partners semiannual and annual reports. Evaluation will be conducted through implementation science that will be initiated in year 2 following the roll-out to improve service delivery and also through periodic surveys (Kenya Demographic and health survey, Kenya Indicator AIDS Survey, and Kenya Service Provision Assessment).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	2,600,000	0

Narrative:

National PMTCT activities are coordinated by Ministry of Public Health and Sanitation (MOPHS) through the National AIDS and STI Control Program (NASCOP). In APR 2010 national coverage was 81% CT, 78% maternal and 63% infant ARV prophylaxis, 55% Early Infant Diagnosis (EID) with an MTCT rate of 8%. NASCOP, with stakeholders, has developed an elimination of MTCT (e-MTCT) framework focusing on three key elements: health system strengthening, community systems strengthening, and effective partnerships to strengthen PMTCT.

MOPHS will spearhead policy guidelines and supportive supervision that will lead to roll out and implementation of the new guidelines, scale up of PMTCT services from the current 4,500 sites to all 6,000 health facilities in Kenya, integration of HIV/Reproductive health services within the MCH, transition from WHO Option A to Option B plus (HAART for life) for all HIV positive pregnant mothers, and safe infant feeding options. MOPHS will work jointly with Division Reproductive Health (DRH) and Division of Child Health (DCH) to enhance integration of PMTCT into maternal and child services including: EID, immunization, growth monitoring, insectide-treated nets (ITNs), safe water, follow up of HIV exposed infants until confirmatory HIV test at 18 months, initiation of care and ART for HIV infected infants within MCH, family planning, IYCF, and cancer screening.

MOPHS with DRH/DCH will convene stakeholders meetings for the PMTCT TWG and for guidelines review. MOPHS is developing a PMTCT training curriculum and will support use of ANC/maternity registers, HEI Register, and Mother-Baby Booklet. NASCOP will provide leadership for the national roll out of the eMTCT framework and comprehensive integrated PMTCT services addressing all four PMTCT prongs, including provision of family planning services and couples counseling and testing.

The Provincial PMTCT TWGs working at the district level will be supported to enhance community participation, coordinate partner activities, review district plans, and support use of program data for programming.

A comprehensive plan for supportive supervision to all the regions will be strengthened by facilitating Provincial and District AIDS and STI coordinating Officer (PASCOS and DASCOS) to provide supportive supervision to

improve PMTCT services. Strategies to reduce maternal and child mortality, in accordance with Kenya GHI Strategy, will be supported including: increasing hospital delivery from a current 43% to 80%; increasing immunizations; preventing/promoting treatment for the leading causes of child mortality including pneumonia, malaria, diarrhea, malnutrition, measles, HIV/AIDS and tuberculosis; and leading causes of maternal mortality including hemorrhage, infections, and unsafe abortions.

MOPHS will support infrastructure improvement, equipping facilities including provision of delivery beds and delivery packs, hiring staff, safe water, and carrying out community sensitization. MOPHS will work closely with Division of Family Health to strengthen community units and the community strategy to create demand for services and to work with the private sector to ensure coordinated, efficient and timely reporting to the national program and to PEPFAR. To optimize PMTCT uptake, MOPHS will support national strategies to promote male involvement and couple counseling and testing in order to strengthen Prevention with Positives.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,354,630	0

Narrative:

Ministry of Public Health and Sanitation (MOPHS) coordinate all ART activities including development and implementation of ART policies, guidelines, and training curriculums. MOPHS chairs the national ART taskforce. By June 2011, approximately 450,000 adults were receiving ART in over 1000 treatment sites.

MOPHS supports mentorship and supportive supervision to improve quality of care and data. MOPHS has developed a training curriculum, ART guidelines, and adopted quality of care indicators (HIVQUAL) for monitoring the quality of HIV treatment services and to improve clinical outcomes.

MOPHS will continue to oversee the implementation of all HIV care and ART programs for people living with HIV in Kenya, which includes training of 200 health care workers, coordination of all partners in the area of ART provision and supervision of treatment in Government of Kenya (GoK) supported and all other facilities. MOPHS will also continue to coordinate with other sources of support such as Global Fund and Clinton Foundation.

MOPHS will improve the national system for tracking the number of people receiving ART and provide financial and administrative support to the Provincial AIDS and STI coordinating Officer (PASCO) who coordinate regional HIV activities. The PASCOs are responsible for establishment of services at additional sites, conducting site evaluations and accreditations, and the supervision of ART programs. All activities are closely linked to other GoK and PEPFAR supported HIV treatment and prevention activities, the networks of care in the Private and Mission sectors, and Kenya Pharma/Chemonics supported logistics/systems strengthening (particularly for the Kenya Medical Supplies Association). Emphasis will be placed on developing regional trainers who will provide training

and mentorship of health care workers at the facility level.

MOPHS will continue to support implementation of HIV prevention activities in clinical care settings, development of referral systems and care linkages for HIV positive mothers and infants identified, and decentralization of care and treatment services to lower level health facilities to increase access and reduce the waiting list at the provincial and district hospitals. These activities are essential to the overall implementation and coordination of HIV treatment programs in Kenya. MOPHS supported activities are essential to the formation and strengthening of linkages needed in the network model and to the development of a sustainable system to provide HIV treatment in Kenya.

All partners have been encouraged to extend efforts to further strengthen linkages by coordinating with and supporting all ART activities by participating in national efforts such as policy/guideline revision and national stakeholders meetings. This activity includes emphasis on development of networks, human resources, policy and guidance development, quality assurance and supportive supervision, training, and strengthening use of electronic medical records system and strategic information.

Monitoring and evaluation of the adult ART program will be strengthened through the revision of data collection tools and supporting prompt, accurate reporting. MOPHS will support the planned Longitudinal Survey of Adult Care and Treatment in Kenya. The outcome of this survey will be used to inform adult program outcomes and strategies to improve the national pediatric program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	466,914	0

Narrative:

The Ministry of Public Health and Sanitation (MOPHS) through the National AIDS and STI Control Program (NASCOP) oversees the implementation of all HIV care and antiretroviral treatment (ART) programs for people living with HIV/AIDS in Kenya. NASCOP will continue to oversee and coordinate the implementation of all pediatric HIV antiretroviral treatment programs for the under 15 year olds in Kenya. NASCOP will continue coordinating other sources of support for pediatric ART treatment from including the Global Fund and Clinton Foundation. NASCOP will coordinate all partners who provide pediatric ART including chairing the national ART task force and supervising the pediatric treatment activities in Government of Kenya (GOK) supported and private sector facilities.

In order to improve quality of care for children on ART, regular national stakeholders and regional meetings of pediatric ART providers will be supported. NASCOP will maintain a supervisory structure including central staff at a national level and field staff responsible for monitoring and evaluation activities in the health facilities.

Administrative support to the Provincial AIDS and STI coordinating officers (PASCO) will be strengthened so that they can carry out regional support supervision and coordination of pediatric HIV/AIDS treatment activities including: tracking and decentralization of pediatric ART to increase access and reduce congestion at the Provincial and District hospitals, conducting site evaluations, and accreditation. NASCOP will continue to support the development of standard protocols, job aids, and the finalization and dissemination of new pediatric treatment guidelines.

To improve on the quality of pediatric/adolescent care and treatment, NASCOP will lead the Technical Work Group (TWG) in development of a package of care for HIV infected adolescents. Dissemination of this package and that of the already developed psychosocial package will be done including training of health care workers.

Emphasis will be placed on developing regional trainers who will provide classroom training and mentorship of health care workers at the facility level in order to build the capacity and confidence of clinicians. Working with the Divisions of Child Health and Reproductive Health, NASCOP will support the integration of pediatric HIV services at the maternal and child health clinics (MCH) in order to optimize identification and enrollment into care of HIV positive children. Strategies to strengthen the use of the Mother-baby booklet, universal provider-initiated testing and counseling, and family testing will be developed and implemented. These will support program effectiveness by improving identification and linkages to ensure the exposed child is enrolled into HIV care and receives all routine child health services, including immunizations and malaria prevention. The national system for documenting and tracking the children will be strengthened to ensure linkage to care and ART services and maximize retention.

Monitoring and evaluation of the pediatric program will be strengthened including the revision of the data collection tools and ensuring prompt, accurate reporting. The ongoing Longitudinal Survey of Pediatric Care and Treatment in Kenya (LSPCTIK) and dissemination of the findings will be supported. This data will be used to inform on pediatric program outcomes and inform strategies to improve the national pediatric program.

Implementing Mechanism Details

Mechanism ID: 13072	**Mechanism Name: Leadership, Management and Sustainability Program**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	

G2G: No	Managing Agency:

Total Funding: 567,137	
Funding Source	**Funding Amount**
GHP-State	567,137

Sub Partner Name(s)

Strathmore University Business School		

Overview Narrative

The overarching goal of the Leadership, Management and Sustainability Program (LMS) in Kenya is to improve health systems at all levels by strengthening the leadership and management capacity across the Ministries of Health (MOH) and other partner organizations, including University of Nairobi, Kenya Medical Training College, and FBOs. At the end of the five-year award period, strong program and management systems will be established, and personnel will be trained and empowered to be effective leaders to manage and maintain these systems. The specific objectives are to:

• Build effective leadership and skilled management in the health sector in order to ensure delivery of quality health services in priority areas such as HIV/AIDS, TB, FP/RH, MCH, and malaria (Intermediate Result (IR) 1);

• Support the MOH, select FBOs, and other USAID partners by providing technical assistance in governance, management, and operational systems to accelerate improvements in health services and thereby improve the health of the population at large (IR 2);

• Increase sustainability and ability to manage change through the development of a career ladder structure for health service management; strengthen the capacity of local training institutions; and assist in the development of a network of health sector leadership to exchange lessons learned and best practices relevant to current health needs (IR 3). LMS purchased a 14 seater van to transport staff to workshops and trainings in FY11 but is not planning to purchase any vehicles in FY12. This acitivity supports GHI/LLC and is completely funded by pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	500,000

TBD Details

(No data provided.)

Key Issues

Safe Motherhood
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**13072**
Mechanism Name:	**Leadership, Management and Sustainability Program**
Prime Partner Name:	**Management Sciences for Health**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	0	0

Narrative:

The overarching goal of the Leadership, Management and Sustainability Program (LMS) in Kenya is to improve health systems at all levels by strengthening the leadership and management capacity across the MOH and other partner organizations, including University of Nairobi, Kenya Medical Training College, and FBOs. At the end of the five-year award period, strong program and management systems will be established, and personnel will be trained and empowered to be effective leaders to manage and maintain these systems.
The generation and use of strategic information plays a critical role in both monitoring program progress and in facilitating health systems strengthening among program partners and participants. For example, under IR 2 "Improved management and systems in health organizations and priority health programs", activities for 2012 include the development of strategic plans at seven Level 5 hospitals, beginning with three hospitals in Coast, Western and Eastern Province. Additional activities include measured and documented improvements at facilities in leadership and governance, human resource management, health management information systems, financial management, commodity and supply chain management, and referral systems. Under IR 3 "Increased sustainability and ability to manage change", activities include development of the capacity of local training institutions to offer health leadership and management courses, including e-learning and a program website housed by Kenya Medical

Training College.
Strategic information will contribute to the overarching goal of LMS to strengthen leadership and management skills within Kenya's health sector and improve intervention outcomes. LMS will train GoK health management staff at the facility and county levels on leadership and management skills with the aim of improving management of HMIS and overall health programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	367,137	0

Narrative:

The overarching goal of the Leadership, Management and Sustainability Program (LMS) in Kenya is to improve health systems at all levels by strengthening the leadership and management capacity across the MOH and other partner organizations, including University of Nairobi, Kenya Medical Training College, and FBOs. At the end of the five-year award period, strong program and management systems will be established, and personnel will be trained and empowered to be effective leaders to manage and maintain these systems.
During FY12, activities under IR 1 "Improved management and leadership of the health sector and priority health programs on HIV/AIDS, TB, FP/RH, MCH, and malaria", include the implementation of pre- and in-service trainings on leadership and management for health-sector workers; the roll-out of pre- and in-service curricula on leadership and management; and the development and implementation of leadership and management mentoring programs for newly promoted health-sector managers, senior leaders, and community leaders. These activities are a continuation of leadership development initiatives, which began in 2010 and included coverage across Kenya and among numerous partnering organizations. These initiatives utilized teams to identify and address feasible workplace and community challenges.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	200,000	0

Narrative:

The funds will be used in the training of health workers in management and leadership positions to better integrate the HIV/AID interventions in to Reproductive health and Family planning. Using the challenge model the facility managers will be trained in groups to be more efficient in resource identification, mobilization, utilization and evaluation for integrated services.

Implementing Mechanism Details

Mechanism ID: 13097	Mechanism Name: Ungana Project
Funding Agency: U.S. Department of Health and	Procurement Type: Cooperative Agreement

Human Services/Centers for Disease Control and Prevention	
Prime Partner Name: Liverpool VCT and Care	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: PR/SR	
G2G: No	Managing Agency:

Total Funding: 2,780,081	
Funding Source	**Funding Amount**
GHP-State	2,780,081

Sub Partner Name(s)

Action for Research and Development (AFORD)	Bar Hostess Empowerment and Support Programme (BHESP)	Better Poverty Eradication Organization
Blood Link Foundation	Catholic Diocese of Muranga	Discordant Couple of Kenya
Hope Community Centre (Christian Life Centre)	Integrated Development Facility (IDF)	Kenya Long Distance Truck Drivers Union VCT
World Provision Centre	Zinduka Afrika	

Overview Narrative

Goals and objectives: Mechanism goal is to strengthen the response of local indigenous organizations to establish operational organizational systems that foster successful and sustainable HIV/AIDS programs. This goal is achieved through building their technical, managerial and financial capacity to be able to deliver quality HIV programs following national guidelines. At the end of the project, these local organizations should be able to acquire funding and manage programs to implement HIV prevention programs. These objectives are linked to three GHI principles: encouraging country ownership by building the capacity of local organizations; building sustainability through health systems strengthening; and building partnerships with private sector, CSOs and CBOs.
Cost-efficiency strategy: The LVCT capacity development model, which includes assessment of needs, coaching and mentorship, is unique as there are no consultancy costs as it is implemented by LVCT staff with content expertise.
Transition to country partners: LVCT is an indigenous Kenyan organization, one of the pioneer recipients of PEPFAR funding, and a leader in HIV interventions informed by research. The LVCT subpartners are helped to build partnerships and network with relevant government of Kenya agencies. They use the national monitoring and evaluation framework and tools. One of the key outputs of this cooperative agreement is to help the sub-partners be

able to apply, access and manage funds on their own for sustainability.
Vehicle information: The partner has purchased 2 vehicles; One in FY 2006 to support field activities and one in FY 2008 to support HTC campaigns.
This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Workplace Programs
End-of-Program Evaluation

Budget Code Information

Mechanism ID:	**13097**
Mechanism Name:	**Ungana Project**
Prime Partner Name:	**Liverpool VCT and Care**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	180,264	0
Narrative:			

"The Ungana Project is a capacity building program to improve the technical, managerial and financial capacity of local indigenous organizations to implement quality HIV prevention care and support services. These organizations most of them community based, do not have the capacity to respond to these essential functions for an effective health system. LVCT carries out a participatory gaps analysis by working with the organizations to identify gaps and weaknesses. They then employ a mentorship approach in building the capacity of this organization that were recruited in a competitive solicitization process. The mentorship is done by the LVCT staff who is engaged in similar functions as part of their job specifications at LVCT in their other Coag management activities. LVCT has concentrated in strengthening the organizational systems as well as technical support to ensure that they provide quality service. Specific activities include strengthening governance systems to comply with statutory requirements, sound financial policies and procedures laid down an, the management of the organizations streamlined by focusing on strategic policy development to guide operations, and training of staff to be able to provide quality HIV services.

Achievements include 7 sub-partners developed strategic plans. Disco-k supported to launch their strategic plan; 13 sub-partners clearly differentiated the roles and responsibilities of the Board of trustees & Management – resulting to strengthened, active BOTs. 13 sub-partners developed /revised key organization policy documents - E.g. constitution, HR, finance and procurement policies

9 sub-partners had legal audits carried out on their organizations. All13 sub-partner complying with statutory requirements. 13 sub-partners aligned program reporting to national M&E structures.

In 2012 the remaining sub partners will be helped to develop their strategic plans, the emphasis will now be put in implementation of the structures that have been put in place; continued guidance in proposal writing, sound financial management and transparent managerial factions as well as quality services. Two more organizations are being recruited this year and the same process will be employed.

Monitoring and evaluation are conducted through site visits which are conducted one to three times per quarter with every sub-grantee. Objectives of the visit are shared prior to the visit, findings are discussed at the visit reports are written and shared with the prime and the sub- partner and corrective actions put in place. These are reviewed at the next visit. The prime shares quarterly report with CDC where performance is also reviewed."

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	385,000	0

Narrative:

Objectives and approaches

LVCT will contribute to the prevention of HIV transmission by providing AB HIV prevention and other evidence

based interventions to potential blood donors while mobilizing for safe blood supply in the country. It will work within the Kenya National Blood Transfusion Service (KNBTS) policy and the blood donor mobilization strategy and in line with approaches that will be guided by the National Blood Donor Services sub-committee of the KNBTS Advisory Committee. LVCT will work closely with KNBTS regional centers to ensure they achieve the set blood donation targets in the regions.

This partner will work comprehensively within the target population to ensure maximum reach of potential blood donors. It will train a pool of mobilizes that will reach all market segments of blood donors including the youth in schools and out-of-school; colleges and universities; the working and those in faith based or community based groups. Those reached will be given HIV prevention messaging; healthy lifestyles including nutrition and donor education on all aspects of blood donation. Additionally LVCT will support establishment of blood donor clubs among the youth such as Pledge-25 as well as among the adult population. It will also support donor counseling and in collaboration with NBTS help in donor results notification and referral of those needing care and treatment. It will create a culture of regular blood donation among those found to be safe and free of transfusion transmissible infections.

Integration with other activities

HIV AB and other prevention messaging will be integrated in the blood donor mobilization activities. Those seeking only to know their status will be referred to the HCT program; conversely those people found to be HIV negative and are eligible to donate will be informed of blood donation activities and encouraged to become regular blood donors. Those found to be HIV positive from the blood donation program will be referred for care and treatment. They will be encouraged to disclose and engage in partner referral or Prevention-with-the-positives interventions.

Coverage and scope

The activities will cover all potential blood donors from 16 years to 65 years in line with KNBTS policy guidelines. The partner will cross-cut all blood donor market segment but will primarily target safer donors (avoiding populations perceived to be most-at-risk). The geographical coverage for this activity will be national and as guided by KNBTS based on the needs. Through this grant LVCT will mobilize 80,000 units of blood in collaboration with NBTS while reaching at least 200,000 people with HIV prevention and healthy lifestyles messages.

Country ownership and Sustainability

The program is mainly led by local staff and will be working to enhance the work of KNBTS which is a local MOH organization led by Kenyans. The partner will work with sub partners to train community people to work as mobilizes even beyond the time of the project. Secondly it will promote formation of blood donor clubs that will out-live the life of the project. Lastly once the culture of regular blood donation is inculcated people will continue to donate even in the absence of the partner.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	78,883	0

Narrative:

In COP 2012, the Ungana mechanism will implement a wide range of evidence-informed behavioral interventions (EBIs) adopted and adapted for national dissemination and to be integrated in combination prevention. Ungana is a capacity building program with a wide range of local organizations that target priority populations. The populations that will be targeted in this mechanism are youth in school and parents with adolescents of both sexes. This mechanism will cover Nairobi, Eastern and Central regions of the country where the partner local organizations are located.

Families Matter Program (FMP) is a 5 weekly session intervention targeting parents with children age 9-12 years. The goal of FMP is to reduce sexual risk behavior among adolescents, including delaying onset of sexual debut, by training parents to deliver primary prevention messages to their children. More effective parental communication can help to delay their children's sexual behavior and increase protective behaviors as their children get older. The intervention also links parents to other critical evidence-based interventions including HTC and VMMC. Quality assurance of FMP is promoted through rigorous training and certification of facilitators, ongoing process monitoring with standardized tools, and quality assurance site visits by a capacity building agency. A total of 1000 youth and parents will be reached.

Healthy Choices I (HC I) targets in-school youth aged 10-14 years and aims to delay sexual debut by providing knowledge and skills to negotiate abstinence, avoid negative peer pressure, avoid or handle risky situations and to improve communication with a trusted adult. HC I consists of 8 modules of approximately one hour each. It can be delivered in 4 sessions of 2 hours each or in 8 sessions of 1 hour each. Quality assurance of HC is promoted through rigorous training and certification of facilitators, ongoing process monitoring with standardized tools, and quality assurance site visits by a capacity building agency. The total youth in school aged 10-14 that will be reached through HC 1 are 1,100.

Being faithful interventions will be promoted among 744 HIV discordant couples.

Process evaluation will be done as determined and developed by the technical working group and the national program and the impact evaluation will be done in larger surveys like the Demographic health survey incorporating HIV markers.

For further quality assurance, LVCT has put in place for all sites the following: use of approved national curricula; emphasis of importance of fidelity to the respective curricula; use of trained and certified pair of gender balanced facilitators; trainings on EBIs are conducted by certified national trainers; observed practice of implementation is done soon after training; use of standardized, national data tools at every stage of EBI implementation; and regular field visits by trained program staff to check on delivery of EBIs and offer support supervision.

Targets are tracked on a monthly basis through respective field reports. Results are analyzed on a quarterly basis. Monitoring and evaluation will be conducted with EBI approved data capture / monitoring tools. Field staff will send reports on a monthly basis; these reports will be compiled into an overall report quarterly which will be submitted to CDC.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	1,375,934	0

Narrative:

The Ungana Project is a capacity building program to improve the technical, managerial and financial capacity of local indigenous organizations to implement quality HIV interventions. HTC is offered as part of the combination prevention services. The local organizations are in Nairobi (prevalence 7.0%), Eastern (prevalence 3.5%) and Central (4.6%) provinces.

The CBOs target different populations depending on their original inception agenda; some discordant couples, others female sex workers, yet some youth and general population with emphasis on rural men and women.

Coverage for couples has remained poor at paltry 16% and yet data show that the driver of the epidemic in Kenya is infection occurring in marriages and sexual partners. The approaches to HTC include client initiated in community settings and provider initiated approaches in health facilities where the target coverage is 80% for inpatients and 50% for outpatients. Other PITC approaches include workplace and moonlight services in strategic hot spots to target key populations.

In the last year the program reached 394,000 clients who were tested and counseled (91,000 clients in CITC and 303,159 clients in PITC). In 2012 the program has a target of 329,000 individuals reached with testing and counseling services divided a s follows 263,000 in PITC,1 VCT- 32,900; workplace - 3290 and mobile- 29,610, with 30% being couples.

A total of 171 providers were trained in PITC while 45 providers were offered refresher training in HTC integration and re-testing recommendations and additional 1000 providers were taken through CMEs covering PITC, quality management and integration of services.

The program uses the national testing algorithm. Referral uptake among clients remain a challenge and the strategies used to improve this are use updated, comprehensive referral directories available in all sites., PLHIV CHWs are used to make follow up, they make home visits where possible, use phone calls and send short messages (sms) to clients to ensure referral uptake. The clients are followed up and tracked for 3 months and a register is maintained to ensure referral uptake.

The program follows the national quality management guidelines and participates in the proficiency testing quarterly and collection of DBS for the 20th client tested and counseled per counselor. Support supervision is carried out for the service providers on continuous basis.

The program develops work plans and conducts biannual data quality audits and monthly data supervision is carried out and this informs the program implementation improvement.

The national M&E framework is used including use of national registers and data collection tools and reporting will be through the DHIS in future. New indicators like couples tested, discordant couples, MARPs and people with disability have been incorporated in the national tools and the program captures these.

Promotional activities for demand creation include the print and electronic media; for specific populations like the youth, social media is used through face book. A hot line is operated that has a national reach. Mass media is used for the general population and peer led mobilization is used for the MARPs. Mobilization is also carried out in churches and couples hot spots aiming at couples.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVOP	760,000	0

Narrative:

In COP 2012, Ungana will implement a wide range of EBIs which will have been adopted by the country for combination prevention. Ungana is a capacity building program with a wide range of local organizations that target different populations in their areas of operation with HIV interventions. Most of the EBIs await adaptation and adoption by the country but the following have been identified for adaptation.

Healthy Choices II (HCII) targets both in and out of school youth aged 13 – 17 years and aims to delay sexual debut, promote secondary abstinence or have protected sexual intercourse, by providing knowledge and skills on correct and consistent condom use, handling peer pressure, and learning one's HIV status. HC II consists of 8 modules of approximately one hour each. It can be delivered in 4 sessions of 2 hours each or in 8 sessions of 1 hour each.

Eban/Connect is a six session, relationship-based intervention that teaches couples including those discordant, techniques skills to enhance the quality of their relationship, communication, and shared commitment to safer sexual behaviors and will allow couples to work together to solve shared problems.

RESPECT targets ages 20-24 females and 30-44 males with STI. It has 2 brief individual sessions targeting general population and youth, originally for heterosexual negative persons. It focuses on reduction of STDs/HIV, risk reduction, condom use and clients understanding of personal risk

Sister to Sister is a brief (20-minute), one-on-one, skill-based HIV/sexually transmitted disease (STD) risk-reduction behavioral intervention for sexually active women 18 to 45 years old. The purpose of Sister to Sister is to: provide intensive, culturally sensitive health information to empower and educate and help women understand the various behaviors that put them at risk for HIV and other STDs; and enhance women's knowledge, beliefs, motivation, confidence, and skills to help them make behavioral changes that will reduce their risk for STDs, especially HIV

PwP is an individual intervention promoting positive living and strategies to reduce HIV transmission and re-infection, promotes enrolment to care and treatment, drug adherence, family planning, continued counseling and promotes partner testing and disclosure of status as well as proper and consistent condom use.

These populations are most at risk of HIV infection and have the prevalences higher than the national average. The female sex workers do not have the skills for negotiation for safe sex and this increases their vulnerability. Sex is not discussed in family relationships and further couples do not know each other's HIV status and HIV discordance is high in the country about 45% of HIV infected persons.

Quality assurance of all these interventions is promoted through rigorous training and certification of facilitators, ongoing process monitoring with standardized tools, and quality assurance site visits by a capacity building agency. Appropriate evaluation modalities will be developed by the Technical working group to assess the impact.

Gender: The Ministry of Gender, Children and Social Development (MOGCD),Ministry of Health and other Stakeholders to define a comprehensive national package of services for victims of Gender-Based Violence (GBV) and harmonize Monitoring and Evaluation of GBV services.

Implementing Mechanism Details

Mechanism ID: 13121	**Mechanism Name: Partnership in Advanced Clinical Education (PACE)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Maryland	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,630,000	
Funding Source	**Funding Amount**
GHP-State	1,630,000

Sub Partner Name(s)

Kenya Pediatric Association	University of Nairobi	

Overview Narrative

The University of Maryland Partnership for Advanced Clinical Education (PACE) goal is to increase the impact, efficiency, and sustainability of pre-service and in-service HIV training in Kenya. The main objective is to support Kenya's 6 public universities to deliver HIV education which is based on core competencies for HIV service delivery and uses teaching methodologies that maximize adult learning. The PACE strategies link to Kenya's GHI strategies as the program is designed around the Kenya National AIDS Strategic Plan (KNASP) III and working through Ministry of Health (MoH) and local universities by supporting a national training cascade and system for managing in-service HIV training. PACE directly relates to Kenya's Partnership Framework in that HIV service delivery depends on an efficiently trained workforce of highly competent healthcare workers.

PACE will implement a more efficient and sustainable model of HIV training in Kenya by reducing the requirement for costly off-site and hotel-based trainings.

PACE is collaboration between the University of Maryland Baltimore and the University of Nairobi (UON). UON is taking on increasing responsibility for planning and implementing the program and all direct implementation of

activities will transition to UON during the grant period.

PACE is developing an M&E framework with output, outcome, and impact indicators that will measure how this new training model improves clinical practice and patient outcomes.

PACE has procured 2 vehicles between FY10 and FY11. An additional vehicle will be required for travel to the 6 public universities and to regional training centers which will pilot the new in-service training model.

Cross-Cutting Budget Attribution(s)

Gender: GBV	7,000
Gender: Gender Equality	15,000
Human Resources for Health	767,800

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	**13121**		
Mechanism Name:	**Partnership in Advanced Clinical Education (PACE)**		
Prime Partner Name:	**University of Maryland**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVTB	230,000	0
Narrative:			
The University of Maryland Partnership for Advanced Clinical Education (PACE) in partnership with University of			

Nairobi (UON) will continue to support pre-service and in-service TB training nationally with focus on three training areas: Pre-service University HIV Education and Training, In-service HIV Training, and Pre-service and In-service HIV Laboratory Education and Training.

PACE is a national program targeting pre-service and in-service health care workers and trainers/mentors. The PACE goals and objectives are being achieved using strategies that link to Kenya's GHI strategies of increased impact through strategic efficiencies, country ownership, strengthening health systems, and rigorous M&E (through implementation of an M&E framework to measure output, outcome, and impact indicators). PACE also directly relates to Pillar 1 of Kenya's Partnership Framework in that HIV service delivery depends on a growing workforce of highly competent healthcare workers and that workforce will be more efficiently trained as a result of PACE.

The PACE program objectives are to support Kenya's 6 public universities to deliver HIV education based on core competencies for HIV service delivery and that uses appropriate adult learning teaching methodologies; partner with the Ministry of Health (MoH) in designing and implementing an integrated competency-based in-service HIV training curriculum that utilizes self-learning and on-site mentorship delivered through a coordinated training network (including TB/HIV); and develop capacity within universities, medical training colleges, and MoH health facilities to provide structured, practical, and high quality in-service training in HIV laboratory services, including TB diagnostic competencies.
PACE's contribution to scaling up TB/HIV activities is through the development and implementation of the new integrated in-service HIV curriculum that includes the 5Is of TB/HIV prevention and co-management, including universal testing for HIV in TB services, routine screening for TB in HIV patients, isoniazid preventive therapy, early initiation of ART in TB/HIV co-infected patients, and infection control in the HIV patient care areas. PACE will build capacity of HCWs and facilities for TB/HIV by training and supporting mentorship/training teams at the regional training centers, which will cascade the new curriculum to their own site and peripheral health facilities.

PACE is adequately equipped with Human Resource Capacity to support the development of regional training capacity, comprised of a National Technical Assistance team of Clinical Nurse Trainer, Community Based Treatment Support Nurse Trainer, Medical Laboratory Specialist, CQI Specialist, Pharmacy Specialist, and Strategic Information Specialist. In FY 12 and 13, this team will support 7 regional training centers, in collaboration with MoH and other implementing partners, by assisting in the development of clinical care delivery systems that provide high quality patient care and thus support effective training as well as build the capacity of the regional training teams in these sites.

As part of the sustainability strategy, UON is taking on increasing responsibility for planning and implementing the program and all direct implementation of activities will transition to UON during the grant period. In addition, the program has involved UON faculty as national level master trainers/mentors with an aim to increase exposure to level 3.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	0	0

Narrative:

The child health training program will build knowledge and capacity of 6500 health workers in community case management of pneumonia, malaria and diarrheal diseases in the highest HIV prevalence areas of Western, Nyanza and Coast Provinces. The training curricula consist of community case management of uncomplicated pneumonia, diarrheal diseases, and malaria in areas with poor access to healthcare, and the ability to refer complicated cases to the facility level. Activities for the health workers include training targeted at increased diagnosis and management of pneumonia, diarrheal diseases, and malaria. These activities will be achieved through implementation and scale-up of the Integrated Management of Childhood illnesses (IMCI) and use of rapid diagnostic tests for HIV, malaria, and other diarrheal diseases. All of these activities are defined as Government of Kenya (GOK) priorities and are stipulated in the national health services strategic plan. The GOK and other partners will continue to support these activities either through the national or county governments in the event that PEPFAR funding is only provided for the initial implementation period.

The Government of Kenya has also developed a community health strategy that relies on community based health workers to reach mothers and their children within their households. Lifesaving interventions and messages will be scaled up to reach children living with HIV/AIDS and therefore enable prevention of opportunistic infections which will result in improvement of quality of life. Proposed activities include the development and deployment of eLearning materials and messages that can be deployed through a variety of different mobile technologies to include smartphones, SMS, DVD, and internet-based. The focus of these will concentrate mainly on promotion of prevention methods, healthy behaviors at household level including exclusive breastfeeding for children below 6 months, appropriate complementary feeding, dietary diversity targeting -9 to 24 months period, use of long-lasting insecticide-treated bed nets (LLINs), hand washing with soap, safe water storage and treatment and community-led total sanitation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	300,000	0

Narrative:

The Partnership for Advanced Clinical Education (PACE) is a partnership between University of Maryland Baltimore (UMB), as a prime partner and University of Nairobi (UON) to support the strengthening of pre-service and in-service HIV education and training in Kenya, since COP 2009. In their first two years of project implementation, PACE has registered various laboratory-related accomplishments, key of which include: revised and developed an integrated in-service base-level laboratory curriculum; a standard pre-service teaching lab to be

used by the Kenyan universities or MTCs for skills training; identified 4 mentorship training centers to provide in-service cost-recovery training; trained a total of 264 laboratory personnel: 83 in computer literacy(ICDL), 95 in Laboratory inspection, and 86 on laboratory ART monitoring techniques.

In the FY12 and beyond, PACE will build on previous achievements and lessons learnt to sustain the PACE partnership with more local universities, training institutions and the ministry of health. During this period, this partnership will transition into a mechanism for sustainable exchange of knowledge, skills, best practices between UMB and Kenya. In the long term, this mechanism will provide high-level technical capacity to Kenyan training institutions to ensure greater academic and strategic medical independence. To achieve these broad goals and specific deliverables (below), a budget of $350,000 for the FY 2012 is proposed for the PACE partnership:

Support and sustain regional training centres: PACE will provide TA to the 4 regions developed in the FY 11 to facilitate and cascade training to lower facilities. Through these training centres, standardized lab tools and packages will be used to train 200 laboratory staff in FY 2012 and a similar number in FY 2013

Support to KMTCs to administer cost-recovery in-service training: In FY 12, PACE will continue providing TA to KMTC laboratory mentorship training facilities on cost-recovery and training activities. The TA will be directed to the 3 KMTC facilities established in FY 2011. By the end of FY 2012, 100 laboratory staff will have been trained at these facilities.

The activities proposed for PACE will have strong linkages with the PEPFAR technical area on training and retention of laboratory professionals as it relates to sustaining pre-service training and also providing required technical competencies and skills transfer to staff already in service.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	50,000	0

Narrative:

The University of Maryland Partnership for Advanced Clinical Education (PACE) in partnership with University of Nairobi (UON) will continue to support pre-service and in-service training nationally with focus on three training areas: Pre-service University HIV Education and Training, In-service HIV Training, and Pre-service and In-service HIV Laboratory Education and Training.

The overarching goal of PACE is to increase the impact, efficiency, and sustainability of pre-service and in-service HIV training in Kenya. The objectives are to support Kenya's 6 public universities to deliver HIV education which is based on core competencies for HIV service delivery and uses teaching methodologies that maximize adult learning; partner with Ministry of Health (MoH) in designing and implementing an integrated competency-based

in-service HIV training curriculum that utilizes self-learning and on-site mentorship delivered through a coordinated training network; and develop capacity within universities, medical training colleges, and MoH health facilities to provide structured and practical high quality in-service training in HIV laboratory services. PACE is a national program targeting pre-service and in-service health care workers and trainers/mentors.

PACE will provide on-site mentorship and systems strengthening through its national Technical Assistance team comprised of a Clinical Nurse Trainer, Community Based Treatment Support Nurse Trainer, Medical Laboratory Specialist, Continuous Quality Improvement Specialist, Pharmacy Specialist, and Strategic Information Specialist. In FY12, this team will support 7 regional training centers, in collaboration with MOH and other implementing partners, by assisting in the development of clinical care delivery systems that provide high quality patient care and thus support effective training as well as build the capacity of the training team in these sites. In addition, the program has involved UON faculty as national level master trainers/mentors with an aim to increase exposure to level 3 and 4 facilities.

The PACE contribution to scaling up HVCT services is through the development and implementation of the new in-service HIV curriculum that includes HTC and through improving capacity at the regional training centers to operationalize the new guidelines. PACE will build capacity of health care workers and facilities to provide HVCT services by training and supporting mentorship/training teams at the regional training centers, which will cascade the new curriculum to their own site and peripheral health facilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	200,000	0

Narrative:

The University of Maryland Partnership for Advanced Clinical Education (PACE) in partnership with University of Nairobi (UON) will continue to support pre-service and in-service training nationally with focus on three training areas: Pre-service University HIV Education and Training, In-service HIV Training, and Pre-service and In-service HIV Laboratory Education and Training.

The overarching goal of PACE is to increase the impact, efficiency, and sustainability of pre-service and in-service HIV training in Kenya. The objectives are to support Kenya's 6 public universities to deliver HIV education which is based on core competencies for HIV service delivery and uses teaching methodologies that maximize adult learning; partner with Ministry of Health (MoH) in designing and implementing an integrated competency-based in-service HIV training curriculum that utilizes self-learning and on-site mentorship delivered through a coordinated training network; and develop capacity within universities, medical training colleges, and MoH health facilities to provide structured and practical high quality in-service training in HIV laboratory services. PACE is a national program targeting pre-service and in-service health care workers and trainers/mentors.

PACE will provide on-site mentorship and systems strengthening through its national Technical Assistance team comprised of a Clinical Nurse Trainer, Community Based Treatment Support Nurse Trainer, Medical Laboratory Specialist, Continuous Quality Improvement Specialist, Pharmacy Specialist, and Strategic Information Specialist. In FY12, this team will support 7 regional training centers, in collaboration with MOH and other implementing partners, by assisting in the development of clinical care delivery systems that provide high quality patient care and thus support effective training as well as build the capacity of the training team in these sites. In addition, the program has involved UON faculty as national level master trainers/mentors with an aim to increase exposure to level 3 and 4 facilities.

The PACE contribution to scaling up PMTCT services is through the development and implementation of the new in-service HIV curriculum that includes PMTCT and through improving capacity at the regional training centers to operationalize the new guidelines including early entry into care and completion of the PMTCT cascade. Training also includes competencies on early infant diagnosis, PITC, effective ARV regimens for PMTCT, and appropriate use of laboratory diagnosis and monitoring. PACE will build capacity of 200 health care workers and facilities to provide PMTCT services by training and supporting mentorship/training teams at the regional training centers, which will cascade the new curriculum to their own site and peripheral health facilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	800,000	0

Narrative:

The University of Maryland Partnership for Advanced Clinical Education (PACE) in partnership with University of Nairobi (UON) will continue to support pre-service and in-service training nationally with focus on three training areas: Pre-service University HIV Education and Training, In-service HIV Training, and Pre-service and In-service HIV Laboratory Education and Training.

The overarching goal of PACE is to increase the impact, efficiency, and sustainability of pre-service and in-service HIV training in Kenya. The objectives are to support Kenya's public universities to deliver HIV education which is based on core competencies for service delivery and uses teaching methodologies that maximize adult learning; partner with the Ministry of Health (MoH) in designing and implementing an integrated competency-based in-service HIV training curriculum that utilizes self-learning and on-site mentorship delivered through a coordinated training network; and develop capacity within universities, medical training colleges, and MoH health facilities to provide structured, practical, and high quality in-service training in HIV laboratory services.

Pre-service training to 600 HCWs in FY 12 and 500 in FY 13 will include training university faculty and internship supervisors on innovative teaching methods to enable them to utilize principles of adult learning and better engage

their students. Additionally, the pre-service institutions are able to use the competency based in-service integrated HIV training curriculum to support pre-service HIV training. PACE also supports a multi-disciplinary, in terms of student cadres and the training faculty, HIV "consolidation" workshop for final year health science students at Kenya's public universities to help navigate the transition between training and practice.

For in-service training, PACE will provide on-site mentorship and systems strengthening to 500 HCWs in FY 12 and 400 in FY 13 through its national Technical Assistance team comprised of Clinical Nurse Trainer, Community Based Treatment Support Nurse Trainer, Medical Laboratory Specialist, Continuous Quality Improvement Specialist, Pharmacy Specialist, and Strategic Information Specialist. In FY13 this team will support 7 regional training centers, in collaboration with MOH and other implementing partners, by assisting in the development of clinical care delivery systems that provide high quality patient care and thus support effective training as well as build the capacity of a regional training team in these sites. In addition, the program has involved UON faculty as national level master trainers/mentors with an aim to increase exposure to level 3 and 4 facilities.

PACE tracks and evaluates the program's performance through data collected during the trainings. This tracking specifically accounts for the number of health care workers, faculty, or students who successfully complete the training. PACE is developing an M&E framework that goes beyond the standard training evaluations of recall-based assessments to also measure how this new training model improves clinical practice and patient outcomes. This evaluation will be accomplished through analysis of routinely collected program data and leveraging on formal evaluations funded through other mechanisms such as CQI data collected through NASCOP's HIVQUAL program and the national longitudinal patient-level outcome studies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	50,000	0

Narrative:

The University of Maryland Partnership for Advanced Clinical Education (PACE) in partnership with University of Nairobi (UON) will continue to support pre-service and in-service pediatric training nationally with a focus on three training areas: Pre-service University HIV Education and Training, In-service HIV Training, and Pre-service and In-service HIV Laboratory Education and Training.

The overarching goal of PACE is to increase the impact, efficiency, and sustainability of pre-service and in-service HIV training in Kenya. The objectives are to: support Kenya's 6 public universities to deliver HIV education which is based on core competencies for HIV service delivery and uses teaching methodologies that maximize adult learning; partner with Ministry of Health (MoH) in designing and implementing an integrated competency-based in-service HIV training curriculum that utilizes self-learning and on-site mentorship delivered through a coordinated training network; and develop capacity within universities, medical training colleges, and MoH health

facilities to provide structured and practical high quality in-service training in HIV laboratory services. PACE is a national program targeting pre-service and in-service health care workers and trainers/mentors. *PACE will provide on-site mentorship for pediatric and systems strengthening through its National Technical Assistance team comprised of a Clinical Nurse Trainer, Community Based Treatment Support Nurse Trainer, Medical Laboratory Specialist, Continuous Quality Improvement Specialist, Pharmacy Specialist, and Strategic Information Specialist. PACE, in collaboration with MoH and other implementing partners, will provide technical assistance to 500 specialists in FY 12 and 400 in FY 13 by assisting in the development of clinical care delivery systems that provide high quality patient care and thus support effective training as well as building the capacity of the training team in these sites. In addition, the program has involved UON faculty as national level master trainers/mentors with an aim to increase exposure to level 3 and 4 facilities.* *PACE will contribute to scaling up of pediatric treatment through the development and implementation of the new in-service HIV curriculum that includes pediatric HIV care and treatment. Training also includes competencies on early infant diagnosis, PITC, appropriate use of laboratory diagnosis and monitoring, and adolescent-specific services. PACE will build capacity of health care workers and facilities to treat children by training and supporting mentorship/training teams at the regional training centers, which will cascade the new curriculum to their own site and peripheral health facilities.*

Implementing Mechanism Details

Mechanism ID: 13164	**Mechanism Name: Strengthening Public Health Laboratory Systems in Kenya**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,427,214	
Funding Source	**Funding Amount**
GHP-State	2,427,214

Sub Partner Name(s)

(No data provided.)

Overview Narrative

MSH will partner with AMREF to strengthen integrated laboratory services for the prevention, diagnosis, surveillance and management of HIV/AIDS, STI, TB, Malaria, neglected tropical diseases and non-communicable diseases. Specifically, MSH will: Strengthen the capacity of Ministry of Health to provide stewardship, technical guidance and oversight for laboratory services through coordination of partners and targeting of available resources; empower county health systems establish high performing laboratories at all levels of care for better equity and universal access to quality, efficient, and cost effectiveness laboratory services; strengthen the regulatory environment for policy and governance of laboratories; support lab accreditation efforts, laboratory networking and establishment of structures for a national quality assurance system ; and develop capacity of lab managers to use facility data for planning, budgeting and mobilization of resources.

MSH strategy has been to use local Kenyan or regional staff and not long term expatriates. MSH will gradually transition administrative and project management functions to local operating units to reduce financial costs. Facility based training has been employed to improve on cost-efficiency.

Transition to country: The MSH approach enhances country buy-in and ownership, collaboration, and empowerment thus leads to self confidence, replication of processes and practices and eventual sustainability. The partnership between AMREF and MSH will be maintained and strengthened.

Vehicle information: This partner has not used PEPFAR funds for vehicle purchase in the past. The partner will apply to purchase a vehicle in FY12 to facilitate provision of TA to laboratories across the country. This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	200,000

TBD Details

(No data provided.)

Key Issues

TB

Budget Code Information

Mechanism ID:	**13164**		
Mechanism Name:	**Strengthening Public Health Laboratory Systems in Kenya**		
Prime Partner Name:	**Management Sciences for Health**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	2,027,214	0

Narrative:

The overarching goal of the CDC cooperative agreement with Management sciences for Health (MSH) is to strengthen medical laboratory Systems in Kenya. KNASP III acknowledges laboratories as an essential part of the country's healthcare plan to support HIV/AIDS prevention, treatment, and care and proposes to increase the percentage of health facilities with the capacity to perform clinical laboratory tests for HIV patients. This activity takes cognizance of GHI principles of principles of country ownership, sustainability and health systems strengthening by focusing on capacity building and development of laboratory policies for MOH. In COP12, MSH will continue to strengthen and expand laboratory systems with emphasis on gaining efficiencies, program quality and country ownership.

Support for policy formulation and organizational restructuring will strengthen management and leadership capacity, forecasting for laboratory supplies, budget negotiations and financial management. Lab managers will be empowered to develop budgets and annual operational plans at all levels of service delivery.

An integrated systems strengthening approach will be taken with emphasis on; improving access to laboratory services through strengthening of defined and coordinated laboratory networks for specimen referral. These networks which will be operationalized through facility based PEPFAR Care & Treatment partners will also be used to reinforce quality systems and support dissemination of the laboratory policies through a regional approach. MSH will support laboratory accreditation efforts for 25 laboratories, supported at facility level by ASCP and AGHPF, through GCLP/QMS, biosafety, ISO 15189, and leadership trainings. Leadership and management training, follow-on to SLMTA, will target hospital management teams including clinicians, administrators and laboratorians. A total of 200 health care workers will be trained. Support to the national accreditation steering committee (NLASC) will enable MOH make significant moves towards driving the accreditation process. All accreditation applications to KENAS and other accrediting bodies will be channeled through MSH. This will ensure that no conflict of interest arises between the assessors and partners directly supporting QMS improvements.

MSH will strengthen laboratory monitoring and evaluation systems and D4DM at national and regional level through implementation of reporting tools, data analysis and dissemination.

In partnership with AMREF, MSH will expand national EQA access through the East African Community REQAS program. Additionally AMREF will directly support accreditation of five Nairobi City Council health centers through the WHO Step-wise accreditation process.
To build leadership and country ownership for medical laboratory activities, MSH will work with local laboratory related professional associations such as AKMLSO and KACP to develop a core of opinion leaders to diffuse supportive innovations and ideas. Training in writing of scientific papers in peer reviewed journals and grant proposal applications will be supported so as to enhance sustainability of laboratory improvements in Kenya.
The integrated approach to laboratory strengthening will benefit not only HIV testing but also testing related TB, malaria, opportunistic infections and neglected tropical diseases.
Please see the partner's overview narrative for information on the strategy to transition to local partners.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	400,000	0

Narrative:

Goals and Objectives
Management Sciences for Health (MSH) will contribute to the prevention of medical transmission of HIV (and other blood borne pathogens) through sharps and other medical waste. It will do this by supporting training in Biosafety and blood collection/phlebotomy. Blood drawing has been recognized as a high risk procedure in the country that puts health workers at risk of acquiring HIV and other blood borne pathogens. CDC worked in partnership with NASCOP and BD Company in a public-private partnership (PPP) to pilot this training in 8 health facilities in 2010. In 2011 MSH together with NASCOP have expanded to 19 more facilities throughout the country. Through this funding MSH will scale up these trainings to reach all regions and health workers who draw blood. Additionally MSH will strengthen Biosafety through trainings; this is a key component of laboratory quality and accreditation.
Coverage and scope of activities
MSH will support training of 600 health workers in safe blood collection and 600 health workers in Biosafety. Initial training will aim to develop regional capacities by ensuring that every county in the country has some trained trainers (TOT). Blood collection training will target laboratory workers, clinical officers, doctors, nurses and all health workers identified to collect blood. The training will incorporate some aspects of IPC and waste management. The Biosafety training will target laboratory workers and will also aim to strengthen quality systems. Additionally MSH will support development and dissemination of occupational safety and post-exposure prophylaxis (PEP) policies as well as strengthen sharps injury surveillance system.
Integration into program
MSH will ensure integration of injection safety, Biosafety, waste management and infection prevention and control principles into HIV and other health programs by training on the same. It will support the pre-service training institutions to integrate the same into training curricula.
Country ownership and sustainability

MSH will adopt the TOT approach to ensure that the country has a pool of qualified and competent trainers throughout all counties. These will then cascade the trainings further down and will ensure sustainability of the efforts. *Partnerships and collaboration* *MSH will work closely with NASCOP and other partners to roll out its activities. As different partners are supporting the Biosafety training it will need to be coordinated by the Biosafety office at national public health laboratories (NPHLS).* *Quality improvement and M&E* *Quality assurance and improvements will be a key component of this program. MSH will ensure this by rolling out a strong monitoring and evaluation system with indicators for tracking along the lifespan of the project.* *Commodity security* *The training in safe phlebotomy and blood collection will have a component on commodity and logistics management. This will ensure that even as health workers join the working field they have the capacity to ensure appropriate forecasting, procurement and usage of various blood drawing devices.*

Implementing Mechanism Details

Mechanism ID: 13179	**Mechanism Name: Emory University**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Association of Schools of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 721,056	
Funding Source	**Funding Amount**
GHP-State	721,056

Sub Partner Name(s)

Emory University		

Overview Narrative

1. Goals and objectives:
This program seeks to strengthen Human resources information systems and data use to inform HR policies and equity in the health workforce. The HRIS will monitor the MOH and PEPFAR commitments through the partnership framework, to increase the number of trained health workers in the health sector. 2. Cost-efficiency strategy:
Emory project is working closely with the USAID funded Capacity project to mutually leverage the resources towards a comprehensive HR information system. The Capacity project supports the broader iHRIS that covers all personnel in the MOH, including non-medical employees of the MOH (e.g. administrators, support staff, etc). Enhancing interoperability between iHRIS, KHWIS and the payroll data provides vital information such as health workers who are no longer in employment and any skewed distribution of health workers. These save significant personnel cost.The introduction of a web-based system for tracking online application and payment for licensure and retention will reduce the cost and time spent by health workers visiting the regulatory bodies for these statutory requirements resulting in more time spent at the health facilities.3. Transition to country partners:
The Kenya Health Workforce Information System (KHWIS) was developed by a local company and is maintained by Kenyan programmers who work closely with the HR department of the MOH and the regulatory bodies. 4. Vehicle information: No vehicles have been/will be procured with PEPFAR funds.The target population is health workers, program managers and policy makers. The program has a national coverage. This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	721,056

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**13179**
Mechanism Name:	**Emory University**

Prime Partner Name:	Association of Schools of Public Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	721,056	0

Narrative:

Human resources are a key component of the national health systems. Failure to track the training (pre-service and in-service), deployment, attrition and other related HR attributes can be a major obstacle to delivery of health care. This mechanism is used track various cadres of health workers from training to the point they leave service, and the tracking system is maintained and used by the MOH and regulatory/professional associations. The Emory Project is in the process of developing HRIS for 4 health professional regulatory boards (Nursing Council of Kenya (NCK), Medical Practitioners and Dentists Board (KMPDB), Laboratory Technologists/Technicians Board, (KMLTB) and the Clinical Officers' Council (COC)). The project is planning to begin developing a system for the Pharmacy and Poisons Board (PPB) in project year 2011 – 2012.

Key activities include: 1.Completion of current systems implementation and evaluation for the KMPDB and KMLTB by October 2012 and transition to the maintenance of these systems. Implementation of the evaluations on the KMPDB, KMLTB and COC will be carried out in 2012-2013. 2.Continuous capacity building throughout the process, which will continue in 2012-2014 due to staff changes. The project will work with MOH and the Boards to put in place sustainable training models. 3.Interoperability of both the deployment iHRIS (Capacity, Dept of Personnel) and the supply databases (Emory, CDC, Kenyan regulatory agencies). Interoperability is critical for workforce management, health program planning, and policy development. CDC-Atlanta has funded Emory to examine the interoperability between the HR databases and the HMIS data with a focus on the District level during 2011 – 2012, and is likely to continue into 2013. The recommendations from the assessment will be implemented in 2013-2014. 4.Develop a web-based tool for professional associations. Most agencies would like to have functions, such an online application and payment for licensure. User specifications will be done during project year 2012.

5. Improving long-term research capability in collaboration with KEMRI-Wellcome Trust so that Kenyan scholars and scientists may conduct research related to Health Systems Strengthening, especially HRH. 6.Leveraging continuous professional development system toolkits, developed through funding from CDC-Atlanta for the establishment of the African Regulatory Collaborative. These materials will assist Kenyan agencies to create CPD systems, allowing them to monitor continuing training/education of their staff.

The Emory project works in collaboration with the USAID funded Capacity project to ensure a broader coverage of HR issues at the MOH, leveraging each partner's comparative advantage. While Emory's work focuses on the

supply (training) and regulatory components, Capacity project focuses on deployment of various cadres of health workers. The MOH has recently set up a data center with servers that host all health data. The HRIS databases will be migrated to the MOH owned data storage, significantly cutting the cost of server space and connectivity that was previously met by PEPFAR. Overall, these systems will help in the tracking of training and distribution of health workers, ensuring that skills/personnel are matched with facilities'/regions' needs.

Implementing Mechanism Details

Mechanism ID: 13210	**Mechanism Name: Strengthening Laboratory Accreditation Services in Kenya**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Global Healthcare Public Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 630,000	
Funding Source	**Funding Amount**
GHP-State	630,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Goals and objectives: A Global Healthcare Public Foundation (AGHPF) will continue to support laboratory accreditation efforts. A two pronged approach will focus on strengthening the regulatory framework through sensitization and advocacy of high level Ministry of Health and in particular the Dept. of Standards and Regulatory Services (DSRS) and Dept. of Diagnostics and Forensic services (DDFS) and to enable Kenya National Accreditation Services (KENAS) acquire international recognition as a formal ISO accrediting body. In the second and third years of PEPFAR funding, AGHPF took on cumulatively direct strengthening of thirteen laboratories through the WHO stepwise process towards ISO 15189 accreditation. This effort will continue. Additionally, 100 laboratory professional will be trained in quality systems management. Cost-efficiency strategy: AGHPF has instituted all interventions within Ministry of Health systems and garnered significant support from local

authorities. This approach will ensure sustainability of this activity. The innovative SLMTA approach espouses laboratory improvements with resources available at facility level. Transition to country partners: AGHPF will work closely with local institutions including MOH-DSRS, MOH- DDFS and KENAS supporting institutionalization of accreditation activities. This partner has not used PEPFAR funds for vehicle purchase in the past and is not requesting funds for vehicle purchase in FY12.This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	300,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**13210**		
Mechanism Name:	**Strengthening Laboratory Accreditation Services in Kenya**		
Prime Partner Name:	**Global Healthcare Public Foundation**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	630,000	0
Narrative:			
Under COP 12 AGHPF will continue to give direct support in laboratory quality improvement through SLMTA training and mentorship to nine Ministry of Health (MOH) and four Faith Based laboratories with the goal of attaining accreditation through the WHO-Step-wise process. Specifically, AGHPF staff experienced in laboratory quality systems will work shoulder-shoulder with MOH laboratory quality officers and managers to implement ISO 15189 standards at each laboratory. In addition AGHPF will conduct end term assessment of 10 laboratories, carry			

out accreditation sensitization and baseline assessments for 3 new laboratories and follow up with requisite SLMTA workshops. To support facility based improvement projects AGHPF will procure stationery items and minor essential laboratory supplies such as thermometers, timers, safety boxes, diamond pencils, signage and safety devices. *AGHPF will train 100 health care workers in biosafety, equipment /method validation, GCLP, internal audits and quality management systems taking a task-based approach at facility or regional level. This will ensure taught skills are implemented and that laboratory workers are not taken away from their routine service delivery duties unnecessarily.* *Through support to the MOH Department of Standards and Regulation, AGHPF will strengthen Kenya's regulatory framework for laboratory accreditation. Kenya has up to 400 laboratories all of which cannot benefit from the accreditation initiative unless laboratory accreditation efforts are internalized within MOH structures and systems. AGHPF will work with MOH to facilitate an accreditation supportive environment.* *AGHPF will also strengthen Kenya National Accreditation Service (KENAS) to attain international recognition by the International Laboratory Accreditation Cooperation (ILAC) and position itself to confer external objective accreditation of medical laboratories in Kenya. This will involve the conduct joint assessments with a recognized accreditation body such as South African National Accreditation System (SANAS). Prior to full accreditation, KENAS will assess laboratories using the WHO-AFRO checklist and award recognition stars. Specific activities with KENAS will include development of a national application clearing center, training of national laboratory assessors (14), printing and dissemination of the medical Laboratory accreditation services (MLAS) policy guide and checklist.* *This cooperative agreement will be monitored by CDC Kenya through regular quarterly meeting to review progress on the work plan, compliance to the Notice of Award and USG regulations. It will be ensured that the MOH-National Laboratory Accreditation Committee guidelines are followed.* *This activity will contribute directly to thirteen accredited laboratories in Kenya and training of at least 100 health care workers. The exact cost of improving laboratory quality through the WHO Step- wise accreditation process and of running a quality HIV management laboratory support service are not yet known. This activity will provide critical information for more accurate forecasting, planning and budgeting for laboratory support for program activities. MOH laboratory managers will acquire skills in developing facility budgets and advocating for a fair share of resources both centrally and at facility level.* *Please see the partner's overview narrative for information on the strategy to transition to local partners.*

Implementing Mechanism Details

Mechanism ID: 13287	**Mechanism Name: Establishment of Medical Waste Management Systems in Kenya**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and	Procurement Type: Cooperative Agreement

Prevention	
Prime Partner Name: Program for Appropriate Technology in Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,200,000	
Funding Source	**Funding Amount**
GHP-State	1,200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Goals/objectives:

PATH will contribute to the prevention of HIV transmission through sharps and other medical waste. This will contribute to the Kenya National AIDS Strategic Plan (KNASP-III) goal of eliminating HIV transmission in healthcare settings in the next two years. It will promote safe and environmental friendly medical waste disposal practices and integration of injection safety, infection prevention and control practices into all health programs. It will build the capacity of health workers on waste management and work safety while promoting PEP uptake. It will support MOH to leverage resources from multilateral partners. It will strengthen health systems in line with the Global Health Initiative principles.

Cost-efficiency strategy

To improve cost efficiency PATH will support pooled waste management systems. It will promote waste segregation to ensure only infectious waste is treated while general waste is recycled. This will minimize the use of incinerators and other equipment thus lower running costs. It will support installation and purchase of non-incinerator waste management technologies that are more cost-efficient. It will also implement an M&E plan that will generate data for better programming.

Transition to country partners

PATH will train and build capacity of local health workers through a TOT approach. Expatriates coming will twin with local staff to get specialized skills. Special training for newer technologies will be given to biomedical engineers for future servicing.

Vehicle information

PATH was handed over 2 vehicles from a previous project in FY10; however one of the vehicles has been having mechanical breakdowns. A vehicle will be procured in FY12 for supportive site visits.

This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	240,000

TBD Details

(No data provided.)

Key Issues

Workplace Programs

Budget Code Information

Mechanism ID:	**13287**
Mechanism Name:	**Establishment of Medical Waste Management Systems in Kenya**
Prime Partner Name:	**Program for Appropriate Technology in Health**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	1,200,000	0

Narrative:

Goals and Objectives
PATH will contribute to the prevention of medical transmission of HIV (and other blood borne pathogens) through sharps and other medical waste. It will support training, behavior change communication and information, educational and communication (IEC) materials aimed at improving injection safety; phlebotomy, lancet and other high risk procedures for health workers. It will also strengthen post-exposure prophylaxis (PEP) services for health workers encountering accidental exposure to blood borne pathogens. It will promote safe medical waste management (MWM) practices by supporting implementation of necessary policies and guidelines; training of health workers; ensuring commodities security; decreasing the use of unnecessary injections and supporting installation and maintenance of environmentally friendly equipment.

Coverage and scope of activities
PATH will implement its activities nationally and will ensure that all counties are covered. It will target all health workers and policy makers who influence treatment guidelines and procurement as well as communities as recipients of health services and those at risk of injury. It will support installation of 15 MWM systems, train 50 biomedical engineers and reach 20 counties with policies and guidelines.
Integration into program
Importance will be put on integrating Bio-safety, MWM, universal precautions and infection prevention and control (IPC) measures into existing HIV programs like care & treatment, prevention, counseling & testing and other health programs such as family planning, immunizations and other clinical services. It will support these programs to have a plan and budget to address medical waste and infection control.
Country ownership and sustainability
PATH will facilitate training of health workers through a training of trainer (TOT) model to create a pool of trainers and leaders in MWM and IPC. It will facilitate training of biomedical engineers who will ensure efficient and sustainable operation of cost-effective MWM systems. Additionally it will strengthen the national MOH coordination structures such as the national IPC secretariat and the national MWM TWG to make them fully operational and be able to sustain national oversight for the future.
Partnerships and collaboration
PATH will support the MOH to leverage resources for waste management from key multilateral partners including the WHO and World Bank. It will also explore viable public private partnerships (PPP) that support safe MWM.
Quality improvement and M&E
Quality assurance and improvements will be a key component of this program. PATH will ensure this by rolling out a strong monitoring and evaluation system with indicators for tracking along the lifespan of the project. It will also support a sharps injury surveillance system that will be used to improve programming.
Commodity security
PATH will support commodity procurement and logistics systems in MOH. It will support implementation of the commodity forecasting tool to ensure facility needs are met. It will advocate for single-use syringes and needles as well as safety engineered blood drawing equipment. It will advise on bundling of commodities that ensure protection and safe disposal of the medical MWM commodities to be included in the MOH procurement list in sufficient quantities by Kenya Medical Supplies Agency (KEMSA).

Implementing Mechanism Details

Mechanism ID: 13302	**Mechanism Name: HIV Prevention Activities for Youth and General Population**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement

Prime Partner Name: Hope Worldwide	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: PR/SR	
G2G: No	Managing Agency:

Total Funding: 1,166,855	
Funding Source	**Funding Amount**
GHP-State	1,166,855

Sub Partner Name(s)

I Choose Life		

Overview Narrative

*HWWK is implementing HIV Prevention activities in peri-urban and informal settlement areas in the Eastern part of Nairobi County with the goal of contributing to reduction in incidence of HIV infections in this county with a prevalence of 8.8%.The objectives are to contribute to HIV prevention through implementation of combination evidence informed behavioral, structural and biomedical interventions, increase access to quality comprehensive HIV prevention services for the youth and general population, increase access to confidential HIV testing and counseling services in line with the KNASP III. HWWK also contributes to prevention of HIV transmission through provision of safe blood in Kenya.This is achieved through mobilization and recruitment of safer blood donors while incorporating HIV prevention and healthy life styles contributing to GHI goals of reducing maternal, infant and malaria related mortality.HWWK works in collaboration with the government in the planning of services to ensure these are harmonized with country plans. Involvement and capacity building of local community based organizations and community members key strategies used to ensure activities are supported by recipients. Services are provided within the comprehensive HIV framework for greater HIV prevention impact. In the Blood Safety program, the project will give a comprehensive package of services and will leverage HIV prevention programs to develop a pool of safe regular blood donors.This is a Kenyan partner with country ownership * leadership. This activity will support GHI/LLC.Partner procured 3 vehicles in FY05, FY06 and FY08 to coordinate mobile HTC services - no vehicles for FY12.*

Target pop, geographic coverage, & M&E info are included in the budget code narritives.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	200,000
Education	200,000
Gender: GBV	200,000
Gender: Gender Equality	200,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection

Budget Code Information

Mechanism ID:	**13302**
Mechanism Name:	**HIV Prevention Activities for Youth and General Population**
Prime Partner Name:	**Hope Worldwide**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	190,000	0

Narrative:

HWWK will contribute to the prevention of HIV transmission by providing AB HIV prevention and other evidence based interventions to potential blood donors while mobilizing for safe blood supply in the country. It will work within the Kenya National Blood Transfusion Service (KNBTS) policy and the blood donor mobilization strategy and in line with approaches that will be guided by the National Blood Donor Services sub-committee of the KNBTS Advisory Committee. HWWK will work closely with the Nairobi Regional Blood Transfusion center and the Machakos center to ensure they achieve the set blood donation targets in the region.

This partner will work comprehensively within the target population to ensure maximum reach of potential blood

donors. It will train a pool of mobilizes that will reach all market segments of blood donors including the youth in schools and out-of-school; colleges and universities; the working and those in faith based or community based groups. Those reached will be given HIV prevention messaging; healthy lifestyles including nutrition and donor education on all aspects of blood donation. Additionally HWWK will support establishment of blood donor clubs among the youth such as Pledge-25 as well as among the adult population. It will also support donor counseling and in collaboration with NBTS help in donor results notification and referral of those needing care and treatment. It will create a culture of regular blood donation among those found to be safe and free of transfusion transmissible infections.
Integration with other activities

HIV AB and other prevention messaging will be integrated in the blood donor mobilization activities. Those seeking only to know their status will be referred to the HCT program; conversely those people found to be HIV negative and are eligible to donate will be informed of blood donation activities and encouraged to become regular blood donors. Those found to be HIV positive from the blood donation program will be referred for care and treatment. They will be encouraged to disclose and engage in partner referral or Prevention-with-the-positives interventions.

Coverage and scope:The activities will cover all potential blood donors from 16 years to 65 years in line with KNBTS policy guidelines. The partner will cross-cut all blood donor market segment but will primarily target safer donors (avoiding populations perceived to be most-at-risk). The geographical coverage for this activity will be the Nairobi region by KNBTS definitions which includes the following counties: Nairobi City, Kimbu, Kajiado, Machakos, Makueni and Kitui. Through this grant HWWK will mobilize 40,000 units of blood in collaboration with Nairobi and Machakos RBTC while reaching at least 100,000 people with HIV prevention and healthy lifestyles messages.

Country ownership and Sustainability:The program is mainly led by local staff and will be working to enhance the work of KNBTS which is a local MOH organization led by Kenyans. The partner will train community people to work as mobilizes even beyond the time of the project. Secondly it will promote formation of blood donor clubs that will out-live the life of the project. Lastly once the culture of regular blood donation is inculcated people will continue to donate even in the absence of the partner.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	47,500	0

Narrative:

Hope World Wide supports implementation of comprehensive HIV prevention services targeting the youth and general population in the Eastern region of Nairobi County. In FY 2012, the mechanism will continue to expand access to high quality combination evidence informed behavioral interventions (EBIs) for the following priority

populations: youth 10-14 (7,459) and youth 15-19 years (9,005) who are at risk of early sexual debut and increased risk of HIV acquisition, males 30-44 (3,042) who engage in concurrent and unprotected sexual partnerships and finally the Discordant couples(1,847) and People living with HIV/AIDS (3,189) where there is increased risk of HIV transmission. The EBIs will be implemented in Embakasi, Makadara , Njiru and Districts. All EBIs are linked to other HIV services such as HIV testing and counseling, provision of condoms, care and treatment and community care and support services.

Healthy Choices I and II (HCII) targets both in and out of school youth and aims to delay sexual debut, promote secondary abstinence or have protected sexual intercourse, by providing knowledge and skills on correct and consistent condom use, handling peer pressure, and learning one's HIV status. HC I consists of 8 modules of approximately one hour each. It can be delivered in 4 sessions of 2 hours each or in 8 sessions of 1 hour each.

FMP is an EBI delivered to parents in 5 weekly sessions and promotes positive parenting practices that contribute to effective parent-child communication on sexual related topics. The goal is to reduce sexual risk behavior among adolescents by training parents to deliver primary prevention messages to their children.

Prevention with Positives is an ongoing 5-10min group and individual level intervention that targets HIV infected persons in clinical and community settings, focusing on partner testing, risk reduction, condom use, disclosure, adherence, STI reduction and family planning.

RESPECT will be implemented along with HTC and provision of condoms for males and females ages 20 – 24, males ages 30 -44, and persons with STIs. Respect has 2 brief individual sessions targeting general population and youth, originally for heterosexual negative persons. It focuses on reduction of STDs/HIV, risk reduction, condom use and clients understanding of personal risk.

Eban is a couple and group level intervention targeting sero-discordant couples. It's 8 weekly 2 hour sessions for 3-5 couples focusing on "talker-listener technique", risk assessment, enhancing couple communication and shared health responsibility.

To ensure quality, the program adheres to national standards and guidance from the National Technical Working Group on EBIs. These include use of approved national curricula; maintaining fidelity to the respective curricula and use of trained and certified facilitators. Further, trainings on EBIs are conducted by certified national trainers and there is observed practice of implementation done soon after training. The program uses standardized, national data tools at every stage of EBI implementation and regular field visits by trained program staff are conducted to check on delivery of EBIs and offer support supervision.

Monitoring and evaluation will be conducted with EBI approved data capture / monitoring tools. Mechanism has a

data monitoring plan for tracking program performance.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	345,794	0

Narrative:

Target population: HWWK works in the eastern region of Nairobi county in the urban and peri-urban areas supporting implementation of combination HIV prevention services targeting the youth in school and out of school, as well as the general population. Nairobi has an HIV prevalence of 8.8% with a testing coverage of 75.6% among women and 59.9% for men. HWWK will continue to provide HTC services with a focus on reaching individuals who have never ever been tested and those at increased risk of HIV acquisition particularly the HIV discordant couples. The program will target: youth out of school as part of the combination HIV prevention services and the general population with a focus on couples.
HTC approaches: Services will be provided through the client initiated as well as provider initiated approaches to reach the specific target groups within the community. These will be provided in various settings such as mobile or outreach HTC, stand alone VCT and Home-based HTC via index client or door to door HTC.

Targets and achievements: During 2010 COP, HWWK provided HTC services to 41,110 individuals out of a target of 40,000. During this period, the program reached 21% first time testers and 9% couples. In FY 2012, HWWK will provide HTC services to 40,000 individuals with a target of 60% new testers and 55% men. The program will also target to reach 30% couples.

Testing algorithm: National HIV testing algorithm used.

Referrals and linkages: The referral mechanism in place ensures newly diagnosed HIV positive clients are linked to the GoK and other PEPFAR supported HIV care and treatment sites for the continuum of HIV prevention, care and treatment services. The program uses the NASCOP referral tool, and in collaboration with HIV care and treatment sites reviews data periodically to determine the success rate in the referral and linkage strategies. HIV infected clients are enrolled into the Positive Health Dignity and Prevention program which enhances follow up through the community structures. Using this strategy, the program is able to track individuals who have not accessed services referred to, and is also tracks success of linkage to other care and treatment programs.

Quality management: To ensure quality in testing and counseling, national standards in training, certification and supervision of HTC providers is enforced. Program uses nationally approved and recommended HIV rapid test kits and algorithm. HTC providers receive regular updates and participate in proficiency testing in line with the national QA strategy.

Monitoring and evaluation: All HTC service delivery points use the national HTC lab register to capture data that includes individuals and couples tested. Data is further disaggregated in line with the PEPFAR indicators and analyzed by the program on a regular basis to determine progress and achievement. Rapid data quality assessment is undertaken periodically to ensure data quality.

Promotional activities: Mass media campaigns and targeted community mobilization strategies are used for demand creation. The community mobilization strategy utilizes peer educators who interact with community members and educate them on the importance of accessing HIV testing as an entry point to HIV prevention, care and treatment programs. Education on the importance of knowing one's and sexual partner's HIV status is emphasized in order to reach couples and individuals who have never been tested.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	583,561	0

Narrative:

Hope World Wide supports implementation of comprehensive HIV prevention services targeting the youth and general population in the Eastern region of Nairobi County. In FY 2012, the mechanism will continue to expand access to high quality combination evidence informed behavioral interventions (EBIs) for the following priority populations: youth 15-19 years (9,005) who are at risk of early sexual debut or may be involved in unprotected sex and so are at increased risk of HIV acquisition, males 20-24 (6,390) and females 20-24 (21,436) who are at increased risk of HIV acquisition related to a number of factors such as low self perception of HIV risk, low condom use and lack of negotiation skills for condom use especially among the females. Males 30-44 (3,042) who engage in concurrent and unprotected sexual partnerships and finally the Discordant couples(1,847) and People living with HIV/AIDS (3,189) where there is increased risk of HIV transmission will also be targeted. The EBIs will be implemented in Embakasi, Makadara , Njiru and Districts. All EBIs are linked to other HIV services such as HIV testing and counseling, provision of condoms, care and treatment and community care and support services.

Healthy Choices II (HCII) targets both in and out of school youth aged 13 – 17 years and aims to delay sexual debut, promote secondary abstinence or have protected sexual intercourse, by providing knowledge and skills on correct and consistent condom use, handling peer pressure, and learning one's HIV status. HC II consists of 8 modules of approximately one hour each. It can be delivered in 4 sessions of 2 hours each or in 8 sessions of 1 hour each.

Prevention with Positives is an ongoing 5-10min group and individual level intervention that targets HIV infected persons in clinical and community settings, focusing on partner testing, risk reduction, condom use, disclosure, adherence, STI reduction and family planning.

RESPECT will be implemented along with HTC and provision of condoms for males and females ages 20 – 24, males ages 30 -44, and persons with STIs. Respect has 2 brief individual sessions targeting general population and youth, originally for heterosexual negative persons. It focuses on reduction of STDs/HIV, risk reduction, condom use and clients understanding of personal risk. *Eban is a couple and group level intervention targeting sero-discordant couples. It's 8 weekly 2 hour sessions for 3-5 couples focusing on "talker-listener technique", risk assessment, enhancing couple communication and shared health responsibility.* *To ensure quality, the program adheres to national standards and guidance from the National Technical Working Group on EBIs. These include use of approved national curricula; maintaining fidelity to the respective curricula and use of trained and certified facilitators. Further, trainings on EBIs are conducted by certified national trainers and there is observed practice of implementation done soon after training. The program uses of standardized, national data tools at every stage of EBI implementation and regular field visits by trained program staff is conducted to check on delivery of EBIs and offer support supervision.* *Monitoring and evaluation will be conducted with EBI approved data capture / monitoring tools. Mechanism has a data monitoring plan for tracking program performance.*

Implementing Mechanism Details

Mechanism ID: 13307	**Mechanism Name: Prevention for Youth and General Population**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Impact Research and Development Organization	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,096,498	
Funding Source	**Funding Amount**
GHP-State	2,096,498

Sub Partner Name(s)

(No data provided.)

Overview Narrative

IRDO is a Kenyan NGO based in Kisumu, Nyanza Province. Its principal mandate is to design, implement and evaluate public health programs and research. In October 2004, IRDO was funded by PEPFAR, through a CoAg with CDC, to design and implement a HIV prevention program that promotes abstinence and being faithful among the youth living in the informal (slum) settlements of Kisumu City. The program has expanded both in geographical coverage (from 5 small slums to the entire Kisumu East, Suba, Kisumu West, Nyando, Siaya, Bondo and Rarieda districts) and expanded the programmatic areas scope to cover more comprehensive preventions programs including male circumcision, EBIs and biomedical interventions.
It's goals for 2012 are to reach out to 7,600 members of the general population and youth aged 9–15 with individual or small group HIV prevention interventions that are evidence-based (Families Matter! Program and Healthy Choices I) and meet the minimum standards required; Provide 146,000 individuals with testing and counseling services for HIV with all receiving their test results. Provide services to 13,450 most at risk populations (MSM, Fisherfolk, FSWs) and 16,183 youths 15-24 years with evidence based HIV prevention interventions that meet the minimum standards. MARPs will receive community PwP, FSW program, MSM program, stepping stones and sister-to-sister. Provide 5,000 PLHIV with minimum package of Community-PwP interventions
The general population will be provided with 5,000 RESPECT services.

IRDO purchased 2 vehicles in FY 2011 which will be used during the planning period, it would be both cost-effective and convenient to purchase the vehicles instead of renting. The vehicles will be used entirely for PEPFAR project activities. This activity supports GHI/LLC

Cross-Cutting Budget Attribution(s)

Economic Strengthening	5,000
Gender: GBV	100,000
Gender: Gender Equality	100,000
Human Resources for Health	838,600
Key Populations: FSW	260,000
Key Populations: MSM and TG	20,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Mobile Population
TB
Family Planning

Budget Code Information

Mechanism ID:	**13307**		
Mechanism Name:	**Prevention for Youth and General Population**		
Prime Partner Name:	**Impact Research and Development Organization**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	95,000	

Narrative:

IRDO will support the implementation of HIV prevention services in Kisumu East, Nyando, Rongo, and Bondo/Rarieda Districts with interventions targeting the youth age 9 to 17 years of age. The objective is to provide the youth with information to help them make informed choices about their sexual and reproductive health. IRDO will support provision (individually or in small groups) of the selected and appropriate age specific and evidence/theory-based HIV/AIDS prevention interventions to 7,600 youth aged 9 – 15years
Healthy Choices (HC) I &II
HCI targets in-school youth aged 10-14 years and aims to delay sexual debut by providing knowledge and skills to negotiate abstinence, avoid negative peer pressure, avoid or handle risky situations and to improve communication with a trusted adult. HC I consists of 8 modules of approximately one hour each. It can be delivered in 4 sessions of 2 hours each or in 8 sessions of 1 hour each. The Youth out of school will be identified through their social networks, trained peer leaders and youth activities like sports and music extravaganzas. Culturally sensitive and

relevant IEC materials specific to sex and age groups will be designed, developed and distributed for promoting HVAB. Mature minors will be linked to HIV testing and counseling services.

The Families Matter! Program (FMP)

FMP is an evidence-informed, parent-focused intervention for parents, guardians, and other primary caregivers (hereafter referred to as "parents") of preadolescents ages 9–12 years. Delivered in 5 weekly sessions to give parents time to internalize new information and practice skills, the program promotes positive parenting practices such as positive reinforcement and parental monitoring and effective parent-child communication on sexual topics and sexual risk reduction. The goal of FMP is to reduce sexual risk behavior among adolescents, including delaying onset of sexual debut, by training parents to deliver primary prevention messages to their children. More effective parental communication can help to delay their children's sexual behavior and increase protective behaviors as their children get older. The intervention also links parents to other critical evidence-based interventions including HTC and VMMC

Quality Assurance

To promote quality assurance, IRDO will provide On Job Trainings (OJTs), mentorships, Continuous Medical Education (CMEs) and refresher courses where knowledge and/or skill gaps are identified. The trainings will target all individuals who are involved in the AB programs including health care workers, peer educators and facilitators. Quality assurance of FMP is promoted through rigorous training and certification of facilitators, ongoing process monitoring with standardized tools, and quality assurance site visits by a capacity building agency. All data generated by the facilitators and other service providers will be entered into standard data base and periodically analyzed to improve programming. IRDO will seek to share experiences, lessons learnt and best practices with other PEPFAR partners and other stakeholders. With the technical assistance from NASCOP and CDC, IRDO will enhance field site supervision to provide technical support to the service providers and ensure adherence to the guidelines and ethics

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	921,513	0

Narrative:

The goal of the country as reflected in Kenya National Aids strategic plan (KNASP III) is to reach 80% knowledge of HIV status in the country by 2013. Nyanza Province, which has a population of about 5.1 million people, carries the highest HIV burden in Kenya. With an estimated adult HIV prevalence of 14.9% compared to the national 7.1%, ~500,000 people are living with HIV

IRDO – The Pembe Tatu Project supports the Provision of Integrated HIV Prevention Interventions, including Voluntary Medical Male Circumcision (VMMC) in Nyanza Province. This mechanism covers several program areas and activities that include HIV testing and Counseling in outreaches/mobiles and national Rapid Response Initiative (RRI) campaigns. Many of these activities build synergies between HIV testing and counseling, male circumcision and HIV care and treatment services in a sustainable way. The overall goal of HTC program is to

increase the proportion of individuals who know their correct HIV status in Kisumu East, Nyando, Rongo, and Bondo/Rarieda Districts
In FY10, IRDO supported HTC in the two counties using various approaches including national RRI campaigns, mobile/outreach and moonlight HTC. Between October 2010 and March 2011, a total of 51,443 people were offered comprehensive HTC services. Individuals identified as HIV infected were linked to care and treatment services.
Guided by gaps identified in KAIS, KDHS 2009 and program data, IRDO will continue to support HTC service implementation in the two counties with specific area of focus being outreach/mobile and targeted HTC approaches to most-at-risk populations. This mechanism will work with the Ministry of Health (MOH) at the county, District and community levels to jointly plan, coordinate and implement HTC services for both adults and children in support of the KNASP III, the Partnership framework and the District and Provincial level MOH annual operation plans
IRDO will target couples, sexually active youth, youth out of school and general population amongst others with intent to enhancing diagnosis of HIV status among individuals with unknown HIV status, enhanced knowledge of HIV status with emphasis of identifying HIV infected individuals and HIV sero-discordant couples and strengthened linkage to appropriate HIV prevention, care and treatment services and ensuring disclosure as a key strategy of strengthening HIV prevention among sero-discordant couples. The program will target a total of 146,000 individuals with HBTC of whom 10% will be pediatrics
Effort will be directed towards building capacity of MOH staff to provide safe and quality services, as well as minor renovations in MOH facilities to ensure ownership for sustainability
Working with other relevant stakeholders, the program will strengthen appropriate referral and linkages between Community HTC and other HIV/AIDS prevention, care and treatment services in the selected districts. The program will also work with the GoK system and in particular NASCOP to support the following activities at district level: Commodity management, Training of HIV service providers, Implementation of the WHO recommended multistep approach to Quality Assurance and National Quality Assurance Strategy on HIV Testing, Supervision and Implementation of the community PwP strategy. The program will continue to strengthen data collection, analysis, utilization and reporting at all levels to increase and improve performance and reporting to NASCOP and PEPFAR

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1,079,985	0

Narrative:

IRDO will continue to expand access to a high quality comprehensive package of HIV prevention services for the general population (36,783) and MARPS (13,450) in Nyanza Province specifically in Kisumu East, Nyando and Bondo/Rarieda Districts. This program will continue to target high risk sexual behavior prevalent among these populations including incorrect and inconsistent condom use particularly with regular sex partners.
IRDO will work with the beach management units to select, recruit and train fisher folk peer leaders on peer

education and facilitation skills of peer sessions of the stepping stones EBI. Small groups of 20 individuals are identified by the peer educators based on age and gender to enhance discussion. During the peer sessions, demand creation and referrals for other services like HTC VMMC, STI treatment, HIV care and treatment services will be offered. Each group undergoes 5 sessions on various SRH topical issues to for a person to qualify. Follow up sessions will be conducted after 6 months for each group. Other behavioral risk factors that will be addressed include excessive alcohol and substance abuse, gender based violence and low adherence to treatment among fisher folk. *This mechanism will support implementation of the Combination Prevention Interventions for FSWs as defined in the National Guidelines for the package of services for SWs. These comprise evidence-informed behavioral, biomedical and structural interventions. Behavioral interventions include peer education and outreach, condom and lubricant demonstration and distribution and risk assessment, risk reduction counseling and skills building. Specific EBIs for this group will be RESPECT, Sister-to-Sister and Safe in the City. Biomedical interventions include HTC, VMMC, STI screening and treatment, TB screening and referral to treatment, HIV care and treatment, RH services, Emergency contraception and Pre-exposure prophylaxis.* *IRDO is considering initiating Treatment as Prevention for MARPS and initiating Pre-exposure prophylaxis where feasible, malaria treatment all within its drop in and service centres. Among the discordant couples IRDO will implement an EBI – EBAN with an objective of lowering the rate of risky behavior among HIV-discordant couples and promoting the safe sex through increased condom uptake in this sub population. This shall be offered in an integrated setup with other services also available* *Youth aged 13 – 17 years both in and out of school will be reached with Healthy Choices II (HCII) that aims to delay sexual debut, promote secondary abstinence or have protected sexual intercourse, by providing knowledge and skills on correct and consistent condom use, handling peer pressure, and learning one's HIV status.* *To promote quality assurance, IRDO will provide On Job Trainings (OJTs), mentorships, Continuous Medical Education (CMEs) and refresher courses where knowledge and/or skill gaps are identified and addressed through mentorship, trainings and exchange visits for bench marking. All data generated by the facilitators and other service providers will be entered into standard data based and periodically analyzed for programming purposes. IRDO will seek to share experiences, lessons learnt and best practices with other PEPFAR partners and other stakeholders. Quarterly support supervision with NASCOP, ministry if fisheries and DHMTs will ensure quality of services delivered is of the expected standard*

Implementing Mechanism Details

Mechanism ID: 13309	**Mechanism Name: Kenya Medical Research Institute**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement

Prime Partner Name: Kenya Medical Research Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 7,140,966	
Funding Source	**Funding Amount**
GHP-State	7,140,966

Sub Partner Name(s)

(No data provided.)

Overview Narrative

KEMRI supports the MOH in implementation of HIV services at the NNPGH and service provision in Siaya and Bondo Districts as well as Kibera. KEMRI will ensure high quality, comprehensive HIV prevention, care and treatment services including combination prevention HBCT, abstinence and other preventions programs, PMCT, TB/HIV, adult and pediatric HIV care and treatment and PITC. KEMRI will support provision of the selected and appropriate age specific and evidence/theory-based HIV/AIDS prevention interventions/information and counseling to youth in and out of school. Goals include decentralization and integration of HIV services into existing clinics including maternal and child health and TB clinics. KEMRI supports the national M&E system and will support the scale-up of EMR at facilities. EMR will allow for efficient reporting and support patient outcomes analysis to inform program improvement. KEMRI supports OR and public health evaluation implementation science, will support pilot testing of new evidence-informed interventions including EBIs and Treatment as Prevention, they will establish a GBV recovery center at NNPGH and systematically support the center transitioning to the MOH.

Strategies to reduce cost will include: support for government-led programs to avoid duplication; decentralization of trainings to the districts; and support for an integrated district mentorship program in order to build the capacity of district teams to conduct mentorship and promote ownership and sustainability of the program

KEMRI will support building the capacity of local NGOs as a strategy for transitioning the program and also the PHMTs and DHMTs and carries out joint planning to promote ownership and sustainability.

KEMRI procured 7 vehicles in FY10 and have no plans to buy more

Cross-Cutting Budget Attribution(s)

Gender: GBV	80,000

Human Resources for Health	3,412,475

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	13309		
Mechanism Name:	Kenya Medical Research Institute		
Prime Partner Name:	Kenya Medical Research Institute		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	300,000	0

Narrative:

Kenya Medical Research (KEMRI) has been supporting HIV adult care and support at New Nyanza Provincial General Hospital (NNPGH), a referral regional facility for Nyanza Province, since 2004. KEMRI has completed year one of their 5 year co-operative agreement with CDC and in FY12 will continue to support integrated comprehensive clinical services in NNPGH. KEMRI will work with the Ministry of Health (MoH) at all levels to jointly plan, coordinate, implement and ensure provision of quality HIV care and support to 7,183 current adult patients in FY13 and 8,180 current patients in FY13.

KEMRI will provide comprehensive care and support package of services including HIV testing to family members of index patients and refer/ linking those HIV positive to care and support; clinical assessment for ART eligibility

and linking eligible PLHIV to treatment; laboratory monitoring including 6 monthly CD4 testing; WHO staging; Basic Care Kit (safe water vessel, multivitamins, insecticide-treated mosquito nets, condoms, chlorine for water treatment and educational materials); adherence assessment counseling and support; nutritional support including supplemental and therapeutic nutrition (FBP) to all eligible HIV positive patients; prevention with positives(PwP); cervical cancer screening to all enrolled women; and ensure referral and linkages to other clinical services including RH/FP.

KEMRI in collaboration with MoH will support targeted training (of 100 health care workers in FY12 and 80 in FY13) and mentorship and additionally provide continuous medical education on care and support and OI management; identify human resources and infrastructure gaps and support in line with guidelines; and support good commodities management practices to ensure uninterrupted availability of commodities.

KEMRI will continue to support ongoing psychosocial and community activities including education by peer educators; referral and linkages to community based psychosocial support groups to strengthen adherence; effective and efficient retention strategies of patients on follow up; water, sanitation and hygiene programs; income generating activities; Home Based Care; vocational training; social and legal protection; and food and nutrition programs. KEMRI will adopt strategies to ensure access to friendly services to youth, elderly and physically or mentally challenged populations.

KEMRI will continue to strengthen data collection to improve reporting to MoH and PEPFAR; adopt the new PEPFAR generation indicators; and support the development and use of electronic medical records system in accordance with MoH guidelines. KEMRI will adapt cohort analysis and quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV care and support services and integrate them into routinely collected data and use the results to evaluate and improve program activities. Additionally, KEMRI will evaluate and carry out operation research on implemented programs.

KEMRI will support joint Annual Operation Plan (AOP) planning, implementation, monitoring and evaluation; build the capacity of MOH staff and systems to facilitate sustainability; and collaborate with other partners to leverage and maximize on available USG and non-USG resources.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	500,000	0

Narrative:

Kenya Medical Research Institute (KEMRI) has supported the New Nyanza Provincial General Hospital (NNPGH), a regional referral facility, since 2004. Nyanza Province, with a population of 5.4 million, has an estimated adult HIV prevalence of 14.9% compared to the national average of 7.1%. In 2010, out of 19,295 notified TB cases, 64%

tested HIV positive. KEMRI will continue to support integrated comprehensive HIV/TB clinical services at NNPGH aligned to the Ministry of Health (MOH) 5-Year National AIDS and TB Strategic Plans in the next phase (FY 12 and 13).

To reduce the HIV burden for TB patients, KEMRI will support HIV screening for all TB patients and ensure 95% of co-infected patients are provided with comprehensive HIV care, including co-trimoxazole prophylaxis, nutritional support and early initiation of ART in line with new MOH policy guidelines. To reduce TB burden for HIV infected patients, 6,385 patients in HIV care in FY12 and 7,271 in FY13 will be screened for TB leading to identification of 319 and 364 TB cases, respectively. These patients will be put on TB treatment while those without active TB will be considered for isoniazid preventive therapy (IPT). Based on the completed TB infection risk assessment report, the partner will support implementation and monitoring of basic administrative and environmental TB infection control measures in this facility.

To improve MDR-TB surveillance, KEMRI will ensure expedited turn-around times (TATs) for TB culture and DST for all TB re-treatment cases whose sputum specimens will be processed within KEMRI TB laboratory located close to NNPGH. To increase access to MDR-TB treatment, KEMRI will continue to support the MOH expand the community treatment model. Further, KEMRI will support establishment of regional TB culture and MDR-TB isolation capacity at NNPGH, and support staff mentorship for MDR-TB diagnosis and treatment, and external quality control. More efficient detection of both regular and MDR-TB will be achieved through introduction of the geneXpert.

KEMRI will also support training of 50 HCWs in FY12 and 30 in FY13, expand access to HIV prevention (PwPs) and support community-based activities to ensure TB and HIV treatment defaulters are traced and retained in to care. They will continue to strengthen the data quality and support preparation of comprehensive quarterly reports for the MOH and PEPFAR using custom and new generation indicators, respectively. KEMRI will undertake cohort analysis and support all efforts to improve the quality and outcomes of integrated TB/HIV services. Current efforts to expand use of electronic medical records will be enhanced.

Additionally, over the 2 years, KEMRI will support implementation of collaborative 5 -7 operation research projects whose outcomes will enable MOH adopt more efficient and effective use of evidence-based TB/HIV interventions, evaluate impact of these interventions and build capacity for more effective MDR TB response in Nyanza Province.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	80,000	0

Narrative:

KEMRI has been supporting comprehensive HIV pediatric care and support services at the New Nyanza Provincial General Hospital (NNPGH) since 2004. By March 2011 NNPGH had 1,192 children enrolled in care with 812 currently receiving care.

In the FY 12 KEMRI will provide care and support services to 750 children currently on care. The number of children currently on care will increase to 870 during the FY 13. KEMRI will provide comprehensive, integrated quality services, and scale up to ensure 922 HIV infected infants are put on ARV prophylaxis and all HIV exposed children access pediatric care services.

KEMRI will provide a package of care and support services including HIV testing to family members of index patients, referring and linking those HIV positive to care and support; clinical assessment for ART eligibility and linking eligible PLHIV to treatment; laboratory monitoring including 6 monthly CD4 testing; WHO staging; Basic Care Kit; nutritional assessment counseling and support with vitamin A and zinc supplementation when indicated; de-worming; and ensure referral and linkages to other clinical services.

KEMRI will support integration of HIV services into well child welfare clinic services, including Integrated Management of Childhood Illnesses (IMCI); optimal in-patient care; community outreach efforts; and routine child health care and survival services in the maternal child health department. KEMRI will also support care of the newborn by supporting health facility delivery, prophylactic eye care and comprehensive care services to the newborn.

KEMRI will support targeted training (to 100 health care workers in FY12 and 80 in FY13) and mentorship and continuing medical education on care and support and OI management; identify human resources and infrastructure gaps and support in line with guidelines; and support good commodity management practices to ensure uninterrupted availability of commodities.
KEMRI will strengthen community activities and support groups to strengthen adherence, play therapy, effective and efficient retention and defaulter tracing strategies. Referral and linkages of the care takers to other services like IGAs; Home Based Care; social and legal protection; and food and nutrition programs will also be strengthened to improve the welfare of the pediatrics.

KEMRI will adopt strategies to ensure access to pediatric and adolescent friendly services, strategies to ensure retention and access to pediatric care and support services including scaling up identification of HIV exposed infants, ARVs prophylaxis and follow up, HIV testing (PCR-DNA or antibody) and linking those positive to treatment.

KEMRI will adopt the new PEPFAR generation indicators; and support the development and use of electronic medical records system in accordance with MoH guidelines. KEMRI will adapt cohort analysis and quality of care

indicators (CQI, HIVQUAL) for monitoring the quality of HIV care and support services and integrate them into routinely collected data, and use the results to evaluate and improve program activities. Additionally, KEMRI will evaluate and carry out operation research to advance program implementation approaches.

KEMRI will support joint Annual Operation Plan (AOP) planning, implementation, monitoring and evaluation, capacity building and health system strengthening to facilitate sustainability and collaborate with other partners to leverage and maximize on available resources.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	780,000	0

Narrative:

KEMRI lab has been a PEPFAR funded National Lab program implementer since 2004. KEMRI offered support for equipment and reagents procurement distribution, basic and specialized tests scale up (Rapid tests, CD4, chemistries, hematology, EID, viral load, DRT, MDR TB screening), personnel hiring, related trainings and lab policy formulation.

KEMRI has will support integrated comprehensive lab services in FY12 and 13. This will be at National (with NHRL and TB CRL), regional (Provincial/County) and facility levels (i.e transforming the New Nyanza Provincial General Hospital Lab into a centre of excellence).

KEMRI will work towards universal support in coordination and implementation of quality Lab services in line with PEPFAR and MoH guidelines. Attention will be given to cross cutting activities within PMTCT, Prevention, Care and Treatment, TB HIV program areas as well as S.I to provide data for decision making.

The goals includes:

- *Increase access to specialized tests including, EID, Viral load, TB culture, DRT and Gene Xpert.*
- *Continue mentoring the NNPGH and Siaya DH towards accreditation.*
- *Validate new tests ,equipments and technologies(rapid tests, point of care tests e.t.c)*
- *Support the KEMRI Production Unit gain ISO/WHO or and GMP certification for the production of RHT Kits as well as EQA and IQA panel production and distribution to attain 90% country coverage.*
- *Support specialized microbiological testing for diagnosis of opportunistic infections in persons living with HIV/AIDS.*
- *KEMRI is a hub for national Lab networking for specialized tests including HIV PCR, TB Culture and HIV viral load. These funds will facilitate related human resource, supervision, transport, training, and 10% Lab buffer supplies.*
- *Transfer skills & technology of specialized testing to MOH-NHRL and support the NHRL in the coordination of multi level EQA activities for HIV testing.*
- *Offer a National/International Biosafety /Biosecurity course annually to reach at least 35 MoH*

facility-based biosafety officers per annum.
KEMRI lab will conduct other activities including training and mentoring individuals for the WHO Stepwise Accreditation through SLMTA expertise. KEMRI lab will tap into available in-country expertise to provide a hands-on user competency training on use of biosafety cabinets and an annual certification in conjunction with MoH engineers.
KEMRI will harness its research & experience to generate data for operational research for the lab program by working closely with MOH. This will include participation in National Surveillance activities i.e. KAIS 2013 & KDHS. KEMRI will support policy formulation by participation and supporting joint Annual Operation Plan (AOP) planning, implementation, monitoring and evaluation and policy document reviews.
The KEMRI M & E plan for verification of programmatic progress/key Indicator will include reporting on

- *Number of lab personnel trained Biosafety and Biosecurity*
- *Number of safety cabinets certified ,those up and running*
- *Number of labs offering specialized testing /and those networked to specialized testing labs*
- *Number of labs accredited*
- *Number of in country trained SLMTA mentors through KEMRI support*
- *MDR lab up and running at NNPGH*
- *QA networks formed and running*
- *PT panels produced in the KPU; the coverage in percentage by this service*

In total 100 health care workers will be trained.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	1,504,202	0

Narrative:

Over the next two years, KEMRI will be supported to strengthen the capacity of the HISS team to facilitate operational research and program evaluations in Nyanza and at the national level. The strategic information team will support this initiative through the following activities:

- *Developing and applying innovative ICT tools to improve data collection for HIV and TB programs, HIV and TB surveillance and for operational research. This will include use of cell phones, netbooks, tablet PCs and other mobile devices for data collection. KEMRI/CDC will work with other partners such as ITECH and ICAP to pilot EMR interoperability through the OpenEMRConnect (OEC) that is currently ongoing in Siaya and Bondo counties. Findings of this pilot will inform the MOH's rollout of interoperable EMRs nationally.*

- *Providing data management support for programmatic work undertaken by KEMRI-CDC at the New Nyanza Provincial General Hospital, Siaya and Bondo counties and other parts of Nyanza province. The SI team*

will also participate in operational research to evaluate technologies that enhance efficient service delivery and improved health outcomes. In order to achieve this, some resources will be invested in building staff capacity on research methodology, data analysis, interpretation, scientific writing and dissemination.

• The SI team will continue to generate biannual PEPFAR reports for supported HIV and TB programs. They will support the MOH's initiatives to roll-out the revised M&E tools and conduct training to health workers at supported health facilities in Nyanza and Nairobi.

• Supporting data collection, management, analyses and distribution at the Demographic Surveillance Systems (DSS) in Nyanza and Nairobi – including Home Based Testing and Counseling – to better understand the HIV/AIDS epidemic. These activities will include the development, piloting, and rollout of suitable software and piloting of innovative technologies. KEMRI will also continue to conduct mortality surveillance by cause at the two DSS sites through sample vital registration using Verbal autopsy (SAVVY).

• Supporting the Division of Leprosy, TB and Lung Diseases (DLTLD) to maintain PDA based electronic TB register five provinces.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	150,000	0

Narrative:

KEMRI will contribute to the prevention of medical transmission of HIV through training of health care workers on IPC/biosafety. This will contribute to the Kenya National AIDS Strategic Plan (KNASP-III) goal of eliminating HIV transmission in healthcare settings. This will be achieved by building the capacity of health workers on biosafety, which will promote safe work practices, infection prevention and control practices among other occupational health programs. This will contribute to health systems strengthening and is in line with the Global Health Initiative principles.

KEMRI will support equipment maintenance and certification activities in the country. This is more cost-efficient as it will be done by local medical engineers compared to bringing in international expatriates as was happening before. Additionally the health workers trained will acquire skills that will enable them use safety equipment in an efficient and more sustainable way.

KEMRI is a local partner who is already integrated into the government system.

This is a national program and will target health workers in MOH. During the training course evaluations will be done (pre- and post-tests). Additionally annual support supervision combined with re-certification activity will be

done.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

This mechanism shall implement abstinence and being faithful services in Siaya and Bondo Districts within the Health and Demographic Surveillance Systems (HDSS) and Gem Division with interventions targeting the youth aged 9 to 17 years. The objective is to provide the youth with information to help them make informed choices about their sexual and reproductive health. KEMRI will support provision (individually or in small groups) of the selected and appropriate age specific and evidence/theory-based HIV/AIDS prevention interventions/information and counseling to youth in and out of school and will work to identify referral mechanisms to ensure clients receive appropriate services, focusing more on the girl child who are more vulnerable to HIV infection.

Healthy Choices 1(HCI) targets in-school youth aged 10-14 years and aims to delay sexual debut by providing knowledge and skills to negotiate abstinence, avoid negative peer pressure, avoid or handle risky situations and to improve communication with a trusted adult. HC I consists of 8 modules of approximately one hour each. It can be delivered in 4 sessions of 2 hours each or in 8 sessions of 1 hour each. Health Choices 2 (HCII) will target youth out of school who will be identified through their social networks, trained peer leaders and youth activities like sports and music extravaganzas. Culturally sensitive and relevant IEC materials specific to sex and age groups will be designed, developed and distributed for promoting HVAB. The mature minors will be linked to HIV testing and counseling services.

Families Matter! Program (FMP) is an evidence-based, parent-focused intervention for parents, guardians, and other primary caregivers (hereafter referred to as "parents") of preadolescents ages 9–12 years. Delivered in 5 weekly sessions to give parents time to internalize new information and practice skills, the program promotes positive parenting practices such as positive reinforcement and parental monitoring and effective parent-child communication on sexual topics and sexual risk reduction. The goal of FMP is to reduce sexual risk behavior among adolescents, including delaying onset of sexual debut, by training parents to deliver primary prevention messages to their children. More effective parental communication can help to delay their children's sexual behavior and increase protective behaviors as their children get older. The intervention also links parents to other critical evidence-based interventions including HTC and VMMC.

To promote quality assurance, KEMRI will provide On Job Trainings (OJTs), mentorships, Continuous Medical Education (CMEs) and refresher courses where knowledge and/or skill gaps are identified. The trainings will target all individuals who are involved in the AB programs including health care workers, peer educators and facilitators. Quality assurance of FMP is promoted through rigorous training and certification of facilitators, ongoing process monitoring with standardized tools, and quality assurance site visits by a capacity building

agency. All data generated by the facilitators and other service providers will be entered into standard data base and periodically analyzed for programming purposes. KEMRI will enhance field site supervision to provide technical support to the service providers and ensure adherence to the guidelines and ethics.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	1,239,773	0

Narrative:

The goal of the country as reflected in Kenya National Aids strategic plan (KNASP III) is to reach 80% knowledge of HIV status in the country by 2013. Nyanza Province, which has a population of about 5.1 million people, carries the highest HIV burden in Kenya. With an estimated adult HIV prevalence of 14.9% compared to the national 7.1%, ~500,000 people are living with HIV

KEMRI supports direct implementation of comprehensive prevention, care and treatment activities in 1 district and 1 provincial general hospital in Nyanza Province. It covers several program areas and activities that include HIV Testing and Counseling in health care settings and home based settings. The overall goal of HTC by KEMRI is to increase the proportion of individuals who know their correct HIV status and carry out programmatic evaluations to inform the national program in 2 districts of Nyanza Province, Kenya

In FY 10, KEMRI supported Provider Initiated Testing and Counseling (PITC) services and Home-based Counseling and testing (HBCT) in 2 districts with emphasis in the Home-based setting, Outpatient department, Inpatient and Child welfare Clinics. Between October 2010 and August 2011, a total of 161,938 people were offered comprehensive HTC services through HBCT and over 200,000 were counseled and tested at the health facilities

Guided by gaps identified in KAIS, KDHS 2009 and program data and its core mandate of programmatic evaluations, KEMRI will support HTC implementation at the New Nyanza Provincial General Hospital (NNPGH) with specific area of focus being facility-based PITC approach, in HDSS area in Siaya county through door to door and outreach and Kibera slums in Nairobi through door to door and outreach approaches. KEMRI will work with the Ministry of Health (MOH) at the county, District and health facility levels to jointly plan, coordinate and implement HTC services for both adults and children in support of the KNASP III and the District and Provincial level MOH annual operation plans

KEMRI will target patients, family members and couples at the out-patient, in-patient and child welfare clinics with emphasis on enhancing diagnosis of HIV status among individuals with unknown HIV status, enhanced knowledge of HIV status with emphasis of identifying HIV infected individuals and HIV sero-discordant couples and strengthened linkage to appropriate HIV prevention, care and treatment services. KEMRI will target a total of 103,000 individuals with HTC of whom 10% will be pediatrics. These will contribute 2.6% of the national targets which aims at increasing knowledge of HIV status to at least 80% of the Kenyan adult population

KEMRI will work to identify areas with training and mentorship needs, staff shortages and support appropriately through a MOH driven mechanism which ensures ownership and program sustainability

All HIV-infected persons will be linked to care, treatment and other HIV prevention services at the facility and community level. Referrals will be strengthened by working together with SI team in implementing an effective referral strategy. HIV-negative individuals will be referred to PEPFAR supported prevention services. KEMRI will strengthen the WHO recommended multistep approach to Quality Assurance in counseling and testing. QA audit teams will be strengthened at the counties. KEMRI will continue to strengthen data collection, analysis, utilization and reporting at all levels to increase and improve reporting to NASCOP and PEPFA

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	720,753	0

Narrative:

KEMRI will continue to expand access to a high quality comprehensive package of HIV prevention services for general population and MARPS in Nyanza Province specifically within the Health and Demographic Surveillance Systems (HDSS) and Gem Division (HDSS) areas in Siaya County. This program will continue to target male and female youth aged 13 to 17 with HC II, a four session group level evidence –informed behavioral intervention (EBI). The sessions are delivered outside of school to a mixed gender group of 12-16. Two facilitators, one male and one female, deliver the intervention which aims to delay sexual debut, promote secondary abstinence or have protected sexual intercourse, by providing knowledge and skills on correct and consistent condom use, handling peer pressure, and learning one's HIV status.

HIV sero-discordant couples will be targeted by Eban, an EBI that seeks to enhance effective communication between couples and will form a basis for referral to PwP and formation of discordant couple support groups. RESPECT, an individual one session EBI delivered during HIV testing and counseling, will target males and females in the general population at risk of HIV infection.
KEMRI will support implementation of the combination prevention, composed of EBIs, biomedical and structural interventions for all above target populations. Behavioral interventions include peer education and outreach, condom and lubricant demonstration and distribution, risk assessment, risk reduction counseling, and skills building. Biomedical interventions include HTC, VMMC, STI screening and treatment, TB screening and referral to treatment, HIV care and treatment and RH services. Structural interventions include interventions to keep girls in school.

PEPFAR support to KEMRI will establish a comprehensive gender-based recovery center (GBVCR) at the Nyanza Provincial Hospital. The GBVRC will offer comprehensive clinical, psychological and social services and safe houses to victims of GBV. KEMRI will work closely with the USAID supported Center for Rights Education and Awareness program to ensure victims of GBV receive adequate legal services. Upon completion of the center, KEMRI will work closely with the Ministry of Medical Services to transition the administrative, human resource and financial management of the center to the Nyanza PGH.

To promote quality assurance, KEMRI will provide On Job Trainings (OJTs), mentorships, Continuous Medical Education (CMEs) and refresher courses where knowledge and/or skill gaps are identified and addressed through mentorship, trainings and exchange visits for bench marking. All data generated by the facilitators and other service providers will be entered into standard data base and periodically analyzed to inform and improve programming. KEMRI will seek to share experiences, lessons learnt and best practices with other PEPFAR partners and other stakeholders. Quarterly support supervision with NASCOP, ministry of education and DHMTs will ensure quality of services delivered is of the expected standard. The program will continue to strengthen data collection, analysis, utilization and reporting at all levels to increase and improve performance and reporting to NASCOP and PEPFAR.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	78,121	0

Narrative:

The Kenya drug use epidemic's prevalence is 18.3%, over two times more than that of the general population. HIV prevalence amongst PWID is 18.3% amongst needle-sharing sharing IDUs, prevalence is 30% while for non-needle sharing PWID, it is 5%. This mechanism will target the PWUD/PWID population with appropriate targeted responses to each of the sub-groups within the PWUD/PWID population to address their varied risk profiles. These will include social networks of drug-users, addressing high risk sexual practices e.g. multiple sexual partners and unprotected sex as well and drug injecting practices such as needle-sharing and flash-blood practices among users and their peers. Women who use or inject drugs face additional risks due to their engagement in sex work and in transacting sex for drugs. They also face additional stigma, which becomes exacerbated in the event of a pregnancy. These behaviors are reinforced by multiple determinants such as criminalization of injecting drug use, and poverty among majority of the self-identified PWUD/PWID. Children of female PWID will also be linked to appropriate wrap around services that address gender and the needs of continually abused children. This mechanism will support the set-up and scale up of a comprehensive package of services targeting 100 PWID with MAT services and 100 with other wrap-around services in Nyanza. This will include capacity strengthening for Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH) whose key staff will receive training, support supervision, and mentorship. A 9-intervention package of services per the PEPFAR and UNAIDS/UNODC guidelines will be offered i.e. Medication-Assisted Treatment (MAT) for drug-dependence treatment, ART, HTC, STI prevention and treatment, Condom demonstration and distribution for PWID and their partners, targeted behavioral interventions and IEC materials, TB diagnosis and treatment and vaccination, diagnosis and treatment of viral hepatitis. Methadone and other MAT drugs and supplies will be centrally procured through a designated supply chain and therefore funds under this mechanism may not be used for drug procurement, unless under special circumstances. Per PEPFAR guidance, funds in this mechanism may not be used to procure Needle and Syringe Program (NSP) supplies but the program may work with other partners to support NSP. This program will work

collaboratively with the public health sector/Nyanza Provincial Director of Medical Services; participate in national MARPS and PWUD/PWID forums careful planning with a broad range of community and local administration stakeholders with a view of enlisting the crucial buy-in and support for an enabling environment. Training will be conducted in collaboration with the national training program for use of national PWID guidelines and MAT treatment protocols. Out-patient treatment will be the desirable model of offering MAT, backed by a close follow-on addiction counseling therapy. PWID/PWUD and MAT treatment services will be integrated with the HIV comprehensive care and treatment program that is currently

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	215,000	0

Narrative:

Kenya Medical Research Institute (KEMRI) has been supporting PMTCT at the New Nyanza Provincial General Hospital (NNPGH), which is a provincial referral facility, since 2010. By end of March 2011 SAPR results, KEMRI supported counseling and testing of 2,002 pregnant women; provided ARVs prophylaxis to 530 HIV positive pregnant women, supported early infant diagnosis and follow up of HIV exposed infants, and trained 36 HCWs on PMTCT.

In FY12, KEMRI will offer HIV counseling and testing to 6,000 pregnant women at the ANC and give ARV prophylaxis to 882 HIV infected pregnant women. The HIV infected women will receive a CD4 test after undergoing a WHO clinical staging. KEMRI will give HAART to all eligible HIV positive pregnant women, in line with the revised PMTCT national guidelines. In FY13, KEMRI will increase the number of pregnant women counseled to 6,300 offer ARV prophylaxis to 1,072 pregnant women and 922 infants, and do EID for 922 infants. KEMRI will focus on the 4 prongs of PMTCT: primary prevention; prevention of unwanted pregnancies, ARV prophylaxis to all HIV positive pregnant mothers and exposed infants, and care and treatment to eligible HIV positive mothers, partners and children. The minimum care package will include health and HIV education, individual/ family HIVCT, clinical/laboratory monitoring and assessment, OI screening and /or treatment, ARV prophylaxis and treatment for both mother and baby, nutritional support, psychosocial support, PWP, follow up & retention , and referral and linkages. KEMRI will incorporate TB screening into routine antenatal care.

KEMRI will reach 1,890 of 1st ANC attendees with couple CT to identify discordant and concordant couples to improve primary prevention and facilitate linkage to HIV care and treatment for the eligible. KEMRI will support integration of ART in MCH clinics, access to FP/RH services, establish or strengthen infection control and waste management activities.

KEMRI will support hospital delivery through provision of delivery beds and sterile delivery packs, working with CHWs and TBAs to promote community- facility referral mechanism, health education and community services

providing skilled birth attendance.

KEMRI will support safe infant feeding practices as per national guidelines; and enrollment and follow up 922 babies born to HIV infected mothers to access CTX, ARV prophylaxis and EID services using the HIV exposed infant register till 18 months. KEMRI will facilitate ART initiation for those who test positive before 2 years.

KEMRI will adopt efficient retention strategies for mothers and babies by supporting use of diaries and registers for tracking defaulters, having a structured mentorship and supervision plan, enhancing data quality and streamlining M&E gaps including orientation of new MOH ANC/maternity registers and utility of data at facility level for program improvement and quarterly progress reports to CDC.

Program quality and proficiency testing will be emphasized to validate PMTCT results. KEMRI will train HCWs on PMTCT and provide orientation to the revised PMTCT and infant feeding guidelines and engage in community activities for demand creation for health services such as male involvement with couple CT services, referral and linkages.

KEMRI will continue to support provincial level activities e.g. EID laboratory testing and conduct operation research on implemented programs.

KEMRI will train 30 health workers in FY12

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,423,117	0

Narrative:

Kenya Medical Research Institute (KEMRI) has been supporting adult HIV treatment at the New Nyanza Provincial General Hospital (a provincial referral facility), since 2004. As of March 2011 SAPR results, NNGPH had supported a cumulative 9,523 adults on ART and 4,095 were active.

Nyanza province has an estimated population of 5.4 million with an estimated adult HIV prevalence of 14.9% compared to the national 7.1%. In FY12, KEMRI will work with the Ministry of Health (MoH) at all levels to jointly plan and ensure provision of quality adult HIV treatment to 5,762 adults currently receiving ART and 329 new adults resulting to cumulative 6,914 adults ever initiated on ART. In FY 13, this number will increase to 6,009 adults currently receiving ART and new 333 resulting to cumulative 7,247 adults ever initiated on ART.

KEMRI in collaboration with MoH will support in-service training of 50 and 30 health care workers in FY 12 and FY 13 respectively; identify human resources and infrastructure gaps and support in line with MoH guidelines; and

support good commodity management practices to ensure uninterrupted availability of commodities. KEMRI will also support provincial level activities, including supporting viral load lab testing for Western region.

KEMRI will support provision of comprehensive package of services to all PLHIV including ART initiation for those eligible; laboratory monitoring including biannual CD4 testing, viral load testing for suspected treatment failure (through strengthened laboratory network); cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH; and improved OI diagnosis and treatment including TB screening, diagnosis and treatment.

KEMRI will continue to support linkages to ongoing community activities and support for HIV infected individuals including education by peer educators; use of support groups to strengthen adherence; effective and efficient retention strategies; referral and linkages to psychosocial support groups; economic empowerment projects; and Home Based Care; and food and nutrition programs. KEMRI will support provision of friendly services to youth and special populations.
KEMRI will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services and integrate them into routinely collected data; and use the results to evaluate and improve clinical outcomes; and additionally support short term activities with great impact and better patient outcomes.
KEMRI will adopt strategies to ensure access and provision of friendly HIV treatment services to all including family focused care and treatment. KEMRI will continue to strengthen data collection and reporting at all levels and improve reporting to NASCOP and PEPFAR. Use of an electronic medical records system will be supported and strengthened. Additionally, KEMRI will evaluate and carry out operation research on implemented

Please see the partner overview narrative for information on the strategy to transition to local ownership.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	150,000	0

Narrative:

Kenya Medical Research Institute (KEMRI) has been supporting comprehensive pediatric care and support services at New Nyanza Provincial General Hospital (NNPGH), a provincial referral facility, since 2004. Nyanza province has an estimated population of 5.4 million with an estimated adult HIV prevalence of 14.9% compared to the national 7.1%, and approximately 12,440 paediatrics have ever been initiated on ART as at May 2011. As of March 2011 SAPR results, KEMRI through NNPGH had supported a cumulative 812 paediatric on ART and 710 were active.

In FY12, KEMRI will work with the Ministry of Health (MoH) at provincial, district and hospital management levels to jointly plan, coordinate, implement and ensure provision of quality paediatric HIV treatment to 1,054

pediatrics currently receiving ART and 211 new pediatrics resulting to cumulative 1,265 pediatrics ever initiated on ART. In FY 13, this number will increase to 1,111 pediatrics currently receiving ART and 190 new, resulting to cumulative 1,455 pediatrics ever initiated on ART.

KEMRI will support comprehensive pediatric ART services including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization; management of childhood illnesses; OI screening and diagnosis; WHO staging; ART eligibility assessment; laboratory monitoring including 6 monthly CD4, hematology and chemistry (through strengthening of lab networks); Pre-ART adherence and psychosocial counseling; initiation of ART as per MoH guidelines; toxicity monitoring; treatment failure assessment through targeted viral load testing; adherence strengthening; enhanced follow up and retention; support of EID as per MoH guidelines; PITC to all children and their care givers attending Child Welfare Clinics; support family focused approach; community outreach efforts; and integration of HIV services in other MNCH services.

KEMRI will support hospital and community activities to support the needs of the HIV infected adolescents: support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services and support their transition into adult services.
KEMRI will support in-service training of 50 and 30 HCWs in FY 12 and 13 respectively, continuous mentorship and capacity building of trained health care workers on specialized pediatric treatment including management of ARV treatment failure and complicated drug adverse reactions; identify human resources and infrastructure gaps and support in line with MoH guidelines; and support good commodities management practices to ensure uninterrupted availability of commodities. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will additionally be optimized.

KEMRI will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, KEMRI will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. KEMRI will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya. Additionally, KEMRI will evaluate and carry out operation research on implemented programs.

Implementing Mechanism Details

Mechanism ID: 13312	**Mechanism Name: Afyainfo**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Abt Associates	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No

Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

ICF Macro	Training Resources Group	

Overview Narrative

This mechanism will support the GoK's efforts to move toward a single unified and integrated Health Information System (HIS)—which will replace the many, disease specific 'vertical' monitoring and reporting systems. The GoK and its internal and external stakeholders agree that there is a need for a single unified and integrated HIS system. USAID/Kenya believes that this is a unique opportunity to make a significant improvement in the HIS, and its impact on health outcomes. In 2010 the GoK issued the Health Information System Policy, 2010, and the Health Management Strategic Plan 2009-2014 to guide the process towards a strengthened, unified and integrated HIS. The support under this contract will now contribute to the building of the capacity of the HIS to enable it be the sole source of data for all the health sector stakeholders, including development partners and USAID/Kenya's APHIAplus and other USG partners. USAID/Kenya will provide support directly through GoK systems to ensure that all support has full GoK ownership and leadership. This system strengthening support will ensure that USG support will not create parallel support structures that could weaken national systems. This program is to support the ongoing activities by the GoK to design and build an effective HIS that will improve decision making and ultimately help improve the health of Kenyans. As such, it will respond to the results outlined in the USAID/Kenya Implementation Framework 2010-2015, whose strategic goal is "health outcomes and impact through sustainable country-led programs and partnerships" which aims to ensure sustainable health impact through strengthening the overall health system. This activity supports GHI/LLC and is completely funded by pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	13312		
Mechanism Name:	Afyainfo		
Prime Partner Name:	Abt Associates		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	0	0

Narrative:

This activity will provide secretariat support to the national SI team. It will ensure coordinated, complete and accurate implementing partner reporting for all the PEPFAR indicators through the USG reporting system KePMS. HMIS will also support the SI team in consolidating the SAPR and APR reports, holding the PEPFAR review meeting for both reporting periods attended by Government of Kenya, Ministry of Health participants. Working with the MoH, Division of HIS, this project will work to strengthen the government routine HIS (DHIS2). The USG KePMS reporting will transition to the national HIS. Part of the process will include indicator harmonization to ensure inclusion of the PEPFAR NGI. It also involves working with the National AIDS Control Council and the Division of Community Health Services at MoH to harmonize and integrate the community level reporting databases with the national HIS. The project will also collaborate with the sub-national partners to ensure establishment of DHIS2, through training of facility and district health management teams in data collection, transcription, data entry, retrieval, analysis, use for local action and archiving. This also includes working with HIS management teams at all levels to institutionalize good monitoring and evaluation (M&E) practices, establish learning and knowledge systems that produce M&E products that support effective programming through established joint partners/GoK monitoring forums. The project has engaged the Kenya Medical Training College, to work with MoH and other stakeholders to accomplish two tasks. 1) Revise the pre-service training curriculum for health records officers to include competency and skills to apply the advancements in technology in HIS and techniques in data manipulation for M&E and surveillance. 2) To develop an in-service short course curriculum to

upgrade the existing workforce to match the current industry and workplace realities, role and responsibilities, including use of the new ICT platforms.

Implementing Mechanism Details

Mechanism ID: 13340	**Mechanism Name: APHIAPlus Rift Valley**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 4,181,397	
Funding Source	**Funding Amount**
GHP-State	4,181,397

Sub Partner Name(s)

AMREF	Catholic Relief Services	Liverpool VCT and Care
National Organisation for Peer Educators (NOPE)		

Overview Narrative

APHIAplus Rift Valley's overarching goal during FY12 is to improve the quality of service delivery in the region. The objectives are to: (1) strengthen the Clinical Services program by improved mentorship and supervisory support to specific facilities to achieve better care and treatment outcomes; (2) re-align service demand creation activities to facility service delivery; (3) strengthen and expand support for the implementation of the community health strategy and linked interventions addressing social determinants of health (SDH). The implementation framework will be consistent with a country-driven process facilitated by partners as outlined in the USAID/Kenya PFIP.

To improve quality of service delivery, additional technical personnel will be recruited and deployed to provide mentorship and supervisory support to local partners, communities, and facilities, and augment the current project staff. Need-based short-term engagement with required technical experts will also be considered to offer necessary skill building support.

Local facilities and implementing partners have been engaged formally through agreements and work plans to build and enhance systems to develop and sustain capacity required for effective service delivery. Inputs to support the implementing mechanisms at both the community and facility levels will be handed over when capacity for their use and distribution is established. Under this award, FHI has purchased 2 vehicles to support the outreach mentorship and supervisory teams based regionally. FHI also uses vehicles from previous awards. An additional 40 motorbikes will be needed in FY12 for social workers to reach the various target groups. This activity supports GHI/LLC and is funded primarly with pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	500,000
Gender: GBV	100,000
Renovation	118,000
Water	50,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**13340**		
Mechanism Name:	**APHIAPlus Rift Valley**		
Prime Partner Name:	**FHI 360**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	0	0
Narrative:			

The target audience for HBC will include HIV-positive children, adolescents, and adults, both at the community and health facility. The aim is to reach 80,000 individuals through facility-based and community home based care in 10 counties in Rift Valley. Service providers will be familiarized with the recently launched PWP guidelines. Lifelong Cotrimoxazole (CTX) will be offered to all HIV-positive patients to prevent opportunistic infections. Partner and family testing will be promoted through active invitation to the health facility using the index client approach. Promotion of condom use, especially among couples, will reduce re-infection and enhance prevention. Screening and treatment for TB and STIs will be offered routinely. Anthropometric measurement and nutritional assessment will be performed on the HIV-positive patients and individuals who are malnourished will be rehabilitated with supplemental or therapeutic feeding. FP counseling will be strengthened and dual methods of protection will be offered. Peer counselors (community health volunteers living positively) at the health facilities will facilitate bi-directional linkages and referrals between the facilities and community programs.

Using a family centered approach, APHIAplus will ensure OVCs in HCBC households receive support to address the social determinants of health, such as livelihood and economic strengthening, skill building, commodities to address hygiene and sanitation, social protection particularly for women and children, and food security and nutrition. The OVC program will have linkages with PMTCT, TB/HIV, health communication, and counseling and testing programs. APHIAplus will provide services based on the PEPFAR care service menu and focus on treatment literacy, relief of symptoms, FP interventions, safe water, HIV testing for family members, condom distribution, alcohol abuse counseling, disclosure support, gender violence support services, food security activities, health education, and household economic empowerment.

District institutions will be supported to integrate, plan, lead, monitor, and evaluate home and community care support programs. Quality assurance and quality improvement for community interventions will be key in ensuring that standards of care are met. APHIAplus will support the District HBC coordinators and CHEWs to monitor and evaluate HCBC and community PWP activities. The project will also roll out a longitudinal database to monitor service provision to all OVCs and improve reporting.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	1,610,000	0

Narrative:

APHIAplus Nuru ya Bonde's prime partner Family Health international (FHI) was competitively selected to implement this activity. The implementing partners will provide comprehensive support to 95,000 OVC and their families, based on PEPFAR OVC guidance, both directly and through leveraged resources from other partners in selected sites in ten counties within Rift Valley province. The activities target OVCs, caregivers of OVCs, and CHWs in selected counties and will be delivered through local implementing partners. The local capacity of each organization will be strengthened through support supervision and mentorship to ensure quality service provision to OVCs. The implementing partners will work with community leaders, religious leaders, and volunteers as well as partner with other existing community-based and faith-based organizations.

In 2012, APHIAPlus will support integration of the OVC project within the government's KEPH strategy thereby ensuring that OVC volunteers are part of the CUs; particularly vulnerable OVC are referred to nutrition programs; OVCs requiring food and nutritional services receive food supplements through the NHP program; government OVC standards for quality improvement are rolled out; and OVC coordination and child protection structures are strengthened at the community level. The capacity of local implementing partners will be strengthened through trainings and mentoring and support supervision to ensure the activities are implemented in line with the required standards

APHIAPlus will also work with the government to improve coordination, supervision, and monitoring of OVC activities. Key to this objective is the need to strengthen the reporting system and support supervision at the local level. Monthly reporting tools for CHWs will be used to collect information at the community and will be analyzed at the implementing partners level. The project will utilize a longitudinal database to monitor service provision to all OVCs and improve data quality.

The capacity of implementing partners will be strengthened through the training of trainers on high quality comprehensive OVC care. Key community stakeholders will be engaged through structures such as the AACs and child protection committees and will be given the authority to identify vulnerable children and their needs, assess existing community resources and gaps, establish a coordination and referral mechanism, and plan and monitor a joint response to the OVC.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	25,435	0

Narrative:

APHIAplus Nuru ya Bonde together with the Capacity Project has hired and trained 4 multi-disciplinary VMMC teams using the national VMMC curriculum. The teams are based at Naivasha District Hospital and Nakuru Provincial General Hospital. The project will support the MOH to expand the VMMC activities in Nakuru County to reach the uncircumcised males, the majority of whom are migrant workers. APHIAplus aims to reach 3,500 males in the next year. VMMC promotional activities will be carried out at community level and in work places around Naivasha and Nakuru. In addition, the project will work with the MOH to build the capacity of P/DHMTs and health care workers to plan and provide VMMC services as part of an integrated HIV prevention package that includes community education and mobilization activities. APHIAplus will support the MOH to disseminate the national VMMC M&E tools to ensure appropriate documentation, follow-up, and recording of adverse events. For quality assurance, a VMMC expert will be engaged on a quarterly basis and will provide targeted mentorship to individual team members and train them on how to manage adverse events.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	61,290	0

Narrative:

APHIAplus Nuru Ya Bonde will expand HCT by supporting all districts to undertake targeted HIV Counseling and Testing services to reach youth out of school. In addition, outreach activities will be integrated into community promotion activities through mass media, community dialogue, action days, and social and sporting events. CT activities will also target market days that congregate traders and business persons. VMMC outreaches will integrate CT services into workplaces targeting men especially from non-circumcising communities. Integrated MARPs outreaches will target CSWs along business routes and centers. All community outreach CT services, including house-to-house CT activities, will refer individuals who test positive to facilities.

Facility-based HIV CT services in APHIAplus zone 3 will target pregnant women, couples and partners of PLWHA, MARPs, youth seeking YFS, and clients accessing services at the supported health facilities. At all 642 APHIAplus supported health facilities, provider initiated HIV testing & counseling (PITC) will be the predominant approach. HIV testing is routinely offered to patients, their family members, and visitors seeking ANC, maternity, postnatal, MNCH, TB, in-patient and other outpatient services with the option to opt-out. Other approaches include outreach/mobile voluntary counseling and testing (VCT) targeting hard to reach populations and campaigns like the couple testing community RRIs. Youth friendly counseling centers will be strengthened to increase access to HIV CT for youth. Service providers will be oriented on adolescent and youth-friendly sexual and reproductive health services. Health facilities will also identify index HIV clients and CHWs and community counselors will provide family-based HIV testing to promote early identification of HIV infected family members and access to HIV CT.

The nationally recommended HIV testing algorithm will be in used in all APHIAplus supported sites and all service providers will receive information on the revised HTC guidelines through facility-based CMEs and technical updates. An additional number of providers will receive information on the national HTC quality assurance strategy and an initial 150 health facilities enrolled into the national proficiency HTC testing program. Further provider training on the re-testing recommendations contained in the HTC guidelines will be given to facilitate a structured approach in implementation. Partner testing will be promoted in care settings through active invitation for partners of identified cases seeking HIV CT services. Support groups linked to supported health facilities will be strengthened and community peer volunteers identified to facilitate intra-facility referrals into community programs and facilitate tracing of defaulters to follow-up CT. Service providers and peer volunteers will use mobile phone messaging to communicate with individuals after HIV CT to enhance linkages for enrollment, follow-up, and retention in CT. Existing HTC tools will be used at all entry points and summary reports prepared by HTC mentors based in the health facilities and the anchor CU facilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	633,652	0

Narrative:

APHIAplus Nuru Ya Bonde is supporting 642 PMTCT sites of which 114 sites are offering comprehensive PMTCT interventions with intensified mentorship support to achieve the EMTCT goal, which ensures all these facilities have

achieved a reduction in HIV transmission to <5% for all exposed neonates. In the next two years, 230 sites will receive comprehensive PMTCT support towards achieving the EMTCT goal. Concurrently, a minimum PMTCT package of targeted intervention support will be provided at the remaining PMTCT sites through outreach mentorship and linkages to national training, commodities management, and district supportive supervision, with the aim of progressively transitioning to comprehensive EMTCT packages.

Through engagement with the existing 114 sites, costing of the interventions will be undertaken to obtain the unit cost per PMTCT client reached. In the next two years, innovative measures will be instituted to address high burden areas to reduce the unit cost and facilitate expanded coverage and program effectiveness. Strategies to achieve decentralized PMTCT services will include: expanded integration of HIV prevention into facility-based and outreach RH/FP services, and ARV prophylaxis and maternal/infant therapy into MNCH services; focus on the unmet needs for FP services among all HIV-positive women and their partners through PwP implementation; linkages with male neonatal, sibling, and partner circumcision services; and improvements in PNC service delivery and follow-up of 'infected mother-exposed baby' pairs. In addition, activities to achieve decentralized PMTCT services include: integration into the Community Strategy; early identification of pregnancy by CHWs; access to counseling and testing for couples and families; improved follow-up care and treatment for pregnant HIV-positive women; and facility deliveries through referrals vis-à-vis integration of mobile phone technology for information alerts and reminders.

APHIAplus has developed PMTCT intervention package standards compliant with current National PMTCT Guidelines. They will be used as a basis for monitoring implementation and compliance of quality standards. District supervision and program mentorship teams at the district and project-supported site levels will use the standards to monitor facility quality, determine needs for improvement, and set targets. Existing national PMTCT quality assurance tools will be made available at all facility sites and providers will be supported, through the mentorship teams, to use the tools. National data collection and reporting tools will be distributed to the sites. Through facility Quality Improvement Teams, all data collected will be analyzed and then utilized for decision making and planning for service delivery improvement. This will be undertaken through data review exercises at six month intervals to capture the progress in the implementation of the PMTCT care services and the outcomes for mother and infants at both the facility and community levels. Clinic data on immunizations, growth monitoring, including nutrition support, rehabilitation and treatment services for exposed and infected babies will inform the collection of outcome data. Service outcome indicators from the community strategy indicator data, such as community mobilization for PMTCT, stigma reduction interventions, male involvement, and couple counseling and testing, will be analyzed and monitored from the catchment CUs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,742,710	0

Narrative:

APHIAplus Nuru Ya Bonde is currently supporting 114 HIV care and treatment sites with comprehensive

interventions packages. Due to the variable performance in the different treatment sites, APHIAplus will focus on strengthening the quality of services offered at these supported facilities and progressively decentralize treatment services to other sites using an outreach mentorship approach. To strengthen the quality of care and treatment services, APHIAplus will review the comprehensive package of interventions, deploy six regional multidisciplinary mentorship teams, provide intensive support to 16 poorly performing care and treatment sites, provide on-going enhanced support to 25 other sites, and maintain regular support to the remaining 71 sites to ensure adoption and maintenance of quality care and treatment standards for adults and adolescents. In addition, APHIAplus will upgrade six regional hub laboratories to support the delivery of quality laboratory networking services for the participating care and treatment sites. Integrated post-training clinical mentorship will be conducted for the individual providers and sites through the mentorship teams in order to refine and improve their skills. Mentor and mentee logbooks will be used to objectively monitor and assess the impact of the mentorship activities. Additional validation of mentorship effectiveness will be undertaken through the adoption of the on-line Therasim evaluation approach for individual providers. In-facility Quality Improvement Teams will be established and operationalized to undertake oversight of improvement initiatives, which address poor performance.

APHIAplus will increase access to CD4 tests and viral load testing by supporting the transportation system of samples and results between health facilities and the laboratory hubs in network and National HIV reference laboratory. To improve retention in care and treatment, mobile phone messaging for patients on treatment, patient support groups, and linkages to CHW home-based follow-up will be established in functional CUs.

Adolescent-friendly clinic days will be established to cater for this unique cohort.

Monthly ART cohort reports will be compiled and used to review clinical outcomes. Active default tracing mechanisms will be instituted through the community structures, the patients support group, peer counselors, and through SMS messaging. To adequately address co-morbid conditions, the proportion of patients screened and diagnosed with TB, of TB-HIV co-infected patients on HAART, and of patients diagnosed with NCDs will be monitored. Intensified ART adherence counseling will be conducted for all new patients initiating treatment and medication use counseling will be provided during follow-up to increase ART adherence.

ADR and adverse event monitoring will be instituted. Thus, patients who develop treatment failure will have access to non-standard regimens, facilitated through the Level 5 Hospital Treatment Review Team. Targeted focus on ART adherence counseling for frontline service providers will build their capacity to offer the service. Peer counselors will be deployed from the support groups to further support retention to treatment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	108,310	0

Narrative:

APHIAplus NYaB will scale-up pediatric care and treatment in the region. At present about 10% of current, newly and ever enrolled on CT are aged 0-15 years. This proportion will be increased to approximately 15% in the next two years. In the next two years, all adult/adolescent CT sites will strengthen the delivery of pediatric CT services

to ensure optimization of entry points into CT and improved follow-up through integration of pediatric HTC into MNCH services and in-patient pediatric care services. Identification of HIV exposed and infected children will be intensified through longitudinal follow-up of HEI and PITC for the infants with unknown status in the health facilities. Early infant diagnosis facilities will be scaled-up to ensure provider competence to collect quality DBS samples and transport samples to regional laboratories for HIV DNA PCR diagnosis. Mentorship teams will ensure providers minimize missed opportunities for HIV diagnosis among exposed children. OJT for service providers on collection of DBS samples will be conducted in the facilities to improve diagnosis of HIV among the HEI.
Turnaround times for receipt of results will be analyzed for each facility and optimized through measures to reduce time waiting for and relaying results to mothers. Service providers will be mentored on the prompt initiation of ART for children less than two years old with confirmed HIV status, while access to CD4 and viral load testing will be facilitated through laboratory networks linking regional labs with the National HIV Reference Laboratory to enhance evaluation and monitoring of patients. APHIAplus will build the capacity of health service providers in pediatric HIV management through targeted trainings and clinical mentorship to ensure that regimen dosing is age appropriate. Nutritional assessments of pediatric patients and therapeutic and supplemental feeding will be an integral part of their evaluation and monitoring. Access to all other immunization care, supplementation, and growth monitoring services will be undertaken in compliance with National Guidelines.
Adolescent-friendly clinic days will be established and adolescent support groups formed. These will be managed separately from the adult and pediatric clinic days and facilitated by providers who have been trained in adolescent care. Adolescent clubs promoting healthy and positive living will be linked to adult role model mentors who are living positively.

The use of the HEI register and mother-baby booklets will be promoted and data complied to assess HIV transmission rates every month. Other outcomes will be analyzed to enable the development of facility-based responses to address poor outcomes. This effort will be undertaken by the pediatric HIV care and treatment mentor based in the supported health facility in conjunction with the Quality Improvement Team.

Implementing Mechanism Details

Mechanism ID: 13346	**Mechanism Name: Support Services for HIV Pandemic**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: World Health Organization	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	

G2G: No	Managing Agency:

Total Funding: 642,004	
Funding Source	**Funding Amount**
GHP-State	642,004

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Goal: To support the Ministry of Public Health and Sanitation (MoPHS) to scale up of HIV prevention, care & treatment services, and health systems strengthening for a more effective, comprehensive & sustainable HIV/AIDS response. Objectives: •Technical support in setting of standards and development of strategies for accelerated scale-up of HIV prevention interventions and increased access to HIV treatment and care
•Technical support HIV program monitoring and evaluation
•Technical support for forecasting, quantification, logistics management and quality assurance systems
•Technical support in developing HIV service delivery frameworks to facilitate integration of HIV services with other related interventions •Technical support in capacity building
•Technical support in advocacy and resource mobilization of HIV prevention, treatment & care services
Cost-efficiency strategy: WHO will provide technical support on GHI country objectives, maximizing on sustainable health impact, increasing health outcomes through strengthened health systems, targeted national capacity building, and harmonizing health systems for the delivery of HIV interventions. This will improve program efficiencies; facilitate national ownership; leverage partnerships; and increase sustainable impact of the HIV program.Through WHO's good technical competence and long-term presence in Kenya, support is sustainable.Transition to country partners:Through this mechanism, WHO a special United Nations agency mandated to support country led country programs will be supported. This activity supports GHI/LLC. Vehicle information:This partner has not used PEPFAR funds for vehicle purchase in the past and is not requesting funds for vehicle purchase in FY12.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	642,004

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	13346		
Mechanism Name:	Support Services for HIV Pandemic		
Prime Partner Name:	World Health Organization		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	200,000	0

Narrative:

WHO Country, Regional and HQ team in Geneva work closely with CDC and PEPFAR in supporting implementation of HIV prevention and HIV/AIDs management strategies. HLAB will support a WHO Medical laboratory advisor position in Kenya. WHO commands significant influence at Ministry of Health and will be a strategic partner for CDC in advocating for adoption and implementation of key laboratory systems strengthening related policies in Kenya. Laboratory remains one of the weakest and least funded health departments within the Ministry of Health. The human resource scheme of service for laboratorians peaks significantly earlier than for nurses ,pharmacists and doctors thus locking these professionals out of top leadership positions. Consequently, laboratory personnel are not represented in many decision making committees both at national and regional level. The laboratory advisor will play a key role in advocating for repositioning of the medical laboratory department. The advisor will support ratification of key policies including those to support laboratory networking, laboratory accreditation, standardization of laboratory equipment and infrastructure and harmonization of pre and in – service medical laboratory training across training institutions and programs. This will achieve major efficiencies both for PEPFAR and the government of Kenya.

Additionally, the advisor will give key support in designing and institutionalizing HIV surveillance programs including sentinel surveillance, HIV drug resistance, AIDS indicator survey and Demographic/Behavioural Health survey. The overall goal of the WHO/CDC supported surveillance initiatives is to provide global, regional, and country level guidance to prevent new HIV infections, and minimize the emergence and transmission of HIV drug resistance (HIVDR), thus prolonging and maximizing the effectiveness of available first- and second-line regimens

and the quality of life of people living with HIV.

Since PEPFAR 1, USG has supported the WHO concept of one semi-autonomous national blood transfusion service with blood collection from voluntary non-remunerated blood donors. The laboratory advisor will advocate for implementation of NBTS semi-autonomy in Kenya including direct funding from government of Kenya.

The staff to be hired will have a clinical laboratory and epidemiology background with an understanding of HIV. Field experience in implementation of public health projects will be highly desirable. WHO will involve CDC in the selection process.

The success of this position will be measured by the CDC Kenya office through monitoring of laboratory policies implemented.

Please see the partner's overview narrative for information on the strategy to transition to local partners.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	113,621	0

Narrative:

This mechanism will support the recruitement of an HIV expert by WHO to be based at the Ministry of Health. The HIV expert will support the Ministry of Health in the following areas:

•Technical assistance to all HIV prevention technical working groups (TWG) to support policy formulation and guideline development
•Training and certification of service providers including supporting the development of appropriate curricula for high quality services
•Support MoH in maintaining high quality HIV prevention services
•Support MoH to improve efficiency and achieve appropriate targets in all HIV Prevention interventions
•Support the packaging and roll-out of combination prevention interventions for greater effectiveness in HIV prevention
•Support effective referrals and linkage of clients to prevention, care and treatment services and provide expertise to the development of integration guideline with other community services
•Support the development of a comprehensive communication strategy to improve the demand of HIV Prevention services
•Support the devolution of HIV prevention services to the county level

HIV Prevention services will be monitored through the various TWG minutes and KePMS reports, while evaluation

will be conducted through periodic surveys including Kenya AIDS Indicator Survey, Kenya Service Provision Assessment and Kenya Demographic and Health Survey.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	90,522	0

Narrative:

This mechanism will support WHO to recruit a dedicated position to provide technical assistance to the Kenya Ministries of Health (MoH) in HIV prevention programs including HIV testing and counseling (HTC). Specific responsibilities include supporting:

•Technical assistance to all HIV prevention technical working groups (TWG) to support policy formulation and guideline development
•Training and certification of service providers including supporting the development of appropriate curricula for high quality services
•Supporting the establishment of a database for HTC service providers to ensure appropriate training updates and monitoring of quality of service
•Support MoH in maintaining high quality of services
•Support MoH to improve efficiency and achieve appropriate targets in all HIV Prevention interventions
•Support the packaging and roll-out of combination prevention interventions for greater effectiveness in HIV prevention
•Support effective referrals and linkage of clients to prevention, care and treatment services and provide expertise to the development of integration guideline with other community services
•Support the development of a comprehensive communication strategy to improve the demand of HIV Prevention services
•Support the devolution of HIV prevention services to the county level

HIV Prevention services will be monitored through the various TWG minutes and KePMS reports, while evaluation will be conducted through periodic surveys including Kenya AIDS Indicator Survey, Kenya Service Provision Assessment and Kenya Demographic and Health Survey.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	37,861	0

Narrative:

HVOP
This mechanism will support the recruitment of an HIV Prevention expert by WHO to be based at the Ministry of Health. The expert will have the following responsibilities:

- *Technical assistance to all HIV prevention technical working groups (TWG) in order to support policy formulation and guideline development*
- *Training and certification of service providers including supporting the development of an appropriate curricula*
- *Support MoH in developing standard and quality of HIV prevention services*
- *Support MoH to improve efficiency and achieve appropriate targets in all HIV Prevention interventions*
- *Support the packaging and roll-out of combination prevention interventions for greater effectiveness in HIV prevention*
- *Support effective referrals and linkage of clients to prevention, care and treatment services and provide expertise to the development of integration guideline with other community services*
- *Support the development of a comprehensive communication strategy so to improve the demand of HIV Prevention services*
- *Support the devolution of HIV prevention services to the county level*

HIV Prevention services will be monitored through the various TWG minutes and KePMS reports, while evaluation will be conducted through periodic surveys including Kenya AIDS Indicator Survey, Kenya Service Provision Assessment and Kenya Demographic and Health Survey.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	200,000	0

Narrative:

World Health Organization (WHO) support in Kenya for the HIV care and treatment program primarily focuses on development of program strategic documents including program plans/strategies, treatment guidelines/protocols, service delivery frameworks, program and patient monitoring tools/system, commodities management, HIV drug resistance prevention, and pharmacovigilance protocols among others. WHO has also been key in strengthening local partnerships, resource mobilization from GFATM, provision of catalytic funding for implementation of developed tools/strategies, capacity building of managers and health workers, global/regional monitoring of HIV care and treatment as well as advocacy and brokerage for the adoption of simplified cost-effective approaches, equitable scale-up of care and treatment services, task shifting, and greater involvement of PLHIV. WHO has recognized the need to strengthen its capacity in order to improve its technical support in Kenya, commensurate with the continued growth of the HIV program in Kenya. In FY12 and FY13, WHO will expand its technical capacity in Kenya in order to effectively support the National AIDS and STI control program (NASCOP) to provide effective leadership and facilitate lower levels to better implement the expanding package of HIV care and

treatment services in a more decentralized and integrated manner. WHO will increase technical capacity of its HIV team from the current one to at least three staff members. Two of the staff members will focus on HIV care and treatment (one on full time basis and the other up to 60% of time). The full-time staff member will be based in NASCOP and will focus on building national capacity on patient and treatment monitoring, HIVDR monitoring, and pharmacovigilance. The other staff member will provide overall support on all technical and strategic issues on HIV care and treatment. WHO will support operationalization of two HIVDR longitudinal monitoring sites in Nairobi in addition to the two sites being supported in Nyanza. WHO will also continue to build capacity for NASCOP to offer specialized treatment, including management of patients with ARV treatment failure and complicated drug adverse reactions. WHO supported the first Early Warning Indicator (EWI) survey conducted in Nairobi and will support the nation-wide representative EWI survey to be conducted per stakeholder recommendation. WHO will also support HIVDR threshold survey (TS) using remnant EID samples, using a new TS protocol developed by the HIV DR technical working group. Support will be offered to NASCOP for the adult longitudinal survey in 2012 to assess HIV care and ART provision, building on a similar survey done in 2007.

Implementing Mechanism Details

Mechanism ID: 13354	**Mechanism Name: Kenya AIDS Response (KARP)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Kenya Episcopal Conference	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 6,320,943	
Funding Source	**Funding Amount**
GHP-State	6,320,943

Sub Partner Name(s)

Catholic Relief Services	Futures Group	Health Strat Kenya
Mission for Essential Drugs and		

Supplies		

Overview Narrative

Kenya Episcopal Conference (KEC) has a new award to implement HIV prevention, care and treatment activities in Faith based organization (FBO) facilities previously supported by the CRS Track 1 mechanism. KEC's goal is to reduce HIV related morbidity and mortality through provision of high quality, sustainable HIV prevention, care and treatment services. KEC's goal and objectives are linked to Kenya's Partnership Framework (PF) and Global Health Initiative (GHI) strategies and are aligned to PF pillars 1-3: prevention, care and mitigation, treatment, and systems strengthening. Strategies to reduce maternal and child mortality and eliminate MTCT include supporting integration of MTCT within MCH. M&E plans will align with PEPFAR and country PF. Training on and use of MOH HMIS systems will be supported to eliminate parallel M&E. Cost efficiency will be addressed through integration of services, reduction of the technical teams by increased capacity building of the FBO staff, use of existing evidence-based strategies, task shifting, relying on facility-based training and mentorship rather than offsite training, evaluating cost effective strategies for defaulter management, laboratory networking, and mobilization.KEC will work with FBO facilities and MOH to build a country owned program. Emphasis will be placed on data demand and use to inform decision making thereby increasing site ownership of data. Quarterly dashboard reviews will be conducted to monitor the programs quality and related resource expenditure. KEC will support health facilities to integrate the HIV/AIDS program into health systems of the facility for ownership and sustainability purposes. KEC will purchase 2 vehicles with COP 12 funds to support supervision. This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	63,209
Gender: GBV	5,000
Gender: Gender Equality	10,000
Human Resources for Health	1,837,073
Motor Vehicles: Purchased	205,000
Renovation	50,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**13354**
Mechanism Name:	**Kenya AIDS Response (KARP)**
Prime Partner Name:	**Kenya Episcopal Conference**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	400,000	

Narrative:

Kenya Episcopal Conference (KEC) was awarded a new CDC grant in Oct 2011 to support comprehensive HIV care and support in previously CRS-HRSA supported sites in Nyanza Province.
KEC will work with the Ministry of Health (MoH) at the provincial, district and health facility level, to jointly plan, coordinate, implement and ensure provision of quality HIV care and support to 15,634 current adult patients in FY12 and 19,800 current patients in FY13 in public, faith based and high volume private health facilities within agreed limits of rationalization and towards universal access to care and support services.
KEC will offer a package of services including HIV testing to partners and the family members of index patients and enrolling or referring/linking those that test HIV positive to care and support; provision of Basic Care Kit (safe water vessel, multivitamins, insecticide-treated mosquito nets, chlorine for water treatment and educational materials); supplemental and therapeutic nutrition (FBP) to all eligible HIV positive patients; prevention with positives(PwP); and cervical cancer screening to all enrolled women.
KEC, in collaboration with MoH, will support targeted capacity building (training of 150 health care workers in FY12 and 100 in FY13, and mentorship) and additionally offer continuous medical education on care and support, e.g. OI diagnosis and treatment. KEC will identify areas with staff shortages and support recruitment of additional staff as well as support good commodities management practices to ensure uninterrupted supply of commodities.

KEC will continue to support ongoing psychosocial and community activities including peer education; referral and linkages to community based psychosocial support groups to strengthen adherence; effective and efficient retention strategies of patients on follow up; water, sanitation and hygiene programs; income generating activities; Home Based Care; vocational training; social and legal protection; and food and nutrition programs.
KEC will adopt strategies to ensure access and provision of friendly services to youth, elderly and disabled populations. Strategies to increase access of care services by men will be employed, including supporting male peer educators, mentors and support groups, and supporting women to disclose and bring their male partners for testing and care and treatment.
KEC will continue to strengthen data collection and reporting at all levels to improve reporting to NASCOP and PEPFAR. KEC will adopt the new generation indicators and support the development and use of electronic medical records system in accordance with NASCOP guidelines. KEC will continue using the quality of care indicators (CQI) for monitoring the quality of HIV care and support services, integrate them into routinely collected data, and use the results to evaluate and improve clinical outcomes. KEC will do cohort analysis and report retention rates as required by the NASCOP.
KEC will support joint Annual Operation Plan (AOP) development, implementation, monitoring and evaluation and health system strengthening to facilitate sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	300,000	0

Narrative:

Kenya Episcopal Conference (KEC) was awarded a new grant to support TB/HIV activities in seven facilities previously supported by the CRS-HRSA grant in Nyanza Province. KEC will provide TB/HIV services in line with the Ministry of Health's Division of Leprosy, Tuberculosis and Lung Disease (DLTLD) and the National AIDS and STI Control Program (NASCOP). KEC will align and adhere to the Kenya's 5-Year National AIDS and TB Strategic Plans shared objectives to ensure co-infected TB patients and suspects receive quality and comprehensive care and that the threat of drug resistant TB is contained. KEC will support training and hiring of additional staff, procurement of simple laboratory TB diagnostics, and minor renovations of TB Clinics to ensure better infection control practices. KEC will use the existing national TB and HIV M&E framework and tools to report on TB/HIV Indicators.
In FY12 and FY13, KEC will continue to intensify efforts to detect TB cases through clinical exams, laboratory investigations and ensure successful TB treatment through provision of appropriate treatment. KEC will ensure that facility staffs are adequate and well trained and that laboratories well equipped to support optimal TB diagnosis. Laboratory support will include sputum specimen transport where laboratory services are unavailable. KEC will ensure that adequate supplies of anti-TB drugs are available and that the national TB treatment guidelines are followed. All TB patients on treatment will be monitored both clinically and through periodic sputum examination. KEC will ensure that all TB patients are screened for HIV and 95% of TB-HIV co-infected patients are put on

cotrimoxazole and ARVs as early as possible regardless of the CD4 count as per the national guidelines. KEC will support the "one stop" model that provides integrated TB and HIV services in all TB clinics. All TB clinics will be stocked with cotrimoxazole and ARVs, and TB staff trained as needed.

To reduce the burden of TB in HIV infected patients, 13,896 and 17,600 HIV infected patients will be screened for TB in HIV care settings in FY12 and in FY13 respectively; 694 co-infected patients identified in FY12 and 880 co-infected patients identified in FY13 will be put on TB treatment, and those without active TB will be provided with Isoniazid Preventive Therapy (IPT) as per national IPT protocol.

KEC will ensure that the national IC guidelines are available and staff are trained (100 staff trained in FY12 and 80 in FY13) at all sites. KEC will support scaling up of at least 2 components of the national TB infection control strategy in HIV care settings, one of which should be fast tracking of patients with cough for expedited diagnostic work up and treatment. KEC will support timely transport of sputum specimens of TB retreatment cases from health facilities to the central reference laboratory for drug susceptibility testing and ensure return of the results to those facilities. KEC will expand prevention with positive (PwP) services in TB clinics, strengthen linkages between facility and community-based services, improve patient referrals and tracking systems and increasing support for TB-HIV operations research. KEC will support reporting of custom indicators to assist with program management and evaluation and monitoring of new activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	58,602	0

Narrative:

Kenya Episcopal Conference (KEC) has just received a new CDC award starting Oct 2011. KEC will implement comprehensive, integrated pediatric care services to children in Nyanza Province in seven facilities that were previously supported by CRS-HRSA Track 1 activities.

In FY 12, KEC will provide care and support services to 1,674 children currently on care. The number of children currently on care will increase to 2,106 during FY 13. KEC will provide comprehensive, integrated quality services, and scale up to ensure 335 HIV infected infants are put on ARV prophylaxis and all HIV exposed children access pediatric care services. The focus of pediatric care services will continue to be provision of comprehensive, integrated quality services including strengthening the use of the Mother-baby booklet, early infant diagnosis, universal provider initiated testing and counseling, and ensuring those identified HIV infected are linked to care and ART services.

KEC will ensure children enrolled in care, receive quality clinical care services, including clinical history and physical examination, WHO staging, CD4 tests, and other basic tests; opportunistic infection diagnosis, prophylaxis and management; TB screening and treatment; pain and symptom relief and management; and psychosocial support. Additional key care services will include nutritional assessment, counseling and support based on the WHO and IYCF guidelines (including provision of therapeutic or supplementary feeding, support to

children with growth faltering, provision of vitamin A, zinc, and de-worming); provision of safe water, sanitation and hygiene interventions (WASH) in the community and in health facilities; and malaria screening, treatment and provision of long lasting insecticide treated nets in malaria endemic areas.
KEC will support integration of HIV services into routine child health care and survival services in the maternal child health department, including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization guidelines; case management of diarrhea, pneumonia, and other childhood illnesses; and community outreach efforts. They will also support the care of the newborn by supporting hospital delivery and ensuring that there is provision for newborn resuscitation and care (thermal care, hygiene cord care), and prophylactic eye care. Exposed children management and follow up will continue to be supported and will include enrollment, HIV testing (PCR-DNA and antibody testing) as per the national guidelines, provision of Nevirapine throughout the breastfeeding period, follow up and retention, and linkages of those positive to care and ART services.
KEC will support hospital and community activities to meet the needs of HIV infected adolescents: support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, support for transitioning into adult services and teaching life skills.
Commodity access and infrastructure development as well as relevant trainings will continue to be supported (training of 150 health care workers in FY12 and 100 in FY13). KEC will strengthen pediatric data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR and cohort analysis to inform programming.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	8,401	0

Narrative:

Target population: KEC will support HIV testing and counseling services in several mission/faith-based health facilities in following counties: Migori, Homabay, Kisumu, Siaya, Bungoma, Kakamega, Kiambu, Kirinyaga, Nyeri, Nyandarua, Kitui, Embu, Tharaka-Nithi, Meru, and Taita-taveta. Target population will include all patients, their family members and caretakers who access out and in patient services in all the supported facilities.
HTC Approaches: The program will utilize provider initiated opt out approach and the services are offered within all out patient departments, TB clinics, FP, ANCs, special clinics, HIV clinics (targeting family members) and in patient departments. The counseling and testing is either done within the consultation rooms by trained clinicians or in counseling rooms by lay counselors within the outpatient departments if space is available or at the laboratories.
Targets and achievements: In COP 2012, CHAK will target to provide HTC services to a total of 30,000 persons of which 20% will be tested as couples and 10% will be children below the age of 15.
Testing algorithm: National algorithm is being used.
Referrals and linkages: In order to strengthen referrals, KEC will put in place several important strategies. They

include: use of peer educators as patient escorts from one hospital department to the CC; same day enrollment of clients to CCC; use of an integrated defaulter tracing system for tracing patients who default on care or ART upon enrollment; introduction of documented referral system by use of the NASCOP referral booklet; use of mobile phones to follow up whether the client was actually enrolled.
Quality management: In order to improve and monitor quality of HTC services, KEC will put in place the following strategies: Training and continuing education of HTC providers; strict adherence to the standard operating procedures outlined in the national HTC guidelines; management of HIV rapid kits as per the guidelines; putting in place a functional QA systems as provided for in the national HTC guidelines; participation in EQA- proficiency testing and finally conducting support supervisory visits.

Monitoring and evaluation: KEC will use all ministry of health' tools to capture HTC data, both for couples and individual patients. These include HTC lab Register and Monthly summary tool (MOH 711). MOH approved HTC lab registers will be introduced at all HIV testing points except PMTCT.

Promotional activities for HTC: All patients attending the supported facilities will be given health talks including the need for HIV counseling and testing and the importance of couple testing. Couples are given priority services. Sexual partners of HIV positive clients will be given individualized invitations though the index clients and available avenues for testing including individualized home testing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

KEC implements comprehensive prevention, care and treatment programs in Nyanza province. In FY 2012/13, KEC will expand HIV prevention services to include evidence based behavioral interventions (EBIs) for specific target populations in clinical settings at comprehensive care center (CCC), TB and Maternal Child Health (MCH) clinics as part of HIV combination prevention programs. The EBIs will include Positive Health and Dignity Prevention (PHDP) targeting adult male and female and adolescents living with HIV (PLHIV); and Sister to Sister EBI (S2S) targeting sexually active HIV negative women attending the MCH clinics.
PHDP is an ongoing 5-10min group and individual level intervention that targets PLHIV in clinical and community settings. This mechanism will support this intervention which constitutes of ART adherence counseling and support; partner and family testing; provision of PEP to the discordant spouse; treatment for prevention once approved; safer pregnancy counseling and provision of modern contraception; sexual risk reduction counseling including reduction of sexual partners, alcohol counseling, promoting of consistent and correct condom use; Sexually Transmitted Infections (STI) screening and treatment and using meaningful involvement of people living with HIV/AIDS (MIPA). The efficacy of PHDP has been shown to be 68% in preventing transmission of HIV, and 96% in treatment for prevention.

S2S is a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use. Condoms are 80% effective in heterosexual relationships when used correctly and consistently.
KEC will use HVOP funding to recruit and support appropriate peer educators/counselors to reinforce prevention messages delivered by health providers as a feasible model for task-shifting in the provision of PHDP in clinical settings, and specifically promote MIPA. It will support placement of 5 Peer Educators at the MCH, TB and CCC Clinics in hospitals, and 2 Peer educators at health centres and provide appropriate counseling space. One of the peer educators will do regular client home follow up to strengthen ART adherence.
Approximately 1.6 million Kenyans are PLHIV. The Kenya AIDS Indicator Survey 2007 showed 6% of couples to be in discordant relationships. Nyanza province has the hisghest HIV Prevalence (14.9%). KEC will reach 8827 (60%) PLHIV in FY2012 and 13034 (70%) in FY 2013 with a minimum package of PHDP. It will implement S2S EBI on a pilot basis.
Quality assurance for EBIs will be promoted through appropriate training and certification of peer educators using approved national curricula, standard job-aids and guidelines and regular supervision.
KEC will work with appropriate national Technical Working Groups (TWG) to support integration of HIV prevention into care and treatment programs in clinical settings. These programs will also be linked to other HIV community programs. PLHIV will be specifically linked to STI and FP services, as necessary, through patient escorts.
Monitoring of PHDP and S2S will be done through the review/input of KEC implementation plan, analysis of KePMS data, quarterly reviews, semiannual and annual reports. Evaluation will be conducted through operation research of combination HIV prevention and periodic surveys (Kenya Demographic and health survey, Kenya Indicator AIDS Survey, Kenya Service Provision Assessment)

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	300,000	0

Narrative:

KEC will implement comprehensive PMTCT services to pregnant mothers in Nyanza region is seven facilities that were previously supported by CRS-HRSA. KEC will strengthen PMTCT services in the 7 main facilities and satellites by integrating ART into the MCH clinics. In FY12, KEC will offer HIV counseling and testing to 2,095 pregnant women at the ANC and give ARV prophylaxis to 320 HIV infected pregnant women.
KEC will support the 4 prongs of PMTCT: primary prevention, referral and linkages for family planning, provide ARV prophylaxis to all HIV positive pregnant mothers and exposed infants, and care and treatment to eligible HIV positive mothers, partners and children. The HIV infected women will receive clinical evaluation including WHO staging and CD4 testing. KEC will give HAART to all eligible HIV positive pregnant women in line with the revised PMTCT national guidelines. In FY13, KEC will increase the number of pregnant women counseled to 2,200 offer

ARV prophylaxis to 389 pregnant women and 335 infants, and do EID for 335 infants. Effective retention strategies for mothers and babies through care will be supported through use of appointment diaries, and use of registers for tracking defaulters. Efforts will be made to reduce the cost of service provision to < $18 dollar per woman by leveraging on other activities like malaria prevention in line with GHI principles.
KEC will work to improve ANC attendance and hospital deliveries by working with existing community programs to increase demand for skilled delivery and promote community- facility referral. Maternity services will be strengthened by supporting provision of basic equipment at the hospitals. To optimize PMTCT uptake, male involvement and couple counseling and testing will be prioritized to strengthen Prevention with Positives. Scale up of uptake of RH services including FP referral and linkages in MCH will be supported. PITC will be promoted including counseling and testing of mothers at the well baby and post natal clinics which will identify HIV exposed infants.
KEC will work with the Ministry of Health at all levels to jointly plan, coordinate and implement comprehensive PMTCT services, in line with the Kenya National Strategic Plan III, the GOK and USG Partnership Framework, and the district and provincial annual operation plans.

Areas of staff shortages will be identified and recruitment of additional staff will be supported. KEC will build the capacity of 30 health care workers in FY12 and equal number in FY 13 by supporting trainings on the revised PMTCT guidelines, early infant diagnosis and safe infant and young child feeding; a structured mentorship and supervision plan to support facilities.
Data collection and reporting will be strengthened by orientation of health care workers on the revised data tools and facilities will be encouraged to use their own data for program improvement.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	5,103,940	0

Narrative:

Kenya Episcopal Council (KEC) will support treatment services in 7 faith based facilities in Nyanza which are currently supported by CRS Track 1 mechanism. As of 2011 SAPR, a cumulative 9,118 adults were ever initiated on ART and 6,158 were active.
In FY12, KEC will jointly work with the Ministry of Health (MoH) to continue supporting expansion and provision of quality adult HIV treatment services in line with MoH guidelines to 12,360 adults currently receiving ART and 1,734 new adults, resulting to cumulative 14,832 adults who have ever been initiated on ART. In FY13, this number will increase to 13,663 currently receiving ART and 1,784 new adults, resulting to 16,616 adults who have ever been initiated on ART.
KEC, in collaboration with MoH, will support in-service training of 100 and 80 health care workers in FY12 and FY13 respectively; identify human resources and infrastructure gaps and support in line with MoH guidelines; and support good commodities management practices to ensure uninterrupted availability of commodities.

KEC will support provision of comprehensive package of services to all PLHIV including ART initiation for those eligible; laboratory monitoring including biannual CD4 testing, viral load testing for suspected treatment failure (through strengthened laboratory network); cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH; and improved OI diagnosis and treatment including TB screening, diagnosis and treatment.
KEC will continue to support ongoing psychosocial and community activities including peer education; referral and linkages to community based psychosocial support groups to strengthen adherence; effective and efficient retention strategies of patients on follow up; water, sanitation and hygiene programs; income generating activities; Home Based Care; vocational training; social and legal protection; and food and nutrition programs. KEMRI will adopt strategies such as family focused care and treatment to ensure access to friendly services to youth, elderly and physically or mentally challenged populations.
KEC will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services and integrate them into routinely collected data; use the results to evaluate and improve clinical outcomes; and additionally support short term activities with great impact and better patient outcomes. Additionally, KEC will do cohort analysis and report retention rates as required by the national program and discuss the analysis results with facility staff in order to improve program performance. KEC will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Use of an electronic medical records system will be supported and strengthened.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	150,000	0

Narrative:

Kenya Episcopal Council (KEC) will support HIV pediatric treatment services in seven sites previously supported by CRS-HRSA in Nyanza province. As of March 2011 SAPR results, these sites had a cumulative 1,170 pediatrics on ART of whom 737 were active.
In FY12, KEC will jointly work with the Ministry of Health (MoH) at all levels to continue supporting, expanding and ensuring provision of quality pediatric HIV treatment services as per MoH guidelines to 1,805 pediatrics currently receiving ART and 361 new pediatrics resulting to cumulative 2,166 pediatrics ever initiated on ART. In FY 13, this number will increase to 1,952 pediatrics currently receiving ART and new 324 resulting to cumulative 2,490 pediatrics ever initiated on ART.
KEC will support comprehensive pediatric ART services including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization; management of childhood illnesses; OI screening and diagnosis; WHO staging; ART eligibility assessment; laboratory monitoring including 6 monthly CD4, hematology and chemistry (through strengthening of lab networks); pre-ART adherence and psychosocial counseling; initiation of ART as per MoH guidelines; toxicity monitoring; treatment failure assessment through targeted viral load testing; adherence strengthening; enhanced follow up and retention; support of EID as per MoH

guidelines; provision of PITC to all children and their care givers attending Child Welfare Clinics; support family focused approach; community outreach efforts; and integration of HIV services in other MNCH services. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will additionally be optimized. *KEC will support hospital and community activities to meet the needs of the HIV infected adolescents: support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services and support their transition into adult services.* *KEC will support in-service training of 100 and 80 HCWs in FY 12 and 13 respectively, continuous mentorship and capacity building of trained health care workers on specialized pediatric treatment including management of ARV treatment failure and complicated drug adverse reactions; identify human resources and infrastructure gaps and support in line with MoH guidelines; and support good commodities management practices to ensure uninterrupted availability of commodities.* *KEC will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, KEC will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. KEC will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.*

Implementing Mechanism Details

Mechanism ID: 13366	**Mechanism Name: Expanding High Quality HIV Prevention, Care and Treatment within Faith-Based Health Facilities**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Christian Health Association of Kenya	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 6,997,288	
Funding Source	**Funding Amount**
GHP-State	6,997,288

Sub Partner Name(s)

Catholic Medical Mission Board	Futures Group	University of Maryland

Overview Narrative

Christian Health Association of Kenya (CHAK) will implement high quality, comprehensive HIV prevention, care and treatment activities in Faith based (FBO) facilities previously supported through CRS Track 1 mechanism. The program goal and objectives are linked to Kenya's Partnership Framework (PF) and Global Health Strategy (GHI) strategies and are directly aligned to PF pillars 1-3, prevention, care and mitigation, treatment, and systems strengthening. Strategies to reduce maternal and child mortality and eliminate MTCT include supporting family planning integration into HIV clinics. Monitoring and evaluation (M&E) plans will align with PEPFAR and country PF. Training on and use of MOH HMIS systems will be supported to eliminate parallel M&E.

Cost efficiency is being addressed through integration of services, reduction of the technical teams with increased capacity building of the FBO staff, use of existing evidence-based efficient strategies, task shifting, implementing more facility-based training and mentorship as opposed to offsite training, evaluating cost effective strategies for defaulter management, laboratory networking, and mobilization

CHAK is a registered FBO in Kenya. The program model promotes local ownership and sustainability at all levels; enhances district-level linkages and non-clinical capacity building to empower local leadership to manage HIV services in a cost effective, comprehensive and collaborative approach.

CHAK has already procured one vehicle with FY2011 funds and will procure another one with FY2012 funds to support program implementation activities, e.g. TA site visits, supervision and monitoring. The vehicle will enhance efficiency and effectiveness in the execution of program activities. This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	69,473
Gender: GBV	4,000
Gender: Gender Equality	9,000
Human Resources for Health	1,693,503
Motor Vehicles: Purchased	132,082

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**13366**
Mechanism Name:	**Expanding High Quality HIV Prevention, Care and Treatment within Faith-Based Health Facilities**
Prime Partner Name:	**Christian Health Association of Kenya**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	550,000	0

Narrative:

Christian Health Association of Kenya (CHAK) has just received a CDC award to start implementing HIV care services from Oct 2011. CHAK will support comprehensive HIV care and support previously supported by CRS-HRSA in Eastern, Central and Nairobi region.

CHAK will work with the Ministry of Health (MoH) at the provincial, district and health facilities levels to jointly plan, coordinate, implement and ensure provision of quality HIV care and support to 19,542 current adult patients in FY12 and 24,750 current patients in FY13 in public, faith-based and high volume private health facilities, within agreed limits of rationalization and towards universal access to care and support services.

CHAK will offer a package of services including: HIV testing to partners and family members of index patients and enrolling or referring/linking those that test HIV positive to care and support; provision of Basic Care Kit (safe water vessel, multivitamins, insecticide-treated mosquito nets, chlorine for water treatment and educational

materials); supplemental and therapeutic nutrition (FBP) to all eligible HIV positive patients; prevention with positives (PwP), and family planning and reproductive health services including cervical cancer screening to all enrolled women.

CHAK in collaboration with MoH will support targeted capacity building (training and mentorship) for health care workers and offer continuous medical education on care and support, such as OI diagnosis and treatment. CHAK will identify areas with staff shortages, support recruitment of additional staff, and support good commodities management practices to ensure uninterrupted supply of commodities. CHAK will also support ongoing community interventions for HIV infected individuals, including education by peer educators and use of support groups to provide adherence messaging. Effective and efficient defaulter tracing and follow up will continue to be supported and strengthened to improve retention in all facilities. CHAK will support referral and linkages to community based psychosocial support groups; water, sanitation and hygiene programs; economic empowerment and income generating activities; home-based care services; gender-based violence support programs; vocational training; social and legal protection; and food and nutrition and food security programs. CHAK will adopt strategies to ensure access and provision of friendly services to youth, elderly and disabled populations. Strategies to increase access of care services by men will be employed, including supporting male peer educators, mentors and support groups, and supporting women to disclose and bring their male partners for testing and care and treatment. CHAK will continue to strengthen data collection and reporting at all levels to improve reporting to NASCOP and PEPFAR.

CHAK will adopt the new generation indicators and support the development and use of electronic medical records system in accordance with NASCOP guidelines. CHAK will continue using the quality of care indicators (CQI) for monitoring the quality of HIV care and support services, integrate them into routinely collected data and use the results to evaluate and improve clinical outcomes. CHAK will do cohort analysis and report retention rates as required by the NASCOP. CHAK will support joint Annual Operation Plan (AOP) planning, implementation, monitoring and evaluation and health system strengthening to facilitate sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	600,000	0

Narrative:

Christian Health Association of Kenya (CHAK) is a new grant that will support TB/HIV activities in six facilities that were previously supported by the CRS-HRSA grant in the Nairobi, Central and Eastern regions. CHAK will provide TB/HIV services in line with the Ministry of Health Division of Leprosy, Tuberculosis and Lung Disease (DLTLD) and the National AIDS and STI Control Program (NASCOP). CHAK will align and adhere to Kenya's 5-Year National AIDS and TB Strategic Plans objectives to ensure co-infected TB patients and suspects receive quality and comprehensive care to contain the threat of drug resistant TB.

In FY 2012 and 2013, CHAK will continue to intensify efforts to detect TB cases through clinical exams and

laboratory investigations and ensure provision of appropriate TB treatment. CHAK will ensure that facility staffs are adequate and well trained. Laboratories will be equipped to support various TB diagnostic tests including sputum specimen transport where laboratory services are unavailable. CHAK will ensure that adequate supplies of anti-TB drugs are available and that the national TB treatment guidelines are followed. All TB patients on treatment will be monitored both clinically and through periodic sputum examination. CHAK will ensure that at all TB patients are screened for HIV and 80% TB-HIV co-infected patients are put on cotrimoxazole and ARVs as early as possible regardless of the CD4 count as per the national guidelines. CHAK will support the "one stop" model that provides integrated TB and HIV services in all TB clinics. All TB clinics will be stocked with cotrimoxazole and ARVs.

To reduce the burden of TB in HIV infected patients, CHAK will support intensified TB screening in HIV care for 17,371 in FY12 and 22,000 in FY13 at each clinical encounter using the national screening tool. 869 co-infected patients identified in FY12 and 1,100 in FY13 will be put on TB treatment and those without active TB will be provided with Isoniazid Preventive Therapy (IPT) as per national IPT protocol

CHAK will ensure that the national IC guidelines are available at all sites and staff are trained on IC. CHAK will support scaling up of at least 2 components of the national TB infection control strategy in HIV care settings, one of which should be fast tracking of patients with cough for expedited diagnostic work up and treatment. CHAK will support timely transport of sputum specimens of TB retreatment cases from health facilities to the central reference laboratory for drug susceptibility testing and ensure return of the results to those facilities. CHAK will expand prevention with positive (PwP) services in TB clinics, strengthen linkages between facility and community-based services, improved patient referrals and tracking systems, and increase support for TB-HIV operation research. CHAK will report selected custom indicators to assist with program management and evaluation and monitoring of new activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	150,000	0

Narrative:

Christian Health Association of Kenya (CHAK) will implement comprehensive integrated pediatric care services to children in Eastern, Central and Nairobi region in six facilities that were previously supported by CRS-HRSA Track 1 activities.

In FY 12 period, CHAK will ensure provision of pediatric care and support services to 2,092 children. The number of children on care will increase to 2,633 during FY 13.

CHAK will provide comprehensive, integrated quality services and scale up to ensure 307 HIV infected infants are

put on ARV prophylaxis and all HIV exposed children access pediatric care services. The focus of pediatric care services will continue to be provision of comprehensive, integrated quality services including strengthening the use of the Mother-baby booklet, early infant diagnosis, universal provider initiated testing and counseling, and ensure those identified HIV infected are linked to care and ART services.

CHAK will ensure children enrolled in care receive quality clinical care services, including clinical history and physical examination, WHO staging, CD4 tests and other basic tests; opportunistic infection diagnosis, prophylaxis and management; TB screening; pain and symptom relief and management; and psychosocial support. Additional key care services will include nutritional assessment, counseling and support based on the WHO and IYCF guidelines (including provision of therapeutic or supplementary feeding, support to children with growth faltering, provision of vitamin A, zinc, and de-worming); provision of safe water, sanitation and hygiene interventions (WASH) in the community and in health facilities; and malaria screening, treatment and provision of long lasting insecticide treated nets in malaria endemic areas.

CHAK will support integration of HIV services into routine child health care and survival services in the maternal child health department, including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization guidelines; case management of diarrhea, pneumonia, and other childhood illnesses; and community outreach efforts. They will also support the care of the newborn by supporting hospital delivery and ensuring that there is provision for newborn resuscitation and care (thermal care, hygiene cord care) and prophylactic eye care. Exposed children management and follow up will continue to be supported and will include enrollment, HIV testing (PCR-DNA and antibody testing) as per the national guidelines, provision of Nevirapine throughout the breastfeeding period, follow up and retention, and linkages of those positive to care and ART service.

CHAK will support hospital and community activities to support the needs of the HIV infected adolescents: support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, support for transitioning into adult services, and teaching life skills.

Commodity access and infrastructure development will continue to be supported. Relevant trainings will continue to be supported. CHAK will strengthen pediatric data collection and reporting at all levels to increase and improve reporting to NASCOP/PEPFAR and conduct a cohort analysis to inform programming.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	369,382	0

Narrative:

Target population: CHAK will support HIV testing and counseling services in several mission/faith-based health

facilities in following counties: Migori, Homabay, Kisumu, Siaya, Bungoma, Kakamega, Kiambu, Kirinyaga, Nyeri, Nyandarua, Kitui, Embu, Tharaka-Nithi, Meru, and Taita-taveta. Target population will include all patients, their family members and caretakers who access out and in patient services in all the supported facilities.
HTC Approaches: The program will utilize provider initiated opt out approach and the services will be offered within all out patient departments, TB clinics, FP, ANCs, special clinics, HIV clinics (targeting family members) and in patient departments. The counseling and testing will either be done within the consultation rooms by trained clinicians or in counseling rooms by lay counselors within the outpatient departments if space is available or at the laboratories.
Targets and achievements: In COP 2012, CHAK will target to provide HTC services to a total of 37,000 persons of which 20% will be tested as couples and 10% will be children below the age of 15.
Testing algorithm: National algorithm will be used.
Referrals and linkages: In order to strengthen referrals, CHAK will put in place several important strategies. They include: use of peer educators as patient escorts from one hospital department to the CCC; same day enrollment of clients to CCC; use of an integrated defaulter tracing system for tracing patients who default on care or ART upon enrollment; introduction of documented referral system by use of the NASCOP referral booklet; use of mobile phones to follow up whether the client was actually enrolled.
Quality management: In order to improve and monitor quality of HTC services, CHAK will put in place the following strategies: Training and continuing education of HTC providers; strict adherence to the standard operating procedures outlined in the national HTC guidelines; management of HIV rapid kits as per the guidelines; putting in place a functional QA systems as provided for in the national HTC guidelines; participation in EQA-proficiency testing and finally conducting support supervisory visits.

Monitoring and evaluation: CHAK will use all ministry of health' tools to capture HTC data, both for couples and individual patients. These include HTC lab Register and Monthly summary tool (MOH 711). MOH approved HTC lab registers will be introduced at all HIV testing points except PMTCT.

Promotional activities for HTC: All patients attending the supported facilities will be given health talks including the need for HIV counseling and testing and the importance of couple testing. Couples are given priority services. Sexual partners of HIV positive clients will be given individualized invitations though the index clients and available avenues for testing including individualized home testing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

CHAK implements comprehensive prevention, care and treatment programs in Central and Eastern provinces. In FY 2012/13, CHAK will expand HIV prevention services to include evidence based behavioral interventions (EBIs)

for specific target populations in clinical settings at comprehensive care center (CCC), TB and Maternal Child Health (MCH) clinics as part of HIV combination prevention programs. The EBIs will include Positive Health and Dignity Prevention (PHDP) targeting adult male and female and adolescents living with HIV (PLHIV); and Sister to Sister EBI (S2S) targeting sexually active HIV negative women attending the MCH clinics.

PHDP is an ongoing 5-10min group and individual level intervention that targets PLHIV in clinical and community settings. This mechanism will support this intervention which constitutes of ART adherence counseling and support; partner and family testing; provision of PEP to the discordant spouse; treatment for prevention once approved; safer pregnancy counseling and provision of modern contraception; sexual risk reduction counseling including reduction of sexual partners, alcohol counseling, promoting of consistent and correct condom use; Sexually Transmitted Infections (STI) screening and treatment and using meaningful involvement of people living with HIV/AIDS (MIPA). The efficacy of PHDP has been shown to be 68% in preventing transmission of HIV, and 96% in treatment for prevention.

S2S is a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use. Condoms are 80% effective in heterosexual relationships when used correctly and consistently.

CHAK will use HVOP funding to recruit and support appropriate peer educators/counselors to reinforce prevention messages delivered by health providers as a feasible model for task-shifting in the provision of PHDP in clinical settings, and specifically promote MIPA. It will support placement of 5 Peer Educators at the MCH, TB and CCC Clinics in hospitals, and 2 Peer educators at health centres and provide appropriate counseling space. One of the peer educators will do regular client home follow up to strengthen ART adherence.

Approximately 1.6 million Kenyans are PLHIV. The Kenya AIDS Indicator Survey 2007 showed 6% of couples to be in discordant relationships. HIV Prevalence in Central is (3.6%) and (4.6%) in Eastern province. CHAK will reach 11033 (60%) PLHIV in FY2012 and 16293 (70%) in FY 2013 with a minimum package of PHDP. It will implement S2S EBI on a pilot basis.

Quality assurance for EBIs will be promoted through appropriate training and certification of peer educators using approved national curricula, standard job-aids and guidelines and regular supervision.

CHAK will work with appropriate national Technical Working Groups to support integration of HIV prevention into care and treatment programs in clinical settings. These programs will also be linked to other HIV community programs. PLHIV will be specifically linked to STI and FP services, as necessary, through patient escorts.

Monitoring of PHDP and S2S will be done through the review/input of CHAK implementation plan, analysis of

KePMS data, quarterly reviews, semiannual and annual reports. Evaluation will be conducted through operation research of combination HIV prevention and periodic surveys (Kenya DHS, Kenya Indicator AIDS Survey, Kenya Service Provision Assessment).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	300,000	0

Narrative:

Christian Health Association of Kenya (CHAK) will implement comprehensive PMTCT services to pregnant mothers in six facilities located in Eastern, Central and Nairobi region that were previously supported by CRS-HRSA track 1 activities. CHAK will strengthen PMTCT services in the 6 main facilities and their satellites by integrating ART into the MCH clinics.

In FY12 CHAK will offer HIV counseling and testing to 6,524 pregnant women at the ANC and give ARV prophylaxis to 297 HIV infected pregnant women. The HIV infected women will receive a CD4 test after undergoing a WHO clinical staging. CHAK will give HAART to all eligible HIV positive pregnant women in line with the revised PMTCT national guidelines. In FY13 CHAK will increase the number of pregnant women counseled to 6,850 and offer ARV prophylaxis to 361 pregnant women and 310 infants. 310 infants will receive an early infant diagnosis test using PCR.

CHAK will work to improve ANC attendance and hospital deliveries by working with existing community programs to increase demand for skilled delivery and promote community- facility referral. Maternity services will be strengthened by supporting provision of basic equipment at the hospitals.

Scale up of uptake of RH services including FP referral and linkages in MCH will be supported. PITC will be promoted including counseling and testing of mothers at the well baby and post natal clinics, which will identify HIV exposed infants. CHAK will work with the MoH at all levels to jointly plan, coordinate and implement PMTCT services, in line with the Kenya National Strategic Plan III, the GOK and USG Partnership Framework, and the district and provincial annual operation plans.

Areas of staff shortages will be identified and recruitment of additional staff will be supported. CHAK will build the capacity of health care workers by trainings on revised PMTCT guidelines, early infant Diagnosis, safe infant and young child feeding and a structured mentorship and supervision plan to support facilities. 30 health care providers will be trained in FY12 and equal number in FY13.

Data collection and reporting will be strengthened by orientation of health care workers on the revised data tools and facilities will be encouraged to use their data for program improvement.

CHAK will support the 4 prongs of PMTCT: primary prevention; referral and linkages for family planning; provide ARV prophylaxis to all HIV positive pregnant mothers and exposed infants; and care and treatment to eligible HIV positive mothers, partners, and children. A minimum care package that includes health and HIV education, individual and family HIV counseling and testing, clinical and laboratory monitoring and assessment, OI screening and /or treatment, clinical (WHO criteria) and immunological (CD4 cell count) staging, ARV prophylaxis and

treatment for both mother and baby, nutritional support, TB screening, psychosocial support, PWP, follow up, and retention/referral linkages will be provided. Enrollment, follow up, early Infant Diagnosis, and ART initiation of those who test positive before 2 years of HIV exposed infants will be supported. Effective retention strategies for mothers and babies through care will be supported through use of appointment diaries and registers for tracking defaulters.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	4,727,906	0

Narrative:

Christian Health Association of Kenya (CHAK) will support treatment in 6 sites located within Eastern, Central and Nairobi provinces. Eastern, Central and Nairobi provinces have an estimated population of 5.6, 4.4 and 3.1 million people respectively with an estimated adult HIV prevalence of 4.6%, 3.6% and 8.8% respectively compared to the national 7.1%. These services are currently being supported by CRS through the Track 1 mechanism but will be handed over to CHAK from Oct 2011. As per 2011 SAPR results, a cumulative 8,887 adults had ever been started on ART and 6,407 were active.

In FY12, CHAK will work with the Ministry of Health (MoH) to continue supporting expansion and provision of quality adult HIV treatment services as per MoH guidelines to 15,450 adults currently receiving ART and 2,169 new adults resulting to cumulative 18,540 adults who have ever been initiated on ART. In FY13, this number will increase to 17,078 currently receiving ART and 2,193 new adults resulting to 19,271 adults who have ever been initiated on ART.

CHAK will support in-service training of 150 and 100 HCWs in FY 12 and 13 respectively, identify human resources and infrastructure gaps and support in line with MoH guidelines, and support good commodities management practices to ensure uninterrupted availability of commodities.

CHAK will support provision of comprehensive package of services to all PLHIV including ART initiation for those eligible; laboratory monitoring including CD4 and viral load testing for suspected treatment failure; cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH; and improved OI diagnosis and treatment including TB screening, diagnosis, and treatment. Ongoing community interventions for PLHIV will include peer education and use of support groups to provide adherence messaging and defaulter tracing and follow to improve retention in all sites. CHAK will also support provision of friendly services to youth and special populations. CHAK will adopt strategies to ensure access and provision of friendly HIV treatment services to all including peer education, support groups, disclosure, partner testing and family focused care and treatment.

CHAK will provide support for community activities to HIV infected individuals including peer education, use of support groups to strengthen adherence, effective and efficient retention strategies, referral and linkages to psychosocial support groups, economic empowerment projects, Home Based Care, and food and nutrition programs.

CHAK will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services, integrate them into routinely collected data, use the results to evaluate and improve clinical outcomes, and additionally support short term activities with increase impact and improve patient outcomes.
CHAK will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Use of an electronic medical records system will be supported and strengthened. Cohort analysis will be performed and retention rates reported as required by the national program and discuss the analysis results with facility staff in order to improve program performance.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	300,000	0

Narrative:

Christian Health Association of Kenya (CHAK) will support pediatric treatment services in 6 Faith based facilities in Eastern, Central and Nairobi provinces previously supported by CRS-HRSA Track 1 mechanism. As per 2011 SAPR results, a cumulative 1,019 paediatrics had ever been started on ART and 679 were active.

In FY12, CHAK will jointly work with the Ministry of Health (MoH) at all levels to continue supporting, expanding and ensuring provision of quality pediatric HIV treatment services as per MoH guidelines to 2,256 pediatrics currently receiving ART and resulting to cumulative 2,707 pediatrics ever initiated on ART. In FY 13, this number will increase to 2,256 pediatrics currently receiving ART and new 406 resulting to cumulative 3,113 pediatrics ever initiated on ART.

CHAK will support comprehensive pediatric ART services including growth and development monitoring, immunization as per the Kenya Expanded Program on Immunization, management of childhood illnesses OI screening and diagnosis; WHO staging; ART eligibility assessment; laboratory monitoring including 6 monthly CD4, hematology and chemistry (through strengthening of lab networks); Pre-ART adherence and psychosocial counseling; initiation of ART as per MoH guidelines; Toxicity monitoring, treatment failure assessment through targeted viral load testing; Adherence strengthening; enhanced follow up and retention; support EID as per MoH guidelines and PITC to all children and their care givers attending Child welfare clinics; support family focused approach; community outreach efforts and integration of HIV services in other MNCH services.

CHAK will support hospital and community activities to support the needs of the HIV infected adolescents: support

groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services and support their transition into adult services.

CHAK will support in-service training of 150 and 100 HCWs in FY 12 and 13 respectively, continuous mentorship and capacity building of trained health care workers on specialized pediatric treatment including management of ARV treatment failure and complicated drug adverse reactions; identify human resources and infrastructure gaps and support in line with MoH guidelines; support good commodities management practices to ensure uninterrupted availability of commodities. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will additionally be optimized.

CHAK will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, CHAK will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. CHAK will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.

Implementing Mechanism Details

Mechanism ID: 13385	**Mechanism Name: Prevention for MARPS**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Manitoba	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,875,290	
Funding Source	**Funding Amount**
GHP-State	2,875,290

Sub Partner Name(s)

(No data provided.)

Overview Narrative

1. Goals and objectives: The goal of this mechanism is to increase access to quality comprehensive HIV prevention services for Most-At Risk Populations (MARPS) in Nairobi Province. The objectives are to provide continued support to the implementation and scale-up of a combination of evidence-based package of services to SWs, MSM and PWID. The project also serves as a learning hub for other MARPS projects in the country.
2. Cost-efficiency strategy: Implementation of this project has a strong community engagement and uses a peer-led approach in outreach services and delivering behavioral interventions. The mechanism leverages from the Health ministries and has a broad stakeholder involvement. The central drop in center will serve as a center of excellence through Gates foundation partnership and provide a learning hub to support other MARPS programs in the region.
3. Transition to country partners: This project forms an integral part of the national Technical working group hosted by NASCOP. It works in a collaborative partnership with University of Nairobi and is establishing a Kenyan entity to carry on this program. It also partners with the NOSET, a local CSO that implements services for PWID.
4. Vehicle information: Four project vehicles have been bought so far, all under a previous mechanism in FY06, 07, 08. These vehicles support field outreach activities and transport staff and peers to the various hotspots in the entire Nairobi province. They also support supervision and logistical activities across the ten drop in centers/clinics for sex workers that are located in fairly distant parts of the city. Additionally, they support distribution of supplies. This partner is not requesting vehicle purchase in FY12.
This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Gender: GBV	15,000
Gender: Gender Equality	10,000
Human Resources for Health	260,000
Key Populations: FSW	2,300,000
Key Populations: MSM and TG	260,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**13385**
Mechanism Name:	**Prevention for MARPS**
Prime Partner Name:	**University of Manitoba**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	200,000	0

Narrative:

University of Manitoba (UOM) will support HIV care for the general population as well as Most at Risk Populations (MARPS) with a focus on Men who have sex with Men (MSM) and Sex Workers (SW). By March 2011, UOM had cumulatively enrolled 8,226 patients in HIV care of whom 7,950 individuals were active and 7,567 patients were on Cotrimoxazole prophylaxis.

UOM will work with the Ministry of Health (MoH) at the provincial, district, and health facility level to jointly plan, coordinate, implement, and ensure provision of quality HIV care and support to 5,370 current adult patients in FY12 and 6,613 current patients in FY13.

UOM will offer comprehensive care and support package of services including HIV testing to partners and family members of index patients and enrolling or referring/linking those that test HIV positive to care and support; provision of Basic Care Kit (safe water vessel, multivitamins, insecticide-treated mosquito nets, condoms, chlorine for water treatment and educational materials); therapeutic nutrition (FBP) to all enrolled HIV positive patients; prevention with positives(PwP); and cervical cancer screening to all enrolled women.

UOM in collaboration with MoH will support targeted capacity building (training and mentorship) for health care workers and additionally offer continuous medical education on care and support, e.g. OI diagnosis and treatment. UOM will identify areas with staff shortages, support recruitment of additional staff, and support good commodities

management practices to ensure uninterrupted supply of commodities.

UOM will also support ongoing community interventions for HIV infected individuals including peer education and use of support groups to provide adherence messaging; effective and efficient defaulter tracing and follow up to improve retention in all facilities; referral and linkages to community based psychosocial support groups; water, sanitation and hygiene programs; economic empowerment - income generating activities (IGAs); home based care services; gender based violence support programs; vocational training; social and legal protection; food and nutrition programs. UOM will adopt strategies to ensure access and provision of friendly services to youth, elderly and disabled populations. Strategies to increase access of care services by men will be employed such as supporting male peer educators, mentors and support groups, and supporting women to disclose and bring their male partners for testing and care and treatment.

UOM will continue to strengthen data collection and reporting at all levels to improve reporting to the National AIDS & STI Control Programme (NASCOP) and PEPFAR. UOM will do cohort analysis and report retention rates as required by NASCOP. UOM will adopt the new generation indicators and support the development and use of electronic medical records system in accordance with NASCOP guidelines. UOM will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV care and support services, integrate them into routinely collected data, and use the results to evaluate and improve clinical outcomes. UOM will to support joint Annual Operation Plan (AOP) development, implementation, monitoring and evaluation, and health system strengthening to facilitate sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	100,000	0

Narrative:

University of Manitoba (UOM) will support TB/HIV activities in the Nairobi region which has an HIV prevalence of 7% and reported 17,444 cases of TB. UOM targets both general population as well as Most at Risk Populations (MARPS) with a focus on Men who have sex with Men (MSM) and Sex Workers (SW). The HIV prevalence in TB infected patients is 45.5%. UOM has been supporting TB/HIV services in 5 sites in line with the Ministry of Health Division of Leprosy, Tuberculosis and Lung Disease (DLTLD) and the National AIDS and STI Control Program (NASCOP). Between October 2010 and March 2011, 121 TB patients received HIV counseling and testing and all the 82 (100%) TB HIV co-infected patients identified received cotrimoxazole prophylaxis.
In FY12 and 13, UOM will intensify efforts to detect TB cases through clinical exams and laboratory investigations and ensure successful TB treatment through provision of appropriate treatment. UOM will ensure that each facility providing TB/HIV services has adequate and well trained clinical staff supported by well equipped and staffed laboratory, including sputum specimen transport where laboratory services are unavailable. UOM will ensure that adequate supplies of anti-TB drugs are available and that the national TB treatment guidelines are followed. All TB

patients on treatment will be monitored both clinically and through periodic sputum examination.
To reduce the burden of HIV in TB patients, UOM will ensure that at least 95% of TB patients are screened for HIV and all TB-HIV co-infected patients are put on cotrimoxazole and ARVs as early as possible regardless of the CD4 count as per the national guidelines. UOM will support the "one stop" model that provides integrated TB and HIV services in all TB clinics. All TB clinics will be stocked with cotrimoxazole and ARVs and 30 HCW will be trained in FY12 and 20 in FY13.
To reduce the burden of TB in HIV infected patients, UOM will support intensified TB screening for 4,774 in FY12 and 5,878 in FY13 at each clinical encounter using the national screening tool. 239 co-infected patients identified in FY12 and 294 in FY13 will be put on TB treatment and those without active TB will be provided with Isoniazid Preventive Therapy as per national IPT protocol.
To strengthen TB infection control in HIV settings, UOM will ensure that the national IC guidelines are available at all sites and training of staff on IC is done. UOM will support scaling up of at least 2 components of the national TB infection control strategy in HIV care settings, one of which should be fast tracking of patients with cough for expedited diagnostic work up and treatment.
To improve surveillance and management of drug-resistant TB, UOM will support timely transport of sputum specimens of TB retreatment cases from health facilities to the central reference laboratory for drug susceptibility testing and ensure return of the results to those facilities. UOM will also support scaling up of drug-resistant treatment sites thus expanding access to MDR-TB treatment.
UOM will also support expansion of prevention with positive services in TB clinics, TB/HIV control activities in the prisons, strengthening linkages between facility and community-based services, and improving patient referrals and tracking systems. To strengthen HVTB program monitoring, UOM will support reporting of selected custom indicators to assist with program management and evaluation and monitoring of new activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	30,000	0

Narrative:

University of Manitoba (UOM) will continue to support 5 facilities in Nairobi Province. UOM targets both general population and children born to Most at Risk Populations (MARPS). By March 2011, UOM had ever enrolled 276 children with 146 active and receiving Cotrimoxazole.

In FY12, UOM will provide care and support services to 561 children currently on care. The number of children currently on care will increase to 704 in FY13. UOM will provide comprehensive, integrated quality services and scale up to ensure all HIV exposed children access pediatric care services.

The focus of pediatric care services will continue to be provision of comprehensive, integrated quality services including strengthening the use of the Mother-baby booklet, early infant diagnosis, universal provider initiated

testing and counseling, and ensure those identified as HIV-infected are linked to care and ART services.

UOM will ensure children enrolled in care receive quality clinical care services including clinical history and physical examination; WHO staging, CD4 tests, and other basic tests; opportunistic infection diagnosis, prophylaxis and management; TB screening; pain and symptom relief and management; and psychosocial support. Additional key care services will include nutritional assessment, counseling and support based on the WHO and IYCF guidelines (including provision of therapeutic or supplementary feeding, support to children with growth faltering, provision of vitamin A, zinc, and de-worming); provision of safe water, sanitation and hygiene interventions (WASH) in the community and in health facilities; and malaria screening, treatment and provision of long lasting insecticide treated nets in malaria endemic areas.

UOM will support integration of HIV services into routine child health care and survival services in the maternal child health department including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization guidelines; case management of diarrhea, pneumonia, and other childhood illnesses; and community outreach efforts. They will also support the care of the newborn by supporting hospital delivery and ensuring that there is provision for newborn resuscitation and care (thermal care, hygiene cord care) and prophylactic eye care. Exposed children management and follow up will continue to be supported and will include enrollment, HIV testing (PCR-DNA and antibody testing) as per the national guidelines, provision of Nevirapine throughout the breastfeeding period, follow up and retention, and linkages of those positive to care and ART services.

UOM will support hospital and community activities to meet the needs of the HIV infected adolescents: support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, support for transitioning into adult services and teaching life skills.

Commodity access, infrastructure development, and relevant trainings will continue to be supported.

UOM will strengthen pediatric data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	262,514	0

Narrative:

The University of Manitoba is a MARPs project targeting Female sex workers and Male sex workers including MSMs and IDUs. The mechanism operates 7 clinics for the sex workers within Nairobi city. The exact population of these groups is not known but size estimation exercise is underway. The prevalence from program data across those

seven sites range from 16% to 31% for the female sex workers and 37% for the male sex workers. Couples are also served in the wider combination prevention (sex workers with regular partners). IDUs are a much harder population to access.

The HVCT approach used is Provider initiated testing and counseling (PITC) and all clients are appropriately given HIV education, offered testing and given risk reduction counseling. Those who test HIV positive are enrolled into care and treatment offered within the clinics. The same clients are screened for STIs and offered appropriate treatment. The clients are tested every three months, and as risky behavior are reported as per the national guidelines. HTC is provided as part of combination prevention.

Over the last 9 months have tested and counseled 8,167 clients (8059 female sex workers and 108 male sex workers). In 2012 the program will reach 41,000 clients with testing and counseling services. This number includes the re-testing that happens every three months and when a risky act has occurred. Out of these 20% will target couples while 60% will target new testers. Work with IDU will be rolled out in 2012 once the guidelines are finalized.

The program uses the national testing algorithm.

The clients receive comprehensive package of services including care and treatment in the clinics but follow up by phone is done for clinic defaulters.

The program follows the national quality management guidelines and participates in the proficiency testing quarterly and collection of DBS for the 20th client tested and counseled per counselor. Support supervision is carried out for the service providers on continuous basis.

The program develops work plans and conducts biannual data quality audits and monthly data supervision is carried out and this informs the program implementation improvement.

New indicators like couples tested, discordant couples have been incorporated in the data collection tools.

The national M&E framework is used including use of national registers and data collection tools and reporting will be through the DHIS in future. Quality services is ensured by adherence to national guidelines, use of national certified kits and participation in the External quality assurance through proficiency testing run by the government.

Promotional activities are conducted by peer mobilization and mass media from the national perspective on the need to know status.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	939,133	0

Narrative:

The University of Manitoba will continue to expand access to a high quality comprehensive package of services for MARPS including SWs and MSM. Majority of the individuals targeted will be women aged 18-55 years. An estimated 10% of the target will be male sex workers, some of whom are MSM. High risk sexual behavior

prevalent among sex workers including incorrect and inconsistent condom use particularly with regular sex partners will be a key focus. Other risk factors that will be addressed include douching practices, excessive alcohol and drug use, and low adherence to treatment.

This mechanism will support implementation of the Combination Prevention Interventions for SWs as defined in the National Guidelines for the package of services for SWs. Behavioral interventions include peer education and outreach, condom and lubricant demonstration and distribution and risk assessment, risk reduction counseling and skills building. Specific evidence-based behavioral interventions for this group will be Sister to Sister, a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use. Safe in the City, a video-based intervention for use in waiting rooms for condom skills-building. Biomedical interventions include HTC, STI screening and treatment, TB screening and referral to treatment, HIV care and treatment, RH services, Emergency contraception and Pre-exposure prophylaxis. There is also a strong consideration for initiating Treatment as Prevention for these MARPS groups and initiating Pre-exposure prophylaxis where feasible. There will be screening for drug and alcohol abuse, referral for treatment, provision of psychosocial support and linkages to family and social services, especially to address the vulnerability of children of SWs. Structural interventions will focus on enhancing a 100% condom use Program (CUP) nationally, mitigation of sexual violence and support to expand choices beyond sex work as a risk-reduction strategy.

The geographic focus of these activities will be Nairobi Province. Up to fifteen sites/drop-in-centers will be supported to intensify coverage and increase access to services. A close collaboration with the City council health facilities, particularly the Casino STI clinic downtown to improve their capacity in serving high-risk populations will be established. This project will reach an estimated 36,000 SWs in Nairobi, including 30,000 FSWs with a HIV prevalence of 29.3% and 2500 MSW/MSM, 500 PLWHIV with community PWP intervention and 3025 PLWHIV with clinical PWP. Further size estimation and mapping exercises will be conducted in Nairobi to provide an objective re-assessment of population sizes and provide a validated estimate to guide programming and planning.

A center of excellence in the SWOP City branch will be established through partnership with the Gates foundation to serve as a learning hub for programs providing services to SWs. Services are closely linked to other public and non-government services e.g. the clinics/drop in centers are registered to receive some drug, condoms and other supplies from central drug procurement mechanisms and report to their local District and provincial health authorities. Quality assurance will be enhanced through a close project monitoring, use of standardized national tools across sites, regular staff and peer review forums.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	274,476	0

Narrative:

The drug use epidemic in Kenya has a HIV prevalence over two times more than that of the general population.

HIV prevalence amongst PWID is 18.3%. Amongst needle-sharing sharing IDUs, prevalence is 30% while for non-needle sharing PWID, it is 5%. This mechanism will therefore target the PWID population in general, and provide appropriate targeted responses to each of the sub-groups within this population to address their varied risk profiles. Among social networks drug-users, high risk sexual and injecting practices include multiple sexual partners, unprotected sex among injecting peers, needle-sharing and flash-blood sharing. Women who use or inject drugs face additional risks due to their engagement in sex work and in transacting sex for drugs. They also face additional stigma, which becomes exacerbated in the event of a pregnancy. These behaviors are reinforced by multiple determinants such as criminalization of injecting drug use, and poverty among majority of the self-identified IDUs.

This mechanism will support the set up and scale up of a comprehensive package of services targeting 8,300 PWID/PWUD who will receive a 8-intervention package of services per the PEPFAR and UNAIDS/UNODC guidelines. These services include Medication-Assisted Treatment (MAT) for drug-dependence treatment, ART, HTC, STI prevention and treatment, Condom demonstration and distribution for PWID and their partners, targeted behavioral interventions and IEC materials, TB p, diagnosis and treatment and vaccination, diagnosis and treatment of viral hepatitis. Some program interventions will be implemented for the first time in Kenya, and will involve careful planning with a broad range of stakeholders, including involvement of local administration with a view to enlisting the crucial buy-in and support for an enabling environment. This activity will be carefully rolled out to assure efficiency in rolling out drug dependency treatment. Service providers in this program will receive training in addiction counseling and managing drug dependence treatment, in collaboration with the national Treatnet II program and will be closely linked with the National drug-dependence treatment centers ie Mathare Hospital and Coast General Hospital for on-going mentorship. Out-patient treatment will be the desirable model of offering MAT, backed by a close follow-on addiction counseling therapy.

Situational assessments in Nairobi and Mombasa in June 2010 revealed large underserved needs in Nairobi and Ukunda, an emerging drug-shooting hub in the South Coast which require an intense coverage. This mechanism will facilitate this rapid roll-out of services through a subaward with UNODC to support the Nairobi Outreach services Trust (NOSET), an IDU-serving CSO in Nairobi and another CSO in the Ukunda region as appropriate. The IDU Technical working group led by NASCOP, with participation from the Health Ministry's Mental Health Services will adapt and disseminate national PWID program guidelines, MAT treatment protocols and reporting tools to guide implementation. Training, supportive supervision and mentorship will be provided to these program. Other key players with who this program will work with include the UNODC, NACADAA and the HIV treatment and care programs. PWID/PWUD will be served in the SWOP MARPS clinics to ensure a close follow-on to their treatment and adherence.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	50,000	0

Narrative:

University of Manitoba (UOM) has been implementing PMTCT services in Nairobi targeting both the general and Most at Risk Population (MARPS) In Nairobi Provinces. Nairobi province has an estimated population of 3.1 million people with an estimated adult HIV prevalence of 8.8% compared to the national 7.1%.

In FY12, UOM will offer HIV counseling and testing to 952 pregnant women at the ANC and give ARV prophylaxis to 82 HIV infected pregnant women. The HIV infected women will receive a CD4 test after undergoing a WHO clinical staging. UOM will give HAART to all eligible HIV positive pregnant women in line with the revised PMTCT national guidelines. In FY13, UOM will increase the number of pregnant women counseled to 1000 offer ARV prophylaxis to 102 pregnant women and 88 infants and do EID for 88 infants.

UOM will focus on 4 prongs of PMTCT: primary prevention; prevention of unwanted pregnancies, ARV prophylaxis to all HIV positive pregnant mothers and exposed infants, and care and treatment to eligible HIV positive mothers, partners and children. The Minimum care package will include health and HIV education, individual/ family HIVCT, clinical/laboratory monitoring and assessment, OI screening and /or treatment, ARV prophylaxis and treatment for both mother and baby, nutritional support, psychosocial support, PWP, follow up, retention , referral and linkages. UOM will incorporate TB screening into routine antenatal care.
UOM will reach 300 of 1st ANC attendees with couple CT to identify discordant and concordant couples to improve primary prevention and facilitate linkage to HIV care and treatment for the eligible.

UOM will support integration of ART in MCH clinics, access to FP/RH services, establish or strengthen infection control and waste management activities.

UOM will support hospital delivery through provision of delivery beds and sterile delivery packs, training, working with CHWs and TBAs to promote community- facility referral mechanism, health education and community services providing skilled birth attendance. UOM will train 30 health care workers in FY12 and equal number in FY13.

UOM will support safe infant feeding practices as per national guidelines; enrollment and follow up of 88 of babies born to HIV infected mothers to access CTX, ARV prophylaxis and EID services using the HIV exposed infant register till 18 months. UOM will facilitate ART initiation for those who test positive before 2 years.

UOM will adopt efficient retention strategies for mothers and babies by supporting use of diaries and registers for tracking defaulters, having a structured mentorship and supervision plan, enhancing data quality and streamlining M&E gaps including orientation of new MOH ANC/maternity registers and utility of data at facility level for program improvement and quarterly progress reports to CDC.

Program quality and proficiency testing will be emphasized to validate PMTCT results.
UOM will train HCWs on PMTCT and provide orientation to the revised PMTCT and infant feeding guidelines and

engage in community activities for demand creation for health services such as male involvement with couple CT services, referral and linkages.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	969,167	0

Narrative:

University of Manitoba (UOM) will support treatment targeting both the general and Most at Risk Population (MARPS) in Nairobi Province. Nairobi Province has an estimated population of 3.1 million people with an estimated adult HIV prevalence of 8.8% compared to the national 7.1%. By March 2011 SAPR, UOM had supported 3,626 adults ever initiated on ART and 3,094 were active as per SAPR 2011.

In FY12, UOM will jointly work with the Ministry of Health (MoH) to continue supporting expansion and provision of quality adult HIV treatment services in line with MoH guidelines to 3,991 patients currently receiving ART and 1,210 new adults resulting to cumulative 4,789 adults who have ever been initiated on ART. In FY13, this number will increase to 4,899 currently receiving ART and 1,224 new adults resulting to 6,013 adults who have ever been initiated on ART.

UOM in collaboration with MoH will support in-service training of 30 and 20 health care workers in FY12 and FY13 respectively, identify human resources and infrastructure gaps and support in line with MoH guidelines, and support good commodities management practices to ensure uninterrupted availability of commodities.

UOM will support provision of comprehensive service package to all PLHIV including ART initiation for those eligible; laboratory monitoring including biannual CD4 testing, viral load testing for suspected treatment failure; cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH; and improved OI diagnosis and treatment including TB screening, diagnosis, and treatment.

UOM will continue to support ongoing community activities and support for HIV infected individuals including peer education and support groups to strengthen adherence, effective and efficient retention strategies, referral and linkages to psychosocial support groups, economic empowerment projects, Home Based Care, and food and nutrition programs. UOM will support provision of friendly services to youth and special populations. UOM will adopt strategies to ensure access and provision of friendly HIV treatment services to all including supporting peer educators, support groups, disclosure, partner testing, and family focused care and treatment.

UOM will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services, integrate them into routinely collected data, use the results to evaluate and improve clinical outcomes, and

support short term activities with greater impact and better patient outcomes. Additionally, UOM will do cohort analysis and report retention rates as required by the national program and discuss the analysis results with facility staff in order to improve program performance. UOM will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Use of an electronic medical records system will be supported and strengthened.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	50,000	0

Narrative:

University of Manitoba (UOM) will support implementation of pediatric HIV services in Nairobi. Nairobi Province has an estimated population of 3.1 million people respectively with an estimated adult HIV prevalence of 8.8% compared to the national 7.1%. UOM targets both general population and children born to Most at Risk Populations (MARPS). UOM will support integrated, comprehensive pediatric HIV treatment services in Nairobi Province. As of March 2011 SAPR, UOM had enrolled 144 children on ART with 120 active on treatment.

In FY12, UOM will jointly work with the Ministry of Health (MoH) at all levels to continue supporting, expanding and ensuring provision of quality pediatric HIV treatment services as per MoH guidelines to 228 pediatrics currently receiving ART and 46 new pediatrics resulting to cumulative 274 pediatrics ever initiated on ART. In FY13, this number will increase to 269 pediatrics currently receiving ART and new 41 resulting to cumulative 315 pediatrics ever initiated on ART.

UOM will support comprehensive pediatric ART services including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization; management of childhood illnesses; OI screening and diagnosis; WHO staging; ART eligibility assessment; laboratory monitoring including 6 monthly CD4, hematology and chemistry (through strengthening of lab networks); Pre-ART adherence and psychosocial counseling; initiation of ART as per MoH guidelines; Toxicity monitoring; treatment failure assessment through targeted viral load testing; Adherence strengthening; and enhanced follow up and retention. UOM will also support EID as per MoH guidelines, PITC to all children and their care givers attending Child welfare clinics, family focused approach, community outreach efforts, and integration of HIV services in other MNCH services.

UOM will support hospital and community activities to meet the needs of the HIV infected adolescents such as support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services and support their transition into adult services.
UOM will support in-service training of 50 and 30 HCW in FY12 and FY13 respectively, continuous mentorship and capacity building of trained HCW on specialized pediatric treatment including management of ARV treatment failure and complicated drug adverse reactions. UOM will also identify human resources and infrastructure gaps

and support in line with MoH guidelines as well as support good commodities management practices to ensure uninterrupted availability of commodities. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will additionally be optimized. *UOM will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, UOM will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. UOM will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.*

Implementing Mechanism Details

Mechanism ID: 13399	**Mechanism Name: Partnership for Advanced Care and Treatment (PACT)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Maryland	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 5,027,321	
Funding Source	**Funding Amount**
GHP-State	5,027,321

Sub Partner Name(s)

(No data provided.)

Overview Narrative

University of Maryland Partnership for Advanced Care and Treatment (PACT) in partnership with University of Nairobi supports the Ministry of Health (MoH) and Nairobi City Council in 9 districts in Nairobi to expand and maintain provision of comprehensive, high quality HIV prevention, care and treatment services.
PACT supports decentralization of HIV services by integrating these services into existing clinics including maternal and child health and TB clinics.Cost efficiency is being addressed through integration of services,

reduction of the technical teams with increased capacity building of the MoH staff, use of existing evidence-based strategies, task shifting, implementing more facility-based training and mentorship rather than offsite training, evaluating cost effective strategies for defaulter management, laboratory networking, and mobilization.
The PACT program is strengthening capacity of the provincial and district health teams (PHMT/DHMT) and facility management to provide oversight for HIV services through several interventions that will support full integration of HIV prevention and care programs within these structures. The program has adopted a mentorship model that will build capacity in the DHMT. PACT supports employment of key staff, but will work with MoH to have these staffs absorbed into MoH payrolls before Year 5. PACT, in collaboration with the MoH, has developed a strategic information strategy for Comprehensive Care Clinic (CCC) and non CCC sites that will ensure timely and accurate reporting through district level mechanisms to the MoH and the donor. Data quality shall be monitored using biannual data quality assessment.
PACT procured 3 vehicles in 2010 and is not requesting for any vehicles in FY12.
This activity suports GHI/LLC principles

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	50,273
Gender: GBV	6,000
Gender: Gender Equality	12,000
Human Resources for Health	1,546,169
Motor Vehicles: Purchased	37,000
Renovation	350,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities

Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	13399		
Mechanism Name:	Partnership for Advanced Care and Treatment (PACT)		
Prime Partner Name:	University of Maryland		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	330,931	0

Narrative:

University of Maryland Partnership for Advanced Care and Treatment (PACT) project will support treatment activities in Nairobi City Council clinics, where it has been supporting HBHC since 2010. By March 2011 PACT had cumulatively enrolled 12,717 patients in HIV care and of these, 8,766 individuals were provided with HIV-related palliative care including 5,643 patients on cotrimoxazole prophylaxis. Patient booking diaries have been introduced and a total of 10 sites are now able to identify missed appointments. Community health volunteers have been engaged to assist in following up missed appointments. PACT will work with the Ministry of Health (MoH) at the provincial, district and health facility level to jointly plan, coordinate, implement and ensure provision of quality HIV care and support to 8,485 current adult patients in FY12 and 10,414 current patients in FY13.

PACT will offer comprehensive care and support package of services including: HIV testing to partners and family members of index patients and enrolling or referring/linking those that test HIV positive to care and support; provision of Basic Care Kit (safe water vessel, multivitamins, insecticide-treated mosquito nets, condoms, chlorine for water treatment and educational materials); therapeutic nutrition (FBP) to all enrolled HIV positive patients; prevention with positives (PwP); and cervical cancer screening to all enrolled women.

PACT, in collaboration with MoH, will support targeted capacity building (training and mentorship) for health care workers and offer continuous medical education on care and support, e.g. OI diagnosis and treatment. PACT will identify areas with staff shortages, support recruitment of additional staff, and support good commodities management practices to ensure uninterrupted supply of commodities.

PACT will also support ongoing community interventions for HIV infected individuals including peer education and

support groups to provide adherence messaging; effective and efficient defaulter tracing and follow up to improve retention in all facilities; referral and linkages to community based psychosocial support groups; water, sanitation and hygiene programs; economic empowerment - income generating activities (IGAs); home based care services; gender based violence support programs; vocational training; social and legal protection; and food and nutrition programs.

PACT will do cohort analysis and report retention rates as required by the National AIDS & STI Control Programme (NASCOP). PACT will continue to strengthen data collection and reporting at all levels to improve reporting to NASCOP and PEPFAR. PACT will adopt the new generation indicators and support the development and use of electronic medical records system in accordance with NASCOP guidelines. PACT will adopt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV care and support services, integrate them into routinely collected data, and use the results to evaluate and improve clinical outcomes. PACT will to support joint Annual Operation Plan (AOP) development, implementation, monitoring and evaluation and health system strengthening to facilitate sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	300,000	0

Narrative:

University of Maryland-Partnership for Advanced Care and Treatment (PACT) program will support TB/HIV activities in Nairobi, where they have been working since 2010. In 2010, 190 TB patients were tested for HIV; 426 HIV patients were screened for TB and 25 trained in TB/HIV.

In FY12 and 13, PACT will intensify efforts to detect TB cases through clinical exams and laboratory investigations and ensure successful TB treatment through provision of appropriate treatment. PACT will ensure that each facility providing TB/HIV services has adequate and well trained clinical staff supported by well equipped and staffed laboratory, including sputum specimen transport where laboratory services are unavailable. PACT will ensure that adequate supplies of anti-TB drugs are available and that the national TB treatment guidelines are followed. All TB patients on treatment will be monitored both clinically and through periodic sputum examination.

To reduce the burden of HIV in TB patients, PACT will ensure that at least 95% of TB patients are screened for HIV and 100% and 80% TB-HIV co-infected patients are put on cotrimoxazole and ARVs respectively as early as possible regardless of the CD4 count as per the national guidelines. PACT will support the "one stop" model that provides integrated TB and HIV services in all TB clinics. All TB clinics will be stocked with cotrimoxazole and ARVs and be staffed with 80 trained HCW trained as needed.

To reduce the burden of TB in HIV infected patients, PACT will support intensified TB screening for 7,542 in FY12

and 9,257 in FY13 at each clinical encounter using the national screening tool. 377 co-infected patients identified in FY12 and 463 in FY13 will be put on TB treatment and those without active TB will be provided with Isoniazid Preventive Therapy (IPT) as per national IPT protocol. To strengthen TB infection control in HIV settings, PACT will ensure that the national IC guidelines are available at all sites and training of staff on IC is done. PACT will support scaling up of at least 2 components of the national TB infection control strategy in HIV care settings, one of which should be fast tracking of patients with cough for expedited diagnostic work up and treatment.

To improve surveillance and management of drug-resistant TB, PACT will support timely transport of sputum specimens of TB retreatment cases from health facilities to the central reference laboratory for drug susceptibility testing and ensure return of the results to those facilities. PACT will also support scaling up of drug-resistant treatment sites thus expanding access to MDRTB treatment.

PACT will also support expansion of prevention with positive (PwP) services in TB clinics, TB/HIV control activities in the prisons, strengthening linkages between facility and community-based services, and improving patient referrals and tracking systems. To strengthen HVTB program monitoring, PACT will support reporting of selected custom indicators to assist with program management and evaluation and monitoring of new activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	100,000	0

Narrative:

University of Maryland-Partnership for Advanced Care and Treatment (PACT) program is a family-focused, comprehensive HIV prevention, care and treatment program working collaboratively with the Government of Kenya in Nairobi Province since 2010. PACT will support pediatric services in Nairobi.

By March 2011, PACT had enrolled 332 children in care with 149 receiving HIV care, 265 on cotrimoxazole prophylaxis, and 343 children on ARV prophylaxis. In FY12, PACT will provide care and support services to 887 children currently on care. The number of children currently on care will increase to 1,108 during FY13. PACT will provide comprehensive, integrated quality services, and scale up to ensure 3,028 HIV exposed infants are put on ARV prophylaxis and access pediatric care services.

PACT will improve access to cryptococcal antigen testing; TB screening and management; pain and symptom relief and management; and psychosocial support (including disclosure counseling and support) provided through education, counseling, and linkages to facility or community based support groups. PACT will strengthen the provision of therapeutic or supplementary feeding support to children with growth faltering; provision of vitamin A, zinc, and de-worming; provision of safe water, sanitation and hygiene interventions in the community and health facilities to prevent diarrhea and other illnesses among the HIV infected, exposed, and other children in the community; and malaria screening, treatment, and provision of long lasting insecticide treated nets in malaria

endemic areas. Emphasis will be on enhanced follow up and retention of all identified HIV infected and exposed children.

PACT will support the integration HIV services into routine child health and survival services in the maternal child health department including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization guidelines; case management of diarrhea, pneumonia, and other childhood illnesses; and community outreach efforts. They will also support the care of the newborn by supporting hospital delivery and ensuring that there is provision for newborn resuscitation and care (thermal care, hygiene cord care) and prophylactic eye care.

PACT will also support hospital and community activities to meet the needs of the HIV infected adolescents such as support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, support for transitioning into adult services, and teaching life skills. PACT will ensure optimized linkages of children to various programs including TB/HIV, PMTCT and OVC services, and other community based programs such as education, protection, and legal and social services. PACT will also support relevant class-based and on-job trainings including continuous medical education.

PACT will strengthen pediatric data collection and reporting at all levels to increase and improve reporting to the National AIDS & STI Control Programme (NASCOP) and PEPFAR. With guidance from the national PEPFAR office, the new generation indicators will be adopted. To improve the quality of care and strengthen pediatric services, PACT will support supervision and mentorship activities and integrate the NASCOP adopted quality of care indicators (CQI and HIVQUAL) into routinely collected data for monitoring the quality of pediatric HIV services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	54,593	0

Narrative:

Target population: University of Maryland's HIV testing and counseling activities targets all patients and accompanying relatives and friends attending health care facilities with unknown HIV status. Target population include: all out and in-patients together with their accompanying relatives and friends. They include couples, pregnant women, post natal clients, family planning clients, TB patients, outpatient clients, maternity patients, child welfare clinics and in the in-patient wards.

HTC Approaches: UOM utilizes both client and provider initiated HIV testing and counseling (PITC) strategies. Family testing has been introduced in an effort to reach out to sexual partners and children of HIV infected index clients.

Past targets and achievements: In the past one year, UOM had a target to counsel and test 33,000 persons in health facilities and they managed to reach a total of 22,414 (68%). Those who are HIV positive are enrolled into chronic care at the same facility or referred to facilities of their choice. A total of 30 health care workers have been trained in PITC while 50 health care workers will receive training on DBS collection. For COP 2012, UOM will provide HTC services to a total of 39,000 persons of which 20% will be tested as couples and 10% will be children below the age of 15.

Testing algorithm: National HIV testing algorithm is used.

Referrals and linkages: Clients who test HIV positive are escorted to CCC where their demographic details are taken including the patients' contact information. Use of client referral forms has been introduced and mentorship is ongoing on use of the forms to refer clients to HIV care delivery points. Community health volunteers have been engaged to assist in tracing clients who miss clinic appointments. UOM is working with facility management to strengthen facility based multi-disciplinary committees' part of whose mandate will be to monitor intra-facility referrals and linkages. Facilities supported by UOM will receive support to confirm inter facility referrals. UOM technical assistance teams participates in District stakeholders forums that provide forums to evaluate district performance.

Promotional activities for HTC: All patients are given health talks including the need for HIV counseling and testing and the importance of couple testing. Couples are given priority services. Sexual partners of HIV positive clients are given individualized invitations though the index clients and available avenues for testing include individualized home testing

Quality management: In collaboration with District Health Management Teams (DHMT), UOM also provide onsite mentorship on HIV testing and DBS collection. The team is in the process of scaling up number of sites participating in proficiency testing. UOM will support HIV counselors' supervision starting year 2.

Monitoring and evaluation: UOM in collaboration with the DHMT is supporting the roll out and mentorship on of use of HTC registers. The registers are being introduced at all HIV testing points except PMTCT. The team is working in close collaboration with the facility management team to ensure timely and accurate reporting to Ministry of Health and to the Donor. Bi annual data quality assessment will facilitated as per recommendation from Ministry of Health.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

UOM PACT implements comprehensive prevention, care and treatment programs in Nairobi province. In FY 2012/13, UOM PACT will expand HIV prevention services to include evidence based behavioral interventions (EBI) for specific target populations in clinical settings at comprehensive care center (CCC), TB and Maternal Child Health (MCH) clinics as part of HIV combination prevention programs. The EBI will include Positive Health and Dignity Prevention (PHDP) targeting adult male and female and adolescents living with HIV (PLHIV); and Sister to Sister EBI (S2S) targeting sexually active HIV negative women attending the MCH clinics.

PHDP is an ongoing 5-10min group and individual level intervention that targets PLHIV in clinical and community settings. This mechanism will support this intervention which constitutes of ART adherence counseling and support; partner and family testing; provision of PEP to the discordant spouse; treatment for prevention once approved; safer pregnancy counseling and provision of modern contraception; sexual risk reduction counseling including reduction of sexual partners, alcohol counseling, promoting of consistent and correct condom use; Sexually Transmitted Infections (STI) screening and treatment and using meaningful involvement of people living with HIV/AIDS (MIPA). The efficacy of PHDP has been shown to be 68% in preventing transmission of HIV, and 96% in treatment for prevention.

S2S is a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use. Condoms are 80% effective in heterosexual relationships when used correctly and consistently.

UOM PACT will use HVOP funding to recruit and support appropriate peer educators/counselors to reinforce prevention messages delivered by health providers as a feasible model for task-shifting in the provision of PHDP in clinical settings, and specifically promote MIPA. It will support placement of 5 Peer Educators at the MCH, TB and CCC Clinics in hospitals, and 2 Peer educators at health centres and provide appropriate counseling space. One of the peer educators will do regular client home follow up to strengthen ART adherence.

Approximately 1.6 million Kenyans are PLHIV. The Kenya AIDS Indicator Survey 2007 showed 6% of couples to be in discordant relationships. Nairobi province HIV Prevalence is high (8.8%). UOM PACT will reach 4780 (60%) PLHIV in FY2012 and 6855 (70%) in FY 2013 with a minimum package of PHDP. It will implement S2S EBI on a pilot basis.

Quality assurance for EBIs will be promoted through appropriate training and certification of peer educators using approved national curricula, standard job-aids and guidelines and regular supervision.

UOM PACT will work with appropriate national Technical Working Groups (TWG) to support integration of HIV prevention into care and treatment programs in clinical settings. These programs will also be linked to other HIV community programs. PLHIV will be specifically linked to STI and FP services, as necessary, through patient escorts.

Monitoring of PHDP and S2S will be done through the review/input of UOM PACT implementation plan, analysis of KePMS data, quarterly reviews, semiannual and annual reports. Evaluation will be conducted through operation research of combination HIV prevention and periodic surveys (Kenya Demographic and health survey, Kenya Indicator AIDS Survey, Kenya Service Provision Assessment)

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	IDUP	434,718	0

Narrative:

The Kenya drug use epidemic's prevalence is 18.3%, over two times more than that of the general population. HIV prevalence amongst PWID is 18.3% amongst needle-sharing sharing IDUs, prevalence is 30% while for non-needle sharing PWID, it is 5%. This mechanism will provide training and capacity strengthening services for service providers and programs serving PWID as well as target the PWUD/PWID population with appropriate targeted responses to each of the sub-groups within the PWUD/PWID population to address their varied risk profiles. These will include social networks of drug-users, addressing high risk sexual practices e.g. multiple sexual partners and unprotected sex as well and drug injecting practices such as needle-sharing and flash-blood practices among users and their peers. Women who use or inject drugs face additional risks due to their engagement in sex work and in transacting sex for drugs. They also face additional stigma, which becomes exacerbated in the event of a pregnancy. These behaviors are reinforced by multiple determinants such as criminalization of injecting drug use, and poverty among majority of the self-identified PWUD/PWID. Children of female PWID will also be linked to appropriate wrap around services that address gender and the needs of continually abused children. This mechanism will support the set up and scale up of a comprehensive package of services targeting 1400 PWID with MAT services and 5,000 with other wrap-around services in Nairobi. This will include capacity strengthening for Mathare National Mental hospital. A 9-intervention package of services per the PEPFAR and UNAIDS/UNODC guidelines will be offered i.e Medication-Assisted Treatment (MAT) for drug-dependence treatment, ART, HTC, STI prevention and treatment, Condom demonstration and distribution for PWID and their partners, targeted behavioral interventions and IEC materials, TB diagnosis and treatment and vaccination, diagnosis and treatment of viral hepatitis. Methadone and other MAT drugs and supplies will be centrally procured through a designated supply chain and therefore funds under this mechanism may not be used for drug procurement, unless under special circumstances. Per PEPFAR guidance, funds in this mechanism may not be used to procure Needle and Syringe Program (NSP) supplies but the program may work with other partners to support NSP. This program will play a key role in supporting training and mentorship for service providers and programs implementing services for PWID. They will work collaboratively with the public health sector/Nairobi Provincial Director of Medical Services; participate in national MARPS and PWUD/PWID forums careful planning with a broad range of community and local administration stakeholders with a view to enlisting the crucial buy-in and support for an enabling environment. Training will be conducted in collaboration with the national training program for use of national PWID guidelines and MAT treatment protocols. Out-patient treatment will be the desirable model of offering MAT, backed by a close follow-on addiction counseling therapy. PWID/PWUD and MAT treatment services will be integrated with the HIV comprehensive, care and treatment program that is currently implemented under this mechanism.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,040,000	0

Narrative:

University of Maryland-Partnership for Advanced Care and Treatment (PACT) project will support PMTCT services in Nairobi Province, which has an HIV prevalence of 15.1%. PACT has been implementing PMTCT services in Nairobi since 2010. By March 2011 SAPR, PACT had counseled and tested 35,049 women in Maternal Child Health (MCH), 1950 received ARV prophylaxis, and 938 HIV exposed infants were offered PCR at 6 weeks.

In FY12, PACT will offer HIV counseling and testing to 32,810 pregnant women at ANC and give ARV prophylaxis to 2,898 HIV infected pregnant women. HIV infected women will receive a CD4 test after undergoing WHO clinical staging. PACT will give HAART to all eligible HIV positive pregnant women in line with the revised PMTCT national guidelines. In FY13, PACT will increase the number of pregnant women counseled to 34,450, offer ARV prophylaxis to 3,520 pregnant women and 3,028 infants, and do EID for 3,028 infants.

PACT will focus on 4 prongs of PMTCT: primary prevention; family planning; ARV prophylaxis to all HIV positive pregnant mothers and exposed infants; and care and treatment to eligible HIV positive mothers, partners and children. The minimum care package will include health and HIV education, individual/family HIVCT, clinical/laboratory monitoring and assessment, OI screening and/or treatment, ARV prophylaxis and treatment for both mother and baby, nutritional support, psychosocial support, PWP, follow up, retention, referral, and linkages. PACT will also incorporate TB screening into routine antenatal care.

Efforts will be made to reach 10,335 of 1st visit ANC attendees with couple CT to identify discordant and concordant couples to improve primary prevention and facilitate linkage to HIV care and treatment for the eligible and also support integration of ART in MCH clinics, access to FP/RH services, and establish or strengthen infection control and waste management activities.

PACT will support hospital delivery through provision of delivery beds and sterile delivery packs, training, working with CHWs and TBAs to promote community-facility referral mechanism, health education and community services providing skilled birth attendance.

PACT will support safe infant feeding practices as per national guidelines and enrollment and follow up of 3,028 of babies born to HIV infected mothers to access CTX, ARV prophylaxis, and EID services using the HIV exposed infant register till 18 months. PACT will facilitate ART initiation for those who test positive before 2 years.

PACT will adopt efficient retention strategies for mothers and babies by supporting use of diaries and registers for tracking defaulters, having a structured mentorship and supervision plan, and enhancing data quality and streamlining M&E gaps including orientation of new MoH ANC/maternity registers and utilization of data at facility level for program improvement and quarterly progress reports to CDC.

Program quality and proficiency testing will be emphasized to validate PMTCT results. 90 Health Care Workers will be trained in FY12 and equal number in FY13 on PMTCT. PACT will also provide orientation to the revised PMTCT and infant feeding guidelines and engage in community activities for demand creation for health services such as male involvement with couple CT services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	2,667,079	0

Narrative:

University of Maryland Partnership for Advanced Care and Treatment (PACT) will support treatment in Nairobi Province. Nairobi Province has an estimated population of 3.1 million people respectively with an estimated adult HIV prevalence of 8.8% compared to the national 7.1%. As of March 2011 SAPR, 5,929 adults had been initiated on ART and 4,988 were active; defaulter tracing mechanisms strengthened in 10 sites.

In FY12, PACT will jointly work with the Ministry of Health (MoH) to continue supporting expansion and provision of quality adult HIV treatment services as per MoH guidelines to 5,675 patients currently receiving ART and 223 new adults resulting to cumulative 6,810 adults who have ever been initiated on ART. In FY13, this number will increase to 5,842 currently receiving ART and 226 new adults resulting to 7,036 adults who have ever been initiated on ART.

PACT will support in-service training of 100 and 80 HCWs, continuous mentorship of trained health care workers on specialized treatment including management of patients with ARV treatment failure and complicated drug adverse reactions, identify human resources and infrastructure gaps and support in line with MoH guidelines, and support good commodities management practices to ensure uninterrupted availability of commodities.
PACT will support provision of a comprehensive package of services to all PLHIV including ART initiation for those eligible; laboratory monitoring including biannual CD4 testing, viral load testing for suspected treatment failure (through strengthened laboratory network); cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH; and improved OI diagnosis and treatment including TB screening, diagnosis and treatment.
Ongoing community interventions for PLHIV including peer education and support groups to provide adherence messaging, defaulter tracing, and follow up will continue to be supported to improve retention in all sites. PACT will also support strategies to ensure access and provision of friendly HIV treatment services to all including peer educators, mentors, support groups, and supporting patients to disclose and bring their partners for testing and care and treatment.
PACT will adopt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services, integrate them into routinely collected data, and use the results to evaluate and improve clinical outcomes. PACT will also do cohort analysis and report retention as required by MoH.

PACT will continue to strengthen data collection and reporting at all levels to increase and improve reporting to the National AIDS & STI Control Programme (NASCOP) and PEPFAR. Additionally, PACT will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. PACT will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	100,000	0

Narrative:

University of Maryland-Partnership for Advanced Care and Treatment (PACT) has been supporting and will continue to support pediatric treatment services in Nairobi Province. Nairobi Province has an estimated population of 3.1 million people with an estimated adult HIV prevalence of 8.8% compared to the national 7.1%. As of March 2011 SAPR, 149 children had been initiated on ART and 144 were active. PACT had also provided onsite, clinical mentorship to health care workers on pediatric treatment and established technical teams to plan, manage, mentor, and implement pediatric HIV services.

In FY12, PACT will work with the Ministry of Health (MoH) at all levels to continue supporting, expanding and ensuring provision of quality pediatric HIV treatment services as per MoH guidelines to 183 pediatrics currently receiving ART and 100 new pediatrics resulting to cumulative 220 pediatrics ever initiated on ART. In FY 13, this number will increase to 667 pediatrics currently receiving ART and 90 new resulting to cumulative 757 pediatrics ever initiated on ART.

PACT will support comprehensive pediatric ART services including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization; management of childhood illnesses; OI screening and diagnosis; WHO staging; ART eligibility assessment; laboratory monitoring including 6 monthly CD4, hematology and chemistry (through strengthening of lab networks); Pre-ART adherence and psychosocial counseling; initiation of ART as per MoH guidelines; Toxicity monitoring; treatment failure assessment through targeted viral load testing; Adherence strengthening; enhanced follow up and retention; support EID as per MoH guidelines and PITC to all children and their care givers attending Child welfare clinics; support family focused approach; and community outreach efforts and integration of HIV services in other MNCH services.

PACT will support hospital and community activities to meet the needs of the HIV infected adolescents such as support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services, and support their transition into adult services.

PACT will support in-service training of 100 and 80 HCWs in FY 12 and 13 respectively, continuous mentorship

and capacity building of trained HCWs on specialized pediatric treatment including management of ARV treatment failure and complicated drug adverse reactions, identify human resources and infrastructure gaps and support in line with MoH guidelines, and support good commodities management practices to ensure uninterrupted availability of commodities. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will additionally be optimized. *PACT will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, PACT will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. PACT will strengthen local capacity as part of the transition plan to MoH for sustainable long-term HIV patient management in Kenya.*

Implementing Mechanism Details

Mechanism ID: 13474	**Mechanism Name: HIV Prevention for MARPs**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Hope Worldwide	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: PR/SR	
G2G: No	Managing Agency:

Total Funding: 1,696,363	
Funding Source	**Funding Amount**
GHP-State	1,696,363

Sub Partner Name(s)

FHOK	German Foundation for World Population Consortium	Kenya AIDS NGO Consortium

Overview Narrative

HWWK works in the Rift Valley region, with an HIV prevalence of 6.3 % among the general population and is also one of the regions in Kenya with the highest number of HIV infected adults who are unaware of their infection

status. Using combination prevention evidence informed HIV interventions, the program goal is to contribute to reduction in incidence of HIV among the most-at-risk population (truckers and female sex workers) and youth and general population. In implementing biomedical and behavioral interventions, the project aims to reduce the risk of HIV acquisition and transmission in the target population. HWWK works in partnership with government and community based groups in program implementation. This ensures that activities are anchored and supported within existing and available structures. Provision of integrated services optimizes the population's access and utilization to HIV prevention, care and treatment services, and improving program outcome. This is a Kenyan partner with country ownership and leadership. Received donation of fully loaded truck with mobile unit for conducting mobile HIV Testing and Counseling and provision of services for the MARPs.Target populations, geographic coverage, and M&E plans are included in budget narratives.

Cross-Cutting Budget Attribution(s)

Gender: GBV	220,000
Gender: Gender Equality	250,000
Key Populations: FSW	220,000
Key Populations: MSM and TG	30,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	**13474**
Mechanism Name:	**HIV Prevention for MARPs**
Prime Partner Name:	**Hope Worldwide**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	177,080	0

Narrative:

Hope World Wide (HWW) supports implementation of comprehensive HIV prevention services targeting the youth, general population and MARPs in the Rift Valley region. In FY 2012, HWW will continue to expand access to high quality combination evidence informed behavioral interventions (EBIs) for the following priority populations: youth 10-14 (26,447) and youth 15-19 years (20,042) who are at risk of early sexual debut and increased risk of HIV acquisition, males 30-44 including truckers(4,757) who engage in concurrent and unprotected sexual partnerships and finally the Discordant couples(1,847) and People living with HIV/AIDS (1,643) where there is increased risk of HIV transmission. The EBIs will be implemented in Kajiado, Eldoret, Keiyo and West Pokot counties. All EBIs are linked to other HIV services such as HIV testing and counseling, provision of condoms, care and treatment and community care and support services.

Healthy Choices I and II (HCII) targets both in and out of school youth and aims to delay sexual debut, promote secondary abstinence or have protected sexual intercourse, by providing knowledge and skills on correct and consistent condom use, handling peer pressure, and learning one's HIV status. HC I consists of 8 modules of approximately one hour each. It can be delivered in 4 sessions of 2 hours each or in 8 sessions of 1 hour each.

Prevention with Positives is an ongoing 5-10min group and individual level intervention that targets HIV infected persons in clinical and community settings, focusing on partner testing, risk reduction, condom use, disclosure, adherence, STI reduction and family planning.

RESPECT will be implemented along with HTC and provision of condoms for males and females ages 20 – 24, males ages 30 -44, and persons with STIs. Respect has 2 brief individual sessions targeting general population and youth, originally for heterosexual negative persons. It focuses on reduction of STDs/HIV, risk reduction, condom use and clients understanding of personal risk.
Eban is a couple and group level intervention targeting sero-discordant couples. It's 8 weekly 2 hour sessions for 3-5 couples focusing on "talker-listener technique", risk assessment, enhancing couple communication and shared health responsibility.

To ensure quality, the program adheres to national standards and guidance from the National TWG on EBIs. These include use of approved national curricula; maintaining fidelity to the respective curricula and use of trained and certified facilitators. Trainings on EBIs are conducted by certified national trainers and there is observed practice of implementation done soon after training. The program uses standardized, national data tools at every stage of EBI implementation and regular field visits by trained program staff are conducted to check on delivery of EBIs and offer support supervision.

M&E will be conducted with EBI approved data capture/monitoring tools.HWW has a data monitoring plan for tracking program performance. This activity supports GHI/LLC.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	760,384	0

Narrative:

Target population: HWWK is working in selected districts in the Rift Valley region. The target population includes the Most-At-Risk-Population (MARPs) primarily the female sex workers and long distance truck drivers; as well as the youth and general population. HIV prevalence in this region is 6.8% (KAIS 2007) , however the (national) HIV prevalence among MARPs is 22 %. This region also accounts for one fifth of HIV infections in Kenya, with the HIV testing coverage in men at 39.8% while that in women is 54.2%.(KDHS 2008-2009). In FY 12, HWWK will provide HTC services to increase knowledge of HIV status among female sex workers and their families, long distance truck drivers, Youth in school and out of school, and the general population.

HTC approaches: HTC services are provided through client initiated approaches to reach the specific target populations in the community. Stand alone VCT sites, outreach/mobile sessions including moonlight VCT and targeted campaigns such as the National HTC campaigns are settings where these services are provided.
Targets and achievements: In the past 9 months, HWWK provided HTC services to 31,264 individuals surpassing the annual target of 30,000. 21 counselors received refresher training on HTC focusing on re-testing recommendations and use of the HTC register. In FY 2012, HWWK will provide HTC services to 119,000 individuals with a target of 60% for new testers and 55% men. The program will also target to reach 20% couples in the target population.
Proportion allocation of funding: HTC is a key component in HIV prevention strategies for MARPs and is provided as part of the comprehensive HIV prevention package. 40% of the budget is allocated for this.

Testing algorithm: National HIV Testing algorithm is used.
Referrals and linkages: Following HIV testing and counseling, HIV infected clients are referred to HIV care and treatment sites for further investigations and enrolment into appropriate services. The national (NASCOP) referral form is used for making referrals facilitating access to the HIV care and treatment sites. These referral forms allow for comparison of total clients referred and total clients accessing the referred services. HIV positive clients are also provided with prevention with positive (pwp) interventions which enhances follow up to ensure clients access the services referred to. In the MARPs program, all clients are given a unique identifier that is used to monitor linkages. The peer led network used in this program also allows for follow up. The program gets regular information on individuals not accessing services and through the peer led network is able to make the appropriate follow up. The program reviews data to determine the success rate in the referral and linkage strategies.

Quality management: National HTC guidelines are utilized in service provision, counselor training and certification and testing algorithm. Functional HTC QA systems are in place as per the national guidelines including participation in proficiency testing and support supervision.
Monitoring and evaluation: National HTC tools are used to capture and report data both for couples and individuals receiving HTC services.

Promotional activities: To create demand for HTC services, the program utilizes mass media campaign and community mobilization strategies targeting the general population with key messages. Peer networks are used to encourage the MARPs to access services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	758,899	0

Narrative:

Hope World Wide supports implementation of comprehensive HIV prevention services targeting the youth, general population and MARPs in the Rift Valley region. In FY 2012, the mechanism will continue to expand access to high quality combination evidence informed behavioral interventions (EBIs) for the following priority populations: youth 15-19 (10,325), males 20-24 years including truckers(8,824), females 20-24 (29,601), males 30-44 including truckers(14,273), Discordant couples(5,541), persons suffering from STIs(1,471), People living with HIV/AIDS (4,929 and Female Sex Workers (13,369). The EBIs will be implemented in Kajiado, eldoret, Keiyo and West Pokot counties. All EBIs are linked to other HIV services such as HIV testing and counseling, provision of condoms, care and treatment and community care and support services.

Healthy Choices II (HCII) targets both in and out of school youth aged 13 – 17 years and aims to delay sexual debut, promote secondary abstinence or have protected sexual intercourse, by providing knowledge and skills on correct and consistent condom use, handling peer pressure, and learning one's HIV status. HC II consists of 8 modules of approximately one hour each. It can be delivered in 4 sessions of 2 hours each or in 8 sessions of 1 hour each.

Prevention with Positives is an ongoing 5-10min group and individual level intervention that targets HIV infected persons in clinical and community settings, focusing on partner testing, risk reduction, condom use, disclosure, adherence, STI reduction and family planning.

RESPECT will be implemented along with HTC and provision of condoms for males and females ages 20 – 24, males ages 30 -44, and persons with STIs. Respect has 2 brief individual sessions targeting general population and youth, originally for heterosexual negative persons. It focuses on reduction of STDs/HIV, risk reduction, condom use and clients understanding of personal risk.

Comprehensive HIV prevention interventions will be implemented for female sex workers. These interventions will include Sister to Sister, a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use.

Eban is a couple and group level intervention targeting sero-discordant couples. It's 8 weekly 2 hour sessions for 3-5 couples focusing on "talker-listener technique", risk assessment, enhancing couple communication and shared health responsibility.

To ensure quality, the program adheres to national standards and guidance from the National Technical Working Group on EBIs. These include use of approved national curricula; maintaining fidelity to the respective curricula and use of trained and certified facilitators. Further, trainings on EBIs are conducted by certified national trainers and there is observed practice of implementation done soon after training. The program uses of standardized, national data tools at every stage of EBI implementation and regular field visits by trained program staff is conducted to check on delivery of EBIs and offer support supervision.

Monitoring and evaluation will be conducted with EBI approved data capture / monitoring tools. Mechanism has a data monitoring plan for tracking program performance.

Implementing Mechanism Details

Mechanism ID: 13481	**Mechanism Name: Prevention for MARPs-Central and Eastern**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Nairobi	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 2,026,576	
Funding Source	**Funding Amount**
GHP-State	2,026,576

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of University of Nairobi (UoN) is to increase access to quality comprehensive HIV prevention services for Most-At Risk Populations in Central and Eastern Provinces. The objectives are to provide continued support to the implementation and scale-up of a combination of evidence-based package of services to SWs and MSM. UoN goals and objectives are linked to Kenya's Partnership Framework (PF) and are directly aligned to Kenya National AIDS Strategic Plan (KNASPIII).This mechanism leverages from the Government Health ministries and has a broad multi-sectoral stakeholder involvement. Some drop- in- centers are already integrated within Ministry of health (MoH) facilities sustainability and MoH Health Care Providers seconded to these DICES. Implementation of this project has a strong community engagement and uses a peer-led approach in outreach services and delivering behavioral interventions. Transition to country partners: University of Nairobi is a local State University and a Centre of Excellence for many health programs in Kenya.The project collaborates closely with Ministries of Education and Health and has integrated its MARPs services in government facilities for sustainability. It forms an integral part of the national Multi Sectoral Technical working group at MoH,NASCOP. Vehicle information: No project vehicle has been procured so far. In FY10, procurement process was initiated for two vehicles to support field outreach activities and transport staff and peers to the various hotspots in the entire Central and Eastern provinces. They will also support supervision and logistical activities across the 9 drop in centers/clinics for sex workers in these regions and support distribution of supplies. This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	18,000
Key Populations: FSW	483,000
Key Populations: MSM and TG	160,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources

Budget Code Information

Mechanism ID:	13481		
Mechanism Name:	Prevention for MARPs-Central and Eastern		
Prime Partner Name:	University of Nairobi		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVCT	144,835	0

Narrative:

The University of Nairobi mechanism is a MARPs project targeting female sex workers and male sex workers including MSMs and IDUs. The mechanism covers Eastern and Central Provinces of Kenya. The exact population of these groups is not known but size estimation exercise is underway. The HIV prevalence from program data across the target sub populations is truckers 4%, MSM 4%, IDUs 5.5%, male sex workers 4.25% and female sex workers 12.6%. In 2012 emphasis will be laid on reaching couples and regular partners with 20 % of those tested being partners or couples in 2012.

The HVCT approach used is Provider initiated testing and counseling (PITC) and all clients are appropriately given HIV education, offered testing and given risk reduction counseling. Those who test HIV positive are enrolled into care and treatment offered within the DICEs. The same clients are screened for STIs and offered appropriate treatment. The clients are tested every three months, and as risky behavior are reported as per the national guidelines. Emphasis will be laid on first time testers. HTC is provided as part of combination prevention with 60% of all tested being first time testers in 2012.

Program activities began in March due to logistic reasons and so for the program has reached 12,501 out of a target of 15,000. A rapid results initiative had to be implemented due to late commencement of activities. In 2012 the program will reach 22,000 clients with testing and counseling services. This number includes the re-testing that happens every three months and when a risky act is reported. Out of this 20% will be couples while 60% will target new testers. Work with IDU will be rolled out in 2012 once the guidelines are finalized.

The program uses the national testing algorithm for testing and counseling.

The clients receive comprehensive package of services including care and treatment in the DICEs but follow up by phone is done for clinic defaulters.

The program follows the national quality management guidelines and participates in the proficiency testing quarterly and collection of DBS for the 20th client tested and counseled per counselor. Support supervision is carried out for the service providers on continuous basis. Quality services is ensured by adherence to national

guidelines, use of national certified kits and participation in the external quality assurance through proficiency testing run by the government.

The national M&E framework is used including use of national registers and data collection tools and reporting will be through the DHIS in future. The program will develop work plans and conduct biannual data quality audits and monthly data supervision is carried out and this informs the program implementation improvement.
New indicators like couples tested, discordant couples have been incorporated in the data collection tools.
Promotional activities are conducted by peer mobilization and mass media from the national perspective on the need to know status. (2,991).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1,803,621	0

Narrative:

UoN will expand access to a high quality comprehensive package of services for MARPS including SWs and MSM. It will target women aged18-55 years, MSM, youth 13-17 years and truckers. It will target high risk sexual behaviors prevalent among sex workers including incorrect and inconsistent condom use and douching practices, excessive alcohol, drug use, and low adherence to treatment. UoN will support Combination Prevention Interventions for SWs as defined in the National Guidelines. These comprise evidence-informed behavioral, biomedical and structural interventions. Biomedical interventions include HTC, STI, TB, care and treatment, RH services, Emergency contraception, Treatment as Prevention and Pre-exposure prophylaxis where feasible, drug and alcohol abuse screening, referral for treatment. Structural interventions focus on enhancing a 100% condom use Program and mitigation of sexual violence. Specific EBIs will include; Healthy Choices 2 (HC2) targets youth 13-17 years, in out-of- school settings and focuses on safer sex, condom use, and negotiation and communication skills. It consists of 8 one hour modules. S2S is a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use. Condoms are 80% effective in heterosexual relationships when used correctly and consistently. Respect is a brief individual sessions targeting general population and youth, originally for heterosexual negative persons focusing on reduction of STDs/HIV, risk reduction, condom use and clients understanding of personal risk. UoN will support roll out of video-led EBIs such as Safe in the City to 10800 MARPs. PHDP is an ongoing 5-10min group and individual level intervention that targets PLHIV in clinical and community settings, focusing on partner testing, risk reduction, condom use, disclosure, adherence, STI reduction and family planning. The efficacy of PHDP has been shown to be 68% in preventing transmission of HIV, and 96% in treatment for prevention.. UoN will support placement of Peer Educators to reinforce prevention messages delivered by health providers as a feasible model for task-shifting in the provision of PHDP in clinical and community settings, promotion of MIPA and strengthening ART adherence. UoN works in Central and Eastern provinces. The estimated size of FSWs in these regions is 60,000 with a HIV prevalence of 29.3% .Further size estimation and mapping exercises will be done to provide a validated estimate.9

drop-in-centers will be supported to increase access to services for SWs. In FY 2012/13 UoN will reach 18,000 FSWs, 1200 MSW,1000 MSM and 1600 truckers with comprehensive MARPs services, 2100 PLHIV with PHDP, 5000 youth with HC2,5000 and 8308 with S2S and Respect . Quality assurance for EBIs will be promoted through training and certification of service providers using approved national curricula, standard job-aids, guidelines and regular supervision. Services provided through this mechanism are closely linked to other public services e.g. drug supplies from central drug procurement mechanisms including condoms and to community services. PLHIV will be linked to STI, FP, care and treatment services. Monitoring of EBIs will be done through the review of IMC implementation plan, analysis of KePMS data, quarterly reviews and reports. Evaluation will be conducted through operation research of combination HIV prevention and periodic surveys.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	78,120	0

Narrative:

In Kenya, HIV prevalence amongst PWID is 18.3%, which is over two times more than that of the general population. Amongst needle-sharing sharing IDUs, prevalence is 30% while for non-needle sharing PWID, it is 5%. This mechanism will target the PWUD/PWID population with appropriate targeted responses to each of the sub-groups within the PWUD/PWID population to address their varied risk profiles. These will include social networks of drug-users, addressing high risk sexual practices e.g. multiple sexual partners and unprotected sex as well and drug injecting practices such as needle-sharing and flash-blood practices among users and their peers. Women who use or inject drugs face additional risks due to their engagement in sex work and in transacting sex for drugs. They also face additional stigma, which becomes exacerbated in the event of a pregnancy. These behaviors are reinforced by multiple determinants such as criminalization of injecting drug use, and poverty among majority of the self-identified PWUD/PWID. Children of female PWID will also be linked to appropriate wrap around services that address gender and the needs of continually abused children. This mechanism will support the set-up and scale up of a comprehensive package of services targeting 100 PWID with MAT services and 100 with other wrap-around services in Eastern and Central Provinces. This will include capacity strengthening for several DICES whose key staff will receive training, support supervision, and mentorship. A 9-intervention package of services per the PEPFAR and UNAIDS/UNODC guidelines will be offered i.e Medication-Assisted Treatment (MAT) for drug-dependence treatment, ART, HTC, STI prevention and treatment, Condom demonstration and distribution for PWID and their partners, targeted behavioral interventions and IEC materials, TB diagnosis and treatment and vaccination, diagnosis and treatment of viral hepatitis. Methadone and other MAT drugs and supplies will be centrally procured through a designated supply chain and therefore funds under this mechanism may not be used for drug procurement, unless under special circumstances. Per PEPFAR guidance, funds in this mechanism may not be used to procure Needle and Syringe Program (NSP) supplies but the program may work with other partners to support NSP. This program will work collaboratively with the public health sector/Central & Eastern Provincial Directors of Medical Services; participate in national MARPS and PWUD/PWID forums careful

planning with a broad range of community and local administration stakeholders with a view of enlisting the crucial buy-in and support for an enabling environment. Training will be conducted in collaboration with the national training program for use of national PWID guidelines and MAT treatment protocols. Out-patient treatment will be the desirable model of offering MAT, backed by a close follow-on addiction counseling therapy. PWID/PWUD and MAT treatment services will be integrated with the HIV comprehensive care and treatment program that is currently implemented under this mechanism.

Implementing Mechanism Details

Mechanism ID: 13502	**Mechanism Name: Strengthening HIV Strategic Information Actvities in the Republic of Kenya**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of California at San Francisco	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,600,000	
Funding Source	**Funding Amount**
GHP-State	1,600,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

1. Goals and objectives:

This program seeks to strengthen strategic information in the republic of Kenya.

Specific objectives are:

(1) To provide technical assistance to GOK and their partners in planning, implementation, analysis, and dissemination of surveillance and survey activities

(2) To build the surveillance and epidemiologic skills of GOK and their partners

2. Cost-efficiency strategy:

During year two of the award (Oct. 2010 – Sep. 2011), UCSF provided TA to GOK and their partners in: 1) design, implementation, and dissemination of an assessment of prevention of mother to child transmission (PMTCT) program data for HIV surveillance; 2) implementation and analysis of a bio-behavioral survey of MARPs in Kenya; 4) continued support for data analysis of KAIS 2007 data and planning and preparation for KAIS II; 5) cost-effective analysis of PEPFAR prevention resources. This award supports the continuation of ongoing TA to GOK in these and other priority surveilance activities of the GOK. This award supports year three of the five year award for UCSF.

3. Transition to country partners:
Supporting and building the GOK's capacity in conducting surveys and surveillance activities will lead to full ownership of future national surveillance and survey activities.

4. Vehicle information: this activity does not include the purchase of vehicles.

This Activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	400,000
Key Populations: FSW	200,000
Key Populations: MSM and TG	1,000,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	13502
Mechanism Name:	Strengthening HIV Strategic Information Actvities in the Republic of Kenya
Prime Partner Name:	University of California at San Francisco

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	1,600,000	0

Narrative:

As the national HIV program continues to scale up prevention, care and treatment programs, UCSF will provide technical assistance (TA) to the GOK and its partners to strengthen existing HIV surveillance systems. Key of these is TA in planning, implementation, analysis, and dissemination of the Kenya AIDS Indicator Survey (KAIS) II. KAIS II is a priority national survey designed to provide quality data on HIV prevalence, incidence, HIV-related risk behaviors, service uptake and delivery, and indicators for other diseases in the general population. Other objectives for UCSF are to support ongoing MARPs surveillance, assess the utility of programmatic data for HIV surveillance, and strengthen HIV case reporting in Kenya. Surveillance methods used for these activities are fairly generic and overlap with areas under the Global Health Initiative and US Ambassador's Health Task force initiative in Kenya, including collection of data from other priority diseases and support for integrated disease reporting.

During year 2 of this award (Oct.'10–Sep.'11), UCSF provided TA to GOK and partners in: 1) design, implementation, and dissemination of an assessment of prevention of mother to child transmission (PMTCT) program data for HIV surveillance; 2) implementation and analysis of a bio-behavioral survey of MARPs in Nairobi; 4) continued support for analysis of KAIS 2007 data and planning for KAIS II; 5) a cost-effective analysis of PEPFAR prevention resources across interventions, target populations, and geographic areas.

Activities planned for COP 12 resources are to:
(i) Provide TA to GOK in KAIS II data analysis and report dissemination.
(ii) Provide TA to GOK in bio-behavioral surveillance of MARPs of national priority. In addition, UCSF in collaboration with the national MARPs technical working group and locally-based organizations working with MARPs, will help establishment of MARPs centers of excellence in select regions to facilitate future research and surveillance of MARPS using national protocols.
(iii) Provide TA to GOK in strengthening HIV case-reporting, including guidance on the development of data collection tools, supporting a pilot for HIV case reporting, and providing recommendations for national roll-out.
(iv) Provide TA to GOK in evaluating the use of PMTCT data for HIV surveillance, ensure that recommendations from the 2010 assessment are implemented in the 43 ANC sentinel surveillance sites and support implementation of repeat data quality assessments, as needed, in these and other dual ANC-PMTCT sites, including

support to GOK in protocol development, implementation, data analysis and report writing. *(v) Provide TA on cost-effectiveness evaluations of prevention, care, and treatment programs. This will include supporting GOK to build skills in conducting cost-effectiveness evaluations and integration of findings into resource allocation decisions.* *(vi) Build surveillance skills of GOK in all activities described above, USCF will integrate skills-building activities for GOK, identification of key gaps in capacity and development of strategies to address them.* *Work plans with timed milestones will be used to monitor UCSF performance towards set objectives and numerical targets used where appropriate.*

Implementing Mechanism Details

Mechanism ID: 13517	**Mechanism Name: Strengthening Strategic Information Activities in the Republic of Kenya**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: African Medical and Research Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,375,000	
Funding Source	**Funding Amount**
GHP-State	1,375,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Goal: To strengthen the capacity in Kenya to collect, manage& use M&E and surveillance data to manage national HIV/AIDS response by expanding HIV/STI/TB surveillance projects and strengthening laboratory support for surveillance, diagnosis, treatment, disease monitoring and HIV screening for blood safety. bjectives: Tto strengthen capacity of healthcare workers on M&E including data management, analysis, reporting and use for decision making

•Support review/development and roll-out of HIV/AIDS M&E guidelines, SOPs and curriculum together with national tools roll-out •Strengthen M&E coordination and collaboration at the national, provincial and district levels •Support the improvement of HIV data quality
•Support KAIS II logistics
Cost-efficiency strategy: Use of TOTs selected from the decentralized levels to cascade the M&E training down to facility/ community levels; a mix of on-job mentoring and classroom training; one-time printing of the guidelines and curriculum to be posted to a web for cheaper referencing and joint planning with the government and other partners. KAIS II will utilize experience from KAIS I to avoid unnecessary expenses. Transition to country partners:Main M&E training activities planned and implemented in close collaboration with NASCOP and other Implementing partners. KAIS II taskforce and technical working groups have membership from all health/HIV/AIDS stakeholders in the country including UN, government, development and implementing partners besides USG making both technical and financial and other in-kind contributions.
Vehicle information:1, 5-seater, 2350 CC, Mitsubuishi Pajero, manufactured in 2011, purchased in May, 2011. The vehicle will be used to support training & supervision activities. This activity support GHI/LLC.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	481,250

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**13517**
Mechanism Name:	**Strengthening Strategic Information Activities in the Republic of Kenya**
Prime Partner Name:	**African Medical and Research Foundation**

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Governance and Systems	HVSI	1,375,000	0

Narrative:

As the national HIV program continues to scale up prevention, care and treatment programs, AMREF will continue to provide Monitoring and Evaluation capacity building TA to the GOK and PEPFAR implementing partners to strengthen existing M&E capacity in the country. Also important will be the provision of logistical support to the planning, implementation, analysis, and dissemination of the Kenya AIDS Indicator Survey (KAIS) II. KAIS II is a national survey of high priority which is designed to provide high quality data on HIV prevalence, incidence, HIV-related risk behaviours, service uptake, service delivery, and indicators for other diseases in the general population. Other specific objectives for AMREF will focus on general improvement of national HIV/AIDS M&E capacity building. The Monitoring and evaluation capacity building approaches applied for these activities are fairly generic and will overlap with areas of interest under the Global Health Initiative and US Ambassador's Health Task force initiative in Kenya, including data collection, management, data quality assessments (DQAs) from other priority areas and support for one national M&E system.

During year 2 of this award (Oct. 2010 – Sep. 2011), AMREF Implemented the following major activities: 1) Development of national HIV/AIDS M&E curriculum, guidelines and standard operation procedures; 2) Health care worker training in priority M&E themes including data management, data management software and data quality assessments; 3) Continued support to PHMTs and DHMTs in quarterly data use forums in 3 regions within the country.

Activities planned for using COP 12 resources are:

(i) Train Implementing partners and GOK strategic Information officers on Monitoring and Evaluation courses on a needs basis including PEPFAR reporting requirements. This activity, initially implemented by University of Nairobi's PSRI will be implemented by this partner for the first time during COP2012

(ii) Printing and distribution of the new HIV/AIDS national M&E curriculum, guidelines and Standard operating procedures.

(iii) Continue with the roll-out of healthcare workers training in the use of the new national HIV/AIDS M&E curriculum, guidelines and standard operating procedures

(iv) Support quarterly data review at the district and regional levels.

(v) Provision of logistical support to KAIS II, including recruitment and training of survey and laboratory teams, procure and maintenance of vehicles for field work, implement survey in the field, transport specimens to central laboratory among others.

Quarterly work plans and review meetings with clear milestones will be used to monitor AMREF's performance towards the realization of set objectives. Numerical targets will be used where appropriate.

Implementing Mechanism Details

Mechanism ID: 13543	Mechanism Name: PAMOJA
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Elizabeth Glaser Pediatric AIDS Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 5,121,783	
Funding Source	**Funding Amount**
GHP-State	5,121,783

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)-PAMOJA project works in 11 districts of Nyanza Province to support implementation of high quality, comprehensive HIV prevention, care and treatment services. Aligned with the Kenya GHI principles, POMOJA supports decentralization of HIV services by integrating these services into existing clinics including maternal and child health and TB clinics. PAMOJA will strengthen the health systems by building the capacity of healthcare workers (HCW) through training, hiring additional staff in facilities with shortages and supporting facility renovations. Integrated quality management and mentorship teams will be supported to ensure that skills are transferred to MOH staff for continuity and sustainability.

PAMOJA will support strategies to address cost efficiencies including: assessments to inform targeted assistance based on prioritized needs, co-location of project staff within the district teams, joint planning with the districts to ensure work plans are harmonized, and use of cost effective training methodologies such as on job trainings and mentorship.

PAMOJA will build the capacity of Provincial and District Health Management Teams in planning, mentorship, and supervision by supporting their training in general management, human resource management, and monitoring and evaluation. Improved leadership and management skills by these teams will encourage ownership and allow project

efforts to transition over time to the government.

To optimize the projects geographic coverage a third project vehicle will be procured with FY2012 funds. Two vehicles were purchased in FY11 and are being used to transport staff for supervision and mentorship to the sites. This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	46,217
Gender: GBV	5,000
Gender: Gender Equality	12,000
Human Resources for Health	1,307,090

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**13543**
Mechanism Name:	**PAMOJA**
Prime Partner Name:	**Elizabeth Glaser Pediatric AIDS Foundation**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	500,000	0

Narrative:

Elizabeth Glasier Pediatric Foundation (EGPAF) PAMOJA project has been supporting TB/HIV activities in Homab Bay, Rachuonyo North and South, Ndhiwa, Manga, Masaba North and South, Gucha, and Borabu districts. By March 2011 SAPR, 6,870 patients had ever been enrolled in HIV care and 4,205 were active.

In FY12, PAMOJA will continue to support the same region, and will jointly work with the Ministry of Health (MoH) to continue supporting expansion and provision of quality adult HIV Care and support as per MoH guidelines to 3,346 adults and 3,524 in FY 13.

PAMOJA will provide comprehensive care and support package of services including HIV testing to family members of index patient and referring and linking HIV positive ones to care and support; clinical assessment for ART eligibility and linking eligible PLHIV to treatment; laboratory monitoring including 6 monthly CD4 testing; WHO staging; Basic Care Kit (safe water vessel, multivitamins, insecticide-treated mosquito nets, condoms, chlorine for water treatment and educational materials); Adherence assessment counseling and support including FBP; prevention with positives(PwP), cervical cancer screening to all enrolled women and ensure referral and linkages to other clinical services including RH/FP.

PAMOJA in collaboration with MoH will support targeted training for 100 HCWs in FY 12 and 80 in FY 13 and continuous medical education and mentorship for health care workers on care and support e.g. OI management. PAMOJA will also identify human resources and infrastructure gaps and support in line with guidelines and support good commodities management practices to ensure uninterrupted availability of commodities.

PAMOJA will continue to support ongoing psychosocial and community activities including peer education; referral and linkages to community based psychosocial support groups to strengthen adherence; effective and efficient retention strategies of patients on follow up; water, sanitation and hygiene programs; income generating activities; Home Based Care; vocational training; social and legal protection; and food and nutrition programs. PAMOJA will adopt strategies to ensure access to friendly services to youth, elderly and physically or mentally challenged populations.

PAMOJA will continue to strengthen data collection to improve reporting to MoH and PEPFAR; adopt the new PEPFAR generation indicators; support the development and use of electronic medical records system in accordance with MoH guidelines. PAMOJA will adapt cohort analysis and quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV care and support services and integrate them into routinely collected data and use the results to evaluate and improve program activities. Additionally, PAMOJA will evaluate and carry

out operation research on implemented programs.

PAMOJA will support joint Annual Operation Plan (AOP) development, implementation, monitoring and evaluation, capacity building and health system strengthening to facilitate sustainability and collaborate with other partners to leverage and maximize on available USG and non-USG resources.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	330,000	0

Narrative:

Elizabeth Glaser Pediatric Foundation (EGPAF) PAMOJA project has been supporting TB/HIV activities in Homa Bay, Rachuonyo North and South, Ndhiwa, Manga, Masaba North and South, Gucha, and Borabu districts. By the end of June 2011, 3,186 TB patients were tested for HIV and 53% of the 2,141 TB/HIV co-infected patients were treated for both HIV and TB. EGPAF additionally supported training and hiring of HCWs.

PAMOJA will continue to support scaling up of TB/HIV services to reduce TB among HIV patients and HIV among TB patients through TB/HIV collaborative activities. All TB patients will be screened for HIV and 95% of TB/HIV co-infected patients will be put on cotrimoxazole and ART as per national guidelines. To reduce the burden of TB in HIV infected patients, PAMOJA will support intensified TB screening of 2,974 and 3,133 HIV infected patients in HIV care settings in FY 12 and 13 respectively using the national screening tool. Active TB patients (149 in FY12 and 157 in FY13) will be put on TB treatment and those without active TB will be provided with Isoniazid Preventive Therapy (IPT) as per national IPT protocol. PAMOJA will strengthen TB infection control and support roll out of guidelines and implementation in all sites including baseline infection control assessments. This includes fast tracking patients with a cough and expediting diagnostic work up and treatment.

To improve drug-resistant TB surveillance and management, PAMOJA will strengthen screening of all retreatment cases, sputum sample shipment and return of results from central reference laboratory and facilitate linkages of MDR-TB cases to treatment. PAMOJA will support a standard care package that includes health education, clinical and lab assessments including networking for AFB and CD4,OI screening and management, CTX prophylaxis, nutritional support, BCK, adherence and psychosocial support, ART initiation and monitoring for co-infected patients, toxicity and drug interaction assessments, prevention with positive (PwP) services, strengthening linkages between facility and community-based services through improved referrals and tracking systems.

PAMOJA will support MOH annual operation plan development, implementation and review process while offering technical and non technical support. A structured mentorship and supervision plan will be strengthened to improve service delivery, quality data collection, utilization and reporting at all levels. Program quality will be emphasized

and periodically monitored through standards of care/ clinical quality improvements assessments. EGPAF will support cohort analysis to evaluate outcomes of service delivery and also report selected custom indicators to assist with program management monitoring and evaluation of new activities at NASCOP (DLTLD) and PEPFAR.

PAMOJA will support operations research and also health management teams to strengthen their health systems in governance, lab capacity, and sample networking to increase access in remote facilities, commodity supply chains, targeted infrastructure renovations, hiring of different cadres of HRH and support regular supervision, mentorship and defaulter tracing mechanisms. PAMOJA will train 100 health workers in FY12 and 80 in FY13 on TB/HIV, 5Is and data management trainings.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	50,000	0

Narrative:

Elizabeth Glaser Pediatric Foundation (EGPAF) PAMOJA project has been supporting pediatric ART services as part of integrated comprehensive HIV clinical services in 154 sites in Homa Bay, Rachuonyo North and South, Ndhiwa, Manga, Masaba North and South, Gucha, and Borabu districts. By March 2011 SAPR, 2,665 patients were enrolled into HIV care.

In FY12, PAMOJA will work with the Ministry of Health (MoH) at Provincial and District levels to jointly plan, expand and ensure provision of quality pediatric HIV care and support in all public and faith based health facilities to 350 new pediatrics in FY 12 and 375 in FY 13.

PAMOJA will provide comprehensive care and support package of services including family testing; clinical assessment for ART eligibility and linking eligible ones to treatment; laboratory monitoring including 6 monthly CD4 testing (through strengthened laboratory networking); WHO staging; Basic Care Kit; Nutritional assessment counseling and support; vitamin A, zinc; de-worming and ensure referral and linkages to other clinical services; integration of HIV services into well child welfare clinic services, integrated Management of Childhood Illnesses (IMCI), in-patient, community outreach efforts and routine child health care and survival services in the maternal child health department. PAMOJA will also support care of the newborn by supporting hospital delivery, prophylactic eye care and comprehensive care services to the newborn.

PAMOJA will support in-service training of 100 and 80 HCWs in FY 12 and 13 respectively; continuous mentorship on care and support e.g. diagnosis and management of opportunistic infection; identify human resources and infrastructure gaps and support in line with MoH guidelines; and support good commodities management practices to ensure uninterrupted availability of commodities. Linkage of care and support services to ART, PMTCT, TB/HIV, community programs, and other related pediatric services will additionally be optimized.

PAMOJA will support hospital and community strategies to ensure access to pediatric and adolescent care and support including support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services and support their transition into adult services; scaling up identification of HEIs, ARVs prophylaxis and follow up, HIV testing (PCR-DNA or antibody) and linking those positive to treatment.
PAMOJA will continue to strengthen data collection to improve reporting to MoH and PEPFAR; adopt the new PEPFAR generation indicators; support the development and use of electronic medical records system in accordance with MoH guidelines. PAMOJA will adapt cohort analysis and quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV care and support services, integrate them into routinely collected data and use the results to evaluate and improve program activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	285,513	0

Narrative:

The goal of the country as reflected in Kenya National Aids strategic plan (KNASP III) is to reach 80% knowledge of HIV status in the country by 2013. Nyanza Province, which has a population of about 5.1 million people, carries the highest HIV burden in Kenya. With an estimated adult HIV prevalence of 14.9% compared to the national 7.1%, ~500,000 people are living with HIV.
EGPAF - Pamoja Project supports direct implementation of comprehensive prevention, care and treatment activities in nine districts in Nyanza Province that include: Homabay, Rachuonyo North, Rachuonyo South, Ndhiwa, Manga, Masaba North, Masaba South, Gucha, and Borabu Districts. It covers several program areas and activities that include HTC in health care settings. The overall goal of the Pamoja Project is to increase use of high quality, comprehensive HIV services in nine districts of Nyanza Province, Kenya.
In FY10, Pamoja Project supported Provider Initiated Testing and Counseling (PITC) services in the nine districts with emphasis in the Outpatient department, Inpatient and Child welfare Clinics. Between October 2010 and June 2011, a total of 52,965 people were offered comprehensive HTC services amongst them 32,840 females and 20,125 males. A total of 7,431 (14%) individuals were identified as HIV infected and were linked to care and treatment services.
Guided by gaps identified in KAIS, KDHS 2009 and program data, PAMOJA project will continue to support HTC service implementation in the nine districts with specific area of focus being facility-based PITC approach.
PAMOJA will work with the Ministry of Health (MOH) at the county, District and health facility levels to jointly plan, coordinate and implement HTC services for both adults and children in support of the KNASP III and the District and Provincial level MOH annual operation plans.
PAMOJA will target clients at the out-patient, in-patient and child welfare clinics with emphasis on enhancing diagnosis of HIV status among individuals with unknown HIV infection status, enhanced knowledge of HIV status with emphasis of identifying HIV infected individuals and HIV sero-discordant couples and strengthened linkage to

appropriate HIV prevention, care and treatment services. Pamoja will target a total of 139,000 individuals with HTC of whom 10% will be pediatrics. These will contribute 2.2% of the national targets which aims at increasing knowledge of HIV status to at least 80% of the Kenyan adult population. These targets have been sub-divided to county and district level targets to guide implementation and program monitoring.
Pamoja will work to identify areas with training and mentorship needs, staff shortages and support appropriately through a MOH driven mechanism which ensures ownership and program sustainability.
All HIV-infected persons will be linked to care, treatment and other HIV prevention services at the facility and community level. Referrals will be strengthened by working together with SI team in implementing an effective referral strategy. HIV-negative individuals will be referred to PEPFAR supported prevention services. Pamoja will strengthen the WHO recommended multistep approach to Quality Assurance in counseling and testing. QA audit teams will be strengthened at the counties. Pamoja will continue to strengthen data collection, analysis, utilization and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

EGPAF implements comprehensive prevention, care and treatment programs in Nyanza province. In FY 2012/13, EGPAF will expand HIV prevention services to include evidence based behavioral interventions (EBIs) for specific target populations in clinical settings at comprehensive care center (CCC), TB and Maternal Child Health (MCH) clinics as part of HIV combination prevention programs. The EBIs will include Positive Health and Dignity Prevention (PHDP) targeting adult male and female and adolescents living with HIV (PLHIV); and Sister to Sister EBI (S2S) targeting sexually active HIV negative women attending the MCH clinics.

PHDP is an ongoing 5-10min group and individual level intervention that targets PLHIV in clinical and community settings. This mechanism will support this intervention which constitutes of ART adherence counseling and support; partner and family testing; provision of PEP to the discordant spouse; treatment for prevention once approved; safer pregnancy counseling and provision of modern contraception; sexual risk reduction counseling including reduction of sexual partners, alcohol counseling, promoting of consistent and correct condom use; Sexually Transmitted Infections (STI) screening and treatment and using meaningful involvement of people living with HIV/AIDS (MIPA). The efficacy of PHDP has been shown to be 68% in preventing transmission of HIV, and 96% in treatment for prevention.

S2S is a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use. Condoms are 80% effective in heterosexual relationships when used correctly and consistently.

EGPAF will use HVOP funding to recruit and support appropriate peer educators/counselors to reinforce prevention messages delivered by health providers as a feasible model for task-shifting in the provision of PHDP in clinical settings, and specifically promote MIPA. It will support placement of 5 Peer Educators at the MCH, TB and CCC Clinics in hospitals, and 2 Peer educators at health centres and provide appropriate counseling space. One of the peer educators will do regular client home follow up to strengthen ART adherence.

Approximately 1.6 million Kenyans are PLHIV. The Kenya AIDS Indicator Survey 2007 showed 6% of couples to be in discordant relationships. Nyanza has the highest HIV Prevalence (14.9%). EGPAF will reach 1885 (60%) PLHIV in FY2012 and 2320 (70%) in FY 2013 with a minimum package of PHDP. It will implement S2S EBI on a pilot basis.

Quality assurance for EBIs will be promoted through appropriate training and certification of peer educators using approved national curricula, standard job-aids and guidelines and regular supervision.

EGPAF will work with appropriate national Technical Working Groups (TWG) to support integration of HIV prevention into care and treatment programs in clinical settings. These programs will also be linked to other HIV community programs. PLHIV will be specifically linked to STI and FP services, as necessary, through patient escorts.

Monitoring of PHDP and S2S will be done through the review/input of EGPAF implementation plan, analysis of KePMS data, quarterly reviews, semiannual and annual reports. Evaluation will be conducted through operation research of combination HIV prevention and periodic surveys (Kenya Demographic and health survey, Kenya Indicator AIDS Survey, Kenya Service Provision Assessment) .

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	886,952	0

Narrative:

Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)-PAMOJA project will support implementation of PMTCT in several districts in Nyanza. Nyanza province has an estimated population of 5.4 million people with an estimated adult HIV prevalence of 14.9% compared to the national 7.1% and ANC prevalence of 17%. EGPAF PAMOJA will continue to support PMTCT activities in Homa Bay, Rachuonyo, Ndhiwa, Manga, Masaba, Gucha, and Borabu districts. By March 2011, 17,259 pregnant women were counseled and tested and 1,508 were given ARV prophylaxis.

In FY 12, PAMOJA will work with the Ministry of Health (MoH) to scale up counseling and testing to 47,754 first visit ANC attendees with unknown or known HIV- status through an opt-out approach, assess clinically (WHO

stage) and immunologically (CD4) and provide a more efficacious ARV prophylaxis to 4,813 pregnant women who test HIV+ and HAART to 1,925 per current national PMTCT guidelines. In FY 13, PAMOJA will scale up ANC HIV CT to 50,142 mothers and provide ARV prophylaxis to 5,846 in line with MOH guideline. PAMOJA will also support training and mentorship of 90 HCWs in FY 12 and 90 in FY 13 on comprehensive PMTCT/EID services.

PAMOJA will support all PMTCT prongs: primary prevention (HTC, STI and FP), ARV prophylaxis to all HIV+ pregnant mothers and their exposed infants, enrollment, follow up and retention of mother baby pair and other infected family members. Male involvement in RH and FP services will be strengthened through effective and efficient mechanisms to reach 15,043 couples with couple HTC, primary prevention, PwP and linkages into care.

PAMOJA will support safe infant feeding practices as per national guidelines, support enrollment and follow up of 5,028 HIV-exposed infants to access CTX, ARV prophylaxis and EID services using the HIV-exposed infant register till exit at 18 months. PAMOJA will expedite ART initiation for 250 HIV confirmed pediatrics under 2 years.

PAMOJA will support hospital delivery through needs assessments, equipment support, capacity trainings and develop effective and efficient antenatal and post natal retention strategies for mothers and babies through recruitment of peer educators and use of appointment diaries and registers. The team will engage in community education to promote demand creation for health services, support referral and linkages, and also reach out to non clinic attendants.

PAMOJA will support MoH annual operational planning, implementation and program review while offering technical and non technical support. Approximately $18 dollar per woman will support all PMTCT prongs and other wrap around activities like malaria prevention and other tropical diseases in line with GHI principles. A structured mentorship and supervision plan will be strengthened to improve service delivery, quality data collection, utilization and reporting at all levels. Program quality will be emphasized and periodically monitored through standards of care/clinical quality improvements assessments.

PAMOJA will support cohort analysis to evaluate outcomes of service delivery and also improve reporting to NASCOP and PEPFAR. PAMOJA will strengthen the health systems through improving lab capacity and sample networking to increase access in remote facilities, commodity supply chains, targeted infrastructure renovations, hiring of HCWs and support regular supervision, mentorship and defaulter tracing mechanisms including phone tracing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	2,969,318	0

Narrative:

Elizabeth Glaser Pediatric Foundation (EGPAF) PAMOJA has been supporting HIV activities in Homa Bay, Rachuonyo North and South, Ndhiwa, Manga, Masaba North and South, Gucha, and Borabu districts. By June 2011, 1700 patients were on ART. Since most of the facilities where they work are supported by a different partner, these enrolments have been achieved by integrating ART in MCH and TB clinics.

In FY12, PAMOJA will continue to work in the same region and will work with the Ministry of Health (MoH) to continue supporting expansion and provision of quality adult HIV treatment services as per MoH guidelines to 2,881 patients currently receiving ART and 1,006 new adults resulting to cumulative 3,457 adults who have ever been initiated on ART. In FY13, this number will increase to 3,636 currently receiving ART and 1,018 new adults resulting to 4,475 adults who have ever been initiated on ART.

PAMOJA will support in-service training of 100 and 80 HCWs, continuous mentorship of trained health care workers on specialized treatment, including management of patients with ARV treatment failure and complicated drug adverse reactions; identify human resources and infrastructure gaps and support in line with MoH guidelines; and support good commodities management practices to ensure uninterrupted availability of commodities.
PAMOJA will support provision of comprehensive package of services to all PLHIV including ART initiation for those eligible; laboratory monitoring including biannual CD4 testing, viral load testing for suspected treatment failure (through strengthened laboratory network); cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH; improved OI diagnosis and treatment including TB screening, diagnosis and treatment. Ongoing community interventions for PLHIV including peer education and use of support groups to provide adherence messaging, defaulter tracing and follow up will continue to be supported to improve retention in all sites.
PAMOJA will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment services integrate them into routinely collected data and use the results to evaluate and improve clinical outcomes. PAMOJA will also support strategies to ensure access and provision of friendly HIV treatment services to all, including supporting peer educators, mentors, support groups, and supporting patients to disclose and bring their partners for testing and care and treatment.
PAMOJA will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. PAMOJA will do cohort analysis and report retention as required by MoH. Additionally, PAMOJA will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. PAMOJA will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	100,000	0

Narrative:

Elizabeth Glaser Pediatric Foundation (EGPAF) PAMOJA project has been supporting pediatric ART services as part of integrated comprehensive HIV clinical services in 154 sites in Homa Bay, Rachuonyo North and South, Ndhiwa, Manga, Masaba North and South, Gucha, and Borabu Districts of Nyanza province.

In FY12, PAMOJA will continue to jointly work with the Ministry of Health (MoH) at all levels to continue supporting, expanding and ensuring provision of quality pediatric HIV treatment services as per MoH guidelines to 142 pediatrics currently receiving ART and 100 new pediatrics resulting to cumulative 171 pediatrics ever initiated on ART. In FY 13, this number will increase to 193 pediatrics currently receiving ART and new 90 resulting to cumulative 261 pediatrics ever initiated on ART.

PAMOJA will support comprehensive pediatric ART services including growth and development monitoring, immunization as per the Kenya Expanded Program on Immunization, management of childhood illnesses OI screening and diagnosis; WHO staging; ART eligibility assessment; laboratory monitoring including 6 monthly CD4, hematology and chemistry (through strengthening of lab networks); Pre-ART adherence and psychosocial counseling; initiation of ART as per MoH guidelines; Toxicity monitoring, treatment failure assessment through targeted viral load testing; Adherence strengthening; enhanced follow up and retention; support EID as per MoH guidelines and PITC to all children and their care givers attending Child welfare clinics; support family focused approach; and community outreach efforts and integration of HIV services in other MNCH services.

PAMOJA will support hospital and community activities to meet the needs of the HIV infected adolescents: support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services and support their transition into adult services.

PAMOJA will support in-service training of 100 and 80 HCWs in FY 12 and 13 respectively, continuous mentorship and capacity building of trained health care workers on specialized pediatric treatment including management of ARV treatment failure and complicated drug adverse reactions; identify human resources and infrastructure gaps and support in line with MoH guidelines; support good commodities management practices to ensure uninterrupted availability of commodities. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will additionally be optimized.

PAMOJA will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, PAMOJA will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. PAMOJA will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.

Implementing Mechanism Details

Mechanism ID: 13545	Mechanism Name: Peace Corps
Funding Agency: U.S. Peace Corps	Procurement Type: USG Core
Prime Partner Name: U.S. Peace Corps	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 453,427	
Funding Source	**Funding Amount**
GHP-State	453,427

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In the area of prevention, funds will be used for placement, training and support of Volunteers to work with communities to design and implement context-appropriate and evidence-based prevention interventions addressing the key drivers of the epidemic, including sexual and behavioral risk, vertical transmission from mother to child and harmful gender/cultural norms. Volunteers will also be trained, placed, and supported to aid community members and organizations in designing and implementing care programs for PLHA, OVCs and their caretakers to mitigate the effects of HIV, improve health outcomes for HIV positives, improve the developmental growth of OVCs, improve household nutritional and optimize quality of life of adults and children living with and affected by HIV. PC Volunteers placed in organizations to complement treatment efforts will support enhancement of capacities of service providers to deliver and monitor treatment delivery. Volunteers will also work side-by-side with community partners to leverage all appropriate and locally-available resources and technology for development of sustainable, community-led responses to HIV. Volunteers placed in local organizations strengthen institutional capacities in communication, financial management, outreach to target populations, monitoring, evaluation and reporting. As long-term residents of their communities of service, they are also able on a continuing basis to model transparency, accountability and good governance/good business practices in their projects. Peace Corps Kenya worked diligently to reduce pipeline levels in previous budget cycles and is therefore requesting FY12 funds to enable the activities described above to be adequately planned for and implemented within the FY12 COP implementation period.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**13545**
Mechanism Name:	**Peace Corps**
Prime Partner Name:	**U.S. Peace Corps**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	218,027	0

Narrative:

Volunteers work with communities to design and implement context-appropriate prevention interventions addressing the key drivers of the epidemic, including sexual and behavioral risk, vertical transmission from mother to child and harmful gender/cultural norms. These volunteers work in high epidemic areas such as Nyanza, Rift Valley and Coast regions.

Peace Corps promotes behavior change through use of evidence-based programs and integration of efforts with other USG agencies and implementing partners. Programs also include a cross-cutting focus on reduction of stigma and discrimination. The activities will reach a total of 7,000 girls, women, counterparts and caregivers who are Host Country Nationals through trainings, volunteer placements and Volunteer knowledge and Economic Empowerment projects.

Post will implement intervention strategies for most-at-risk populations (MARPS) through PCV and Host Country National (HCN) training workshops. These will include but not be limited to cross- sector and in-service trainings on HIV/AIDS with training in Behavior Change Communications (BCC) through Education Through Listening (ETL) (e.g., Siri, Gender Based Violence, Multiple Concurrent Partnerships, Men As Partners, Commercial Sex Workers and Men who have Sex with Men).

More specifically, Peace Corps AB Activities will train 2,630 Host Country Nationals through promoting education and empowerment of girls ages 14-18 to reduce early marriages and delay sexual debut and increase abstinence. Peace Corps will also train Host Country Nationals, aged between 18-45 years through campaigns on drug and alcohol abuse among youth through in-school and out-of-school youth intervention programs and promotion of safe circumcision practices amongst communities that practice circumcision and promotion of circumcision amongst traditional non-circumcising communities for HIV prevention.

These nationwide trainings are fashioned on a Training of Trainers (ToT) model in partnership with other PEPFAR and USG partner agencies and will be replicated in the respective communities where volunteers serve.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	235,400	0

Narrative:

Volunteers' work with communities to design and implement context-appropriate prevention interventions addressing the keys drivers of the epidemic, including sexual and behavioral risk, vertical transmission from mother to child and harmful gender/cultural norms. These volunteers work in high epidemic areas such as Nyanza, Rift Valley and Coast regions.

Peace Corps promotes behavior change through use of evidence-based programs and integration of efforts with other USG agencies and implementing partners. Programs also include a cross-cutting focus on reduction of stigma and discrimination. The activities will reach a total of 7000 girls, women, counterparts and caregivers who are Host Country Nationals through trainings, volunteer placements and volunteer knowledge and Economic Empowerment projects.

Post will implement intervention strategies for most-at-risk-populations (MARPS) through PCV and Host Country National (HCN) training workshops. These will include but not be limited to cross- sector and in-service trainings on HIV/AIDS with training in Behavior Change Communications (BCC) through Education Through Listening (ETL) (e.g., Siri, Gender Based Violence, Multiple Concurrent Partnerships, Men As Partners, Commercial Sex Workers and Men who have Sex with Men). *More specifically, Peace Corps OP Activities will train 2,270 Host Country Nationals through promoting education and empowerment of girls ages 14-18 to reduce early marriages and delay sexual debut and increase abstinence. Peace Corps will also train Host Country Nationals, aged between 18-45 years through campaigns on drug and alcohol abuse among youth through in-school and out-of-school youth intervention programs and promotion of safe circumcision practices amongst communities that practice circumcision and promotion of circumcision amongst traditional non-circumcising communities for HIV prevention.* *These nationwide trainings are fashioned on a Training of Trainers (ToT) model in partnership with other PEPFAR and USG partner agencies and will be replicated in the respective communities where volunteers serve.*

Implementing Mechanism Details

Mechanism ID: 13546	**Mechanism Name: Kisumu West**
Funding Agency: U.S. Department of Defense	Procurement Type: Cooperative Agreement
Prime Partner Name: Henry M. Jackson Foundation Medical Research International, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,864,414	
Funding Source	**Funding Amount**
GHP-State	1,864,414

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Kisumu West (KW) program aims to increase access to HIV services, including PMTCT, HTC, PWP, care and treatment. KW will endeavor to support 100% coverage of PMTCT interventions in ANC settings and 80%

knowledge of HIV status among adults by 2012; which is in keeping with Kenya's PFIP. This will be achieved through integration of HIV services within the wider MOH services; and social mobilization to increase demand for HIV services. KW will expand HTC activities through multiple mutually-reinforcing and non-redundant methodologies.Stable patients will be cared for at lower-level health facilities. In addition, a "one-stop shop" for clients will be offered by linking together HIV, non-communicable and communicable disease services (including TB) among infected and affected individuals. These will reduce duplication and improve cost-efficiency of health workforce and management resources.To aid transition to country partners, KW will strengthen local institutions, including the District Health Management Team, through trainings, joint planning and support supervision. A strategic country-driven improvement of the health system to address a multiplicity of health issues, including HIV, will create an efficient, sustainable and cost-effective program.KW will work with MOH to build the capacity of community health workers to deliver services. This will strengthen referral systems, with a focus on reaching the most marginalized groups.KW procured 2 vehicles using FY09 and FY10 funds. These were needed to support logistics, transport laboratory/pharmaceutical commodities, and make site supervisory visits.Target populations, geographic coverage, and monitoring and evaluation plans are addressed in budget code narratives. This activity supports the GHI/LLC.

Cross-Cutting Budget Attribution(s)

Construction	345,000
Economic Strengthening	543
Education	14,000
Food and Nutrition: Commodities	709
Food and Nutrition: Policy, Tools, and Service Delivery	1,500
Gender: GBV	352
Gender: Gender Equality	786
Human Resources for Health	5,495
Key Populations: FSW	923
Key Populations: MSM and TG	789
Water	453

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms

Increase gender equity in HIV prevention, care, treatment and support

Child Survival Activities

Safe Motherhood

TB

Budget Code Information

Mechanism ID:	**13546**
Mechanism Name:	**Kisumu West**
Prime Partner Name:	**Henry M. Jackson Foundation Medical Research International, Inc.**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	159,536	0

Narrative:

Kisumu West (KW) supports HIV care and prevention activities in Kisumu West district, Nyanza province of Kenya. The HIV rates range from 18-29% in KW compared to the national average of 7.1%. USG technical, capacity building and financial support to KW HIV services are factored into District and Provincial Annual Operation Plans (AOP) prepared and coordinated by the Ministry of Health (MOH). KW will continue to support HIV care services for 6000 adults and 1000 children below 15 years. This is aimed at reducing mortality, morbidity and new infections by 50% by 2014. This program will endeavor to enhance activities that foster early identification and management of opportunistic infections, quality provision of the basic care package, individual and facility-based nutritional support, access to cotrimoxazole prophylaxis, as well as enhancing community PwP through condom provision, referral for family planning services, identification and support of discordant couples, provision or /referral to other PWP services, and supporting implementation of the MOH community health strategy.
HIV-positive adults and children identified through HTC services – including PMTCT, TB/HIV, VCT, PITC, and home-based CT – will be linked to care and treatment services. In addition, the program will continue to support other clinical services (pain relief, safe water, multivitamins, prevention and treatment of other complications such as diarrhea, cervical cancer screening and Kaposi's sarcoma); psychological and spiritual services (group and individual counseling, end-of-life care, bereavement services)for all HIV positive clients. In addition, HIV

prevention services (partner/couples testing, risk reduction counseling, adherence counseling, and STI diagnosis and treatment) will be part of our package. Patients in care will be linked, in an integrated manner, to other HIV treatment, care and prevention services including TB screening, treatment and prevention.

KW will strengthen the scope and quality of program activities in 23 health facilities over the next 2 years. Cumulatively, some 7,000 patients, 1,190 of these in the first half of FY 2011, were placed on different spectrum of the basic care package to extend and improve quality of life throughout the HIV illness. This basic care included prevention and treatment of opportunistic infections (OIs).

KW will also support good supply chain practices to ensure uninterrupted supply of commodities. KW will continue to strengthen data collection and reporting at all level; in addition to doing cohort analysis and reporting retention rates as required by the HIV program (NASCOP) and PEPFAR. KW will adopt the new generation care indicators and support on-going development and use of NASCOP's electronic medical records system. The partner will adapt the quality of care indicators (CQI) to monitor HIV care and support services and integrate these into routinely collected data and use the results to evaluate and improve clinical outcomes.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	206,733	0

Narrative:

Kisumu West (KW) supports HIV care and prevention activities in Kisumu West district, Nyanza province of Kenya. The HIV rates range from 18-29% in KW compared to the national average of 7.1%. USG technical, capacity building and financial support are factored into District and Provincial Annual Operation Plans (AOP) prepared and coordinated by the Ministry of Health (MOH). KW currently supports pediatric care services, including Early Infant Diagnosis, in 23 sites. KW plans to expand these services to additional 4 sites in the next phase. KW will continue to provide HIV care services for over 1500 children below 15 years. This is aimed at reducing mortality, morbidity and new infections by 50% by 2014. The program will endeavor to enhance activities that foster early identification and management of opportunistic infections; and provision of clinical, psychological, spiritual, social, and prevention services. In addition, insecticide treated nets, laboratory services, pain and symptom relief, individual and facility-based nutritional support will be offered throughout the continuum of illness.

KW will further decentralize services to attain 80% coverage over the next 2 years. This will lead to a cumulative total of 2000 children on care. KW will work with MOH to improve the quality of services through in-service staff training; mentorship; expanded access to regular CD4 monitoring and better patient retention strategies; including active defaulter tracing practices. Additional 60 health providers will be trained to support expansion of pediatric care services. The partner will strengthen provision of comprehensive HIV services including viral load testing for patients failing treatment, cotrimoxazole prophylaxis, disclosure in a sensitive and culturally appropriate manner,

psychosocial counseling, participation in children support clubs, adherence and disclosure counseling, PWP and nutritional assessment and supplementation. KW will strengthen integration of early infant diagnosis in MCH and inpatient settings. To further strengthen adherence and transition to adult services, childrens' clubs will be stratified based on age, with the older adolescents being separated from younger children. Patients will be screened for TB at each clinic encounter to ensure that those with active disease are promptly put on TB treatment and ARVs based on recently updated MOH guidelines. The diagnosis, prevention and treatment of other OIs and tumors such as candidiasis, and Karposis sarcoma will be enhanced through staff training and support for commodities and infrastructure. KW will support conduct of cohort analysis and report retention rates as per national guidelines. KW will adapt the quality of care indicators for monitoring the quality of pediatric care services and integrate these into routinely collected data used to evaluate and improve clinical outcomes. The partner will continue to strengthen data collection and reporting at all levels to increase and improve the quality and timeliness of data reported to MOH and to PEPFAR. Use of an electronic medical records system will be supported in addition to performing data quality audits. To promote transition to local ownership and sustainability of ART services, the Kenya Government is expanding her budgetary contribution to ART procurement.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	174,413	0

Narrative:

Kisumu West (KW) program supports HIV /TB treatment and prevention activities in Kisumu West district, Nyanza province of Kenya. The HIV rates range from 18-29% in KW compared to the national average of 7.1%. HIV TB co-infection rates are higher at 80% in KW compared to the national rate of 50%. USG technical, capacity building and financial support to KW HIV/TB services are factored into District and Provincial Annual Operation Plans (AOP) prepared and coordinated by the Ministry of Health (MOH).

In FY 11, 157 newly diagnosed TB patients received their HIV results in KW supported sites. Over the same period, 6781 clients in HIV care were screened for TB leading to a yield of 16 active disease.11 TB re-treatment cases were registered with no drug resistant TB detected over this period. In the next 2 years, KW will intensify TB control efforts through timely clinical and laboratory evaluations. KW will screen up to 80% of patients in HIV Clinics for TB; 500 TB patients in TB settings will be counseled and tested for HIV while 200 TB/HIV co-infected patients will be put on treatment. The program will scale up the 3Is –Intensified Case Finding, Isoniazid Preventive Therapy, Infection Control, promotion of Integrated TB/HIV services in the TB Clinic, and immediate initiation of ART in those co-infected patients irrespective of their CD4 count. This is in line with MOH guidelines. Other services provided will include clinical monitoring, related laboratory services, treatment and prevention of tuberculosis, as well as screening and referral of TB clinic clients for HIV testing.

Each site will receive adequately trained and supported clinical and laboratory staff. TB patients on treatment will

be monitored clinically and through periodic sputum examination. KW will support the "one stop shop" model to provide integrated services and ensure continuum of care for individuals with both TB/HIV co-infection. TB and HIV clinical staff will undergo refresher trainings to gain proficiency in management of both diseases. Through the MOH community strategy, the program will train 64 community health workers as cough monitors. They will identify chronic coughers in the community and refer them for screening at health facilities. In addition, cough monitors will track TB patients who miss their drugs or default on their clinic appointments. To reduce TB burden for PLWHA, KW will support intensified TB screening for all patients newly diagnosed with HIV. Those with active TB will be put on treatment. To strengthen TB infection control (IC), KW will support distribution and use of national IC guidelines. Coughers will be triaged by cough monitors and fast tracked at the HIV clinics. To improve surveillance and management of drug-resistant TB, KW will support timely DSTs for TB re-treatments and ensure all MDR-TB cases are followed up using the Demographic and Health Surveillance System (DHSS) and treated to cure.

KW will support good supply chain practices to ensure uninterrupted supply of commodities. KW will continue to strengthen data collection and reporting and do cohort analysis and report retention rates as required by the HIV program (NASCOP) and PEPFAR. KW will adopt the new generation TB/HIV indicators and support timely processing and uploading. Data will be used to evaluate progress and improve clinical outcomes through Continuous Quality Improvement (CQI) initiatives.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	46,302	0

Narrative:

Kisumu West (KW) supports HIV care and prevention activities in Kisumu West district, Nyanza province of Kenya. The HIV rates range from 18-29% in KW compared to the national average of 7.1%. USG technical, capacity building and financial support are factored into District and Provincial Annual Operation Plans (AOP) prepared and coordinated by the Ministry of Health (MOH). KW currently supports pediatric care services, including Early Infant Diagnosis, in 23 sites. KW plans to expand these services to additional 4 sites in the next phase. KW will continue to provide HIV care services for over 1500 children below 15 years. This is aimed at reducing mortality, morbidity and new infections by 50% by 2014. The program will endeavor to enhance activities that foster early identification and management of opportunistic infections; and provision of clinical, psychological, spiritual, social, and prevention services. In addition, insecticide treated nets, laboratory services, pain and symptom relief, individual and facility-based nutritional support will be offered throughout the continuum of illness.

KW will further decentralize services to attain 80% coverage over the next 2 years. This will lead to a cumulative total of 2000 children on care. KW will work with MOH to improve the quality of services through in-service staff training; mentorship; expanded access to regular CD4 monitoring and better patient retention strategies; including

active defaulter tracing practices. Additional 60 health providers will be trained to support expansion of pediatric care services. The partner will strengthen provision of comprehensive HIV services including viral load testing for patients failing treatment, cotrimoxazole prophylaxis, disclosure in a sensitive and culturally appropriate manner, psychosocial counseling, participation in children support clubs, adherence and disclosure counseling, PWP and nutritional assessment and supplementation. KW will strengthen integration of early infant diagnosis in MCH and inpatient settings. To further strengthen adherence and transition to adult services, childrens' clubs will be stratified based on age, with the older adolescents being separated from younger children. Patients will be screened for TB at each clinic encounter to ensure that those with active disease are promptly put on TB treatment and ARVs based on recently updated MOH guidelines. The diagnosis, prevention and treatment of other OIs and tumors such as candidiasis, and Karposis sarcoma will be enhanced through staff training and support for commodities and infrastructure. KW will support conduct of cohort analysis and report retention rates as per national guidelines. KW will adapt the quality of care indicators for monitoring the quality of pediatric care services and integrate these into routinely collected data used to evaluate and improve clinical outcomes. The partner will continue to strengthen data collection and reporting at all levels to increase and improve the quality and timeliness of data reported to MOH and to PEPFAR. Use of an electronic medical records system will be supported in addition to performing data quality audits. To promote transition to local ownership and sustainability of ART services, the Kenya Government is expanding her budgetary contribution to ART procurement.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	244,321	0

Narrative:

Kisumu West (KW) program supports HIV care and prevention activities in Kisumu West district, Nyanza province of Kenya. The HIV rates range from 18-29% in KW compared to the national average of 7.1%. USG technical, capacity building and financial support are factored into District and Provincial Annual Operation Plans prepared and coordinated by the Ministry of Health (MOH). In FY 2010, KW initiated development of a basic data system for documentation of individual patients and will continue to phase-in a data collection, recording, monitoring, reporting, and dissemination system to all treatment and prevention sites. These will be further strengthened to include provision of computerized data automation systems and other communication equipment required for electronic entry of patient-specific encounter data; and enhancement of email and internet system for information sharing and submission of reports in real time. The partner will continue to strengthen data collection and reporting at all levels to increase and improve the quality and timeliness of data reported to MOH and to PEPFAR.

KW will support MOH to establish a functional Electronic Medical Records (EMR) system in 4 health facilities to improve clinical management and program reporting; with initial emphasis in ART program. Paper based system will be strengthened to collect, manage, analyze, and generate routine reports; and carry out cohort analysis. The

partner will adapt DHIS, the national reporting system, and its customization for use in reporting all the health data and information needs. The partner will support implementation of a generic m-health solution to include SMS notification for EID, patient follow-up, commodity and supplies management.

KW will strengthen supportive supervision; mentorship; leadership; management and coordination; ICT technical support; systems capacity development, and knowledge management (including data use) through MOH leadership (HIS) covering all program areas. Data Quality Audits and data reconstruction will be strengthened. In addition, the partner will support stakeholder meetings/data review forums to discuss results, disseminate evaluation reports and set up quality improvement teams. These will aim at building capacity of the data teams to continually use information for routine programming and for better patient management. Capacity building and system strengthening are a strategic component in engaging with the MOH from the highest government level to the medical reception stations where direct patient care is executed. 30 data management personnel will be trained to review community data, develop action plans in data management, data use, demand creation and analysis. Local MOH capacity to carry out M&E activities and rollout national indicator tools will be improved through training of District Health Management Teams (DHMTs).

KW will support the linking of EMR to DOD health and demographic surveillance system. This will enable the partner to generate risk maps and HIV/AIDS density clusters. The information will be used to improve efficiency and effectiveness in service delivery, resistance tracking, second line ART regimen usage, access to care, demand creation and evaluating prevention effectiveness. The information gained will further assist in augmenting the development of health care policies which lends itself to country sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	120,901	0

Narrative:

Kisumu West (KW) program supports HIV care and prevention activities in Kisumu West district, Nyanza province of Kenya. The population is composed of 47.7% males and 52.3% females with 52.6% of the total population being <18years (WRP Kisumu Health and Demographic Surveillance System). The HIV prevalence in rural Nyanza Province is at 14.9% (KAIS 2007). It is estimated that the greater Kisumu District has an HIV prevalence of 18.3% (based on PMTCT national program data). Approximately 21% of pregnant women tested in Kisumu-West District in 2008 were found to be HIV-infected (WRP unpublished data). Further, 14% (76/534) of HIV-exposed infants tested in 2008 were found to be HIV-infected. In FY 11, KW initiated Home-Based Testing and Counseling (HBTC) that has tested 6711 clients with 543 tested positive. HBTC activities will continue and will target testing 70,000 clients. All HIV positives identified will be linked to care and treatment activities and other services including PWP, VMMC, STI screening, family planning, TB and PMTCT. Referrals and linkage will be strengthened through use of community health workers to track HIV-positive individuals not enrolling in care or treatment services. This is in

line with the MOH community strategy.

KW will provide counseling and testing to an extra 10,000 individuals through Provider initiated testing and counseling (PITC). It will focus on increasing HTC access to first time testers and couples (couple counseling should account for over 10% of the target population). Efforts will be geared towards scaling up PITC in all health facilities and reaching the most at risk populations among the fisher-folks with mobile services as well as integration of PWP services in HTC settings and continued promotion of quality assurance. The program will place emphasis on strengthening the health systems capacity to scale up access to quality HTC services and referrals. Each site will receive adequately trained and supported HTC service providers; who will undergo refresher trainings to gain proficiency. Task-shifting to lay counsellors will be emphasized to ease the burden on other healthcare staff. Quality assurance for HCT will be achieved by following MOH national guidelines and standard operating procedures (SOPs); ensuring all HTC providers have been trained; and through the use of standardized pre-printed registers for recording HIV test results. 5-10% of samples will be sent to the national reference laboratory for re-testing. In addition, QA measures will include counseling support supervision to prevent "burn out" of HTC service providers. Demand for HTC will be created through community mobilization and use of local administrative "barazas" in order to reach 80% population coverage. Sign boards will be installed in all HTC sites so that these service delivery points can be clearly identified by clients and patients.

KW will support good supply chain management practices to ensure uninterrupted supply of commodities. KW will continue to strengthen data collection and reporting and report the number of newly diagnosed HIV positive clients successfully linked to care; as required by the HIV program (NASCOP) and PEPFAR. KW will adopt the new generation HIV indicators and support their timely processing and uploading. Data will be used to evaluate progress and improve clinical outcomes through Continuous Quality Improvement (CQI).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	130,590	0

Narrative:

Kisumu West (KW) program supports HIV prevention, care and activities in Kisumu West district, Nyanza province. The HIV rates range from 18-29% in KW compared to the national average of 7.1%. USG technical, capacity building and financial support are factored into District and Provincial Annual Operation Plans (AOP) prepared and coordinated by the Ministry of Health (MOH). KW currently supports PMTCT services in 23 clinics in KW district. In the first half of FY 11, 1660 pregnant women received HIV counseling and testing and received their test results. 124 (7.5%) of these women tested HIV positive out of whom 81 (65 %) received ART prophylaxis to protect their unborn babies. KW will continue to support the provision of HIV counseling and testing to 6,586 pregnant women, and provide ARV prophylaxis to 1,099 HIV positive women and their infants as per the Kenyan MOH guidelines. HIV positive pregnant women eligible for ART will be started on Highly Active Anti Retroviral therapy

(HAART). The partner will facilitate the provision of DNA PCR tests to HIV exposed infants at six weeks. PCR negative exposed infants will be followed up at the MCH clinic and will receive cotrimoxazole and ARV prophylaxis as MOH guidelines. Once their final status is determined, the HIV positive ones will be initiated on ART.

Over the next 2 years, additional services will focus on the four PMTCT prongs: primary HIV prevention; FP to stem unwanted pregnancies; ARV prophylaxis for all HIV positive pregnant mothers and their exposed infants; and care and treatment for eligible mothers, partners and children. The minimum care package will include health education, individual and family HIV counseling and testing, clinical and laboratory monitoring, OI screening, prevention and/or treatment, ART prophylaxis and treatment for both mother and baby, nutritional and psychosocial support. Additional interventions will include TB screening and TB treatment for mothers with active TB. KW will expand couple counseling and testing targeting at least 30% of 1st ANC attendees. This will improve male involvement in PMTCT. HIV prevention interventions will be provided to discordant couples to prevent new HIV transmissions and facilitate linkage to HIV care and treatment services. The partner will promote skilled deliveries and support improvement of infrastructure and adequate supply of commodities such as sterile delivery packs. KW will promote safe infant feeding and postnatal ART prophylaxis practices in line with MOH guidelines. HEI will be monitored for HIV infection by PCR-based early infant diagnostic (EID) tool and children who test PCR positive before 18 months will be initiated on ART. Mothers and their babies will be retained in care through strategic use of community health workers, appointment diaries, and registers to track defaulters.

In collaboration with the District Health Management Team (DHMT), KW will support a structured staff mentorship and support supervision program to ensure that district-wide PMTCT services produce high quality data essential for program planning and evaluation. KW will spend less than $20 per woman and use the same amount to cover other wraparounds such as safe water, FP, safe motherhood and malaria prevention. KW will work closely with the MOH, through the community strategy, to support community mobilization activities, improve quality of ANC services, and create demand for ANC services and safe skilled deliveries.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	709,226	0

Narrative:

Kisumu West (KW) supports HIV care and prevention activities in Kisumu West district, Nyanza province of Kenya. The HIV rates range from 18-29% in KW compared to the national average of 7.1%. USG technical, capacity building and financial support are factored into District and Provincial Annual Operation Plans (AOP) prepared and coordinated by the Ministry of Health (MOH). KW currently supports ART services in 9 sites and plans to expand services to additional 4 sites; with the aim of attaining 80% coverage over the next 2 years. In the first half of FY 11, 466 patients were initiated on ART making a cumulative total of 3,074 patients.

KW will work with MOH to improve the quality of ART services through in-service staff training; mentorship; expanded access to regular CD4 monitoring and better patient retention strategies; including active defaulter tracing practices. The partner will continue to build the capacity of local MOH sites to offer specialized treatment, including management of ARV treatment failure and complicated drug adverse reactions. Additional 45 health providers will be trained to support expansion of ART sites and increased demand for HIV treatment; in addition to adequately managing treatment failures and increased transition to second line drug regimens. KW will identify areas with staff shortages and support recruitment of additional staff. The partner will support provision of comprehensive HIV treatment services including clinical assessment for ART eligibility, toxicity monitoring, laboratory monitoring with biannual CD4 testing, viral load testing for patients failing treatment, cotrimoxazole prophylaxis, psychosocial counseling, participation in patient support groups, adherence counseling and nutritional assessment and supplementation. Additional services will include delivery of HIV prevention (PWP) package including disclosure, partner testing, family planning, and provision or referral to STI diagnosis and treatment. Patients will be screened for TB at each clinic encounter to ensure that those with active disease are promptly put on TB treatment and ARVs while based on recently updated MOH guidelines. The diagnosis, prevention and treatment of other OIs and tumors such as candidiasis, and Karposis sarcoma will be enhanced through staff training and support for commodities and infrastructure. Ongoing community interventions including peer education and use of support groups to provide adherence messaging and defaulter tracing will be supported to improve treatment retention. KW will support conduct of cohort analysis and report retention rates as per national guidelines. KW will adapt the quality of care indicators (CQI) for monitoring the quality of HIV treatment services and integrate these into routinely collected data used to evaluate and improve clinical outcomes. The partner will continue to strengthen data collection and reporting at all levels to increase and improve the quality and timeliness of data reported to MOH and to PEPFAR. Use of an electronic medical records system will be supported in addition to performing data quality audits. To promote transition to local ownership and sustainability of ART services, the Kenya Government is expanding her budgetary contribution to ART procurement. Please see the partner overview narrative for information on the strategy to transition to local ownership.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	72,392	0

Narrative:

Kisumu West (KW) supports HIV care and prevention activities in Kisumu West district, Nyanza province of Kenya. The HIV rates range from 18-29% in KW compared to the national average of 7.1%. USG technical, capacity building and financial support are factored into District and Provincial Annual Operation Plans (AOP) prepared and coordinated by the Ministry of Health (MOH). KW currently supports ART services in 9 sites and plans to expand services to additional 4 sites in the next phase. In the first half of FY 11, 58 children were initiated on ART making a cumulative total of 325 children on ART. KW will expand ART uptake in the current 9 sites and also decentralize further to attain 80% coverage over the next 2 years. This will lead to a cumulative total of 565

children ever on ART. KW will work with MOH to improve the quality of ART services through in-service staff training; mentorship; expanded access to regular CD4 monitoring and better patient retention strategies; including active defaulter tracing practices. The partner will continue to build the capacity of local MOH sites to offer specialized treatment, including management of ARV treatment failure and complicated drug adverse reactions in children. Additional 60 health providers will be trained to support expansion of ART sites and increased demand for pediatric HIV treatment. The partner will support provision of comprehensive HIV treatment services including toxicity monitoring, laboratory monitoring with biannual CD4 testing, viral load testing for patients failing treatment, Cotrimoxazole prophylaxis, disclosure in a sensitive and culturally appropriate manner, psychosocial counseling, participation in children support clubs, adherence and disclosure counseling; and nutritional assessment and supplementation. KW will continue to strengthen Early Infant Diagnosis in all health facilities in KW. To further support adherence and disclosure, children's' clubs will be stratified based on age, with the older adolescents being separated from younger children. Patients will be screened for TB at each clinic encounter to ensure that those with active disease are promptly put on TB treatment and ARVs while based on recently updated MOH guidelines. The diagnosis, prevention and treatment of other OIs and tumors such as candidiasis, and Karposis sarcoma will be enhanced through staff training and support for commodities and infrastructure. Ongoing community interventions including use of support groups to provide defaulter tracing will be supported to improve treatment retention. KW will support conduct of cohort analysis and report retention rates as per national guidelines. KW will adapt the quality of care indicators (CQI) for monitoring the quality of HIV treatment services and integrate these into routinely collected data used to evaluate and improve clinical outcomes. The partner will continue to strengthen data collection and reporting at all levels to increase and improve the quality and timeliness of data reported to MOH and to PEPFAR. Use of an electronic medical records system will be supported in addition to performing data quality audits. To promote transition to local ownership and sustainability of ART services, the Kenya Government is expanding her budgetary contribution to ART procurement.

Implementing Mechanism Details

Mechanism ID: 13548	**Mechanism Name: Health Commodities & Services Management Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 66,907	
Funding Source	**Funding Amount**
GHP-State	66,907

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Management Sciences for Health/Health Commodities and Services Management Program (HCSM) will work collaboratively with NACC and MOH, implementing partners and other stakeholders to support management of the commodities used for HIV diagnosis, care and treatment to promote universal access and quality patient care.
HCSM will continue work peripherally to strengthen systems for health commodity management primarily to the health facility level and to the community level to a limited extent in line with the community strategy. At the peripheral level, HCSM will work to support the county and district health teams to provide stewardship and oversight on commodity management interventions. The system strengthening activities will target decentralization, strengthening of peripheral level structures and task shifting activities.
To improve quality of care and retention of ART patients, HCSM will promote adherence through improved appointment keeping, adherence monitoring, defaulter tracking and reporting of adverse drug reactions and post-market surveillance of ARVs.
At the national level HCSM will support development and implementation of policies and structures that will guide and oversee health commodity management and related services. HCSM will work to promote quality pre-service, internship and continuous professional development programs for efficient supply chain of HIV and other health commodities and quality service delivery.
Key expected results include improved integration of services, national level commodity requirements planning and use of data for decision making, facility commodity usage reporting of ARV medicines(>90%) and HIV laboratory reagents (75%). This activity supports GHI/LLC and is funded completely with pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**13548**
Mechanism Name:	**Health Commodities & Services Management Project**
Prime Partner Name:	**Management Sciences for Health**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	0	0

Narrative:

MSH/HCSM will work with MOMS/MOPHS and other stakeholders to strengthen the delivery of services at the community level in line with the comprehensive service delivery approach and the community strategy as envisioned in the National Health Sector Strategic Plan and HIV & AIDS Services Decentralization Policy guidelines. This approach is meant to enhance community participation and partnership to allow for continuity of care and treatment across all levels of care. Primarily, HCSM will support providers to improve delivery of the 'basic care package' at this level mainly health promotion, disease prevention and home based care. Activities at this level will therefore focus on improving access, medication adherence support, appropriate use and management of health commodities.

To improve access to and management of health commodities, HCSM will continue to work collaboratively with the Department of Primary Health Care, Division of Community Services, HIV/AIDS implementing partners and other stakeholders in the ongoing development and implementation of the commodity management curricula for community health workers. This will target providers to equip them with the basic knowledge and skills needed for accountability and effective management of their designated health commodities. At the policy level, MSH/HCSM will support the selection of health commodities for use at this level and strengthen mechanisms for ordering, monitoring use, reporting, and re-supply.

To support care and appropriate use of health commodities, MSH/HCSM will build on the on-going efforts to develop and disseminate guidelines, tools and materials such as simplified job aids targeting providers at this level. Specifically, MSH/HCSM will continue working with the MOMS/MOPHS, NASCOP, regional implementing partners, PHMTs and DHMTs in the dissemination and monitoring the use of the National Clinical Management and Referral Guidelines for community level [KEPH level 1] and other guidelines.
To address the growing need for medication safety monitoring at all levels, HCSM will collaborate with the Department of Pharmacy and the Pharmacy and Poisons Board and Priority Health Programs to expand pharmacovigilance and medicine quality assurance systems to the community level. This will entail implementation of a consumer reporting system for ADRs and poor quality medicinal products adequately supported through advocacy, community education, IEC materials and appropriate reporting tools. In addition MSH/HCSM will work collaboratively with regional implementing partners, community and patient groups to implement strategies that promote adherence and appropriate medicine use.
To ensure that providers at community level are adequately supported and linked to facility-based services, MSH/HCSM will work to build the capacity of PHC level facilities in health commodity management through training, mentorship and on-the-job-training (OJT) which will enhance implementation and functionality of the referral system between these two levels.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	0	0

Narrative:

MSH/HCSM will work with the MoH and other stakeholders to strengthen effective laboratory supply chain and commodity management at central, regional and facility level thereby improving good laboratory practices in line with the national laboratory policy and strategic plan.

At central level, HCSM will support and strengthen the established National Lab commodity security committee (NLCSC) that oversees and directs all lab commodity management activities, including the development of the lab commodity essential and tracer lists. This will guide selection of lab commodities for procurement at all levels of care. HCSM will strengthen capacity within MoH, specifically NPHLS, NASCOP and other programs in forecasting & quantification, and procurement planning for HIV lab commodities. HCSM will also support the committee to develop the national budget for lab commodity requirements as a tool for resource mobilization as well as supporting the national Lab ICC to disseminate and implement the finalized approved national laboratory policy and strategic plan.

HCSM will collaborate with training institutions to develop and implement pre-service and in-service laboratory training curricula, and develop a pool of trainers on lab commodity management to cascade training to peripheral

levels. For effective tracking of commodity availability and use, HCSM will support NPHLS to develop and implement manual and electronic tools at central and service delivery levels. This includes strengthening and scaling up the laboratory commodity tracking tool from the current six sites to an additional 10 sites, as well as use of routine laboratory data for decision-making at the central and peripheral levels.

At regional level, HCSM will also support and strengthen the established regional and district laboratory commodity TWGs to oversee and strengthen commodity management systems at the facility level. The regional teams will ensure that the facilities have the necessary lab commodity management tools and skills on use to sustain good inventory management. Together with the regional MoH teams and regional partners, HCSM will work to capacitate lab commodity management champions at regional (county, district) and facility level to provide mentorship, OJT and integrated support supervision for continued performance improvement and sustainability. The champions/mentors will disseminate the lab commodity management SOPs and job aids, including those on maintenance of cold chain, and support facilities on their use. As a result reporting rates for HIV test use is expected to improve from 60% to 75%

HCSM will work with district and facility commodity management teams and community-based organizations to strengthen advocacy and systems for accessing lab commodities and commodity tracking at the community level, including development of simple commodity tracking tools.

In collaboration with MoH and other stakeholders HCSM will implement monitoring systems to review the level of access to essential lab tests at the community level. Performance monitoring plan will be developed in line with the NPHLS, PEPFAR and HCSM project indicators to monitor the progress of the implemented activates as corrective action are taken from the lesson learned as provided by progress report for continual improvement towards achieving the project objectives.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

MSH/HCSM will work collaboratively with other stakeholders and implementing partners to support the various HIV/AIDS services offered by the various MOH departments (NASCOP, NPHLS, DDFS, DLTLD, KEMSA, DOP and DRH). The system strengthening activities under COP 2012 will target decentralization, strengthening of peripheral level structures and task shifting activities, including their support policies and guidelines.

At the peripheral level, MSH/HCSM will work to support the county and district health teams to provide stewardship, and oversight on commodity management interventions by strengthening/establishing health

commodity committees. This will include but not limited to mentorship, provision of tools, on-the-job training on specific areas, strengthening planning skills and use of data for decision making. An important aspect to this will be the use of performance based approaches to address the commodity management challenges.

At facility level, MSH/HCSM will work collaboratively with the peripheral level health managers, other implementing partners and other stakeholders to implement interventions that ensure improved systems resulting in increased access to quality pharmaceutical and laboratory services, rational use of commodities and reduced stock outs. Interventions will include mentorship programs for commodity management, operationalization of institutional medicines end therapeutics committees, provision of commodity management tools and job aids, improving use of data for decision making, improving appropriate use of health commodities, training on specific areas of health commodity management among others. MSH/HCSM will also work with the district health teams to improve the commodity management practices at the district stores.
At the national level, MSH/HCSM will work through the national level structures at Ministry of Medical Services (MOMS), Ministry of Public Health and Sanitation (MOPHS), NACC, to strengthen technical working groups in policy formulation/implementation and oversight activities for ensuring improved management of HIV/AIDS health commodities and related services. MSH/HCSM will also work to strengthen leadership and coordination in implementation of HIV/AIDS commodity management interventions. This will include support to development/implementation of policy documents and guidelines, integration of HIV/AIDS commodity management into the overall health services and private sector involvement in cross-cutting issues such as commodity financing, pharmaco-vigilance, procurement and Quality Assurance. MSH/HCSM will also work with other stakeholders to support the rollout of harmonized systems (manual and electronic) for commodity ordering and reporting.

In implementing, monitoring and evaluating interventions for system strengthening, MSH/HCSM will seek to collaborate with stakeholders and leverage for available resources. Stakeholders for the collaboration will include USAID partners, CDC partners, WHO, DANIDA, GTZ, World Bank, Clinton Health Access Initiative, MOMS/MOPHS and its affiliated institutions among others.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	0	0

Narrative:

Management Sciences for Health/Health Commodities and Services Management Program (MSH/HCSM) will work closely and collaboratively with the USG team, KEMSA, NASCOP and other stakeholders to ensure consistent availability of critical medicines for HIV/AIDS services at all service delivery points. This will involve supporting national HIV/AIDS commodity requirements planning, quantification/forecasting, procurement planning, distribution resource planning, generation of routine strategic information on stock status and monitoring of commodity utilization/consumption for prevention, care and treatment services.

At the national/central level, HCSM will provide technical assistance to USG agencies and partners, NASCOP, Department of Pharmacy (DOP), Division of Reproductive Health (DRH), and DLTLD to support policy implementation, and strengthen commodity supply chain systems supporting HIV/AIDS. MSH/HCSM will strengthen systems by applying tried and tested commodity management tools and approaches including SOPs, on-the-job-training, mentorship, M&E and facilitative supervision in support of HIV/AIDS decentralization.

To strengthen pharmaceutical care and management systems in the private/NGO health sector using private-public partnerships, MSH/HCSM will work collaboratively with the DOP, professional associations, private health institutions thereby improving rational use of medicines, and strengthening control of antimicrobial resistance. Typical activities will include implementation of the revised National Pharmaceutical Policy; dissemination of revised ART guidelines; strengthening of hospital based drugs and therapeutics committees; advocate for linkages between the DOP, NASCOP, PPB , KEMSA, NQCL in cross-cutting issues such pharmaco-vigilance, ART drug procurement planning, monitoring and quality assurance.

At regional and facility level, MSH/HCSM will continue to support NASCOP's capacity building efforts on commodity management, including supply chain management, functioning of the national medicines and therapeutics committees. This will involve implementation of Commodity management tools and approaches to support the national program particularly in the area of quantification and forecasting, Pipeline monitoring, continuing medical education and point of service dispensing. MSH/HCSM will also support implementation the ART standard treatment guidelines; update MIS and M&E commodity management indicators and instruments; patient medication counseling materials and methodologies; implementation of quality of care indicators; and adherence measuring systems.

MSH/HCSM will continue to provide technical assistance at all health levels in the commodity systems strengthening such as development and/or adaptation of SOPs and forms; use of inventory management tools patient medication counseling for adherence; commodity management monitoring and evaluation systems, including ART Drug Utilization Reviews (DUR); the design and implementation of ART commodity management information systems; on-going training and monitoring for performance improvement at site level employing the monitoring-training-planning (MTP), a performance improvement approach.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	66,907	0

Narrative:

Management Sciences for Health/Health Commodities and Services Management Program (MSH/HCSM) will work collaboratively with MOH departments (NASCOP, NPHLS, DLTLD, DRH, PPB and Department of Pharmacy),

implementing partners and other stakeholders to support the various HIV/AIDS services towards achieving universal access and quality patient care.
MSH/HCSM will continue to participate and provide technical support to NASCOP & NACC taskforce committees and technical working groups. MSH/HCSM will support development/implementation of capacity building approaches/materials with a focus on HIV health commodity management and services.
MSH/HCSM will continue work with the regulatory authorities (PPB, KMDPB, KMLLTB, and NCK) and the training institutions to promote quality pre-service, internship and continuous professional development programs for efficient supply chain of HIV and other health commodities and quality service delivery. In addition MSH/HCSM will continue to work with Pharmaceutical Society of Kenya (PSK), Kenya Medical Association (KMA) and other professional associations to improve the policy and practice environment surrounding HIV/AIDS commodity management and related services.
MSH/HCSM will build on the achievements made towards strengthening human resources for health through pre-service, in-service and continuous professional development programs. MSH/HCSM will scale-up capacity-building strategies in health commodities management and services that will include systematically implemented task-shifting strategies which combine pre- and in-service training programs; regional trainers, mentorship and preceptorship programs; job aids, standard operating procedures (SOPs) and on-site supportive supervision.
To improve quality of care and retention of patients started on ART, MSH/HCSM will work with NASCOP to build on lessons learned to promote adherence through improved appointment keeping, adherence monitoring and defaulter tracking. This will entail scale up of the use of electronic dispensing tool and mobile technology. To promote patient safety, MSH/HCSM will work with PPB, NASCOP, NQCL and other stakeholders to implement a robust pharmacovigilance system for management, monitoring and reporting of adverse drug reactions (ADRs) and post-market surveillance of ARVs and other medicinal products. In collaboration with other stakeholders MSH/HCSM will continue to support strategies that curb HIV drug resistance.
To promote HIV/TB collaboration, MSH/HCSM will work with NASCOP, DLTLD and other stakeholders to support development and implementation of TB/HIV policy guidelines and commodity management curricula and tools.
MSH/HCSM will cover the public, private and faith based sectors and will advocate for linkages between all key stakeholders in addressing cross-cutting commodity management and service provision challenges.
MSH/HCSM will develop a clear M&E plan that will utilize systems strengthening approach and continuous quality improvement approach (MTP) to design, implement, monitor and evaluate interventions. The expected outcomes will be strengthened commodity management at peripheral health care facilities and at central level; improved pharmaceutical policy and service delivery and strengthened laboratory commodity management at all levels.

Implementing Mechanism Details

Mechanism ID: 13550	**Mechanism Name: Implementation and**

	Expansion of Blood Safety Activities in Kenya
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: National Blood Transfusion Service, Kenya	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: PR/SR	
G2G: No	Managing Agency:

Total Funding: 2,700,000	
Funding Source	**Funding Amount**
GHP-State	2,700,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Goals/objectives

The National Blood Transfusion service (NBTS) will contribute to prevention of HIV transmission through provision of safe blood in Kenya. This will be accomplished through collection, testing, processing and distribution of blood to transfusing health facilities and support for appropriate use. This is in keeping with the Partnership Framework and the Kenya National AIDS Strategic Plan (KNASP-III) goal of eliminating HIV transmission in healthcare settings. This will also contribute to Global Health Initiative (GHI) goals of reducing maternal, infant and malaria-related mortality. Strengthening of NBTS contributes to health systems strengthening which is a GHI core principle.

Cost-efficiency

NBTS will align itself to the new Kenyan constitution by positioning itself as a national body but serving all counties in the country. It will develop a sustainable health financing system that will tap into national resources, multilateral partners and public-private-partnerships. It will ensure cost-efficiency through improved financial management system, efficient automated blood testing and processing and use of blood components and pediatric packs. NBTS will leverage HIV prevention programs to develop a pool of safe regular donors and will use modern technology such as SMS to communicate with them. The M&E system will be strengthened using an information management system and use of data to enhance program efficiency.

Transition to country

This is a Kenyan partner with country ownership and leadership.
Vehicle information
This partner procured 14 double-cabin pick-up vehicles in FY09 for blood collection and distribution of processed blood to health facilities. This partner will not procure any more vehicles in FY2012.
This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	1,200,000

TBD Details

(No data provided.)

Key Issues

Malaria (PMI)
Child Survival Activities
Safe Motherhood

Budget Code Information

Mechanism ID:	**13550**
Mechanism Name:	**Implementation and Expansion of Blood Safety Activities in Kenya**
Prime Partner Name:	**National Blood Transfusion Service, Kenya**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	2,700,000	0

Narrative:

Objectives and approaches
The Kenya National Blood Transfusion Service (NBTS) will contribute to the prevention of HIV transmission by providing safe and sufficient blood in Kenya. It will work with the relevant MOH structures and in-country partners

to update Blood Safety policies to be in line with the new Kenya constitution and current international Blood Safety trends and as guided by WHO. It will work within the NBTS policy and the blood donor mobilization strategy and in line with approaches that will be guided by the National Blood Donor Services sub-committee of the NBTS TWG to ensure blood is mobilized from safe regular donors while advocating for formation of blood donor clubs. It will adopt newer approaches of donor recruitment and retention including use of SMS, internet, tele-recruitment and use of regional blood donation buses. It will create a culture of regular blood donation among those found to be safe and free of transfusion transmissible infections (TTI). It will ensure quality in blood testing laboratories for TTIs and compatibility testing by adopting standard operating procedures and enrollment in external quality assurance schemes. It will further enroll in the WHO-AFRO stepwise accreditation process for its key laboratories to achieve international certification. It will promote component processing while up scaling appropriate utilization in transfusing facilities through training and mentorship programs. The M&E program will be strengthened so as to ensure data analysis and usage for decision making while strengthening software for information management system. NBTS will ensure infrastructure development that will support collection, equitable access and distribution of blood up to the rural areas while supporting innovative cold chain systems that can serve the Northern and arid parts of Kenya.

Integration with other activities

HIV prevention messaging will be integrated in the blood donor mobilization activities. Those seeking only to know their HIV status will be referred to the HCT program; conversely those people found to be HIV negative in the HTC program and are eligible to donate will be informed of blood donation activities and encouraged to become regular blood donors. HIV positive blood donors will be referred for care and treatment. They will be encouraged to disclose and engage in partner referral or Prevention-with-the-positives interventions.

Coverage and scope

The activities will cover all potential blood donors from 16 to 65 years in line with NBTS policy guidelines. NBTS will ensure mobilization from all blood donor market segments with primary target being safer donors (avoiding populations perceived to be most-at-risk). The geographical coverage will be national with coverage of all counties. NBTS will collect 200,000 units of blood; process 70% of these to components; train 180 staff; ensure 50% of the donors are regular and 80% are notified of their TTI results; ensure HIV prevalence among donors is at most 1% and supply 450 facilities with blood.

Country ownership and Sustainability

NBTS is a local MOH organization led by Kenyans. Training will initially target trainers (TOT) to create a pool for future scale up. Secondly, it will promote formation of blood donor clubs including Pledge 25 that will continue without external support. Lastly once the culture of regular blood donation is inculcated people will continue to donate voluntarily.

Implementing Mechanism Details

Mechanism ID: 13588	Mechanism Name: APHIAplus Nyanza/Western

Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Program for Appropriate Technology in Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 6,465,763	
Funding Source	**Funding Amount**
GHP-State	6,465,763

Sub Partner Name(s)

Elizabeth Glaser Pediatric AIDS Foundation	JHPIEGO	World Vision Kenya

Overview Narrative

APHIAplus Western Kenya is a five-year project funded by USAID to be implemented between January 2011 and December 2015 by a consortium led by PATH and comprising EGPAF, JHPIEGO, World Vision, and BroadReach. The project is designed to work with existing structures and build capacity at the provincial, district, facility, and community levels to achieve fully integrated service delivery in Nyanza and Western Provinces. The project team maximizes Kenyan ownership and aligns the aims of the project with the strategies of the USG and the GOK. The project will build the capacity of partners throughout the life of the project, and continuously transfer more responsibility to manage resources and project activities. APHIAplus builds on the lessons learned during APHIA II, expands successful approaches to high-need districts, and provides more support for interventions addressing the social and economic barriers to healthy lives.

The project is divided into two main result areas which contribute to USAID-Kenya's strategic objective of "Improved health outcomes and impacts through sustainable country-led programs and partnerships". This project focuses on improving and expanding health services from Level 5 to Level 1 and increasing the demand for those services. The project also focuses on reducing the barriers that prevent communities from accessing health care and living healthy lives. APHIAplus Western Kenya has purchased seven vehicles in COP10 to support program activities Western and Nyanza Provinces. The vehicles include 3 Toyota Prados (KBQ 974C, KBQ 975C, KBQ 315J) and 4 Toyota Land Cruisers (KBQ 993C, KBQ 992C, KBQ 302J, KBQ 315J, KBQ 243P). This activity supports GHI/LLC and is funded with both FY12 and pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	500,000
Gender: GBV	400,000
Renovation	438,000
Water	100,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**13588**
Mechanism Name:	**APHIAplus Nyanza/Western**
Prime Partner Name:	**Program for Appropriate Technology in Health**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	0	0

Narrative:

The project supports peadiatric care and treatment in 48 sites in Nyanza and 66 in Western. This support will be scaled up to 62 and 75 sites in Nyanza and Western respectively in 2012.
The project will provide commodities at sites to support early infant diagnosis DBS PCR testing, HIV counseling and testing for older children and adolescents, and CD4 testing - including CD4% - in order to allow appropriate care and treatment services. In addition, the project will provide cotrimoxazole prophylaxis, nevirapine prophylaxis for infants and food by prescription for the malnourished children.

The project will continue to establish and facilitate existing peadiatric and adolescent support groups to promote adherence, peadiatric disclosure and psychosocial support for older children and adolescents. The peadiatric and adolescent services will be linked to and/or provided at the comprehensive care centre (CCC) for the continuum of chronic HIV care and treatment. Infant care will be integrated at MCH to offer seamless routinue MCH services like immunization and growth monitoring as well as HIV services.

HCWs will be supported with onsite and off-site mentorship as well as technical exchange visits for improved service provision. The project will facilitate quarterly PHMT and DHMT support supervision to sites for routinue monitoring of service delivery as well as program-specific supportive supervision. QA/QI initiatives using the HIVQUAL model will be introduced to monitor quality of care indicators at all project sites.

The project will carry out quarterly data performance review meetings and routinue continuous quality improvement initiatives at sites. These resources will also provide integrated outreach and clinical diagnostic assistance using IMCI, for improved referral and health services for the children in those communities who are infected or affected by HIV/AIDS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	728,362	0

Narrative:

The project plans to perform 25,000 male circumcisions in COP12. This target will be realized through static service delivery, outreaches and MOVE campaigns. The services will be provided at 21 health facilities in Nyanza and four in Western. These facilities are spread in 10 districts across the region.
The services will conform to WHO and national guidelines and include trainings, supplies, equipment and client follow up. Project staff will work with DHMTs/HMTs to provide supportive supervision to VMMC sites. Supervision will be guided by a checklist that ensures the services conform to WHO and national standards.
As part of the comprehensive MC package, testing and counseling will be provided on site to all clients on voluntary basis. Confidentiality will be observed during these sessions. This service will be extended to spouses or guardians/parents accompanying clients.

MC will be part of a comprehensive package for HIV prevention. Clients will have the benefit of receiving other HIV preventive information and services which include HTC, diagnosis and treatment of STIs, provision of condoms, and information on abstinence and faithfulness to uninfected partners. Clients will be linked to other HIV services including care and treatment services as necessary.
VMMC trainings will be provided using WHO and National VMMC guidelines. Training for MC under local anesthesia will be in two stages; theory sessions (knowledge), and practical (skills). This will be followed by continuous assessments and mentorship before confirmation on competency and certification by NASCOP.
The project will employ several approaches for demand creation. CHWs will be trained and equipped with relevant messages to promote MC in their communities. Peer groups will also be supported to reach youth, men and women with correct BCC messages. Community opinion leaders such as councils of elders and other leaders will continuously be used. Radio spots will be used to air interactive sessions to encourage dialogue on the services. The project shall also use magnet theatre groups to pass the messages during outreaches and during accelerated VMMC activities. Relevant IEC material shall be provided to health facilities and communities.
MC sites will be supplied with M&E tools. HRIOs will be supported to collect complete and timely MC data and transmit it to district levels.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	1,664,575	0

Narrative:

The project supports HTC activities in 66 and 396 sites in Nyanza and Western provinces respectively. It will scale the support to 70 and 140 sites in Nyanza and Western respectively in the next one year. Target populations for APHIAplus Western Kenya include couples in the general population, particularly those who have never been tested before, most at-risk persons (MARPs), and pregnant women.
Strategies to reach these target populations with HIV counseling and testing include supporting the MOH to provide Client Initiated HIV Testing and Counseling (CITC), Provider Initiated HIV Testing and Counseling (PITC), Home-Based Testing and Counseling (HB-HTC), and to conduct targeted special outreaches to bring HTC services closer to priority populations (e.g. outreaches for hard-to-reach communities, fishing communities). The Project also supports HTC services in ANC and TB clinics and engages lay counselors in priority high-volume facilities.
The Project supported the testing of 148,906 Kenyans in its first year in Nyanza and 346,430 in Western, constituting coverage of 13.4%and 64.6% in Nyanza and Western provinces respectively. Of the total, 218,262 were done through PITC (124,081 in ANC clinic; 8481 in TB clinic), 102,432 through CITC, and 6580 through home-based HTC. Through the aforementioned approaches, the project expects to support the MOH to counsel and test over 629,564 Kenyans in 2012. Similar to achievements in year 1, the project expects approximately 390,000 to be achieved through PITC (162,200 in ANC clinic; 20,700 in TB clinic), 11,664 through CITC, 30,000 through home-based HTC and 15,000 through special outreaches.

The project supports the Ministry of Health's recommended algorithm for serial testing. Referrals and linkages to services for clients who test positive are facilitated through community health workers. Monitoring for linkages is facilitated through community-facility linkage meetings. To improve quality HTC services (both testing and counseling), the project facilitates provider and supervisor orientations on external quality assurance (EQA), on-job training for HTC, updates, regular coaching, and supportive supervision. Technical review meetings are held quarterly to discuss HTC performance, issues and promising practices. Dissemination of promising practices and lessons learned is an output of the performance review meetings.
To improve monitoring and evaluation of HTC, the project provides orientations to healthcare workers on M&E. In 2012, the project will support orientations to healthcare workers on the new HTC guidelines rolled out by NASCOP and the new HTC register MOH 362, which captures disaggregated indicators (eg couple, disability, MARPS).
Project support for demand generation and mobilization for HTC is done through two principle strategies: routine mobilization and community education done by community health workers, and project support for high-profile HTC campaigns and events (e.g. HTC Rapid Results Initiative, and World AIDS Day).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	50,000	0

Narrative:

The project will use a combination approach to HIV prevention that incorporates behavioral, biomedical, and structural interventions targeting specific populations in defined geographic settings in Nyanza and Western. Tailored prevention messages targeting needs of individuals and communities will be used to generate demand for service while promoting healthy seeking behavior and risk reduction. Peer education, dialogue groups and use of multimedia channels like magnet theatre, focused outreaches, road shows, print materials and radio will be used. Drivers of vulnerability, reduction of STIs, HIV acquisition and transmission, condom promotion among MARPS and vulnerable populations like fisher folks, low income women and migrant workers will be addressed.
MARPS
Female Sex Workers: 240 bar managers and stakeholders from 10 priority sites will be sensitized on the national MARP strategy prior to selection of 1000 FSWs for Peer Education training. Each trained peer educator will regularly reach 14 peers with repeat-prevention messages aimed at risk reduction, condom promotion and making referrals for service uptake.140,000 (1000 x 14 x 10) people will be reached in Nyanza and Western in FY12.
Men who have Sex with Men (MSM): An updated inventory of MSM hotspots in Kisumu will be developed. Implementation of MSM Intervention will continue using capture-recapture and snowball methods. Sensitizations, selection and training of peer educators based on National Guidelines for Sex workers shall be conducted. Structured repeat-peer education sessions, outreaches and referrals will follow. As per EBI programming, one peer educator will reach 14 peers with prevention messages. In year 2, 14,000 people (100 x 14 x 10 months) will be reached with repeat-prevention messages, condom promotion and referrals for STI management and biomedical services. Value clarification workshop for providers from referral facilities will be conducted to make them more

responsive to MARPS.
Fisher-Folks Interventions: 312 Beach Management Units (BMUS) are located around Lake Victoria out of which 292 are in Nyanza while are in 20 Western. Each BMU has between 450 and 1000 members. Behavioral interventions targeting fisher folks will be delivered through peer education. Periodic biomedical services of HTC and VMMC outreaches will be conducted at popular BMUs. 1740-trained Peer Educators (140 for Western and 1600 for Nyanza) will meet monthly to submit reports, share experiences and plan. Additional 1000 peers will be trained in PEs. By the end of the year, 2,740 Peer Educators will reach about 350,000 people with repeat-prevention messages, condom promotion and referrals for STI management, HTC and VMMC services in Nyanza and Western.
Workplace Interventions: 1500 additional workplace Peer Educators from 30 work sites will be trained in addition to 322 existing PEs in Nyanza and Western to create demand for health service. To the ratio of 1 PE to 14, 226,800 people will be reached with prevention messages, condom promotion and referrals for STI management and biomedical services. To ensure sustained institutional support at the workplaces, the project will conduct two breakfast meetings for Chief Executives from targeted companies.
Low-Income Women: Community outreaches, one-on-one peer education, and small group discussions will be used to facilitate behavior change among women.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	3,582,305	0

Narrative:

The project is supporting comprehensive adult HIV care and treatment in 48 comprehensive ART sites in Nyanza and 66 sites in Western. This will be scaled up to 62 and 75 ART sites in FY 2012. The target population in the zone is 149,250 comprising all adults testing HIV positive and referred into care with coverage of 17.1% in Nyanza and 43.4% in Western provinces.
The package of care and treatment services provided through the project include cotrimoxazole prophylaxis provision, TB screening during all client visits, CD4 testing for initiation and monitoring, lab tests for ART initiation and monitoring (such as HB, urinalysis and creatinine testing) according to national guidelines, food by prescription (FBP) and supply of ARV commodities at ART sites.
For clients enrolled into care and treatment the project supports clinical appointment and drug therapy adherence counseling sessions at the point of enrollment and continually thereafter by HCWs and project supported peer educators. The project helps clients enroll into psychosocial support groups for adherence counseling and stigma reduction support. Home visits by peer educators help follow-up clients with adherence challenges.
To support client retention in care and treatment the project provides daily appointment diaries at the clinic that are used to track daily clinic appointments. At the end of the clinic day, the missed appointments are immediately notified to the peer educators who initiate defaulter tracing by making telephone calls to the clients, carrying out home visits and notifying patient support group leaders. The project is introducing a new modality which features

an SMS reminder system to notify patients expected clinic appointments and which offers patient education on ART. Client retention to date is at 78% in Nyanza and 89% in Western.
For effective monitoring of care and treatment services at the ART sites, the project facilitates PHMT and DHMT integrated support supervision on a quarterly and as-needed basis. Training needs are addressed by supporting on-site and off-site mentorship. The project is supporting district mentorship teams to offer continual mentorship at site level within a district. The project will introduce on-site HCWs modular training at district hospitals with minimal interruption to service provision.
The project carries out quarterly performance data review meetings for the ART sites which form the basis of continuous quality improvement initiatives. The performance data reviews are incorporated in annual M&E plans and involves clinicians, site managers and M& E staff.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	440,521	0

Narrative:

The project supports peadiatric ART services in 48 and 66 sites in Nyanza and Western provinces respectively. The total current cohort as at September 2011 is 5,306 and those newly enrolled is 1,139. The current peadiatric ART cohort is 9% of total ART in the zone. The services will be scaled-up to 62 in Nyanza and 75 sites in Western in FY 2012. The total cumulative ART pediatric cohort is expected to reach 10,120 with a current ART peadiatric population of 8,800 and 1,800 new enrollments.

The project supports on-going on-site and off-site mentorship, exchange visits of newly initiated site clinicians to established peadiatric ART sites and continued site mentorship by the district mentorship teams to new sites. The goal of the mentorship is to better support early identification and initiation of ART in children as per national guidelines.

The project will support early infant diagnosis DBS PCR networks, CD4 testing networks for CD4% availability, and viral load monitoring for suspected treatment failure cases. MCH integration with pediatric care and treatment for infants and children < 18 months will be supported to promote early identification and retention in care and treatment. Linkages to food by prescription for children with malnutrition will be supported at all supported sites.

Retention rates will be improved through the identification and follow-up of HIV exposed infants by peer educators, regular review of PMTCT and HEI registers, home visits and enrollment into support groups. The project will support adolescent clubs/ support groups, adolescent youth friendly services and health education at facilities and focused adolescent adherence counseling and support.

Quarterly PHMT and DHMT support supervision visits will be facilitated as well as program specific support

supervision visits to monitor availability of peadiatric ARV commodities, treatment algorithms and linkages and referrals to nutritional support, peadiatric psychosocial counseling and community support. *Performance review will be done through quarterly data review and performance meetings and quality improvement assessments at facilities.*

Implementing Mechanism Details

Mechanism ID: 13636	**Mechanism Name: APHIAplus Central/Eastern**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: JHPIEGO	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 5,740,992	
Funding Source	**Funding Amount**
GHP-State	5,740,992

Sub Partner Name(s)

African Medical and Research Foundation	Christian Health Association of Kenya	International Center for AIDS Care and Treatment Programs, Columbia University
Kenya Red Cross Society	Land O'Lakes	Liverpool VCT and Care
National Organisation for Peer Educators (NOPE)	Program for Appropriate Technology in Health	

Overview Narrative

The APHIAPLUS KAMILI (A+K) offers a standardized menu of supportive activities in HIV care and treatment as well as family health and malaria across Eastern and Central Provinces. The approach is demand-driven tailoring the specific package of activities implemented at the district level according to the given district's needs. The technical strategies are built on best practices and government guidelines. The A+K team works through the provincial and district health management teams.

The project supports provision of a comprehensive package of TB/HIV care and treatment services for adults and pediatric clients in public/private/FBO facilities and empowers the service providers to own and effectively manage an integrated quality TB/HIV care and treatment service. Lab transport networks will connect the lower level facilities to central sites. Limited numbers and training of staff is the key challenge faced across the two provinces. A+K will enhance service provider skills using on-site approaches, trouble-shooting programmatic areas and linking HIV services with FP and MNCH.

Strengthening the existing 112 community units will be the key focus in 2012. Other services from HIV testing and counseling through PMTCT services and HIV treatment and care will also be key activities linking the community to facilities as needed.

The monitoring and reporting capacity of the health care providers, local implementing partners and Community Health Extension Workers on correct data capture, aggregation, processing and reporting will be enhanced through mentorship, OJT and supportive supervision. A+K plans to procure 5 vehicles and 17 motorbikes with FY11 pipeline funding. This activity supports GHI/LLC and will be funded primarily with pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	5,000,000
Renovation	97,059

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection

Child Survival Activities
Mobile Population
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	13636		
Mechanism Name:	APHIAplus Central/Eastern		
Prime Partner Name:	JHPIEGO		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	0	0

Narrative:

PLWHIV will receive prevention care and treatment services at health facility and community levels. At community level, HBC care and support services will aim at enabling the PLWH access basic services that will include food and nutrition, medical and nursing care to treat cases of opportunistic infections, STIs and tuberculosis, psychosocial support, shelter and legal support. In 2012, the project will sub-contract a total of 32 LIPs (17 in Eastern and 15 in Central). These LIPs will be locally based NGOs, Faith Based Organizations or CBOs with capacity to provide HBC care and support .At the facility level, through the 118 HIV care and treatment facilities supported by project, PLWHV will receive adherence support and those who default clinic visits will be traced to their homes. The psychosocial support groups at the facilities will address the age/gender-adjusted needs by clustering the groups into adolescent, pediatrics, care givers, adults and PMTCT groups. HBC clients within the psychosocial support groups will be empowered on prevention, stigma reduction, cPwP and positive living. The empowered clients will graduate to the community-based psychosocial support groups and serve as champions of prevention. These community support groups will promote community-facility linkages for prevention and treatment, retention, RH/FP, cervical cancer screening, PMTCT, clinical care service and two-way referral system. HBC clients and their support groups will also be linked to community-based nutrition and income generating initiatives such as food banks and MFIs respectively for sustainability. The project will maintain a data base of all the HBC clients served. The project staff will make periodic follow-up of HBC clients to ensure that they are retained in the program to continue receiving the prevention, care and treatment services. CHWs will collect data at a household level to document the type of services received by the client. Community referral tools will be provided to community units and health facilities to facilitate a two-way referral system. The project staff and the

LIPs will closely work with the community units and trained CHWs for service coordination, monitoring and evaluation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	2,829,780	0

Narrative:

Care & Support Services for OVC will them enjoy the basic human rights that include right to food and nutrition, health care, psychosocial support, shelter, education and vocational training and legal protection. To reach the OVC with care and support, the project will sub-contract the Local Implementing Partners (LIPs), train and provide them with grants for OVC/HBC services. In 2012, the project plans to sub-contract a total of 32 LIPs (17 in Eastern and 15 in Central) and reach 123,000 OVC (75,000 in Eastern and 48,000 in Central) and 30,000 HBC clients (8,000 in Central and 22,000 in Eastern). OVC and PLWH will receive care and support at a household level to foster community and family participation as this approach has been shown to reduce stigma and discrimination. Those to benefit from the project as OVC will constitute children aged 0-17 years while ensuring both girls and boys have equal chances of benefiting from the project. Those aged 18 years and above will be considered as beneficiaries on home based care and support. The project will maintain a data base of OVC/HBC clients. Project staff will make periodic follow-ups to ensure retention on the program. The project OVC/HBC staff and the LIPs will work closely with the community units and trained CHWs will be assigned to OVC/HBC households. OVC who test HIV positive will be counseled and referred to health facilities for treatment. To ensure that the OVC and HBC clients on the program receive quality services, the project will train the LIP project staff on QI standards. The LIP will cascade the training to lower levels to reach QI teams. The project staff will also conduct random visits to OVC and HBC clients at their households and schools to verify the type of services provided. The project will support the beneficiaries to engage in viable income generating activities (IGA) through training on group dynamics, identification of viable IGAs and marketing strategies. The project will also encourage the OVC care-givers and PLWH to form and register groups and link the groups to micro-finance institutions to access credit for starting IGAs. In partnership with the line ministries, the partner will support the OVC households in growing drought resistant and high protein food crops to boost food security. The project plans to partner with the LIPs in establishing community food crops to sell cereals at subsidized costs. Data will be collect at a household level by CHWs on type of services received by the OVC and HBC clients on the program. The project staff will conduct quarterly supportive supervision, review OVC/HBC data records and make random visits to the beneficiaries to assess quality of services that are received by the OVC/HBC clients.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	0	0

Narrative:

Support for TB-HIV activity is centered on the DLTLD and NASCOP collaborative activities. The PTLC/PASCO

and the DTLCs and DASCOs lead the processes at the provincial and district levels respectively. Support for intensified case finding through provision and mentorship on use MOH, screening tools at the CCC and MCH, Mentorship on TB HIV integration models, provision of job aids and IEC materials, scaling up ART uptake among TB-HIV co-infected patients and carrying out CMEs on infection prevention/control. We also support implementation of minimum package for infection prevention and control including cough monitors, fast tracking of coughers, ensuring cross ventilation in all the clinical rooms and giving health talks on cough etiquette.
We do carry on-the-job training for service providers as well as sensitizations/CMEs on up-dates.
In this second year more focus is laid on supporting the TB-HIV collaborative meetings and strengthening integration of TB and HIV services. Participation in the quarterly review and planning meetings with the DTLCs, DMLTs and DASCOs continue to be an important factor in ensuring that we address government priorities. HIV testing in the TB clinics has been well over 90% whereas TB screening in the CCC clinic has been averaging 60-70%. Focus will be on scaling up TB screening to about 90-95%.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	0	0

Narrative:

To scale up uptake of pediatric HIV services, we support a mentorship program that takes into account special aspects of children living with HIV. In decentralization, all the facilities providing HIV care and treatment services have been supported to offer pediatric services. The mentorship program has paediatric components that address issues like paediatric psychosocial care, management of opportunistic infections like TB, growth and neurodevelopmental screening, and management of treatment failure.
Adherence and psychosocial support services for children include innovative use of colour-coded labeling of syrups and syringes for the un-educated parents and care givers. Enrollment of children into psychosocial support groups is done according to their age groups thereby taking into account their cognitive development. The adolescent support groups are linked with other youth-friendly services in the facility. Support for care-givers support groups to run concurrently with the children support groups so that adherence measures can be reinforced. Other measures include structuring the parents or care givers clinic days to coincide with the children's appointments. Integration of HIV services in the MCH ensures follow up of the mother and child in one clinic to minimize time spent in the health facilities. This also increases retention by minimizing defaulting. We envision complete integration of MCH and HIV services during the project life. Those missing appointments are linked with the integrated defaulter tracing mechanism through community health strategy and the care takers psychosocial support groups. Follow up of the HIV exposed infants and the PMTCT program continues to be integrated with CCC services to ensure no missed opportunities. Efforts are in place to scale up EID services in tandem with PMTCT services. Family and partner testing is an approach employed at the CCC and the MCH to increase case detection rate among children in the families living with HIV. Provision of PITC services in the pediatric wards minimizes missed opportunities and encourages linkage between CCCs and the in-patient wards. In the

Multi-disciplinary team meetings, one of the agenda is usually to address needs of special populations mainly children. Facilities with more than 10 children are structured to have a special clinic day for children so that they are fully investigated then. The standards of care assessment (SOCs) have a portion for children and adolescents separate from the adults SOCs. The target population/geographic coverage will contribute to scaling up pediatric participation in treatment programs, including pediatric targets. Other activities are to provide drugs, food and other commodities for pediatric clients (HIV exposed infants, HIV infected children and adolescents). Project will support the needs of adolescents with HIV (PwP, support groups, support for transitioning into adult services, adherence support), supervision, improved quality of care and strengthening of health services, promoting integration with routine pediatric care, nutrition services and maternal health services. We wil strengthen laboratory support and diagnostics for pediatric clients. These resources will also provide integrated outreach and clinical diagnostic assistance using IMCI, for improved referral and health services for the children in those communities who are infected or affected by HIV/AIDS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

The project will support AB activities within the framework of the Comprehensive School Health Program which is supported by the Ministries of Public Health and Sanitation and Education. This program will be rolled in schools, tertiary colleges and out of school youth groups in the project intervention areas. These EBIs are an integrated set of planned, sequential, school affiliated strategies, activities and services designed to promote the optimal physical, emotional, social and educational development of learners/education sector actors. This program component will target young people aged 10-24 years both in school, out of school and in tertiary institutions. They will be taken through Life skill sessions using the approved EBIs, such as Healthy Choices, the KIE approved life skills curriculum and the KARHP curriculum. These will be complemented with interventions such as Shuga and other HFG activities. These interventions provide a set of Life Skills and Adolescent Reproductive Health Education that empowers young people make informed decisions and help delay onset of sexual activity and or practice of secondary virginity which may otherwise lead to increased HIV infections amongst youth. These interventions will be implemented in districts such as Tharaka Nithi, Embu Mbeere, Kitui Mwingi and Makueni, Kirinyaga, Nyeri and Kiambu. The project will print and distribute the appropriate curriculum and will support the Ministry of Education officials to conduct supportive supervision in the institutions targeted. The targeted youth will, as appropriate, be linked to the relevant biomedical services such as counseling and testing and condoms. Each school/institution will be supported to undertake a self-assessment and develop an appropriate action plan that will be reviewed annually to assess level of achievement. All the interventions will adopt the Comprehensive Prevention Program approach. They will be the approved Evidence Based Interventions (EBIs) or those that are curriculum based some of which are adapted from those locally developed by PATH in various USAID funded projects (IMPACT, AMKENI, Scouting for Solutions, KARHP) and from the Centre for Disease Control and Prevention (CDC) compendia for

EBIs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	31,568	0

Narrative:

HTC services are supported in 16 Districts in Eastern Province and fourteen districts in Central Province. Eastern has a HIV prevalence of 4% for women and 3% for men while Central is at 6% for women and 3% for men according to KDHS 2008- 2009.HTC services are provided using both PITC and CITC approaches. PITC services are provided at all public and some faith based facilities both in Inpatient and outpatient departments .Community HTC is provided through outreaches, mobile VCT, door to door testing and workplace outreaches. These activities target the general population but with special focus on first time testers and couples. MARPS receive services through targeted outreaches. Working with the BCC team, MARPS are mobilized using the peer led approach and receive combined prevention intervention which include HIV testing and screening for STIs. Moonlight HTC is utilized to reach the subpopulations. Quality assurance for HTC is ensured by linking all facilities to the NHRL to ensure that they participate in the EQA exercise. The DMLTs are supported to organize for quarterly proficiency testing activities within their districts to refresh the providers on laboratory practices. Facilities have regular visits by the District laboratory and counselor supervisors to ensure quality testing is going on at all service delivery points. HTC providers receive regular update meetings to keep them appraised with new HIV testing information and dissemination of guidelines. Ninety HTC providers had refresher training on couple HTC while Three hundred and fifty three HCWs were updated on the retesting guidelines and National Quality management guidelines for HTC. The national algorithm for testing is utilized at all facilities and the national reporting tools and reporting structures are utilized. Referral and linkages to care services will be strengthened by use of the referral forms which the client takes to CCC and a copy left at the testing point. Telephone follow-up to the clients will also be done The facility MDTs will be tasked to document follow up and tracking for clients referred to the CCC.The community units are utilized to create demand for services both at the facility and at the community outreaches. Gender based violence activities are carried out both at the facility and community levels. At the facility level, Post rape care services are provided at the Outpatient department where the clients report. Examination and prophylaxis together with trauma counseling form the PRC package. Update for HCWs on management of survivors of sexual violence is provided regularly and trauma counselors receive supervision on quarterly basis. Sensitization on GBV to community leader's police officers, children's officers and other stakeholders provides them with information for GBV prevention and response. Community units are sensitized to ensure they know where to refer survivors and what a survivor should do or not do when raped. Stakeholders meetings are held to create a forum where stakeholders can share their interventions and also discuss strengthening the medico legal linkages.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	445,907	0

Narrative:

The project will target individuals or groups whose behaviour puts them at very high risk of HIV infection. These include female and male sex workers, IDUs, MSM, truckers, discordant couples, migrant workers, prisoners and other incarcerated individuals and urban slum populations. Other interventions include the comprehensive workplaces wellness program and the community strategy (CS). Mapping of bars and hotspots will be carried out in both Central and Eastern provinces. The project will support the national MARPs mapping exercise and collect specific information that will be useful in programming for MARPs. The interventions for MARPs will be in line with the NASCOP guidelines and meet the minimum standards set. That will include behavioral, biomedical and structural interventions such as health education, provision of condoms, counseling and testing, STI screening and treatment and linkages and partnership (NHIF, MFI, GoK, alternative livelihood skills development). The MARPs program will target the transport corridor specifically Chumvi and Sultan Hamud, urban slums and sex workers in Embu, Meru, Nyeri and Thika and six prison populations. The workplace program will target the big agricultural firms in the Mt Kenya region, specifically the KTDA factories, flower farms and the industrial town of Thika. The CS will continue to be prioritized in the hard to reach and marginalized areas of the Zone such as lower eastern and Mbeere in Eastern and in Kyeni, Thika East and Kirinyaga counties. The community units will be increased to 200 benefitting an estimated population of 1 million people. The interventions will be guided by the minimum standards as defined by NASCOP and the KEPH and will be integrated with the appropriate services. MARPs, Workplaces and community units will be linked to service delivery points as well as integrated outreaches to support hard to reach areas. The activities in CS will be reported through the National CBHIS system, while the MARPs and workplaces within the KEPMS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	714,565	0

Narrative:

Geographical coverage for PMTCT interventions is 17 districts in upper Eastern (289 sites) and in Central Provinces 12 districts (133 sites). Current accomplishments include mapping of all PMTCT sites, formation of PSSG, orientation of the HCW on current PMTCT guidelines; mentorship on PMTCT/EID rolled out; orientation of HCW on DBS sample collection; support for BFI certification; CMEs on PMTCT/EID; targeted SS in PMTCT ; provision of logistical support for lab networking; Support for DBS sample transportation; distribution of PMTCT/EID tools; PMTCT Counselors have undergone orientation in couple testing and identification and support of Champions. Our set Targets are: 80 % of facilities offer minimum package of PMTCT; 95 % HIV exposed infants receive Prophylaxis in MTCT; 2000 HIV positive pregnant women receive ARV prophylaxis; 82% of HIV exposed infants receive EID test within 2 months of birth; 80% of PMTCT supported facilities offer EID services; 90% of facilities visited at least once a quarter; 85% of facilities using SBMR in PMTCT for improved quality of services; 100% of facilities receive mentoring visits; 20% of facilities offer integrated services: PMTCT/RH/FP. The detailed plans for achieving targets include using CMEs, OJT, mentorship, SS, formation and support of PSSGs, Lab

networking for EID services; use of Integrated MCH Model; Use SBMR in PMTCT /EID services; male involvement supported; Identifying and recognizing champions; acceleration of Nutrition HINI/HII; Community PMTCT by mobilization, couple testing, CHWs for defaulter tracing; Integrated MNCH outreaches with support supervision; distribution of PMTCT/EID tools- e.g. HEI registers; share best practices; SMS platform for PMTC Messages; Counselor SS; Linkage of HIV +ve pregnant mothers/infants to replacement feeding programs; Increase Couple PMTCT sessions; and support graduation ceremony for HEI at 18 months before linkage to Care &Treatment team. The project shall measure progress by the No of HIV exposed infants who are negative at 18 months, tracking HEI follow up to care and treatment sites after 18 months; PCR at 18 Months; No of HEI exclusively breastfed infants at 6 months; No of infant's receiving measles vaccine at 6 months; No of HIV women receiving nutrition assessments for food supplementation; HIV positive women of modern FP and dual methods; HIV positive women accessing CECAP services. Increasing coverage will be through increasing number of sites offering PMTCT minimum package of care; decentralize PMTCT mentorship activities to lower facilities; SBMR in PMTCT and nursing process to improve quality of PMTCT/EID services; Integrated Support Supervision. Reducing costs will be by riding on transport network of Care and treatment team in the DBS sample transportation; use SMS for DBS results notification; Integration of activities within MCH: PPFP, FP in ANC, CECAP, TB screening; Use online updates on latest PMTCT guidelines on new changes; Use of champions as mentors at facility level; Global E-learning on PMTCT/EID; Encourage SBA for PMTCT; by motivation e.g provision of mama packs to women; Mentor mothers for defaulter tracing; Synchronize DBS sample collection with KEPI schedule; Staff recognition; Whole market approach in CMEs, OJTs, Mentoring SS; Transitioning to FBO; ARVs, Counseling time, CD4, Viral load, FBC, UECs, LFTs; TB & STI screening and treatment; CECAP; Documentation; SS; Job aids and mobilization cots.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,508,514	0

Narrative:

The project will support implementation of a quality, chronic care model for the care of PLWHIV in 118 health facilities in eastern and central provinces. The supported facilities will cover both public (94) and private facilities (private for profit-7, and private not for profit-17) in a whole market approach. Support to these facilities will entail a government-led technical mentorship utilizing a multidisciplinary team of GOK and Aphiaplus mentors who have a structured mentorship schedule of visits. The project will also support the facilities with basic furniture, job aids, stationery and other tools to facilitate service delivery. Other areas of support include technical and financial support to establish and maintain a laboratory network for CD4 and viral load sample transport from the lower level facilities to the central laboratories. This ensures that patients attended at the dispensaries and health centres have access to laboratory investigations only available in the district hospitals. At the clinic level, the project will continue to offer financial and technical support to the MDTs to manage the clinic and integrate HIV services with the other health services at the facility. Multidisciplinary teams monitor quality of care to the patients by carrying

out a biannual assessment of standards of care (SOC) which are derived from the national guidelines. Defaulter prevention and defaulter tracing mechanisms will be strengthened to ensure patients retention to care and treatment while establishing intra-facility and community linkages. Support to strengthen pharmaceutical and laboratory commodity management serves to minimize acute stock outs as well as mitigating expiry of commodities at the facility. The project will offer technical support through district-based and community-based CME/CPD sessions, On-job training and couching. The project seeks to empower patients through psychosocial support groups, health education, supporting prevention by implementation of PWP package and also the peer educator program. Each facility MDT is supported to recruit two peer educators (expert patients) from among their clients who help to champion adherence and prevention strategies. District and provincial health management teams are supported financially to carry out integrated quarterly support supervision. The project also aims at convening an annual forum for the supported facilities to share best practices. The excelling facilities/champions shall be given recognition. Through this the project encourages health completion among the facilities and service providers as they strive to shine in service delivery.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	210,658	0

Narrative:

To scale up uptake of pediatric HIV services, we support a mentorship program that takes into account special aspects of children living with HIV. In decentralization, all the facilities providing HIV care and treatment services have been supported to offer pediatric services. The mentorship program has paediatric components that address issues like paediatric psychosocial care, management of opportunistic infections like TB, growth and neurodevelopmental screening, and management of treatment failure.

Adherence and psychosocial support services for children include innovative use of colour-coded labeling of syrups and syringes for the un-educated parents and care givers. Enrollment of children into psychosocial support groups is done according to their age groups thereby taking into account their cognitive development. The adolescent support groups are linked with other youth-friendly services in the facility. Support for care-givers support groups to run concurrently with the children support groups so that adherence measures can be reinforced. Other measures include structuring the parents or care givers clinic days to coincide with the children's appointments.

Integration of HIV services in the MCH ensures follow up of the mother and child in one clinic to minimize time spent in the health facilities. This also increases retention by minimizing defaulting. We envision complete integration of MCH and HIV services during the project life. Those missing appointments are linked with the integrated defaulter tracing mechanism through community health strategy and the care takers psychosocial support groups.

Follow up of the HIV exposed infants and the PMTCT program continues to be integrated with CCC services to ensure no missed opportunities. Efforts are in place to scale up EID services in tandem with PMTCT services. Family and partner testing is an approach employed at the CCC and the MCH to increase case detection rate among children in the families living with HIV. Provision of PITC services in the pediatric wards minimizes missed opportunities and encourages linkage between CCCs and the in-patient wards. *In the Multi-disciplinary team meetings, one of the agenda is usually to address needs of special populations mainly children. Facilities with more than 10 children are structured to have a special clinic day for children so that they are fully investigated then. The standards of care assessment (SOCs) have a portion for children and adolescents separate from the adults SOCs.*

Implementing Mechanism Details

Mechanism ID: 13664	**Mechanism Name: APHIAplus Nairobi/Coast**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Pathfinder International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

Christian Children's Fund, Inc	Cooperative League of the USA	Network of AIDS Researchers in East and Southern Africa
Population Services International		

Overview Narrative

The goal of the APHIAplus Nairobi/Coast project is to support the public, NGO and for-profit sectors in Nairobi and Coast Provinces to provide sustainable, integrated, quality health services to Kenyans, resulting in improved health. Through strategic partnerships, the country-led project will capitalize on existing opportunities to make a

lasting contribution to improved health outcomes. All activities are aligned with existing GOK policies, guidelines, strategies and priorities. Activities are also aligned to the PF as they will address issues of health systems strengthening, integrated service provision and demand creation.

APHIAplus will implement integrated programs that include HIV, RH, child survival and malaria. In doing so, efficiencies will be realized in investments in equipment, infrastructure and training as services are co-located and the same staff and facilities are utilized in service delivery. They will also work towards providing TA on task shifting to increase health worker efficiencies. Additionally, they will collaborate with the national work groups exploring options of sustainable financing, such as health insurance schemes and promoting integration of the private sector in service delivery. APHIAplus will provide TA to the GOK programs at the provincial, district and service delivery levels to ensure GOK ownership. Furthermore, they will support strengthening systems, including working with District and Provincial Health Management Teams, and strengthening country ownership and building capacity for a sustainable, long-term GOK response to the HIV pandemic. This partner will procure 8 vehicles using past year funds but none with FY12 funds. This activity supports the GHI/LLC and is funded primarily with pipeline in this budget cycle.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Mobile Population
Safe Motherhood

TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	13664		
Mechanism Name:	APHIAplus Nairobi/Coast		
Prime Partner Name:	Pathfinder International		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	0	0

Narrative:

APHIAPlus Nairobi-Coast HBHC programs support a comprehensive package of care and support services to promote health, improve quality of life, prevent HIV transmission and delay HIV disease progression in PLWHA. The package includes prevention and treatment of OIs, malaria and diarrhea (including provision of commodities such as pharmaceuticals, insecticide-treated nets, safe water interventions and related laboratory services); nutrition assessment, counseling and support; and pain and symptom relief. Involvement of the community and organizations of PLWHA will continue through psychosocial support groups, employment as peer educators, HIV treatment awareness activities, wraparound food programs, and income-generating activities.

APHIAplus will offer an integrated package of care services to all HIV+ patients at the health facility level, including clinical assessment for ART eligibility; lab monitoring; psychosocial counseling, including support for HIV status disclosure, positive living and referral to support groups; adherence counseling and support; nutritional assessment, counseling and supplementation; PwP; family planning; support for family testing for spouses/partners and children; opportunistic infection diagnosis and treatment, including TB; pain management, and increased access to opioids for registered palliative care centers. APHIAplus will work closely with the regional Nutrition and HIV Program (NHP) participating in scale up and implementation support - trainings, equipment, inventory management, and early identification of malnutrition using MUACs for early referrals. APHIAplus will also increase linkages to and implementation of food security and livelihoods interventions as they graduate patients out of therapeutic nutritional care.

In collaboration with facility in-charges multi-disciplinary teams will be established for HIV care and support and treatment. The project will strengthen linkages between health facility committees and the community health committees/CUs for referral. Facilities will be supported to achieve high patient retention and greater adherence by

expanding interventions, such as referral desks that increase health literacy, ensuring availability of psychosocial support, and improving on defaulter tracing. Facility PwP package provision will be promoted at all outlets. STI screening and treatment and the provision of FP will also be integrated.

At community level, support will be provided for training PLHIV (including MSW, FSW, discordant couples and OVC caregivers) on health literacy and PwP thus promoting treatment adherence, positive living and good nutrition for PLHIV. CHWs will be trained on CHBC, PwP, SGBV, defaulter tracing and pediatric counseling. The project will assist support groups, including assistance with regular updates. HH economic strengthening initiatives will improve food support at community level. The project will purchase HBC supplies and fund monthly transport allowance for CHWs. CHWs will be supported to establish support groups (targeting pregnant women, youth, MARPs) for peer-to-peer psychosocial support and treatment adherence.

The project will build on the GOK systems for data collection and reporting at all levels to strengthen data quality and management. The project will support DHRIOs and DASCOs with technical assistance. In FY12 persons reported as receiving basic care and support will receive at least one clinical service, plus at least one service.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	0	0

Narrative:

Pathfinder is an International Organization implementing the APHIAplus program in Nairobi and Coast provinces. APHIAplus works with GOK, CBOs, FBOs, NGOs and communities to serve OVC (in and out of school) and their families, implementing community-based activities aimed at reducing their vulnerability to HIV/AIDS and helping them become productive members of society. In COP12, APHIAplus will build on the Quality Improvement Initiative spearheaded by GOK and will support dissemination of service standards to the point of service delivery. This project targets children 0-18 affected and infected by HIV in Nairobi and Coast provinces. APHIAplus uses an evidence-based community-strengthening approach, as working within community structures is shown to have a more lasting effect on the livelihoods of OVC and project sustainability. APHIAplus will continue to support the GOK to undertake service mapping that will facilitate informed decision making and support coordination of OVC stakeholders.

The goal is to support local implementing partners (IPs) and GOK to deliver services for OVC to address lack of educational opportunities, social and emotional support, inadequate health care, malnutrition, and susceptibility to abuse and exploitation. APHIAplus will provide sustainable, high-quality services to OVC, including: strengthening capacity of families to cope with their situation; strengthening community-based responses; increasing capacity of children to meet their own needs; and raising awareness within communities to create supportive environments for OVC.

APHIAplus fosters close relationships with the Department of Children Services, the Ministry of Gender, Children and Social Development, the National Council for Children Service, the OVC Secretariat, the Nairobi and Mombasa City Councils. APHIAplus also collaborates closely with the Ministries of Education, Youth, Health, and Agriculture. CBOs and FBOs will link with community units (CUs), which will contribute significantly to the sustainability of the project. CUs and IPs will support OVC and their caregivers in accessing health, education, and legal services, and support groups. Activities will be tailored for age and gender, and adolescents will receive information on reproductive health, life skills, and income generation. The investment in accessible health services for OVCs will benefit overall access to comprehensive care within the health system. Health services include growth monitoring of the under-fives, deworming and vitamin A supplementation, and immunization campaigns. For HIV positive children, OVC support groups will improve ART adherence. Support groups for children of all ages will be strengthened and more created where necessary.

Technical support includes planning, budgeting, and delivering quality services (protection, health, food and nutrition, education, psychosocial support, shelter and care and economic empowerment) to OVC guided by priorities at the child, household and community levels, which aligns with PEPFAR's support to OVC through the 6+1 core program areas. APHIA will also help the GOK disseminate policies like the Early Childhood Development policy and the School Health policy, and ensure that stakeholders understand and implement them. In COP12, PEPFAR will support GoK efforts in rolling out and disseminating the recently finalized OVC service standards, and mainstreaming OVC QI standards in service deliver.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	0	0

Narrative:

APHIAplus Nairobi-Coast's overall objective of the HIV/TB care project is to decrease the prevalence of TB in Nairobi and Coast provinces and integrate care of co-infected patients into a comprehensive program that meets the objectives of the Division of Leprosy, Tuberculosis and Lung Diseases (DLTLD) and NASCOP. This activity will support and strengthen the Global Stop TB Strategy, which Kenya has adopted, emphasizing effective DOTS delivery with focus on HIV-associated and drug-resistant TB, health system strengthening (particularly primary care and laboratories) and closer engagement with patients and communities.

Support for expanding TB/HIV services at facility and community levels is stipulated in the national policies and strategic plans. HIV/TB co-infection is approximately 48% of new TB patients. APHIAplus will address challenges in Nairobi and Coast provinces, which include multi-drug resistant TB, poor nutritional support for TB clients, limited HIV/TB integration, and pediatric TB diagnosis and management. Interventions target MARPS, vulnerable children, PLHIV, slum dwellers and transport workers as target groups. Activities aim to improve early

identification of TB and diagnosis, intensify case finding, case management, and improve the cure rate, reporting rate, and infection prevention and control.

TB/HIV integration support includes provision of TB screening tools, defaulter tracing to avoid drug resistance, contact tracing, and transportation of sputum for TB culture and drug sensitivity test (DST) for failed, retreatment, relapsed cases or those returning to treatment after a period of default. The number of diagnostic sites in both provinces (currently 107 in Nairobi and 88 in Coast) will be increased. APHIAplus will support training of service providers, renovations, nutritional support, provision of equipment, staffing, and collaboration with GOK officials. Community desks and health talks are planned at facility level. Treatment support groups will help in defaulter tracing while community forums will help in passing prevention messages. CHWs will be involved and ICF tools will be piloted among OVC.

Support to GOK includes mentorship, support supervision, CME, and OJT, orientations of health workers and CHWs on MDR-TB, IPC and training of CHWs on defaulter tracing. In collaboration with P/DHMTs, needs for facilitators (numbers, refresher training) will be identified and addressed by linkages with national mechanisms. Standardization of CMEs is essential. This project will result in increased demand creation for TB/HIV services, increased access to PITC and ARVs, improved infection prevention and control at the facilities, TB intensified case finding integration into HBCT, CCC, OPD, improved medical and pediatric wards and improved pediatric TB diagnosis and treatment.

APHIAplus will monitor and evaluate this program using identification of M&E tools, distribution of the tools to facilities, orientation of services providers on the use of tools, record keeping, data analysis and use for decision making, data sharing/review forums, supervision by PTLC and DTLC and logistical support to strengthen MDR TB surveillance.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	0	0

Narrative:

APHIAplus Nairobi Coast's pediatric care and support program aims to optimize the continuum of care for HIV exposed and infected infants (HEI) and children through provision of clinical, psychosocial, spiritual, social and prevention services. 141,275 adults and 4,159 children are now on ART treatment in both provinces. APHIAplus will build upon and continue to prioritize the identification of exposed and infected children through EID for those <18 months of age, PITC in clinical settings, family testing through clinical and community HTC strategies, and the launch and use of the combined mother-child card. Activities will involve the intensified identification of HIV-exposed and infected children both at the facility and community level, and collection of samples for DBS and strengthening of DBS networks to all facilities offering PMTCT services. DBS collection will be closely linked to

immunization schedule and regular growth & nutritional monitoring. Exposed children will be followed until their status is confirmed, and are then proactively linked to pediatric care services and ART if infected. The project will help decentralize services so patients get treatment where they are presenting for care.

APHIAplus will support virological testing for 1,616 HIV exposed children. Out of the infants tested those who test positive, 243 newly enrolled will be put on ART while 1,571 will be continuing treatment. A total of 3,780 will continue receiving comprehensive care services. In addition, 52,875 eligible children will be supported to access food and nutrition services. APHIAplus supports holistic care and support services and the availability of a high quality package that includes prevention and treatment of OIs and malaria and diarrhea, including provision of commodities such as pharmaceuticals, insecticide-treated nets, safe water interventions and related laboratory services; nutrition assessment, counseling and support; and pain and symptom relief.

Mentorship of service providers will support the expansion of service outlets providing pediatric HIV care and treatment services. Facilities will be supported to achieve high patient retention and greater adherence by expanding interventions such as referral desks, increased health literacy, availability of psychosocial support, and improvement on defaulter tracing. Lab networking for CD4 and DNA PCR testing for EID in HEI will be supported through skills building of lab technicians on HIV lab services and transportation of lab samples and results.

CCC family days will be supported through provision of edutainment and lunch; OJT will be undertaken for HIV counselors on Hero book to empower children on coping skills for positive living and better treatment adherence. CHWs will be trained on CHBC, PwP, SGBV, defaulter tracing and pediatric counseling. The project will assist support groups, and economic strengthening initiatives will strengthen food support. The project will purchase HBC supplies and fund monthly transport allowance for CHWs. CHWs will be supported to establish support groups (targeting pregnant women, youth, MARPs, including for YLHIV) where clients will be encouraged to form pairs for peer-to-peer psychosocial support and treatment adherence.

These resources will also provide integrated outreach and clinical diagnostic assistance using IMCI, for improved referral and health services for the children in those communities who are infected or affected by HIV/AIDS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	0	0

Narrative:

The APHIAplus Nairobi-Coast VMMC program is one part of a comprehensive prevention package, which is part of a larger package of integrated support at health facilities and communities, holistically addressing HIV prevention, treatment and care. Nairobi province's VMMC three year target is 120,000, of which APHIAplus will circumcise 14,285 men in COP12. APHIAplus currently supports five facilities in Nairobi province to provide

comprehensive VMMC services to males aged 15-49 years, with an increased focus on recruitment of hard-to-reach older men population. APHIAplus will also support the establishment of two more sites in Nairobi in this coming year. APHIAplus will collaborate with Nyanza Reproductive Health Society, who has been training VMMC service providers for Kenya using approved curricula, to ensure APHIAplus staff is trained to highest standards. The target population and their partners will also receive key messages on HIV prevention and family planning as part of an integrated approach.

Community mobilization will take place in the targeted communities where male circumcision is low and where cost remains a barrier to access of services. VMMC messages will be disseminated and mobilizers trained to create demand. Women and girls will be targeted with information and mobilization, as their vital role in decision making and influence regarding VMMC in Kenya is widely recognized. VMMC awareness will be raised during the community days and in opinion leaders' forums. Focus group discussions will be used to dispel myths and misconceptions about VMMC in communities and to brainstorm ways of working around this to remove barriers to access to care. The HCM VMMC video will be screened and this will be followed by small group discussions to ensure that the right messages are imparted.

Dedicated teams are hired on renewable 6-month assignments. Teams consist of a clinical officer, a nurse, a counselor and a hygiene officer. They will mentor other facility staff to ensure sustainability, ownership and continuity of services. Outreach services will be provided to improve access where distance is a barrier whereas the project will participate in the provincial RRI. Minor renovations are in the process at the public facilities. Circumcision kits will be provided by the project and national partners. The project ensures high standards of clinical care and infection prevention, providing TA, supportive supervision, and quality assurance visits. Whole site sensitization of service providers will be conducted to improve interfacility referral and to improve attitude of service providers.

APHIAplus Nairobi Coast will develop an intensive M&E plan in order to ensure the highest quality services are delivered. Activities will include routine site visits, reporting checks, and training of workers in data collection. Adverse events will be closely monitored and steps taken to improve the rate of such events. The partner will ensure standardization of data collection forms and consent forms across all sites and according to national and World Health Organization guidance. This activity supports the Kenya Partnership Framework by using evidence-based, data driven approaches, efficiency of activities, and sustainability of all interventions. The goals and objectives of the partnership framework include providing facilities, personnel, and technical leadership for VMMC facilities, and to support community mobilization and outreach approaches.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

APHIAplus Nairobi-Coast covers Nairobi and Coast provinces and targets general populations, men and women, (especially concurrent partnerships and discordant couples), in and out of school youth, teachers, most-at-risk populations (MARPs), and more with evidence-based intervention (EBI) HIV/AIDS prevention programs that promote abstinence and/or being faithful, and link to condom and counseling and testing programs where appropriate.

In-school small group programs for 10-18 year olds will emphasize support systems to focus on long-term goals, self-esteem and life skills. For example, APHIAplus supports the Kenya Girl Guides Association, which implements a life skills program that targets boys and girls. Girl Guides, young leaders and Guide Leaders will be trained on promoting abstinence, including delay of sexual activity or secondary abstinence and related social and community activities. Gender-sensitive messages that discourage cross-generational and transactional sex, sexual violence and stigma will be passed, giving young people skills to help sustain desirable behaviors. Diverse small-group, evidence-based approaches will be utilized: peer education, outreaches, songs, poems, drama, educational rallies/ fun days, art/essay competitions, etc. Life Skills Promoters will train peer educators to use dialogue groups to conduct peer education sessions using nationally approved curriculum and age-appropriate workbooks and reference materials. Teachers and parents will be involved in programs as much as possible. Programs for adults and youth out of school (15-49), will consist of AB EBI with emphasis on being faithful and reduction of multiple and concurrent sexual partnerships, a main driver of the Kenyan epidemic.

Small group sessions will be carried out by facilitators and CHWs, who will be trained on BCC methodologies. Around 3 million people in Nairobi and Coast live in low income areas such as urban slums and rural areas. Through APHIAplus interventions this population will be targeted directly with at least two in-depth contacts per target in 2012. APHIAplus will implement comprehensive prevention with positives programs by working with PLWHA support groups, linking them to comprehensive care centers and other services, and delivering key messages about living positively. These activities will provide assistance to patient support groups and post-test clubs in VCT centers to encourage abstinence and to empower support group participants to become peer and advocacy leaders in prevention at the community level.

Individual, small group or community level interventions that explicitly address norms about masculinity related to HIV/AIDs will be conducted in Nairobi and Coast, including men-as-champions programs and gender-based violence prevention forums. APHIAplus programs also include interventions that explicitly aim to increase access to income and productive resources for women and girls impacted by HIV/AIDs.

Intensive M&E will include support supervision visits, audit checks, training of facilitators and monitors on data collection and data entry, and progress review meetings with community health workers and community based organizations.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVCT	0	0

Narrative:

In Nairobi and Coast, coverage for HIV testing and counseling (HTC) is relatively high, for both women (Nairobi 83%; Coast 91%) and men (Nairobi 79%; Coast 87%) (KDHS 2008). In the last year APHIAplus Nairobi-Coast reached over 350,000 people with HIV Testing and Counseling (HTC). But in both provinces, coverage is less a problem than achieving sustained quality of HTC, ensuring that most-at-risk populations (MARPs) properly access HTC services and that those testing positive are effectively linked with care. APHIAplus will ensure that HTC services in Nairobi and Coast provinces are readily available, high quality, and meet needs of clients, and are in line with national guidelines.

The project will support various service delivery models for HTC (facility based, PITC, mobile VCT, door-to-door outreaches, couple testing, RRIs) and focus on increasing access and acceptability for men and even greater access for MARPs. The project will support the Provincial and District Health Management Teams (P/DHMT) to strengthen integration of RH/FP and TB screening into HTC services through supporting out and in-reaches. The project will focus on strengthening integration of HIV testing of individuals infected with TB and TB/HIV cross referral systems.

Continuing Medical Education (CME) and orientation sessions will be conducted to ensure that service providers receive updates on HTC guidelines and protocols. Counselor supervision will be supported on a monthly basis in all districts and will prevent burn out. At community level, HTC messages will be integrated into small group communication sessions and in magnet theatre outreaches. The project will train select CHWs, MARPs, and youth as counselors. During outreaches, CHWs and peer educators will target MARPs (CSW, IDU and MSM), youth and OVC and their caregivers for HTC services. The project will support provincial HTC Rapid Results Initiatives (RRI) campaigns at least twice a year.

Pediatric HIV testing will be supported, especially among OVC. HTC will be integrated in services provided by the Tunza franchise, to further improve access. Operational objectives are that all patients tested and found to be positive for HIV are referred for care and treatment.

In order to help DHMTs focus on data, systems and processes, support will be given to increase availability of registers, to use data to analyze service delivery processes, to involve facility teams in data improvement efforts. This will help service providers in setting realistic targets and particularly in setting focused targets: youth, couples, newly tested clients etc.

APHIAplus will provide supervision to ensure that all HTC services adhere to national and international standards of algorithm used, confidentiality, counseling, and consent. Through guidance from the national level, HTC

laboratory proficiency and laboratory quality assurance will be strengthened. During technical support, attention will be paid to integration of HTC in other services as appropriate (e.g. MNCH) and to the fact that HTC serves as an entry-to-HIV care and as a support for HIV preventive behaviors.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

Target Population/ Approx $ Amount/ # Reached
CSW/ $1,400,000/ 14000
MSM/ $100,000/ 2000
Youth 15-24/ $450,000/ 40000
Men 30-44/ $175,000/ 15000
Discordant couples/ $60,000/ 6000
PWP/ $350,000/ 70000

APHIAplus Nairobi Coast will target the populations listed above in Nairobi and Coast provinces with an integrated comprehensive prevention approach that includes small group and individual community outreach evidence-based behavioral interventions (EBI) to promote character formation, abstinence among youth, fidelity, partner reduction, and correct and consistent condom use by sexually active persons targeting populations at risk for transmission or acquisition of HIV. These programs will be tailored to the urban concentration found in these provinces, and will include focus on efficiency of activities, meaningful involvement of PLWHA, and sustainability of programs.

APHIAplus will ensure that community health workers and clinical staff are trained to provide HIV/AIDS prevention programs that promote prevention other than abstinence and being faithful. They will work with PLWHA, with a special focus on youth, support groups, linking them to comprehensive care centers and other services, and empowering participants to become leaders in prevention at the community level. Youth programs will target both in and out of school young people, including peer education, vocational/life skills building, mentorship programs, linkage and referral to youth friendly health services, reduction of harmful gender norms and gender based violence (GBV) prevention, and close collaboration with HIV Free Generation programming to combine the reach of mass media with the intensity of interpersonal communication.

Examples of specific EBI programs used are an adapted form of the Sister to Sister program, addressing low condom use, safe sexual behavior, and concurrent partnerships, among other components, and the Healthy Images of Man (HIM) program, which promotes male involvement in health. Testing and counseling and condom use will be promoted across all adult target groups and audiences.

Aphiaplus will support peer education interventions with at risk youth, transport workers, CSWs and MSM, disseminating prevention messages and linking them to STI, CT, care and support services available at public facilities and at drop in centers. Activities include targeted promotion of correct, consistent condom use and distribution to high-risk populations, stigma reduction, and partner trust, disclosure, and multiple concurrent partners. Quality of STI services will be improved by working through the MOH and other partners.

APHIAplus will continue to expand its programming for GBV survivors with integrated activities including awareness raising for communities, medical personnel, police, leaders, and men/women around women's rights and legal recourse, building capacity of local communities to recognize and fight GBV, and supporting GBV recovery centers and shelters.

The project will work closely with the GOK and other implementing partners to help establish or support provincial MARP TWGs and partner with MARP, youth, and PLWHA groups and encourage their active participation in programming.

Activities for monitoring and evaluation will include support supervision visits, audit checks, training of facilitators and monitors on data collection and entry and progress review meetings with community health workers and community based organizations.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	0	0

Narrative:

APHIAplus Nairobi-Coast's injecting drug user (IDU) and non-injecting drug user (NIDU) program aims to reduce the spread of HIV among the high-risk populations of drug and alcohol users, both male and female, with evidence-based behavioral, structural, and biological interventions in Nairobi and Coast provinces. There is paucity of data on substance abusers in both provinces, but there are known clusters of users in both Coast and Nairobi provinces. The IDU program has an increased focus due to GOK's recent adoption of new guidelines regarding needle exchange and medication-assisted treatment (MAT). APHIAplus will work with both GOK and all other partners working with drug users to minimize overlap and maximize results. The program will utilize both recovering drug users and non-drug-users to make contact with addicts to establish behavior plans to reduce their risk of HIV, as well as reach out to male and female sex workers with anti-drug interventions. Other activities will include a comprehensive mapping exercise of IDU/NIDUs in the different regions of Kenya in collaboration with other partners, which will allow existing programs to strengthen their efforts. Programs will include medically assisted treatment, addiction recovery treatment services, and improving skills in the area of HIV outreach behavior change interventions. The APHIAplus program will continue to ensure effective referrals for relevant

services, including HIV counseling and testing, HIV care and treatment services and male circumcision services.

Behavioral interventions: (i) Comprehensive peer education and outreach. Peer educators will be recruited from former addicts who are familiar with the wide user networks and are trusted by addicts. They will be trained on the Education Through Listening model to conduct facilitative peer education; (ii) Risk assessment, reduction counseling and skills building:-trained counselors and outreach workers will be making contact with addicts and conduct active harm reduction counseling and provide commodities like condoms, bleach, and alcohol swabs; and (iii) Linking IDUs to treatment, rehabilitation, and needle exchange programs.

Biomedical interventions: (i) The peer educators and outreach workers will refer IDUs for integrated services. The outreach workers will conduct mobile clinics near places where IDU congregate. Services offered will include HTC; STI screening, treatment and referrals; TB screenings and referrals; and hep. B screening and management; (ii) Comprehensive condom promotion, demonstration and distribution by peer educators, outreach workers and hotspots managers; (iii) Linking to needle exchange programs; (iv) In Coast, local relevant GOK facilities that offer drug abuse treatment will be supported to offer MAT. (v) Support MARPs-friendly provision of PEP in facilities for users who are victims of GBV.

Structural interventions: (i) Setting up IDU/DU-friendly drop in centers that offer HIV services and information to IDUs; (ii) Setting up of a network of recovering addicts for psychosocial support and counseling; (iii) Family and social services will be offered to recovering addicts to link them with their relatives for easier reintegration into society.

APHIAplus' technical teams will provide TA, supportive supervision, and data management capacity building to subpartners, ensuring high quality, MARP-friendly services and accurate data collection and use.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	0	0

Narrative:

APHIAplus Nairobi–Coast supports facilities in Nairobi and Coast provinces to provide a comprehensive antenatal package for all pregnant women including screening, prevention and treatment of any infections, nutritional support, prophylactic ARVs, Infant and Young Child Feeding (IYCF) support, and provider-initiated HIV counseling and testing (PITC) of women, their partners, and family members. The family-centered approach to care and treatment (C&T) will improve post natal follow up, and help ensure that all HIV-infected pregnant women are enrolled into HIV C&T. To improve access to HIV services, APHIAplus will support the integration of HIV C&T into MCH for the mother and family by strengthening referral lab networks for CD4, decentralization and task-shifting. This family-centered approach will improve C&T retention. APHIAplus will use national referral

tools to link mothers and families to palliative care, including TB services and home-based care; ART; malaria prevention activities; FP services; and income-generating activities.
APHIAplus will collaborate with other partners to support Early Infant Diagnosis (EID) and HIV-exposed infant (HEI) follow up by integrating the PMTCT services with well child and immunization services. APHIAplus will build upon existing ICYF strategies such as involvement of men, grandmothers, PLHIV peer educators, mother-to-mother support groups, and other community leaders at community level and explore the use of ARVs at facility level to make breastfeeding safer. Support to service providers will include mentorship, continuous medical education (CMEs), on-the-job training (OJT) and orientation sessions. Attention will focus on integration of family planning into PMTCT; provision of more efficacious regimes to HIV pregnant women and provision or referral for HAART; adherence through counseling and support from community health workers (CHW); HIV prevention during pregnancy and during lactation; early infant diagnosis (EID) and follow up of HEI; and enrolment of HEI in care and treatment. OJT will be provided on dried blood spot (DBS) harvesting. The lab transport network will be supported so that DBS specimens can reach the labs and that facilities receive the results.

Technical assistance and support supervision will build capacities of HCW. PMTCT protocols will be disseminated, and standardization of services will rely on national guidelines from MOH. The project will support the distribution and proper use of the mother-child booklet and of MOH monitoring tools, and give routine TA to ensure high quality data collection and evaluation. At community level, support will be provided to the DHMT to orient CHWs on PMTCT, EID, and IYCF. In select communities, mentor mothers will be supported to strengthen promotion of PMTCT and IYCF to pregnant women, offer psychosocial support, and link mothers to support structures.

Mobilization will be done during community dialogue days and outreaches to encourage mothers to attend ANC and to know their status. IEC material will be distributed to promote PMTCT services. Absence of male involvement remains an effective barrier to uptake of PMTCT services. Male involvement will be improved using the Healthy Images of Manhood (HIM) approach. APHIAplus will use multiple approaches to reach women currently not accessing ANC due to challenges related to culture, stigma and distance.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	0	0

Narrative:

APHIAplus Nairobi Coast will continue to strengthen facilities to provide quality HIV treatment services in Nairobi and Coast provinces. Activities include infrastructure improvement, training clinicians and other providers, clinical monitoring, lab services, community-adherence activities and management of opportunistic infections (OI).
APHIAplus emphasizes improving access to care and treatment for pregnant women. Currently there is need to initiate around 40,000 more patients on ARV in both provinces, and APHIAplus plans to contribute to roughly 25% of that in COP12, about 90% adults.

Multi-disciplinary teams will be established for HIV care and treatment. While a national mechanism will support technical training of health workers, all other capacity building measures will be supported by the project: exchange visits, mentorship, on-the-job training, continuous medical education (CMEs), whole site training, orientation sessions, on-site TA, and dissemination of clinical guidelines. Lab networks will be strengthened and networked to provide HIV monitoring tests (CD4 tests, hematology and liver function). APHIAplus will support viral load testing for suspected treatment failure cases through the network, and strengthen the case management of 2nd line patients to minimize failure, as 3rd regimen is expensive and not readily available.

At community level, APHIAplus will build capacity and create systems to strengthen facility-community linkages by sharing and implementing best practices. Patient follow up in the community will be critical to enhance adherence. APHIAplus will support communities to improve referrals and linkages to facilities, and follow up to ensure loss to follow up is minimal and adherence rates above recommended levels. The project works with PLWHA, promoting treatment adherence, positive living and good nutrition. CHWs will establish support groups (including for YLHIV) within which clients will be encouraged to form pairs for peer-to-peer psychosocial support and treatment adherence. The project will assist support groups or post-test clubs, including assistance with regular updates. Topical updates will be conducted in monthly support group meetings by PLHIV advocates and service providers from referral facilities. "Education through listening" methodology will be used in small group discussion on various HIV care and treatment messages.

The project will help strengthen linkages between the levels of care by supporting provincial, district and facility management committees, stakeholder forums, establishment of community desks at facilities and having CHWs based in facilities. The project supports the provinces through 3 QI approaches: supportive supervision, mentorship and quality improvement approaches. The multi-disciplinary mentorship team will work with provincial and district mentors to maintain strong management capabilities at facility level.

The project will strengthen data collection, management and use. EMR will be established and strengthened to improve program reporting. EMR will improve patient tracking and be a major resource for the CQI teams. The EMR will improve facility reports in terms of accuracy, completeness and timeliness. The partner will encourage data use at the facility level in order to improve service delivery. In both provinces, the project will work in close collaboration with DHRIOs and DASCOs to whom support and technical assistance will be targeted.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	0	0

Narrative:

APHIAplus Nairobi Coast's pediatric treatment program works in Nairobi and Coast provinces to provide ART

treatment to children, focusing on prioritizing the identification of exposed and infected children through PMTCT and EID for those <18 months of age, conducting PITC in clinical settings, family-testing through clinical and community strategies, and launch and use of the combined mother-child card. 4,159 children are now on ART treatment in both provinces. Expansion will continue in order to fill gaps in comprehensive HIV care and treatment, and in pediatric HIV service delivery. The project, through establishment of family friendly facilities, will support initiation of 1,088 children on treatment in the coming year. EID and pediatric CT will be enhanced to reach more children. APHIAplus will strengthen pediatric TB case finding, diagnosis and treatment, and will increase availability of the cryptococcal antigen test. Nutritional assessment using the WHO height and weight charts will provide a key pillar in monitoring the wellness of pediatric patients.

Mentorship of service providers will support expansion of service outlets. The project will focus on capacity building to improve service provider confidence in management of young children, especially prescribing of ARVs. Facilities will be supported to achieve high patient retention and greater adherence by expanding interventions, such as referral desks, improved health literacy, ensuring availability of psychosocial support, and defaulter tracing. Caregivers will be given treatment literacy training. High volume facilities will introduce the hero book, a psychosocial support program aimed at facilitating pediatric disclosure and adherence.

Orientations, sensitizations, CMEs, OJT and mentorship will ensure continuous capacity building at facility level. Lab networking for CD4 and DNA PCR testing for EID in HIV exposed infants will be supported through skills building of laboratory technicians, and support will be provided for transporting lab samples and results. At community level, CHWs will be trained on defaulter tracing and pediatric counseling. CHWs will facilitate the formation of support groups targeting children, especially adolescents. The project will support P/DHMTs to supervise and monitor facility based service delivery, and project staff will contribute to joint supportive supervision and provision of technical support on HIV/TB, and wrap around services with special focus on pediatric services.

APHIAplus will provide a package of basic care services to exposed/infected/affected children through supported facility, community, and home-based basic care services. Services include nutrition assessment, growth monitoring, safe water interventions, malaria prevention, OI management, psycho-social support, TB screening, and CTX at the service delivery points. Infected children will be provided with a basic care package including a safe water system, CTX for OI prophylaxis, an insecticide-treated bed net, and multivitamins.
The project supports the provinces through 3 QI approaches: supportive supervision, mentorship and quality improvement approaches. The project will strengthen data collection, management and use of data, working in close collaboration with district health teams. The M&E system will build on and improve existing tools. APHIAplus will also support paper based and electronic versions of record keeping at the CCC in line with NASCOP guidelines.

Implementing Mechanism Details

Mechanism ID: 13701	**Mechanism Name: KEMSA/FARA**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Kenya Medical Supplies Agency	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: Both	
G2G: No	Managing Agency:

Total Funding: 9,008,223	
Funding Source	**Funding Amount**
GHP-State	9,008,223

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Kenya Medical Supplies Agency (KEMSA) is a customer-focused integrated medical logistics provider for all public health facilities in Kenya. As a State Corporation, KEMSA is a secure source of value-for-money drugs and other medical supplies to over 5,000 facilities. KEMSA has also received substantial TA and support from USAID in human resource capacity building through the deployment of key advisors in areas of business development, procurement, IT and supply chain management. With USAID support, KEMSA has invested in an effective Enterprise Resource Planning (ERP) system that has led to the full automation and integration of KEMSA operations and overall business processes, resulting in greater efficiency and improved service delivery. KEMSA's fully automated central warehouse in Nairobi is now functioning under the platform of a Warehouse Module System hosted by the ERP. This has significantly improved efficiency in inventory management and processing of health facilities requirements. KEMSA has successfully implemented the Framework Contract system, and all current procurements are aligned to KEMSA's strategic and business plan with enhanced visibility of all health care commodities in the supply chain. Currently KEMSA has a total allocation of KES 5.3 Billion ($60m) for essential medical supplies, approximately KES7.0 billion ($85m) for programs such as HIV, malaria and tuberculosis. KEMSA has been appointed as the procurement agent for the GFATM R10 procurements, and the USG is confident that KEMSA is ready to start handling some PEPFAR commodities. This is a new award, and no vehicle procurement is planned. This activity supports GHI/LLC and is funded primarily with pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**13701**
Mechanism Name:	**KEMSA/FARA**
Prime Partner Name:	**Kenya Medical Supplies Agency**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	0	0

Narrative:

KEMSA will procure basic care kits (BCK) for provision to implementing care and support programs within Kenya. Kemsa will procure the various items of the BCK, pack, warehouse and distribute to the various facilities. KEMSA supplies commodities to the whole country through direct distribution. The commodity aspects of the programs are continually monitored and evaluated using data collected from regular monthly facility-level patient, stock, and distribution reports; internal distribution records from KEMSA; and direct customer feedback from partners and service providers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	0	0

Narrative:

KEMSA will procure reagents, equipments and consumables to support the national TB program. Availiability of

screening and protective materials is necessary for the achievement of the five Is for the TB program. Therefore KEMSA will liaise with NASCOP, the national TB program and the USG to ensure that propoer selection, quantification and procurement of the various TB commodities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	0	0

Narrative:

KEMSA procures lab reagents, equipments and accessaries on behalf of GOK. Under the KEMSA fixed-amount remimbursable agreement (FARA), KEMSA will procure laboratory equipment, reagents and consumables for the national HIV program. KEMSA participates as an active member of the Commodity Security Committee (coordinated by NASCOP, the Kenyan HIV/AIDS coordinating body) and participates in national quantification and procurement planning exercises. KEMSA will warehouse and distribute the lab reagents and consumables. KEMSA will coordinates with both NASCOP and USG team to ensure proper allocation of the various commodities to the health facilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	1,066,713	0

Narrative:

KEMSA will procure equipment and supplies necessary for safe processing, storage and transport of blood and blood products at the blood banks and hospitals. Appropriate blood bags or pediatric and component preparation will be procured.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	0	0

Narrative:

KEMSA will procure equipment and supplies necessary for safe injection, phlebotomy and other blood drawing procedures and medical waste disposal commodities: safety boxes for disposal of medical sharps, color coded waste disposal bins, bags and transfer trolleys, safety lancets, safe lock needles, blood and Intravenous fluid giving sets as well as open and closed phlebotomy systems will be procured. These will facilitate safe injection practice, segregation of health care waste and its appropriate disposal. These supplies will be distributed to health facilities through various partners in the Kenya Injection safety program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	500,000	0

Narrative:

KEMSA will procure HIV rapid test kits for the national program. KEMSA will liaise with NASCOP, USG and other stakeholders in quantifying the required amounts of test kits. Kemsa will procure screening, confirmatory and tie breaker test kits as per the national testing protocol. KEMSA will ware and distribute the test kits based on reports received from the testing facilities. Care will be taken to ensure continuous availability of test kits.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	644,899	0

Narrative:

KEMSA will procure various commodities to support the elimination of mother to child transmission services. KEMSA will liaise with NASCOP and USG in selection and quantification of the various commodities required for provision of pediatric services. KEMSA will warehouse and distribute the various commodities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	3,200,000	0

Narrative:

KEMSA will distribute ARVs procured by the USG to the various ART facilities allocated to KEMSA by NASCOP. KEMSA participates as an active member of the Commodity Security Committee (coordinated by NASCOP, the Kenyan HIV/AIDS coordinating body) and participates in national quantification and procurement planning exercises. In 2011 NASCOP divided the ART facilities into two as a way of eliminating double reporting and facilities receiving commodities from two warehouses. There have been no stockouts of ARVs as commodities shared across the two pipelines. KEMSA actively monitors stocks at all levels of the supply chain and coordinates among other members of the supply chain and among implementing partners to avoid future stockouts.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,964,779	0

Narrative:

KEMSA will procure, warehouse and distribute commodities like CD4 and viral reagents to support HIV treatment services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	1,631,832	0

Narrative:

KEMSA will procure various commodities to support the pediatric treatment services. KEMSA will liaise with NASCOP and USG in selection and quantification of the various commodities required for provision of pediatric

services. KEMSA will warehouse and distribute these commodities all facilities offering pediatric ART services.

Implementing Mechanism Details

Mechanism ID: 13719	**Mechanism Name: Maternal and Child Health Integrated Program (MCHIP)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: JHPIEGO	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 181,972	
Funding Source	**Funding Amount**
GHP-State	181,972

Sub Partner Name(s)

Broad Branch Associates	ICF Macro	John Snow, Inc.
Johns Hopkins University Bloomberg School of Public Health	Population Services International	Program for Appropriate Technology in Health
Save the Children US		

Overview Narrative

MCHIP is a centrally held USAID mechanism that aims to reduce maternal and child mortality in 30 countries through implementations of high impact interventions in HIV, malaria, maternal health including PMTCT, child health and newborn health. The goal of MCHIP is to reduce maternal and child mortality by: 1) Implementing high-impact, effective HIV/AIDS interventions at scale, based on global and local data; 2) building global consensus and sustained government commitment to support results-oriented, evidence-based programs, including mobilizing resources for effective interventions; 3) influencing local programs to incorporate effective, feasible, high-impact interventions and approaches based on global evidence; and 4) strategically integrating critical interventions into existing services and wrap-around programs, emphasizing close-to-client contact and ensuring "no missed opportunities."

MCHIP is designed as a national mechanism that will provide technical assistance in coordination of technical activities at the National AIDS &STIs Control Program (NASCOP), Division of Reproductive Health, Division of Vaccines and Immunization, Division of Child and Adolescent Health and Division of Malaria Control. Some key activities in cervical cancer, infection prevention and PMTCT will be rolled out in selected areas in the country. These include screening and treatment of cervical cancer including training of health workers to provide the services, scale of the reaching every district (RED) approach to identify pregnant women and linking them to PMTCT services. MCHIP will also work closely with other programs to ensure scale-up of high impact cost effective interventions. This activity supports GHI/LLC and is completely funded with pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	13719		
Mechanism Name:	Maternal and Child Health Integrated Program (MCHIP)		
Prime Partner Name:	JHPIEGO		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	181,972	0

Narrative:

Currently, the project supports implementation of integrated PMTCT/MCH interventions in Bondo district, Nyanza province. In collaboration with NASCOP and DRH, MCHIP will scale up the implementation community based maternal and child health interventions using innovative strategies to identify pregnant women and link them to quality MCH and PMTCT services. MCHIP will work with District Health Teams using an adaptation of immunization's Reaching Every District (RED) approach to identify communities with large numbers of pregnant women, mobilize Community Health Workers (CHWs) to bring these women and later their infants into care, and actively monitor and take action to increase PMTCT and MCH service coverage. MCHIP will undertake the orientation of all the CHWs to the new community strategy, to the MCHIP program and to Community Based Health Information System (CB-HIS).

Implementing Mechanism Details

Mechanism ID: 13802	**Mechanism Name: Central Province (CRISSP)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Nairobi	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 3,466,149	
Funding Source	**Funding Amount**
GHP-State	3,466,149

Sub Partner Name(s)

Futures Group	Provincial Medical Offices	Strathmore University Business School
University of Maryland		

Overview Narrative

The Central Province Response Integration, Strengthening and Sustainability Project (CRISSP) of the UON has just been awarded a follow on to the Columbia Track 1 activities in Central Province. CRISSP aims to build the capacity of two districts in Central Province to ensure sustainable, universal access to high quality HIV prevention, care and treatment services, with focus on integration within the broader health and developmental context through an evidence-based, cost-effective and sustainable model of care. In line with the Kenya GHI Strategy, they will strengthen MCH services, support laboratory capacity to for diagnosis of endemic conditions, and promote good governance by supporting training in governance and leadership

Cost efficiency will be addressed through integration of services, reduction of the technical teams by increasing capacity of the Ministry of Health (MoH) staff, use of existing evidence-based strategies, task shifting, implementing facility-based training and mentorship as opposed to offsite training, evaluating cost effective strategies for defaulter management, laboratory networking, and mobilization.

Through the active involvement of MoH and the broader community and by development of standard operating procedures (SOP) and a solid referral network, CRISSP hopes to showcase a model of excellence that will blend into community adoption and ownership, thus ensuring a smooth process of transition to local providers at the end of the project period. To strengthen a common M&E system and to ensure data quality, analysis, reporting, and use for evidence-based programming, electronic medical records systems will be supported.

3 vehicles will be required for technical teams to conduct supervision and mentorship.

this activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	34,461
Gender: GBV	5,000
Gender: Gender Equality	15,000
Human Resources for Health	1,430,486
Motor Vehicles: Purchased	48,000
Renovation	450,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	13802		
Mechanism Name:	Central Province (CRISSP)		
Prime Partner Name:	University of Nairobi		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	230,000	0

Narrative:

The Central Province Response Integration, Strengthening and Sustainability Project (CRISSP) of the University of Nairobi (UON) will support two districts in Central province, which has a combined population of approximately 1.5 million people and an estimated adult HIV prevalence of 3.6% (compared to the national 7.1%).

CRISSP will work with the Ministry of Health (MoH) at provincial, district and health facility levels to jointly plan, coordinate, implement and ensure provision of quality HIV care and support to 7,439 current adult patients in FY12 and 8,838 current patients in FY13.

CRISSP will offer a comprehensive care and support service package including HIV testing to partners and family members of index patients and enrolling or referring/linking those that test HIV positive to care and support; provision of Basic Care Kit (safe water vessel, multivitamins, insecticide-treated mosquito nets, condoms, chlorine for water treatment and educational materials); therapeutic nutrition (FBP) to all enrolled HIV positive patients; prevention with positives (PwP); and cervical cancer screening to all enrolled women.

CRISSP in collaboration with MoH will support targeted capacity building (training and mentorship) for health care workers and additionally offer continuous medical education on care and support, such as OI diagnosis and treatment. CRISSP will identify areas with staff shortages, support recruitment of additional staff, and support good commodities management practices to ensure uninterrupted supply of commodities.

CRISSP will also support ongoing community interventions for HIV infected individuals including peer education and support groups to provide adherence messaging and defaulter tracing and follow up to improve retention in all facilities. CRISSP will continue supporting referral and linkages to community based psychosocial support

groups; Water, sanitation and hygiene programs; Economic empowerment - Income generating activities (IGAs); Home Based Care services; Gender based violence support programs; vocational training; social and legal protection; and food and nutrition programs.

CRISSP will adopt strategies to ensure access and provision of friendly services to youth, elderly and disabled populations. Strategies to increase access of care services by men will be employed including supporting male peer educators, mentors and support groups, and supporting women to disclose and bring their male partners for testing and care and treatment.

CRISSP will continue to strengthen data collection and reporting at all levels to improve reporting to NASCOP and PEPFAR, including a cohort analysis and report retention rates as required by NASCOP. CRISSP will adopt the new generation indicators and support the development and use of electronic medical records system in accordance with NASCOP guidelines. CRISSP will adapt the quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV care and support services, integrate them into routinely collected data, and use the results to evaluate and improve clinical outcomes. CRISSP will support joint Annual Operation Plan (AOP) development, implementation, monitoring and evaluation, and health system strengthening to facilitate sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	300,000	0

Narrative:

The Central Province Response Integration, Strengthening and Sustainability Project (CRISSP) of the University of Nairobi (UON) won an award in 2011 to support HIV activities including TB/HIV. CRISSP will support TB/HIV services in two districts in Central Province, which has a combined population of about 1.5 million people and reported 10,623 TB patients in 2010. Over 10,000 TB patients received HIV testing and 3,531 TB/HIV co-infected patients were identified. 97% and 47% received cotrimoxazole prophylaxis and ART respectively.

In FY12 and FY13, CRISSP will intensify efforts to detect TB cases through clinical exams and laboratory investigations and ensure successful TB treatment through provision of appropriate treatment. CRISSP will ensure that each facility providing TB/HIV services has adequate and well trained clinical staff supported by well equipped and staffed laboratory, including sputum specimen transport where laboratory services are unavailable. CRISSP will ensure that adequate supplies of anti-TB drugs are available and that the national TB treatment guidelines are followed. All TB patients on treatment will be monitored both clinically and through periodic sputum examination.

To reduce the burden of HIV in TB patients, CRISSP will ensure that at least 95% of TB patients are screened for HIV and all TB-HIV co-infected patients are put on cotrimoxazole and ARVs as early as possible regardless of the CD4 count as per the national guidelines. CRISSP will support the "one stop" model that provides integrated TB and HIV services in all TB clinics. All TB clinics will be stocked with cotrimoxazole and ARVs. 80 HCW will be trained in FY12 and 60 HCW will be trained in FY13.

To reduce the burden of TB in HIV infected patients, CRISSP will support intensified TB screening for 6,613 in FY12 and 7,856 in FY13 at each clinical encounter using the national screening tool. 330 co-infected patients

identified in FY12 and 393 in FY13 will be put on TB treatment and those without active TB will be provided with Isoniazid Preventive Therapy (IPT) as per national IPT protocol. To strengthen TB infection control in HIV settings, CRISSP will ensure that the national IC guidelines are available at all sites and training of staff on IC is done. CRISSP will support scaling up of at least 2 components of the national TB infection control strategy in HIV care settings, one of which should be fast tracking of patients with cough for expedited diagnostic work up and treatment.

To improve surveillance and management of drug-resistant TB, CRISSP will support timely transport of sputum specimens of TB retreatment cases from health facilities to the central reference laboratory for drug susceptibility testing and ensure return of the results to those facilities. CRISSP will also support scaling up of drug-resistant treatment sites thus expanding access to MDRTB treatment.

CRISSP will also support expansion of prevention with positive (PwP) services in TB clinics, TB/HIV control activities in the prisons, strengthening linkages between facility and community-based services, and improving patient referrals and tracking systems. To strengthen HVTB program monitoring, CRISSP will support reporting of selected custom indicators to assist with program management and evaluation and monitoring of new activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	50,000	0

Narrative:

The Central Province Response Integration, Strengthening and Sustainability Project (CRISSP) of the University of Nairobi (UON) has just been awarded as a follow on to the Columbia Track 1 activities in Central Province. CRISSP will support pediatric care and treatment services in 8 sites located in two districts in Central Province, with a combined population of about 1.5 million people and an estimated adult HIV prevalence of 3.6% (compared to the national 7.1%).

In FY12, CRISSP will provide care and support services to 777 children currently on care. The number of children currently on care will increase to 940 in FY13. CRISSP will provide comprehensive, integrated quality services and scale up to ensure 949 HIV infected infants are put on ARV prophylaxis and all HIV exposed children access pediatric care services.

CRISSP will focus on strengthening the use of the Mother-baby booklet, early infant diagnosis, universal provider initiated testing and counseling, and ensure those identified as HIV infected are linked to care and ART services. CRISSP will ensure children enrolled in care receive quality clinical care services including clinical history and physical examination; WHO staging, CD4 tests, and other basic tests; opportunistic infection diagnosis, prophylaxis and management; TB screening; pain and symptom relief and management; and psychosocial support. Additional key care services will include nutritional assessment, counseling and support based on the WHO and IYCF guidelines (including provision of therapeutic or supplementary feeding, support to children with growth faltering, provision of vitamin A, zinc, and de-worming); provision of safe water, sanitation and hygiene interventions (WASH) in the community and in health facilities; and malaria screening, treatment, and provision of

long lasting insecticide treated nets in malaria endemic areas.
CRISSP will support integration of HIV services into routine child health care and survival services in the maternal child health department including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization guidelines; case management of diarrhea, pneumonia, and other childhood illnesses; and community outreach efforts. They will also support the care of the newborn by supporting hospital delivery and ensuring that there is provision for newborn resuscitation and care (thermal care, hygiene cord care) and prophylactic eye care. Exposed children management and follow up will continue to be supported and will include enrollment, HIV testing (PCR-DNA and antibody testing) as per the national guidelines, provision of Nevirapine throughout the breastfeeding period, follow up and retention, and linkages of those positive to care and ART services.
CRISSP will support hospital and community activities to meet the needs of HIV infected adolescents such as support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, support for transitioning into adult services, and teaching life skills. Commodity access and infrastructure development will continue to be supported as will relevant trainings.
CRISSP will strengthen pediatric data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	201,496	0

Narrative:

Target population: CRISP will support HIV testing and counseling services in al a number of health facilities in Kiambu and Kirinyaga counties of central province. Target population will include all patients, their family members and caretakers who access out and in patient services a number of health facilities in the 4 counties.
HTC Approaches: The program will utilize provider initiated opt out approach and the services are offered within all out patient departments, TB clinics, FP, ANCs, special clinics, HIV clinics (targeting family members) and in patient departments. The counseling and testing is either done within the consultation rooms by trained clinicians or in counseling rooms by lay counselors within the outpatient departments if space is available or at the laboratories.
Targets and achievements: CRISP is a new mechanism. In COP 2012, CHS will target to provide HTC services to a total of 85,000 persons of which 20% will be tested as couples and 10% will be children below the age of 15.
Testing algorithm: National algorithm is being used.
Referrals and linkages: In order to strengthen referrals, CHS will put in place several important strategies. They include: use of peer educators as patient escorts from one hospital department to the PSC; same day enrollment of clients to PSCs; use of an integrated defaulter tracing system for tracing patients who default on care or ART upon enrollment; introduction of documented referral system by use of the NASCOP referral booklet; use of mobile phones (each facility has a phone supported by ICAP) to follow up whether the client was actually enrolled.

Quality management: In order to improve and monitor quality of HTC services, CRISP will put in place the following strategies: Training and continuing education of HTC providers; strict adherence to the standard operating procedures outlined in the national HTC guidelines; management of HIV rapid kits as per the guidelines; putting in place a functional QA systems as provided for in the national HTC guidelines; participation in EQA-proficiency testing and finally conducting support supervisory visits.
Monitoring and evaluation: CRISP will use all ministry of health' tools to capture HTC data, both for couples and individual patients. These include HTC lab Register and Monthly summary tool (MOH 711). MOH approved HTC lab registers will be introduced at all HIV testing points except PMTCT.
Promotional activities for HTC: All patients attending the supported facilities will be given health talks including the need for HIV counseling and testing and the importance of couple testing. Couples are given priority services. Sexual partners of HIV positive clients will be given individualized invitations though the index clients and available avenues for testing including individualized home testing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

UON CRISSP implements comprehensive prevention, care and treatment programs in Central province. In FY 2012/13, UON CRISSP will expand HIV prevention services to include evidence based behavioral interventions (EBI) for specific target populations in clinical settings at comprehensive care center (CCC), TB and Maternal Child Health (MCH) clinics as part of HIV combination prevention programs. The EBI will include Positive Health and Dignity Prevention (PHDP) targeting adult male and female and adolescents living with HIV (PLHIV); and Sister to Sister EBI (S2S) targeting sexually active HIV negative women attending the MCH clinics.
PHDP is an ongoing 5-10min group and individual level intervention that targets PLHIV in clinical and community settings. This mechanism will support this intervention which constitutes of ART adherence counseling and support; partner and family testing; provision of PEP to the discordant spouse; treatment for prevention once approved; safer pregnancy counseling and provision of modern contraception; sexual risk reduction counseling including reduction of sexual partners, alcohol counseling, promoting of consistent and correct condom use; Sexually Transmitted Infections (STI) screening and treatment and using meaningful involvement of people living with HIV/AIDS (MIPA). The efficacy of PHDP has been shown to be 68% in preventing transmission of HIV, and 96% in treatment for prevention.
S2S is a 20 minute individual level intervention that targets women of reproductive age that focuses on self efficacy, safer sex negotiation skills and condom use. Condoms are 80% effective in heterosexual relationships when used correctly and consistently.
UON CRISSP will use HVOP funding to recruit and support appropriate peer educators/counselors to reinforce prevention messages delivered by health providers as a feasible model for task-shifting in the provision of PHDP in clinical settings, and specifically promote MIPA. It will support placement of 5 Peer Educators at the MCH, TB and

CCC Clinics in hospitals, and 2 Peer educators at health centers and provide appropriate counseling space. One of the peer educators will do regular client home follow up to strengthen ART adherence.
Approximately 1.6 million Kenyans are PLHIV. The Kenya AIDS Indicator Survey 2007 showed 6% of couples to be in discordant relationships. HIV Prevalence in Central province is (3.6%). UON CRISSP will reach 4190 (60%) PLHIV in FY2012 and 5818 (70%) in FY 2013 with a minimum package of PHDP. It will implement S2S EBI on a pilot basis.
Quality assurance for EBIs will be promoted through appropriate training and certification of peer educators using approved national curricula, standard job-aids and guidelines and regular supervision.
UON CRISSP will work with appropriate national Technical Working Groups (TWG) to support integration of HIV prevention into care and treatment programs in clinical settings. These programs will also be linked to other HIV community programs. PLHIV will be specifically linked to STI and FP services, as necessary, through patient escorts.
Monitoring of PHDP and S2S will be done through the review/input of UON CRISSP implementation plan, analysis of KePMS data, quarterly reviews, semiannual and annual reports. Evaluation will be conducted through operation research of combination HIV prevention and periodic surveys (Kenya Demographic and health survey, Kenya Indicator AIDS Survey, Kenya Service

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	600,000	0

Narrative:

The Central Province Response Integration, Strengthening and Sustainability Project (CRISSP) of the University of Nairobi (UON) has just won a PEPFAR award to support the implementation and expansion of PMTCT activities in sites in Kiambu and Kirinyaga Districts in Central Province, which previously were supported by Columbia University's International Center for AIDS Care and Treatment Programs-Kenya (ICAP) Track 1 mechanism.
In FY12, CRISSP will offer HIV counseling and testing to 28,379 pregnant women at ANC and give ARV prophylaxis to 908 HIV infected pregnant women. HIV infected women will receive a CD4 test after undergoing WHO clinical staging. CRISSP will give HAART to all eligible HIV positive pregnant women in line with the revised PMTCT national guidelines. In FY13, CHS will increase the number of pregnant women counseled to 29,798, offer ARV prophylaxis to 1,103 pregnant women and 949 infants, and do EID for 949 infants.
CRISSP will focus on 4 prongs of PMTCT: primary prevention; family planning; ARV prophylaxis to all HIV positive pregnant mothers and exposed infants; and care and treatment to eligible HIV positive mothers, partners and children. The minimum care package will include health and HIV education, individual/ family HIVCT, clinical/laboratory monitoring and assessment, OI screening and treatment, ARV prophylaxis and treatment for both mother and baby, nutritional support, psychosocial support, PWP, follow up, retention, and referral and linkages. CRISSP will incorporate TB screening into routine antenatal care.
CRISSP will reach 8,939 of 1st visit ANC attendees with couple CT to identify discordant and concordant couples

to improve primary prevention and facilitate linkage to HIV care and treatment for the eligible. CRISSP will support integration of ART in MCH clinics, access to FP/RH services, and establish or strengthen infection control and waste management activities.

CRISSP will support hospital delivery through provision of delivery beds and sterile delivery packs, training, working with CHWs and TBAs to promote community-facility referral mechanism, health education, and community services providing skilled birth attendance.

CRISSP will support safe infant feeding practices as per national guidelines and support enrollment and follow up of 949 of babies born to HIV infected mothers to access CTX, ARV prophylaxis, and EID services using the HIV exposed infant register till 18 months. CRISSP will facilitate ART initiation for those who test positive before 2 years.

CRISSP will adopt efficient retention strategies for mothers and babies by supporting use of diaries and registers for tracking defaulters, having a structured mentorship and supervision plan, enhancing data quality and streamlining M&E gaps including orientation of new MOH ANC/maternity registers, and utilization of data at facility level for program improvement and quarterly progress reports to CDC.

Program quality and proficiency testing will be emphasized to validate PMTCT results.

CRISSP will train 60 HCWs in FY12 and equal number in FY 13 on PMTCT and provide orientation to the revised PMTCT and infant feeding guidelines and engage in community activities for demand creation for health services such as male involvement with couple CT services, referral and linkages.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,984,653	0

Narrative:

The Central Province Response Integration, Strengthening and Sustainability Project (CRISSP) of the University of Nairobi (UON) will support treatment in 2 districts (Kiambu and Kirinyaga) in Central Province. Central Province has an estimated population of 4.4 million people with an estimated adult HIV prevalence of 3.6% compared to the national 7.1%. These 2 districts were previously supported by Columbia University Track 1 mechanism.

In FY12, CRISSP will jointly work with the Ministry of Health (MoH) to support expansion and provision of quality adult HIV treatment services in line with MoH guidelines to 5,528 patients currently receiving ART and 1,330 new adults resulting to cumulative 6,634 adults who have ever been initiated on ART. In FY13, this number will increase to 6,527 currently receiving ART and 1,346 new adults resulting to 7,980 adults who have ever been initiated on ART.

CRISSP, in collaboration with MoH, will support in-service training of 80 and 60 HCWs in FY12 and FY13 respectively, identify human resources and infrastructure gaps and support in line with MoH guidelines, and support good commodities management practices to ensure uninterrupted availability of commodities.

CRISSP will support provision of comprehensive package of services to all PLHIV including ART initiation for

those eligible; laboratory monitoring including biannual CD4 testing, viral load testing for suspected treatment failure (through strengthened laboratory network); cotrimoxazole prophylaxis; psychosocial counseling; referral to support groups; adherence counseling; nutritional assessment and supplementation; prevention with positives (PwP); FP/RH; and improved OI diagnosis and treatment including TB screening, diagnosis, and treatment.
CRISSP will continue to support ongoing community activities and support for HIV infected individuals including peer education and use of support groups to strengthen adherence; effective and efficient retention strategies; referral and linkages to psychosocial support groups; economic empowerment projects; Home Based Care; and food and nutrition programs. CRISSP will support provision of friendly services to youth and special populations.
CRISSP will adopt strategies to ensure access and provision of friendly HIV treatment services by supporting peer educators, support groups, disclosure, partner testing and family focused care and treatment.
CRISSP will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. CRISSP will do cohort analysis and report retention rates as required by the national program and discuss the analysis results with facility staff in order to improve program performance. Use of an electronic medical records system will be supported and strengthened. Quality of care indicators (CQI, HIVQUAL) for monitoring the quality of HIV treatment will be adopted, integrated into routinely collected data, and results used to evaluate and improve clinical outcomes. CRISSP will also support short term activities to improve impact and patient outcomes.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	100,000	0

Narrative:

The Central Province Response Integration, Strengthening and Sustainability Project (CRISSP) of the University of Nairobi (UON) will support pediatric treatment services in 8 treatment sites located in Kiambu District in Central Province which previously were supported by Columbia University's International Center for AIDS Care and Treatment Programs-Kenya (ICAP). Central Province has an estimated population of 4.4 million people with an estimated adult HIV prevalence of 3.6% compared to the national 7.1%.
In FY12, CRISSP will jointly work with the Ministry of Health (MoH) at all levels to continue supporting, expanding and ensuring provision of quality pediatric HIV treatment services as per MoH guidelines to 580 pediatrics currently receiving ART and 116 new pediatrics resulting to a cumulative 696 pediatrics ever initiated on ART. In FY13, this number will increase to 725 pediatrics currently receiving ART and 104 new resulting to cumulative 800 pediatrics ever initiated on ART.
CRISSP will support comprehensive pediatric ART services including growth and development monitoring; immunization as per the Kenya Expanded Program on Immunization; management of childhood illnesses; OI screening and diagnosis; WHO staging; ART eligibility assessment; laboratory monitoring including 6 monthly CD4, hematology and chemistry (through strengthening of lab networks); Pre-ART adherence and psychosocial counseling; initiation of ART as per MoH guidelines; Toxicity monitoring; treatment failure assessment through

targeted viral load testing; and adherence strengthening. CRISSP will also support enhanced follow up and retention, EID as per MoH guidelines, PITC to all children and their care givers attending child welfare clinics, family focused approaches, community outreach efforts, and integration of HIV services in other MNCH services. CRISSP will support hospital and community activities to meet the needs of the HIV infected adolescents such as support groups to enhance disclosure and adherence messaging, PwP, substance abuse counseling, teaching life skills, providing sexual and reproductive health services, and support their transition into adult services. CRISSP will support in-service training of 80 and 60 HCWs in FY 12 and 13 respectively as well as continuous mentorship and capacity building of trained health care workers on specialized pediatric treatment including management of ARV treatment failure and complicated drug adverse reactions. CRISSP will identify human resources and infrastructure gaps, support in line with MoH guidelines, and support good commodities management practices to ensure uninterrupted availability of commodities. Linkage of ART services to pediatric care services, PMTCT, TB/HIV, community programs, and other related pediatric services will additionally be optimized. CRISSP will continue to strengthen data collection and reporting at all levels to increase and improve reporting to NASCOP and PEPFAR. Additionally, CRISSP will review data and evaluate programs to inform programming and decision making. Use of an electronic medical records system will be supported and strengthened. CRISSP will strengthen local capacity as part of the transition plan to MOH for sustainable long-term HIV patient management in Kenya.

Implementing Mechanism Details

Mechanism ID: 13805	**Mechanism Name: International Training and Education Center for Health (ITECH)**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Washington	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 3,278,031	
Funding Source	**Funding Amount**
GHP-State	3,278,031

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Goals/objectives:Strengthen HIS & data use in health service delivery.
•Deploying an upgraded EMR at 25% of health facilities offering HIV treatment. Futures Group (FG) will work with implementers of OpenMRS & 1 other nationally recognized EMR to install the applications at 300 ART sites. FG will migrate data from the existing systems to the supported EMRs or install upgrades where previously non-interoperable versions existed. The upgraded EMRs will implement SDMX standards to enable data exchange with the DHIS. ITECH will work with the MOH to establish a training program for 600 HWs (doctors & nurses) to enter data into the system, use its decision support function for patient management and generate routine M&E reports. Extend guidelines and standards for EMRs to cover PHC.
•Complete documentation of interoperability protocols, based on lessons from the pilot in Nyanza province & prepare a blueprint for national scale-up in collaboration with the eHealth team that is currently working on the national health enterprise architecture (EA). ITECH will support selected eHealth activities contributing to the development of the EA.
•Revise training curriculum for HIS for different cadres of HWs & deploy it with the national rollout of EMRs to ensure HWs, managers & policy makers have sufficient capacity for routine reporting, M&E, surveillance & OR.
Cost-efficiency:ITECH is working with partners including FG & USAID funded AfyaInfo to implement standards-based EMRs to eliminate duplication through interoperable systems.
Transition:ITECH will work with local developers of OpenMRS (an EMR system that complies with international standards) to upgrade and extend the system. Most developers work for Kenyan universities & HC providers. This activity support GHI/LLC.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	13805		
Mechanism Name:	International Training and Education Center for Health (ITECH)		
Prime Partner Name:	University of Washington		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	3,278,031	0

Narrative:

ITECH has worked with the Division of HIS and the National AIDS and STI Control Program (NASCOP) to develop the national standards and guidelines for Electronic Medical Records (EMR). The partner is currently working with the National Public Health Laboratory Services (NPHLS) to expand the standards document to include Laboratory Information Management Systems (LIMS). In addition, ITECH is finalizing the piloting of EMR interoperability with the Health Demographic Surveillance Systems, before demonstrating EMR/LIMS data exchange based on standard protocols. Lessons learnt from this pilot will inform the national rollout of the interoperable systems.

The following are the specific activities that ITECH will support over a two-year period (2012-2014):

•Deploying an upgraded EMR at 25% of health facilities offering HIV treatment. Under this activity, ITECH will work with implementers of OpenMRS and one other nationally recognized EMR to install the applications at approximately 300 ART sites. They will migrate data from the existing systems to the supported EMRs or install upgrades versions where previously non-interoperable versions existed. The upgraded EMRs will implement SDMX standards to enable data exchange with the District Health Information System (DHIS). ITECH will work with the MOH to establish a continuing training program for the 600 health workers, including doctors and nurses, to enter data into the system, use its decision support function for patient management and generate routine M&E reports. The partner will also work the MOH to establish regional or county based support mechanism for maintaining installed systems. Such support will include hardware, software and Internet connectivity.

•Extend the guidelines and standards for EMRs to cover primary health care. This will include sub-systems that interact with EMRs, such as LIMS, Pharmacy Information Systems (PIS), DHIS.

•Complete the documentation of the interoperability protocols, based on lessons learnt from the pilot in Nyanza

province and prepare a blueprint for national scale-up. This will be done in collaboration with the eHealth team that is currently working on the national health enterprise architecture (EA). ITECH will also support selected eHealth activities contributing to the development of the EA.

•Revise the training curriculum for HIS for different cadres of health workers. Deploy it alongside the national rollout of EMRs to ensure health workers, managers and policy makers have sufficient capacity to make the best use of the installed systems to support routine reporting, M&E, surveillance and operational research.

The EMRs, although originally intended to collect data for HIV, can be used for any chronic or acute illness and will help collect data for the US ambassador's Health Task Force (HTF). The EMRs, DHIS and national data warehouse will greatly strengthen the country's capacity to perform disease surveillance, reporting, M&E and operational research.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

The Kenya Ministry of Gender, Children and Social Development (MOGCSD) is currently working with other stakeholders to plan a national response that will address gender-based violence (GBV) following completion of the first Violence against Children Survey in 2010. The current system of tracking GBV and services for victims which relies on reporting by 3-4 sentinel sites (provincial hospitals) is inadequate to inform planning and scale up of GBV prevention and services across the country. Through PEPFAR support, the MOGCSD with the support of Liverpool VCT (LVCT)-Ungana will work with other stakeholders to harmonize GBV reporting. The University of Washington, International AIDS Education and Training Center (UW-ITECH) will work in collaboration with MOGCD, Ministry of Health, LVCT and other implementing partners to support the design and implementation of a national gender-based violence (GBV) information system (GBV-IS). The GBV-IS will be integrated with other databases in the national data warehouse through standards based approach. UW-ITECH will work with LVCT to assess gaps in the current M&E system and tools, support harmonization of GBV data collection tools and set up an electronic data base for program and national level reporting at the National Office. PEPFAR funds will support purchase of computer hardware and software for the national office, data base design, installation and training of national level staff in managing the database. The resources will also be used for ongoing maintenance costs. In collaboration with LVCT, UW-ITEC will develop a training package and mount 4-6 national trainings of key GBV service providers in the use of the data base and provide limited support in setting up regional databases to improve data flow. GBV data will be collected monthly from health facilities and linked to other routine health information, surveillance and surveys data and analyzed to inform GBV prevention and programs across the country.

Implementing Mechanism Details

Mechanism ID: 13867	**Mechanism Name: Strengthening Health Outcomes through the Private Sector (SHOPS)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Abt Associates	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 95,000	
Funding Source	**Funding Amount**
GHP-State	95,000

Sub Partner Name(s)

Banyan Global	JHPIEGO	Marie Stopes International
Monitoring Task Group	O'Hanlon Health Consulting	

Overview Narrative

The main objective of this mechanism is to increase the role of the private sector in the sustainable provision and use of quality health services including HIV/AIDS. The project builds upon activities implemented by its predecessor project Private Sector Partnerships-One (PSP-One). This activity supports GHI/LLC and is completely funded with pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**13867**
Mechanism Name:	**Strengthening Health Outcomes through the Private Sector (SHOPS)**
Prime Partner Name:	**Abt Associates**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

The project is expected to work on i) improving the enabling environment for the private sector by addressing policy or regulatory barriers; ii) increasing the uptake of health insurance by addressing supply side issues related to health service providers and also addressing the demand side by providing innovative health insurance models.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	95,000	0

Narrative:

The project is expected to work on i) improving the enabling environment for the private sector by addressing policy or regulatory barriers; ii) increasing the uptake of health insurance by addressing supply side issues related to health service providers and also addressing the demand side by providing innovative health insurance models.

Implementing Mechanism Details

Mechanism ID: 13868	**Mechanism Name: APHIAplus Health**

	Communication and Marketing (APHIAplus HCM)
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 830,538	
Funding Source	**Funding Amount**
GHP-State	830,538

Sub Partner Name(s)

FHI 360	Liverpool VCT and Care	PharmAccess

Overview Narrative

APHIAplus HCM builds on several years of USAID investment in social marketing and SBCC in Kenya. APHIAplus HCM will implement a total market strategy to ensure that each product category becomes more sustainable and that subsidies are better targeted to those in need of subsidized products and services. There are also opportunities to address salient public health issues, including women's vulnerability to HIV infection and non-use of FP/RH and MCH services. This project will continue working with the GOK at the national level with national communication strategies that address national priorities and that are implemented at the county level with full participation of partners.

This new project is expected to implement activities that will improve the preventive behaviors of Kenyans and improve health service utilization related to HIV, FP/RH, MCH, and malaria. From the project's onset, APHIAplus HCM will focus on transitioning social marketing programs towards greater sustainability. This includes defining and achieving milestones in increased operational, financial, institutional, and market sustainability. Other elements of sustainability will include building the capacity of Kenyan organizations, with Kenyan leadership, to design, execute, and measure state-of-the-art social marketing and SBCC initiatives, under the oversight of GOK. Another element is supporting the development of the private sector to provide quality healthcare delivery to underserved and at-risk populations. Together, these activities under APHIAplus HCM will lead to measurable improvements in healthy behaviors and health outcomes. This activity is expected to require purchase of 4 vehicles

in FY12. This activity supports GHI/LLC and is funded primarily with pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

Education	300,000
Gender: GBV	300,000
Motor Vehicles: Purchased	100,000
Water	50,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**13868**		
Mechanism Name:	**APHIAplus Health Communication and Marketing (APHIAplus HCM)**		
Prime Partner Name:	**Population Services International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	640,518	0

Narrative:

In PMCT, APHIAplus HCM will develop and disseminate communication messages and materials on prevention of mother to child activities promoting testing of pregnant women in order to protect the unborn child from HIV infection. This activity will also target People Living with HIV/AIDS (PLWHAs) and especially HIV positive couples planning to have a baby. It is anticipated to promote counseling and testing services and generate demand for PMCT services for both voluntary and provider initiated testing.

This project links with abstinence and being faithful activities and other prevention and counseling and testing activities through the promotion of networking, referrals and linkages. The Health Communications and Marketing project is a national level activity that will enforce messages through mass media. Communication tools will be developed in collaboration with MOH/NASCOP PMCT committee at the national level and projects working at the regional level. Both NASCOP and these provincial projects will "feed into" the development of population-specific messages which will strengthen interventions implemented on the ground. PMTCT messages will primarily focus on adults, both male and female, public and private health providers and NGOs and faith-based programs as well as policy makers. Messages developed will address gender norms and behavior, increased male involvement in matters considering the preservation of the family unit, and reduction of stigma and discrimination.

APHIAplus HCM is primarily a communications activity focusing on the development of information, education and communication.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	190,020	0

Narrative:

APHIAplus HCM will undertake communication activities to influence the targeted audience towards behavior change. This activity will fucus on the development of communication messages targeting HIV positive women and will promote demand and utilization of antenatal, safe delivery, and post natal services for HIV positive women. APHIAplus HCM will work closely with the Ministries of Health through NASCOP and the Division of Reproductive Health (DRH) to determine the gaps in demand and utilization of antenatal, safe delivery, and post natal services and working with key stakeholders to develop, print and disseminate the materials through USG service delivery partners and health facilities. This project links with HIV treatment, care and support, and PMTCT, abstinence and being faithful activities and other prevention and counseling and testing activities through the promotion of networking, referrals and linkages. The Health Communications and Marketing project is a national level activity that will enforce messages through mass media. Communication tools will be developed in collaboration with MOH/NASCOP treatment and DRH committee at the national level and projects working at the regional level. Both NASCOP and these provincial projects will "feed into" the development of population-specific messages which will strengthen interventions implemented on the ground. Messages will primarily focus on adults, both male and female, public and private health providers and NGOs and faith-based programs as well as policy makers. Messages developed will address gender norms and behavior, increased male involvement in matters

considering the preservation of the family unit, and reduction of stigma and discrimination. APHIAplus HCM will leverage other Reproductive Health and Child survival resources and this activity will be transitioned to the Department of Health Promotions and the Division of Reproductive Health. *APHIAplus HCM is primarily a communications activity focusing on the development of information, education and communication. Activities under this budget code directly support the Lets Live Campaign.*

Implementing Mechanism Details

Mechanism ID: 13870	**Mechanism Name: Health Policy Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Futures Group	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 52,973	
Funding Source	**Funding Amount**
GHP-State	52,973

Sub Partner Name(s)

Centre for Development and Population Activities	Futures Institute	Partners in Population and Development Africa Regional Office
Population Reference Bureau	Research Triangle International	White Ribbon Alliance for Safe Motherhood

Overview Narrative

The purpose of the Health Policy Project (HPP) is to provide support to the country in the larger governance sphere. This project is expected to contribute to enhance country-ownership, leadership & management. This activity supports GHI/LLC and is completely funded with pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**13870**		
Mechanism Name:	**Health Policy Project**		
Prime Partner Name:	**Futures Group**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXS	52,973	0
Narrative:			
Specifically the project is expected to support i) the development, dissemination and implemenation of key policies and strategies including the health policy framework and a new health sector strategic plan; ii) devolution as it relates to health in the new consitution; iii) health financing - providing support for the development, dissemination and implmentation of a new health financing strategy; and iv) capacity building of a local entity seeking to establish long term sustainability in Kenya's health policy formulation skills.			

Implementing Mechanism Details

Mechanism ID: 13882	**Mechanism Name: Lea Toto and Nyumbani Village Projects**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Children of God Relief Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 814,729	
Funding Source	**Funding Amount**
GHP-State	814,729

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Lea Toto Program (LTP) is a project of the Children of God Relief Institute (COGRI), an organization based in Nairobi, offering services to children living with HIV/AIDS. With funding from USAID, Lea Toto program provides services to families with HIV positive children in the main informal settlements in Nairobi Province.

The goal of the Lea Toto Project is to mitigate the impact of HIV/AIDS and decrease the risk of HIV transmission by providing and facilitating the implementation of a comprehensive home based care package.

This will be achieved through the following five objectives:

1. To enhance the provision of high quality medical care, nutritional support and counseling services to 8,500 HIV+ children and their families by 2012.

2. To provide a package of social support services to at least 70% of the needy HIV+ children and their families

3. To enhance the organizational capacity of all Lea Toto staff to design, monitor and coordinate quality care services for HIV+ children and their families

4. To enhance capacity of the target local communities to provide care and support to HIV + children and their families.

5. To enhance the capacity of the target communities to carry out preventive measures through negotiation, support and maintenance of safe behavior. This activity supports GHI/LLC and is completely funded by pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**13882**
Mechanism Name:	**Lea Toto and Nyumbani Village Projects**
Prime Partner Name:	**Children of God Relief Institute**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	50,000	0

Narrative:

The project is currently supporting implementation of quality, chronic care model for care of PLWHIV in Kwa-Vonza and Kwa-Mutonga communities of Kitui District and the adolescents over 15 year on follow up at the LeaToto clinics in Nairobi. COGRI offers these services at the Nyumbani Village Clinic and the 8 LeaToto clinics in Nairobi slums by providing comprehensive intevention packages. This projects contributes to the decentralization of treatment services through both facility based and community outreach HIV treatment and monitoring services. Technical support to establish and maintain laboratory network for CD4, VL and other laboratory tests is a key area of support to ensure patients managed by the project access laboratory investigations. COGRI will continue to support the intergration of HIV services with other clinical services. Defaulter prevention and tracing mechanisims will be strengthened to ensure patient retention to treatment and care while establishing intra-facility and community linkages. To further improve retention to care and treatment mobile phone massaging for patients on treatment, patient support groups, and linkages to CHW home based follow-up will be strengthened. Adolescent

friendly clinic days will be established to cater for this unique cohort. Monthly ART cohort reports will be compiled and used to review clinical outcomes. Support to strengthen phamaceutical and laboratory commodity management will be emphasised by the project to minimize risk of acute stock outs as well as mitigating expiry of commodities at the facility. The project will continue to empower patients through psychosocial support groups, health education, supporting prevention by implementation of PWP package and also the peer educator program.The project will also continue its emphasis on TB/HIV collaborative activities including strengthening of TB case finding, diagnosis and management.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	764,729	0

Narrative:

Nyumbani village will scale-up pediatric care and treatment among the community members seeking support at the village clinic. The project will initiate 40 new children on ART over the next 2 years by optimizing the entry points into care and treatment through increased PITC and community mobilization. Identification of HIV exposed and infected children will be intensified through PITC for the infants and longitudinal follow-up of HEI.

The Lea Toto project will expand established programs in targeted slums in Nairobi to include 9 centers; 8 in Nairobi informal settlements. As a result of these activities, 3000 individuals will receive antiretroviral therapy 300 will initiate treatment during the year, with the total of people ever treated reaching 3000, and 160 health care workers will be trained in the provision of antiretroviral therapy

In both projects, early infant diagnosis will be scaled-up to ensure provider competence to collect quality DBS samples and logistical transportation to regional laboratories for HIV DNA PCR diagnosis. OJT for service providers on collection of DBS samples will be conducted at the Nyumbani and Lea Toto clinics to facilitate diagnosis of HIV among the HEI. Service providers will be mentored on the prompt initiation of ART for children less than 2 years with confirmed HIV status while access to CD4 and Viral Load testing will be facilitated through linkage with the Nyumbani diagnostic Laboratory to enhance evaluation and monitoring of patients. Nutritional assessments of pediatric patients and therapeutic and supplemental feeding will be an integral part of their support. Access to all other immunization care, supplementation and growth monitoring services will be undertaken in compliance with National Guidelines. Activities will also include procurement of laboratory services and strengthening rational pharmaceutical management

Orientation to the new MOH tools will be done to ensure that key staff develop the capacity to collect, analyze use data both at local and national level. Adolescent-friendly treatment services will be undertaken through the establishment of adolescent-friendly clinic days and the formation of adolescent support groups. Adolescent clubs to promote healthy and positive living will be linked to appropriate role model mentors from amongst the adult PLHIV in order to allow for smooth transition into adulthood. The program will ensure adherence support to the individuals on follow up including strengthening community facility linkages to curb loss to follow up and improve retention and long term out comes.

These activities will contribute to the Kenya 5-year strategy and increase the number of children on antiretroviral therapy, responds to OGAC objectives of increasing the number of children on ART.

Implementing Mechanism Details

Mechanism ID: 13919	**Mechanism Name: Laboratory Regulatory Support**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Clinical and Laboratory Standards Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 300,000	
Funding Source	**Funding Amount**
GHP-State	300,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

1. Goals and objectives:Since 2008 Kenya Medical Laboratory Technicians and Technologists Board (KMLTTB) has achieved considerable progress in the areas of regulating training of medical lab sciences, setting standards for examination and/or of medical lab practitioners, and regulating best lab practices and QA measures. As a result, the KMLTTB was recently given additional mandate of validating and registering medical lab equipment and reagents before they are put to use in Kenya. KMLTTB will also to establish an inspectorate for HIV testing labs to help in consolidating and reviewing/revising existing documentation for registration of HIV diagnostic and treatment related reagents. To enhance the on-going scale up of quality testing systems and accreditation of medical labs in Kenya, CDC Kenya has identified the CLSI to assist KMLTTB develop and implement guidelines and standards for validation and registration of laboratory equipment and reagents. This activity will capacity-built the KMLTTB secretariat and reference laboratories for validation activities. A mechanism to monitor continued vendor compliance to established standards will also be instituted. CLSI will provide technical assistance through training and technology transfer to KMLTTB to enhance their regulatory/registration functions in Kenya. 2. Coverage:

This is a national activity that will ensure that Kenya has a competent medical laboratory workforce capable of providing quality laboratory services.3. Transition to country partners:
The technical assistance will equip the KMLTTB competencies to sustain the regulation of both training and practice of medical laboratory science in Kenya. 4. Vehicles:
There are no plans to purchase vehicles. This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000

TBD Details

(No data provided.)

Key Issues

Malaria (PMI)
TB
Workplace Programs

Budget Code Information

Mechanism ID:	**13919**		
Mechanism Name:	**Laboratory Regulatory Support**		
Prime Partner Name:	**Clinical and Laboratory Standards Institute**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	300,000	0
Narrative:			
Goals:			

The Kenya Medical Laboratory Technicians and Technologists Board (KMLTTB) was created in 1999 to ensure quality medical lab services by regulating training in medical laboratory sciences in all relevant training institutions. Through PEPFAR support, starting FY 08, KMLTTB has made significant achievements including: assessment of all relevant training institutions, establishing a national database for laboratory workforce, review of training curricula for professional training institutes and setting of standards for examination and registration of all practicing laboratory technicians and technologists. Through a recent subsidiary legislation by the Kenya parliament, the KMLTTB has been mandated to establish a system to register and ensure validation of equipment and reagents before they are put to use in Kenya. Related to this, KMLTTB is also mandated to establish an inspectorate for HIV testing laboratories that will review, consolidate, and revise existing documentation for registration of HIV diagnostic and treatment related reagents.
In order to support the KMLTTB achieve its laboratory regulatory function and ensure quality laboratory practices, including HIV/AIDs diagnosis and management, CDC Kenya has identified the Clinical Laboratory Standards Institute(CLSI)-one of the HHS/CDC/International Laboratory Branch Co-Ag partners as a suitable partner, starting FY 2012. CLSI is known to support the development and application of easy-to-use guidelines and standards for laboratory testing and quality systems development. In addition, CLSI have demonstrated capacity to provide information, technical assistance, training and technical transfer for individuals and organizations to enhance effective service delivery in PEPFAR countries.

Objectives: In COP 2012 CLSI will implement the following activities:

•Support development of policies for registration of medical laboratory reagents, test kits and equipment including HIV diagnostics.
•Support establishment of a system for validation and registration of all medical laboratory equipment and reagents in Kenya.
•Assist in identification and capacity building of local institutions to support validation activities and related tasks.
•Strengthen regulatory function of KMLTTB through training of laboratory inspectors and streamlining of application, verification and licensing processes.
•Establish systems for surveillance and monitoring of effectiveness of regulatory activities.

KMLTTB registered laboratory personnel are deployed at public and private health care facilities serving HIV-infected patients in all parts of the country. They deliver services related to HIV testing, monitoring of anti-retroviral and opportunistic infection therapy, assuring safe blood supplies, measuring the burden of HIV infection in populations and monitoring trends of the epidemic (surveillance). These functions are essential for the implementation and sustenance of all HIV /AIDS prevention strategies such as Counseling and Testing (HVCT), Prevention of Mother to Child Transmission (MTCT) and ARV treatment programs. The activity will also enhance the on-going laboratory accreditation process. The activity will have an in-built M&E component to inform progress and way forward.

Implementing Mechanism Details

Mechanism ID: 13922	**Mechanism Name: Laboratory Leadership Training**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: African Field Epidemiology Network	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,099,419	
Funding Source	**Funding Amount**
GHP-State	1,099,419

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Through this mechanism AFENET will:

Objective 1

Provide support for development of laboratory leadership through facilitation of exchange programs to strengthen international and regional laboratory networking and the sharing of information on best practices in laboratory management and practice.

Objective 2

Support quality systems management through training of regional laboratory assessors for African Society of Laboratory Medicine (ASLM) and facilitation of objective laboratory assessments on WHO step-wise accreditation by Africa Society for Laboratory Medicine assessors. This international assessment will enable benchmarking of quality systems with other laboratories in the region. This activity will advance professional laboratory medicine practice and networks in Africa needed to support preventive medicine, quality care of patients, and disease control through partnerships with governments and relevant organizations.

This activity will contribute to the number of accredited laboratories- 20.

Objective 3
Establish a platform for conducting short course trainings through virtual modalities such as webinars and e-learning modules that would serve to increase epidemiological and laboratory management capacity among mid level public health workers from national and county levels as well as provide systemic opportunities for continued education among FELTP-K graduates and other epidemiologists or scientists within public health and academic sectors in Kenya.

Coverage:
All AEFENET activities will be entrenched in MOH facilities and laboratories. Partnerships with local professional associations will be developed to facilitate long term sustainability of all initiatives

No vehicles will be procured in this activity.
This activity supports GHI/LLC.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	400,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
End-of-Program Evaluation

Budget Code Information

Mechanism ID:	**13922**
Mechanism Name:	**Laboratory Leadership Training**

Prime Partner Name:	African Field Epidemiology Network		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	550,000	0

Narrative:

The African Field Epidemiology Network (AFENET) will provide support for development of laboratory leadership through facilitation of exchange programs to strengthen international and regional laboratory networking and the sharing of information on best practices in laboratory management and practice. This activity will facilitate collaboration of South-South and North-South partnerships to mobilize resources for laboratory systems strengthening. The new crop of laboratory leaders will advocate for public health laboratory strengthening to increase access and the quality of laboratory services for all people in Kenya. Strong laboratory capacities in the region are essential for monitoring antimicrobial resistance, disease outbreaks and diagnosing highly infectious diseases such as: viral hemorrhagic fever, MDR/XDR TB. Strong laboratory leadership will enhance political commitment and ensure adequate and sustained funding for laboratories.

AFENET will support quality systems management through training of regional laboratory assessors for African Society of Laboratory Medicine (ASLM) and facilitation of objective laboratory assessments on WHO step-wise accreditation by Africa Society for Laboratory Medicine assessors. This international assessment will enable benchmarking of quality systems with other laboratories in the region. This activity will advance professional laboratory medicine practice and networks in Africa needed to support preventive medicine, quality care of patients, and disease control through partnerships with governments and relevant organizations. This activity will contribute to the number of accredited laboratories- 20.

Transition to country partners:
All AFENET activities will be entrenched in MOH facilities and laboratories. Partnerships with local professional associations will be developed to facilitate long term sustainability of all initiatives.
No vehicles will be procured in this activity.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	349,419	0

Narrative:

The African Field Epidemiology Network (AFENET) supports one of the key pillars of health system strengthening, Human Resources for Health. Like many countries, Kenya has a shortage of public health professionals graduating from training institutes.

AFENET supports African nations in building strong, effective, and sustainable capacity in field epidemiology, public health, laboratory management, surveillance, disease outbreak response, investigation and prevention, and improves public health systems through training and networking. AFENET will support public health issues including health leadership and management, HIV quality assurance, and Field Epidemiology and Laboratory Training Program (FELTPs) in collaboration with Jomo Kenyatta University of Agriculture and Technology (JKUAT). COP 12 funds will facilitate expansion of the program's reach to mid level public health workers and establish a formal process for continued education of the trained cadre. A virtual FELTP/JKUAT campus that will serve as a training center for strengthening epidemiology and laboratory management training in Kenya will be established. Support to the FELTP program will have broad health systems benefits across all programs not just to the HIV program as these public health professionals will work to address other public health priority problems in the decentralized health system.

The specific objective of this mechanism is to establish a platform for conducting short course trainings through virtual modalities such as webinars and e-learning modules that will serve to increase epidemiological and laboratory management capacity among mid level public health workers from national and county levels as well as provide systemic opportunities for continued education among FELTP-K graduates and other epidemiologists or scientists within public health and academic sectors in Kenya. The proposed curriculum will include topics such as grant writing, monitoring and evaluation, biosafety, laboratory quality management systems, project management, and epidemiology for laboratorians. The virtual campus will provide students and staff access to key journals in public health, including specialized HIV/AIDS journals. The virtual campus will also function as a learning resource for the larger East African community including other countries such as Tanzania, Uganda, Ethiopia, and South Sudan. Key technical positions at MOPHS, the Institute of Tropical Medicine and Infectious Diseases of JKUAT working to address the HIV epidemic in Kenya will be targeted with deliberate incorporation of training modules and short courses useful for control and prevention of HIV in the country. In addition this mechanism will provide field level support to FELTP graduates and trainees at site level to ensure they have the tools and the skills to operate effectively.Key deliverables:1. FELTP/JKUAT virtual campus established and operational 2.Twenty e-learning modules adapted to local circumstances and implemented 3.Twenty FELTP modules adapted into webinar format 4.500 public healthcare workers (two from each county) and scientists trained on epidemiology, laboratory management and management topics through short course training and e-learning modules

5. FELTP practitioners' supported to operate effectively at site level

The indicator used will be # of health care workers who graduated from a pre service training course. The program will be monitored by JKUAT.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	200,000	0

Narrative:

AFENET will support the prevention of HIV medical transmission through strengthening occupational health and safety services in healthcare settings in Kenya. It will support interventions that protect the health workers from exposure to blood and body fluids, respiratory pathogens such as TB and other workplace hazards. It will work with department of Disease Control and Prevention in Ministry of Health (MOH) and Directorate of Occupational Safety and Health (DOSH) in the Ministry of Labor. It will support the development and implementation of post-exposure prophylaxis (PEP) and occupational safety policies and guidelines for health workers. It will advocate for universal access to occupational PEP services and necessary health worker immunization. It will also support integration of Injection Safety and Infection Prevention and Control (IPC) as well as bio-safety and safe medical waste management practices into HIV services and other existing health programs. This is in line with the Global Health Initiative core principle of health systems strengthening. *Integration with other activities* *Occupational health and safety program is an integral part of any workplace intervention. This will be integrated into all HIV, TB and other health programs in the country. Enhancing occupational health and safety is one of the strategies to strengthen human resources for health (HRH) not only in capacity building but also for retention and sustainability.* *Coverage and scope* *This activity will have national coverage and will focus on health facilities. It will support the roll out of the PEP and occupational health policy for health workers. Medical surveillance systems will be set up in these facilities and sensitization and training of health workers across all cadres. Occupational health programs will be set up in 10 health facilities and 200 health workers will be trained.* *Country ownership and Sustainability* *AFENET will work to strengthen occupational health within MOH facilities across the country. Some of the health workers who will be trained will have the capacity to scale this up and support other institutions. This initiative will ensure a safe workplace and thus lead to better retention of health care workers leading to sustainability.*

Implementing Mechanism Details

Mechanism ID: 14009	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14012	**Mechanism Name: AMPATHplus**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement

Prime Partner Name: Moi Teaching and Referral Hospital	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,957,944	
Funding Source	**Funding Amount**
GHP-State	1,957,944

Sub Partner Name(s)

Indiana University	Moi University	

Overview Narrative

The USAID-AMPATH Partnership HIV Program is a comprehensive clinical care program. All HIV and tuberculosis (TB)-related care and treatment are provided free at the point of care for patients through the Kenya National Leprosy, Tuberculosis, and Lung Disease (NLTLD) Program. The HIV clinical care protocols used by AMPATH are consistent with those recommended by the Government of Kenya (GOK) and the World Health Organization (WHO). In addition to providing antiretrovirals to both HIV infected adults and children, AMPATH also has an extensive prevention of Mother-To-Child Transmission (pMTCT) program, conducts facility and community-based HIV counseling and testing, provides nutritional support for its most food insecure and malnourished patients, and builds patient self-sufficiency through offering income security programs including skills training, micro-financing, a fair-trade-certified crafts workshop and an agricultural co-operative. AMPATH's activities take place within GOK and non-governmental facilities, and at the grassroots level in multiple communities. AMPATH cooperates and collaborates with all levels of health providers—from specialists at tertiary care facilities to community health workers—to provide effective and culturally appropriate care. This partner plans to procure 5 vehicles in FY12. This activity supports GHI/LLC and is funded primarily with pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	400,000
Education	200,000

Food and Nutrition: Commodities	200,000
Food and Nutrition: Policy, Tools, and Service Delivery	200,000
Gender: Gender Equality	100,000
Human Resources for Health	500,000
Renovation	52,922
Water	200,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**14012**
Mechanism Name:	**AMPATHplus**
Prime Partner Name:	**Moi Teaching and Referral Hospital**

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HBHC	0	0

Narrative:

AMPATH provides HIV care services to PLHIV which are mainly preventive and include: HIV diagnosis; antiretroviral treatment; CTX prophylaxis; treatment of OIs; palliative care; prevention, early detection and treatment of TB; and nutritional therapy.

Other preventive services include: PMTCT, PEP, couples C&T and PwP. is the adult population aged 18years and above.

Support services provided:

? Six month nutritional support for very ill patients, those with very low socioeconomic power and those with low BMI.

? Social support for patients unable to pay for housing or school fees for their children, transportation support for those who come from far, to pregnant women and those on high risk express care.

? Psychosocial support addresses psychosocial; It aids adherence issues, stigma and co-morbidities e.g. TB infection and substance abuse.

? Outreach services –Outreach workers follow patients missing clinic visits by use of a locator form that is filled on a patient's initial visit and when the patient relocates.

? HAART and Harvest initiative (HHI) - provides demonstration farms for patients on best farming practices to ensure food security and financial stability. In conjunction with WFP, these farms also produce some of the food distributed to our patients in the clinics.

? Family Preservative Initiative provides microfinance for starting up small businesses and boosts the capital base for business expansion. It helps constitute self help groups, provides training on fiscal management, business plans, skills and vocational training e.g. for bead work by women. It also provides employment opportunities at a fair-trade-certified crafts workshop where women patients do bead work for sale.

? Legal Aid Centre for Eldoret (LACE) provides legal representation for patients who have no means of getting legal redress.

? OVC support through provision of basic needs and ensuring protection of their interests as well supporting child-headed households.

? The model of care is facility-based government owned hospitals, HBC for counselling and testing and onward referral and linkage to care is provided. There are currently 25 sites and 40 satellites being run and various other facilities which are being supported within the catchment areas.

Services have been scaled up to improve reach to patients with advanced HIV disease, pregnant women and HIV/TB co-infected patients. Integration of HIV prevention, care and treatment with RH/FP services ensures improved access to care and protection from HIV.

There is a move towards country self sustenance through training and retention of health care workers, managers, administrators, health economists, and other civil service employees critical to functions of a health system and supporting efforts to identify and implement harmonized health systems measurement tools. Enrolled patients undergo nutritional, social, psychosocial assessment and they also give detailed information on their residence.

This helps enhance retention in care.Referrals to care within and out of AMPATH for continuity of care; Patients undergoing inpatient or outpatient treatment are usually referred back to their care centres after they receive the services they had sought to continue with care.Linkages are available with other program sites like APHIA PLUS in the north rift, CDC in Nyanza, and Walter Reed in Nandi that offer HIV care. Cross referrals are also done for continued care of patients from these program sites to AMPATH.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	700,000	0

Narrative:

The OVC Program empowers OVC, their families, and their communities to build a foundation of action and hope for a healthy and sustainable future. The program uses a holistic and multi-disciplinarian approach to strengthen the capacity of families and communities to care and protect their OVC by prolonging the lives of the HIV-infected children and supporting the OVC. The programassists OVC within their families/community, allowing them to socialize, learn and address challenges within their own environment. Our target population is orphans and/or HIV-positive children aged seventeen years and below.Upper age exceptions are made when assisting child-headed households. The program currently functions in seven AMPATH sites. We have registered over 20,000 children.We offer access to education, protection, basic needs/shelter, food security, psychosocial support, medical care and economic empowerment. OVC social workers and community health workers (CHW) work with families on the ground to determine their needs using comprehensive household and individual assessments, and ranking them according to the Child Status Index . This data is entered and monitored in the OVC database. Frequent follow-up visits by the CHW and/or social worker allow proper monitoring and evaluation of the intervention(s) and their impact. Interventions are reported using an intervention coding system. This system allows the OVC program to confirm when needs have been successfully addressed and whether the interventions are effective. OVC families that are struggling economically are linked to Family Preservation Initiative where they gain access to training on agriculture, IGAs, and Group Integrated Savings for Empowerment. A combination of training, saving, and borrowing capital allow long-term economic growth and security for the family. In the districts, we have strong ties to existing children's networks, and Quality Improvement teams; sit on Area Advisory Councils and within the Regional Children's Forum. We also link with Community Development and Bursary Fund managers to bridge gaps in OVC educational funding. AMPATH OVC program has achieved 85% of objectives and targets set in our COP. Our explicit OVC protocols make the program scalable and replicable to any site.Our educational interventions have increased the overall mean grade of our OVC from C plain to C plus. We have enabled OVC households to realize their potential in terms of assets and resources by use of SWOT analysis and setting of smart goals, thus improving the standard of life for most of our OVC. The OVC program has been instrumental in forming over 80 GISE groups in less than a year. These groups are actively saving, loaning and paying dividends to OVC Guardians. This is our exit strategy ensuring that families work towards self-reliance to support their OVC. The OVC program functions on a limited budget despite the fact that the number of OVC increases continually. This

severely limits our expansion to new sites and the ability to offer services to the growing number of OVC in existing sites. Financial limitations have also made it difficult to hire enough data staff to enter data and create reports in a timely manner for purposes of monitoring and evaluation
Transport remains a challenge. OVC has a simple, flexible data collection tool. We continue to adapt our system to meet new and changing reporting needs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	0	0

Narrative:

AMPATH continues to offer Quality TB services in 25 sites targeting all children and adults in parts of North Rift, Nyanza and Western Kenya. The entire population is screened in our catchment area as an entry point for care services for TB or TB/HIV patients. The program serves an estimated population of 15 Million. Testing for TB and HIV both within the communities and health Facilities through the cough monitor program and the home based counseling and testing is provided. Once a client is found positive for any of the 2 diseases they are then referred for continuation of care at the nearest heath facility. Currently 4,000 clients are receiving TB/HIV treatment. Our current TB/HIV activities include;
• ICF Cough Monitor Program based in 49 health facilities within and surrounding the AMPATH catchment areas.
• Screening for TB in the Home-Based Counseling Testing program using counselors
• Community Based MDR-TB program using health care workers who are in-charge of administering the medications throughout the duration of therapy.
• TB/ HIV integration among all AMPATH sites is done in coordination with the ministry of health.
• Provision of IPT to all HIV infected patients without signs of active TB disease and all TB exposed children less than 5 years.
• Opt-out? HIV testing in accordance with Kenya national TB screening guidelines for all patients presenting at AMPATH sites. HIV-TB co-infected patients are managed by AMPATH personnel using standard treatment algorithms for both TB and HIV that have been developed and approved collaboratively by the national Division of Leprosy, TB and Lung Disease and AMPATH.
• Immediate initiation of ART among HIV patients diagnosed with TB in line with the WHO and national guidelines.
• ICF of TB among HIV patients in all the clinics. AMPATH clinics are offered TB culture, when reagents are available.
• Provision of sputum culture for DST for all TB retreatment patients cared for at AMPATH affiliated clinics.
• Nutritional Support is provided for the TB/HIV co-infected patients, and MDR-TB patients. Plans are under way to also include the TB/HIV negative.
• Prevention with Positives program - where we trace, test and screen the partners of our clients whether HIV positive or not.
• The TB/HIV program is involved in continuous on-site and off-site trainings and mentoring of personnel to be able

to carry out their activities.
AMPATH provides a wide range of comprehensive care to all of its patients including nutritional support, legal services, and microfinance.
A central M&E office based at AMPATH verifies our reports ensuring quality data and advising appropriately. This office also ensures continuous update of our reporting tools in line with the program and stakeholders requirements. For standardization and improvement of data quality we have developed TB encounter forms that are used to gather data from patients while receiving care. Data collected is entered into the AMRS, the PDAs and MS-Access databases for research projects. Our Accomplishments are:
• Treated 7 out of 25 enrolled MDR TB patients with the community based DOTS plus program. Our experiences have informed the country program that has now adopted the community based approach to treating MDR TB patients.
• Received the Job Bwayo recognition award for excellence in care and research in Kenya.
• We plan to scale up our cough monitor program to 60 sites and to increase surveillance for MDR TB.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	0	0

Narrative:

Targets for next 2 yrs: 2000-3000 newly enrolled; 1000-2000 new on ART
Target populations: North Rift, Western and Nyanza
• Building capacity of health care providers:
Training on comprehensive HIV care 3 monthly and on adherence and disclosure counseling quarterly; train on procedures including DBS for Early Infant Diagnosis aiming at 100% nurse coverage in next 2 years ; Mentor providers monthly; build laboratory infrastructure to do more tests including biochemistry, CD4 and hematology. Decentralize data entry.
• Building capacity to supervise:
Contribute to development of national targets & tools, pediatric curricula, training guidelines and manuals, reportable indicators for individual patients and individual sites; use the Kenya Pediatric Association mentorship template to evaluate sites; use our electronic medical records to distil reports to the national level through the districts and provinces; use M&E strategic plan to evaluate the pediatric program in the sites,
• Adherence & retention on treatment:
Continued training on adherence counseling to 80% of staff in all sites; introducing adherence screening tools before initiating patients on ART in all sites; training one nurse adherence counselor per site; initiating home visits in all sites for patients who have adherence concerns; daily educational sessions in clinics on importance of continued care and involve the community, , and local media in disseminating information; Introducing community based care in 50% of the sites to decongest clinics.
• Integration & linkage of treatment:

Train MCH personnel to do routine HIV screening during immunization at 6 weeks and 9 months; provide pediatric HIV care in MCH and OPD in 50% of the sites in 3 years; continue aggressive nutritional assessments and management and provide nutritional support to malnourished children and lactating mothers

• Early infant diagnostic services (EID) & PITC HIV testing:

Train Nurses on DBS in all sites; Strengthening linkages between delivery points & testing points for EID; Increasing number of pMTCT sites; Increasing HIV antibody screening in 100% of admitted children; Advocating for Point of care diagnosis & Initiating Home based testing using CHW; for children and adolescents and initiate school based testing

• CD4 % availability & viral load monitoring:

Decentralizing CD4 testing to more health centers and ensuring 6 monthly CD4% testing in all HIV infected children Increasing capacity to do viral testing (by availing transportation of specimen to MTRH) for children before initiating ART and for follow-up in those with suspected treatment failure

• Adolescents' treatment & transitioning to adult services.

Training CO's, nurses on adolescent focused care and introduce encounter forms in all sites with adolescent care; Renovating spaces, Introducing support groups and group counseling for adolescents from age 14-15 as they transition to adult care

• Use of pediatric HIV data with the USG and national program:

Continued use of Electronic Medical Record System to collect data, decentralizing data entry and continue monthly sharing of data with GOK and USG. Analyze data to inform national policy and continue doing operational research. These resources will also provide integrated outreach and clinical diagnostic assistance using IMCI, for improved referral and health services for the children in those communities who are infected or affected by HIV/AIDS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	0	0

Narrative:

The clinical laboratories at AMPATH provide specialist reference laboratory services forAMPATH patients and other patients as per the established laboratory protocols / SOPs.

The laboratories have also capacity to provide technical services for clinical studies as per the study protocols.

The AMPATH Labs have responsibilities for:

• Expanding laboratory capacity to perform routine HIV diagnostic and monitoring tests by ensuring that approximately thirty (30) AMPATH facilities are strengthened to provide enhanced laboratory services annually.

• HIV testing laboratories within the AMPATH catchment areas are accredited according to national or international standards.

• Ensuring that annually six (6) laboratories have capacity to perform HIV ELISA tests, eighteen (18) laboratories

have capacity to perform CD4 tests and thirty (30) laboratories have capacity to perform TB Diagnostics.
• Ensuring that annually forty (40) individuals are trained in the provision of laboratory-related activities.
The AMPATH Laboratories now receives reagents and associated supplies for six thousand (6000) CD4 Tests, six hundred (600) EID and six hundred (600) vViral load tests per month from USAID through CHAI and SCMS. The laboratory has now started receiving requisitions for laboratory tests from non-AMPATH sites (APHIA Plus) for these tests in the North Rift and Western Kenya regions.
The AMPATH Laboratories performs routine laboratory monitoring and diagnostic tests for AMPATH patients including approximately six thousand long ELISAs, two thousand TB microscopy, four hundred TB cultures, eight thousand syphilis diagnostics, one hundred thousand CD4 tests. Eight thousand EID and viral load tests, sixty thousand chemistries and hematologies annually.
To achieve the goal of improving the standards of health facility laboratories in western Kenya and the North Rift region, the AMPATH Laboratories have a mentorship program in GCLP that covers all staff at health facility laboratories. This program has so far covered eighteen health facility labs in western Kenya and six in north rift. By the end of 2012 all laboratory staff at the health facilities in these two regions will have undergone this training. Following this training the facilities will be monitored on quarterly basis to assess progress being made towards improvement in the quality of laboratory services being provided and institute proper corrective and preventive actions. At the end of the year the laboratories will be assessed using the WHO-AFRO Checklist that is used to establish the level of the laboratory services provided at the facility. Already the AMPATH Laboratories have mentored the western provincial general hospital laboratory to a three star laboratory following assessment by KENAS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

HIV prevention interventions focusing on AB will target youth from 15 – 29 years, men and women aged 15 – 49 years at the workplace as well as the general population where feasible.
School-based HIV prevention programs
For the majority of young people, the first sexual relations are not within marriage. On the contrary, first sexual relations are mostly "casual. The proportion of young people who engage in abstinence until marriage has been declining over time.
Strategies:
Campaigns to delay sexual debut among youth between 15 & 19 years in secondary schools within AMPATH coverage areas will be conducted. Parents will be encouraged to start "Abstinence" messaging at an early age through counseling. HIV awareness and prevention will be addressed by in-school youth peer prevention programs. These approaches will be implemented in selected schools as a prototype and replication in other schools encouraged. Campaigns will be done at least thrice a year in the prototype schools.

HIV prevention in tertiary learning institutions
Strategies:
For youths between 19 & 24 years, strategies will be adopted to help them develop life skills for personal risk assessment in order to safely transition from abstinence to sexual activity. These will be youth out of school or those in tertiary learning institutions since studies have revealed that youth in institutions of higher learning engage in behavior that could expose them to the risk of HIV infection through engagement in sexual activities, often with multiple partners.
Workplace HIV Prevention Programs
The workplace involves the environment as well as the culture or practices practiced at the workplace. It is seen to be a convenient and conducive setting for HIV and AIDS control activities and workplace based interventions since it is where a considerable number of men and women meet, interact and educate one another on many issues of importance to human life.
Strategies
Programs with AB and appropriate C messaging and services will be developed to reach men and women between 15 & 49 years in the workplace. Issues relating to adult male behaviour, risk perception and intergenerational and transactional sex will be addressed through interpersonal communication . These prevention messages will be delivered during risk-reduction counseling. Partner reduction messages will be given, emphasizing faithfulness to one partner, mutual fidelity while discouraging intergenerational and multiple sex partnerships.
Prevention with Positives (PwP)
Scaling up of PwP in AMPATH will be integrated in all settings including testing points and where HIV infected persons are being provided with care both at the facility and in the community.
Strategies
Messages on abstinence and being faithful will be continually provided to Adults and adolescent and youth clients who are already HIV infected; through support group sessions and during interaction with the health care providers.
The HIV prevention interventions will be implemented in selected populations in all twenty-five (25) AMPATH sites that are spread throughout the western Kenya region. The population served by AMPATH is approximately 2.8 million people
AB prevention activities provided to the different cohorts is closely linked to the HIV C & T.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	0	0

Narrative:

AMPATH's HIV counseling and testing activities target the general population including couples, pregnant women, MARPs. Activity coverage areas include Western Kenya region with estimated population of 2.8 million in eight districts. The HIV prevalence in this region is estimated at 7.7%. Over the last 12 months AMPATH has tested and

provided results to 132,384 1individuals in the door to door testing in Teso, Port Victoria, Chulaimbo, and Kapsaret sites. This involves the use of client-initiated HIV counseling and testing which mainly focuses on VCT. In addition, AMPATH conducts provider-initiated testing and counseling in outpatient and Inpatient departments and TB Clinics including perpetual home based counseling and testing in all communities.
AMPATH uses the Ministry of Health approved serial testing algorithm in all the sites.
The table below summarizes the targets and achievement for number of individuals who received testing and counseling and were provided with results using the approaches employed during the past one year.
Approach Target and Annual Result
Perpetual Home Based C&T: Target 132,442: Actual 132,384
PITC : Target 140,000 : Actual 130,044
PMTCT: Target 40,000: Actual 79,562
VCT: Target 12,000 : Actual 6,722

To enhance the ability of staff to effectively conduct HIV testing and counseling, AMPATH provided Counselor Refresher trainings, 65 individuals were trained. The trainings will continue during COP 2012.
AMPATH continues to ensure substantial allocation of its budget to support testing and counseling activities. During the last year Kshs 89,566,003 supported the provision of HCT/PHCT activities in the geographical area of coverage. To ensure provision of quality and comprehensive services, AMPATH has an effective referral linkage mechanism that supports identification and linkage of clients to other components of AMPATH program including Care and support, and treatment. All patients' details are recorded in referral forms to facilitate easy tracking of patients who are referred to facilities but do not eventually access care and treatment services.
Emphasis is placed on the safety and storage of test kits. Test kits are stored and handled as per the recommended protocols.
Quality assurance and quality control of results is carried for every 20th client specimen taken by nurse counselors. In cases of discordant couples, samples for Long ELISA are taken for comparison; correct samples are maintained as per laid guidelines. AMPATH reference LAB supervisors also conduct quality checks by internal audit QA and external audit QA
Joint supervisory visits are carried out by AMPATH and MOH staff on a monthly basis.
AMPATH makes use of CHWs, CHEWs to mobilize communities for increased uptake of testing and counseling activities.
Data collected from the Door to door testing is captured electronically using the G1 Android phones, and then synchronized to the AMRS.
Data from the facility based C&T is captured through the MOH data collection Tools.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

Other HIV prevention interventions will target youth from 15 – 29 years, most-at-risk-populations (MARPs) such as long distance truck drivers, sex workers, fisherpersons, prisoners, men who have sex with men as well as the general population.

HIV prevention in tertiary learning institutions
Formation or strengthening of post-test clubs for continued HIV education and awareness will be supported. Condom education and supply will be enhanced in addition to messaging on AB.

HIV Prevention at the Workplace
Workplace support networks for PLHIV will be established at their places of work where possible. There will be education on the use of condoms and supply will be done in collaboration with the ministry of health.

Prevention with Positives (PwP)
There will be education on condom use and supply to individual clients through the existing distribution outlets. Self risk assessment and risk reduction counselling for clients will be conducted.

Most-at-risk-populations
Specific interventions targeting each of the MARPs will be developed. These will include economic empowerment for alternative income for sex workers as well as risk reduction among long distant truck drivers, fisherpersons, prisoners and MSM.

Media advocacy
This will be used as a medium to provide cross-cutting HIV prevention information and educate the audience.

STI education
This will be provided to all audiences considered to be sexually active due to the established association between HIV risk and presence of STIs

Alcohol and substance abuse
Education will be provided to the general population and efforts made to design specific programs targeting the alcohol brewers where feasible.

Mechanisms to Promote Quality Assurance
Support supervision will be done on a continuous basis and performance Gaps identified will be addressed through appropriate strategies.

Integration and /or linkage with other services/platforms

Implementation of the HIV prevention services will be in an integrated manner to ensure effective linkage with, care and support, treatment and PMTCT.

Monitoring & Evaluation Plans
Data will be collected using tools that will be specifically developed for the various interventions and shared with all the stakeholders.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	0	0

Narrative:

Transmission rate by 18 month ELISA is currently 3.6%
The target for the next 2 years:
• To reduce transmission to less than 5% for all districts within AMPATH coverage and within the next 5 years to reduce transmission to less than 1%.
Building capacity:
• PMTCT clinical care is provided by clinical officers and nurses. They identify pregnant and breastfeeding women who need ARVs for prophylaxis and treatment and the protocol for managing them. Training is also provided for routine antenatal and postnatal care and family planning counseling. Consultants, Medical Officers and selected clinical officers provide clinical mentorship, offer support supervision and are consulted on complicated obstetric or medical cases.
• Staffs are trained and involved in identifying HIV infected women at the MCH and Labor Ward, initiate management and refer them to the HIV clinic.
• PMTCT services are offered in 57 comprehensive facilities and 106 satellite sites. There is an initiative to provide PMTCT services to all level III facilities in the AMPATH catchment areas. AMPATH PMTCT managers participate in review of National PMTCT guidelines as well as NASCOP PMTCT Technical Working Groups.
• At regional, district and site level, clinical supervisors monitor the observation of protocols for PMTCT in the various levels and availability of commodities required for PMTCT.

Scale up of PMTCT activities:
• Prevention of infection is done is collaboration with home based counseling and testing in the community. At the facilities there is support of VCT, and strengthening of PITC and testing of all ANC mothers, mothers in MAT and PNC mothers.
• Counseling and provision of FP services to HIV infected women is carried out in the HIV clinic with the aim of having integrated services in all HIV care facilities.
• All pregnant and breastfeeding HIV infected women are evaluated for eligibility for ARVS; HAART is prescribed accordingly. All HIV exposed infants are given prophylactic ARVs.

• PMTCT patients who default are visited at home within 2 weeks of the missed visit. Couple counseling is promoted in all the facilities. In the community, testing of the entire family is done through the HCT team.
Increase of PMTCT uptake:
• All pregnant or lactating women are tested at the MCH clinic. Those found positive are linked to routine ANC, PNC and PMTCT services.
• In the community, community-owned resource persons (CORPS) and community health workers (CHWs) are trained in PMTCT and encourage pregnant women to get tested for HIV and promote PMTCT services. They do undertake community mobilization and talk about various health issues in community gatherings including HIV testing , care, and PMTCT.
Integration of PMTCT with routine MCH/RH services:
• HIV infected patients are comprehensively managed by the AMPATH team. CD4 count and WHO clinical staging are done for eligibility for treatment or prophylaxis in all HIV-infected mothers. ANC and PNC care is routinely carried out.
• Establishment of cervical cancer screening in 4 facilities and the initiative is being rolled out.
• 12 facilities have fully integrated FP in the HIV clinic; this is being rolled out to cover all facilities that offer PMTCT services.
• Pregnant and lactating mothers with inadequate food supply are provided with food support.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	742,459	0

Narrative:

AMPATH training on HIV/AIDS focus on ART both in adult and pediatric patients. Other trainings include palliative care, PMTCT, PITC, Pediatric Disclosure, Cervical Cancer Screening and HCT. Family planning training is conducted under reproductive health.
The program provides mentorship to clinicians, nurses and laboratory staff over a three month period.
Preceptor programs are available using experienced clinicians and nurses who serve as role models and facilitators. They coach, inspire and support the development of new qualified professionals through transition from new learner to practicing professional.

Support supervision helps in addressing quality/performance gaps and allows the program to asses and monitor the quality of services provided to patients. Supervision is based on the National guidelines and protocols.
Indicators used to track and evaluate clinical outcomes include:
Percent of new patients with CD4=200 receiving cART within 3 months; Percent of HIV-positive persons receiving Cotrimoxizole (CTX) Prophylaxis; Number of patients Ever enrolled; Number of patients Ever started of ARV's; Number of patients Active on ARV's; Cumulative Number of patients deceased; Number of patients lost to follow up; Couples tested for HIV (in the last month/ ever tested); No. of women tested for HIV in ANC; and No. of

HIV-positive pregnant women on treatment.

The number of clients tested and enrolled into the program indicates the performance of the professionals. The enrolled clients are then retained in the program.
The data obtained will help identify good performance and areas which require improvement and will guide identification of areas requiring improvement.
The following activities support retention of patients initiated on ART:
Outreach program – for patients who miss appointments; reduces the cumulative numbers of patients lost to follow up and increase the number of No-show patients who are followed up.
To increase staff competence; monthly, quarterly and annual review meetings will be conducted. The meetings will help asses training needs among staff. Trainings will subsequently be conducted to increase knowledge and skills that will be used to improve staff performance. CHWs located around the sites will be engaged to reach clients timely and improve adherence.
The adherence activities supported include:
Psychosocial Counselling - addresses the emotional and social needs of HIV patients
Adherence counseling – Focuses on both adherence to care and treatment and behavior change.
Patient education – for treatment buddies who will supervise or support the patients.
Use of adherence enhancers - using counseling, medication diaries, pill boxes, buddy/partner system, modified DOT and telephone reminders
Six month nutritional support will be provided tor index patients and their dependents
Socio-economic support is given to retain patients on care.
Outreach services -for follow up of clients who miss clinic appointments with no prior communication.
Peer counseling provides psychosocial support to all clients from enrolment through the continuum of care.
The target population is all HIV infected adults in the catchment area. Patients enrolled into care receive ARV treatment when they are eligible; treatment for opportunistic infections, cotrimoxazole prophylaxis and TB screening on enrolment and subsequently depending on signs and symptoms and history of exposure, use on isoniazid for prophylaxis.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	515,485	0

Narrative:

Target populations: North Rift, Western and Nyanza
• Provision of drugs, food and other commodities for pediatric clients:
Continue providing co-trimoxazole for all breastfeeding HIV exposed children, all non-breastfeeding children before confirmation of negative status and all HIV infected children irrespective of age or disease stage; continue providing treatment for opportunistic infections in all sites using revolving pharmacy fund; provide vitamin

supplementation to all HIV infected children; strengthen and facilitate referral to level 3,4 or 5 facilities for complicated disease; provide ITN for children in Malaria endemic areas; continue aggressive nutritional assessments in at all visits by nutritionists, nurses and clinicians; enhance the use of automatically calculated reminders for malnourished children; Continue to provide nutritional supplementation for malnourished children and adolescents and evaluation of socio-economic status.

• Adolescents with HIV:

Continue disclosure, support groups counseling targeting all adolescents; expand adolescent focused care services to 50% of sites in 5 years; initiate group counseling sessions and support groups for adolescents transitioning into adult services; continue adherence screening before initiating ART, initiate home visits and enhanced counseling in adolescents with adherence problems, employ nurse counselors specific to adherence and disclosure counseling support; strengthen counseling on sexuality and risk reduction; initiate support groups for disclosed adolescents for positive living; avail family planning services

• Supervision, improved quality of care and strengthening of health services.

Continue regional consultant visits and mentorship to clinics; continuous quality improvement related to pediatric HIV care primary objectives and continuous medical education during site visits; continue leadership in protocol revisions/updates/dissemination and National representation in development of guidelines and curricula

• Activities promoting integration with routine pediatric care, nutrition services and maternal health services.

Train MCH personnel to do routine HIV screening during immunization at 6 and 9 months; Introduce pediatric HIV care in MCH in 50% of sites .; train outpatient & inpatients nurses and clinicians on HIV care protocols in all level 3 and above facilities

• Activities to strengthen laboratory support and diagnostics for pediatric clients.

Continue to build laboratory infrastructure to do more tests including biochemistry, CD4 and hematology; train and impart skills to nurses in all sites on DBS for early infant diagnosis and rapid HIV testing; continue network to support DNA PCR, CD4, biochemistry and viral loads in facilities unable to do the tests; utilize the existing referral system to level 3,4 5 or 6 facilities.

• Plans for monitoring and evaluation.

Work with M&E team on the strategy for the coming 2-5 years; continue monthly evaluations of the key indicators and dissemination of the report to GOK through the facilities program leaders

Implementing Mechanism Details

Mechanism ID: 14015	**Mechanism Name: National Training Mechanism (FunzoKenya)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: IntraHealth International, Inc	

Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 285,531	
Funding Source	**Funding Amount**
GHP-State	285,531

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This project was awarded in February 24th 2012 to run for a period of five years.The project will aim at supporting the in-service training of health workers, increasing the production (pre-service), strengthening the relevant government departments dealing with health worker trainings and lastly working with key professional bodies to strengthen their role in regulating, accreditation and professional development of their members. This project will procure 2 vehicles in FY12. This activity will support GHI/LLC and will be funded primarily with pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	250,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms

Increase gender equity in HIV prevention, care, treatment and support

Increasing women's access to income and productive resources
Malaria (PMI)
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**14015**
Mechanism Name:	**National Training Mechanism (FunzoKenya)**
Prime Partner Name:	**IntraHealth International, Inc**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	0	0

Narrative:

The project will provide training of health workers at both pre-service and in-service levels to be more effective and efficient in providing home based care to target clients. Gaps in competencies will be identified in collaboration with the USAID implementing partners (regional and national level mechanisms), relevant government departments and other stakeholders. Curriculum, course contents and effective modalities of course content delivery will be supported.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	0	0

Narrative:

These funds will be used to support training activities related to TB services among the health service providers. Curriculum review at the national level and its implementation will be supported; in-service courses and professional development activities at the six levels of service delivery will be supported. Areas of high disease burden will be targeted for high impact. Support to government departments that deal with health education for health workers will be provided to strengthen the health workforce updates and further trainings in TB related courses. E-learning modalities and forums for knowledge exchange will be supported to enhance prevention, diagnostic, treatment and rehabilitation activities related to TB.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	0	0

Narrative:

The funds will be used to scale up training of health workers in Integrated Management of Childhood Illnesses (IMCI), inpatient management of severe malnutrition and on use of rapid diagnostic tests for HIV and malaria. Kenya health system is integrated and so is the health worker training, the health workers training on IMCI will by extension include HIV and related cases that affect children in this country. The intervention will target both Pre-service and in-service courses using modes such as classroom, distance learning, e-learning and M-learning. The existing curriculum will be reviewed to be more responsive to current skills gaps. Upon qualification the health workers will attend to children including those suffering from HIV/AIDs and related cases. The level of knowledge retention will be assessed post training based on set bench marks.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

These funds will be used in support of the health workforce training and professional development activities. The relevant government departments (human resources development, continuing professional development and health education) and Key professional bodies will be supported to be more effective in their operations. The funds will also be used to support scholarships and loans for school fees for qualified students from hardship regions in order to boost the numbers of qualified health personnel from the regions. In the long run the qualified students will be subjected to government bonding mechanism to serve in the hardship regions for a specified duration. This will ensure we meet the PEPFAR commitment of contributing towards the 140,000 new health workers and also retention in the hardship regions. Support will be provided to the training institutions to expand their admission and faculty capacities in order to ensure long term sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

The project will use the funds to train health workers and effectively orient them on HIV prevention approaches relevant to abstinence and being faithful. The trainings will be done at the training hubs and satellite facilities, use of modern training approaches such as distance learning, use of e-learning and mobile learning platforms will be applied as necessary.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	42,669	0

Narrative:

The project will lay emphasis in the area of supporting the training institutions to be more responsive and develop courses that will improve VCT services at the various levels of service delivery. National curriculum reviews and development for pre-service and in-service courses on VCT will be supported. The course content delivery will be done using the most appropriate modalities to ensure wide coverage and access by health workers especially in rural and hard to reach setups. Faculty will be supported to be more effective in content development, dissemination and evaluation of the trainings.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

The project will work with the regional USAID partners and relevant government departments that deal with preventive interventions for HIV and related conditions, to identified training needs and gaps at the various levels of preventive services. Curriculum and course content will be developed and delivered to enable health workers to be more effective in preventive services at the various levels of service delivery. Health workers knowledge, skills and attitude gaps will be addressed through trainings and mentorship to make them more efficient and responsive to preventive service's needs. Primary levels of service delivery i.e. community, dispensary and health center levels will be the key areas of focus as they handle much of preventive services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	0	0

Narrative:

The funds will be used in support of training interventions for health workers in courses related to MTCT. Pre-service curriculum review will be supported in line with the new developments in this field. The health workers training institutions at midlevel and tertiary levels will be engaged in this process. Faculty will be capacity built to provide trainings in the field of MTCT. The quality of trainings will be assessed through follow up of beneficiaries post training and documented for future use.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	148,048	0

Narrative:

The project will support the training of health workers at various levels of service delivery to be more effective in treating adults suffering from HIV and related conditions. Working with the pre-service training institutions, gaps in the training curriculum will be identified to make it responsive to current needs in health workforce training. Modalities to make the trainings accessible to a majority of health workers especially in the rural and hard to reach areas will be supported such as clinical based mentorship, facility based continuing education, e- based learning

and mobile (phone) based learning. Training facilities will be supported to increase the production of health workers to minimize the production-need or vacancy gap for effective service delivery and also in support of PEPFAR commitment of producing 140,000 new health workers. The key professional bodies will be supported to be more effective in regulating the trainings and licencing of health workers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	94,814	0

Narrative:

The project will use these funds to identify health workers knowledge and skills gap in pediatric treatment of HIV and related illnesses. Pre-service curriculum will be revised to reflect the current needs and course content developed, disseminated and evaluated in order to track effectiveness and efficiency of the trainings. Emphasis will be laid on developing a long term system of needs identification, curriculum review, course content development and evaluation for responsive trainings in future. Health workers will be supported through class room, e-Learning and m-Learning modes to enhance their knowledge and skills in pediatrics treatment.

Implementing Mechanism Details

Mechanism ID: 14022	**Mechanism Name: APHIAplus NAL**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: African Medical and Research Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,156,422	
Funding Source	**Funding Amount**
GHP-State	2,156,422

Sub Partner Name(s)

Broadreach	Catholic Relief Services	FHI 360
Land O'Lakes	University of Maryland Baltimore	

Overview Narrative

APHIAplus Northern Arid Lands is a five-year project funded by USAID to be implemented between June 2012 and June 2017 in North Eastern Province and select districts in Coast, Upper Eastern and Upper Rift Valley Provinces. The project is designed to support integrated service delivery and address social determinants of health by working with existing structures at the provincial, county, facility and community levels and building their capacity as necessary to ensure efficiency and effectiveness. The project will work to ensure access to and continuation of services in an area prone to drought, famine, insecurity and other disasters for populations that are nomadic and largely hard to reach. It will build the capacity of partners throughout the life of the project, and continuously transfer more responsibility to manage resources and project activities. APHIAplus builds on the lessons learned during APHIA II, expands successful approaches to high-need districts, and provides more support for interventions addressing the social and economic barriers to healthy lives. It also supports the Let's Live Campaign aimed at ensuring good health outcomes for mothers, new borns and children under 5 years in families infected and affected by HIV/AIDS. This project, which covers a very large geographic region, is expected to procure 8 vehicles in FY12. This activity will be funded primarily with pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	200,000
Food and Nutrition: Policy, Tools, and Service Delivery	300,000
Gender: Gender Equality	100,000
Renovation	428,000
Water	100,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**14022**
Mechanism Name:	**APHIAplus NAL**
Prime Partner Name:	**African Medical and Research Foundation**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	0	0

Narrative:

Care & Support Services for OVC: The services will enable OVC enjoy the basic human rights that include right to food and nutrition, health care, psychosocial support, shelter, education and vocational training and legal protection. Similarly people living with HIV (PLWH) enrolled and provided with nutritional support, shelter, medical and health care, legal protection and psychosocial support. To reach to the OVC and PLWH with care and support, the project will sub-contract the Local Implementing Partners (LIPs), train and provide them with grants for OVC/HBC services. In 2012, the project plans to sub-contract LIPs to reach OVCs and HBC clients in Garissa, Wajir, Mandera, Rana River, Marsabit, Turkana and Isiolo counties. OVC and PLWH will receive care and support at a household level to foster community and family participation as this approach has shown to reduce stigma and discrimination. Those to benefit from the project as OVC will constitute children aged 0-17 years while ensuring both girls and boys have equal chances of benefiting from the project. Those aged 18 years and above will be considered as beneficiaries on home based care and support. Client retention and referrals: The project will maintain a data base of OVC/HBC clients. Project staff will make periodic follow-ups to ensure retention on the program. To ensure that the OVC and HBC clients on the program receive quality services, the project will train the LIP project staff on QI standards. The care & treatment team will be involved for HIV care and support. Sustainability: The project will support the beneficiaries to engage in viable income generating activities (IGA) through training on group dynamics, identification of viable IGAs and marketing strategies. The project staff will conduct quarterly supportive supervision, review OVC/HBC data records and make random visits to the beneficiaries to assess quality of services that are received by the OVC/HBC clients.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	0	0

Narrative:

APHIAplus will continue support the to Department of Children's Services (DCS), to strengthen Area Advisory Councils (AAC) that have been established, build the capacity of new AACs where they do not exist at the district level and to help decentralize the system to the community level. APHIAplus aims to reach OVC households in the zone with care packages addressing needs related to health (including HIV prevention), education, targeted food and nutritional assistance, psychosocial support, shelter, protection, and household economic strengthening. Quality care implies that an appropriate mix of services and support are provided to ensure children affected by

HIV/AIDs grow and develop as valued members of their families and communities. APHIAplus will apply the QI approach that engages teams of OVC care providers and other staff at the point of service delivery to evaluate their own performance and develop plans on how they can perform their work better.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	0	0

Narrative:

This activity will occur in garissa, Wajir, Mandera, Tana River, Samburu, Isiolo and Turkana counties. Support for TB-HIV activity is centered on the DLTLD and NASCOP collaborative activities. The PTLC/PASCO and the DTLCs and DASCOs lead the processes at the provincial and district levels respectively. Support for intensified case finding through provision and mentorship on use MOH, screening tools at the CCC and MCH, Mentorship on TB HIV integration models, provision of job aids and IEC materials, scaling up ART uptake among TB-HIV co-infected patients and carrying out CMEs on infection prevention/control. Support to the implementation of the minimum package for infection prevention and control ensuring cross ventilation in all the clinical rooms and health talks is included.

On-the-job training for service providers as well as sensitizations/Continuing medical education sessions for up-dates conitnues. TB-HIV collaborative meetings and strengthening integration of TB and HIV services are priorities. Participation in the quarterly review and planning meetings with the DTLCs, DMLTs and DASCOs continue to be an important factor in ensuring that we address government priorities. Support will continue for active TB case finding through monthly integrated TB/HIV outreaches in urban centers. This includes on site sputum collection, and testing. Testing for HIV in TB clinics and TB in HIV clinics will continue and improvement of HIV/TB data management.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	0	0

Narrative:

In The Northern Arid land area a mentorship program will be expanded to cover all treatment sites in Garissa, Mandera, Wajir, Turkana, Samburu, Isiolo and tana River Counties. To scale up uptake of pediatric HIV services, a mentorship program that takes into account special aspects of children living with HIV is essential. I The mentorship program has paediatric components that address issues like paediatric psychosocial care, management of opportunistic infections like TB, growth and neurodevelopmental screening, and management of treatment failure.

Adherence and psychosocial support services for children include innovative use of colour-coded labeling of syrups and syringes for the un-educated parents and care givers. Enrollment of children into psychosocial support groups is done according to their age groups thereby taking into account their cognitive development. The adolescent support groups are linked with other youth-friendly services in the facility. Support for care-givers

support groups to run concurrently with the children support groups so that adherence measures can be reinforced. Other measures include structuring the parents or care givers clinic days to coincide with the children's appointments. Integration of HIV services in the MCH ensures follow up of the mother and child in one clinic to minimize time spent in the health facilities. This also increases retention by minimizing defaulting. Follow up of the HIV exposed infants and the PMTCT program continues to be integrated with CCC services to ensure no missed opportunities. Efforts are in place to scale up EID services in tandem with PMTCT services. Other activities are to provide drugs, food and other commodities for pediatric clients (HIV exposed infants, HIV infected children and adolescents). Project will support the needs of adolescents with HIV (PwP, support groups, support for transitioning into adult services, adherence support), supervision, improved quality of care and strengthening of health services, promoting integration with routine pediatric care, nutrition services and maternal health services. Laboratory support and diagnostics for pediatric clients will be strengthened. Additional resources ($300,000) will be used for the procurement of zinc tablets under LLC, to support the management of diarrheal diseases using ORT amongst children under 5 infected or affected by HIV/AIDS. Further, there are hard to reach population groups in NAL who do not utilize health services in facilities. This additional resources will provide integrated outreach health and referral services for the children in those communities who are infected or affected by HIV/AIDS . These resources will also provide integrated outreach and clinical diagnostic assistance using IMCI, for improved referral and health services for the children in those communities who are infected or affected by HIV/AIDS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	0	0

Narrative:

The project's principal strategy for rapid scale up of VMMC services in Turkan County will be to:

1. Coordinate with the Ministries of Health and other VMMC implementing partners in these districts to ensure strong coordination of interventions and avoid duplication of effort. The project will participate in national, provincial and district-level VMMC Task Force Meetings. Through collaboration with the Provincial Medical offices and the USAID capacity project VMMC teams have been deployed in Turkana and received training through the Nyanza Reproductive Health Services.

2. Conduct regular outreach campaigns – based at health facilities, in tents – to circumcise large numbers of men in line with the Ministries' VMMC strategy. APHIAplus will utilize the MOVE approach to VMMC, which is focused on maximizing efficiency in the delivery of high quality VMMC services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

All the interventions will adopt the Comprehensive Prevention Program approach. They will be the approved Evidence Based Interventions (EBIs) or those that are curriculum based. The project will support AB activities within the framework of the Comprehensive School Health Program which is supported by the Ministries of Public Health and Sanitation and Education. This program will be rolled in schools, and out of school youth groups in the project intervention areas. These EBIs are an integrated set of planned, sequential, school affiliated strategies, activities and services designed to promote the optimal physical, emotional, social and educational development of learners/education sector actors. This program component will target young people aged 10-24 years both in school, out of school and in tertiary institutions. They will be taken through Life skill sessions using the approved EBIs, such as Healthy Choices, the KIE approved life skills curriculum and the KARHP curriculum. These will be complemented with interventions such as Shuga and other HFG activities. These interventions provide a set of Life Skills and Adolescent Reproductive Health Education that empowers young people make informed decisions and help delay onset of sexual activity and or practice of secondary virginity which may otherwise lead to increased HIV infections amongst youth. These interventions will be implemented in countiessuch as Garissa, Tana River, Wajir, Isiolo, Samburu, Mandera, Marsabit and Turkana.. The project will print and distribute the appropriate curriculum and will support the Ministry of Education officials to conduct supportive supervision in the institutions targeted. The targeted youth will, as appropriate, be linked to the relevant biomedical services such as counseling and testing and condoms. Each school/institution will be supported to undertake a self-assessment and develop an appropriate action plan that will be reviewed annually to assess level of achievement.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	718,752	0

Narrative:

North Eastern province has a HIV prevalence of 0.9%, Eastern 3.5 percent and Rift Valley 4.7% according to KDHS 2008- 2009. This activity will be focused in eight counties in this region namely Garissa, Wajir, Mandera, TanaRiver, Marsabit, Isiolo, Turkana and Samburu. HTC services are provided using both PITC and CITC approaches. PITC services are not yet comprehensively provided in all counties under this project .Community HTC is provided through outreaches, mobile VCT, door to door testing and moon light outreaches. These activities target the general population but with special focus on first time testers and couples. MARPS receive services through targeted outreaches. Moonlight HTC is utilized to reach the subpopulations. Quality assurance for HTC is ensured by linking all facilities to the NHRL to ensure that they participate in the EQA exercise. The DMLTs are supported to organize for quarterly proficiency testing activities within their districts to refresh the providers on laboratory practices. Facilities have regular visits by the District laboratory and counselor supervisors to ensure quality testing is going on at all service delivery points. HTC providers receive regular update meetings to keep them appraised with new HIV testing information and dissemination of guidelines. The national algorithm for testing is utilized at all facilities and the national reporting tools and reporting structures are utilized. The facility MDTs will be tasked to document follow up and tracking for clients referred to the CCC.The community units are

utilized to create demand for services both at the facility and at the community outreaches. Gender based violence activities are carried out both at the facility and community levels. At the facility level, Post rape care services are provided at the Outpatient department where the clients report. Examination and prophylaxis together with trauma counseling form the PRC package. Update for HCWs on management of survivors of sexual violence is provided regularly and trauma counselors receive supervision on quarterly basis. Sensitization on GBV to community leader's children's officers and other stakeholders provides them with information for GBV prevention and response. Community units are sensitized to ensure they know where to refer survivors and what a survivor should do or not do when raped. Stakeholders meetings are held to create a forum where stakeholders can share their interventions and also discuss strengthening the medico legal linkages.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

The project will target individuals or groups whose behaviour puts them at very high risk of HIV infection. This will cover the Northern Arid Lands area: Tana River, Isiolo, Garissa, Marsabit, Wajir, Samburu, Mandera and Turkana counties. The target group includes female and male sex workers in urban and peri urban area, youth out of school and comunity groups like morans in Samburu amongst others. Other interventions include the the Community Strategy. The identification process to map most at risk populatons will be extended to the new areaas in Tana River and Turkana counties. The project will buy in into the national MARPs mapping exercise and collect specific information that will be useful in programming for MARPs. The interventions for MARPs will be in line with the NASCOP guidelines and meet the minimum standards set. That will include behavioral, biomedical and structural interventions such as health education, provision of condoms, counseling and testing, STI screening and treatment and linkages and partnership (NHIF,MFI, GoK, alternative livelihood skills development). The Community Strategy will continue to be prioritized in this region using appropriate models because of the vast geopgraphical terrain. Schhol based programs through health clubs and parent fora will be important entry points for education and risk reduction. The Community units will be increased to 50 benefitting an estimated population of 1 million people. The interventions will be guided by the Minimum standards as defined by NASCOP and the KEPH and will be integrated with the appropriate services. MARPs, Workplaces and Community units will be linked to service delivery points as well as integrated outreaches to support hard to reach areas. The activities in CS will be reported through the National CBHIS system, while the MARPs and Workplaces within the KEPMS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	705,832	0

Narrative:

Human resources for health continues to be a big challenge in the NAL zone covering Garissa, Wajir, mandera, Tana River, Isiolo, Marsabit and Turkana for this activity. Most facilities have either one or two qualified staff.

There are facilities PMTCT skills are absent. The project will continue to work with the national USAID capacity Project and the Ministry of Public Health and Saniatation to address the issue of additional stafff ofr this region. The project will collaborate with the new USAID Trianing project to train staff on the new PMTCT guidelines. Couple counseling and testing uptake is low in PMTCT settings. Formation of mother-to-mother support grouos in low volume facikIties is hindred by few numbers of HIV positive mothers and long distances between homes. So this activity will be limited to district hospitals and high volume facilties. Increasing coverage will be through increasing number of sites offering PMTCT minimum package of care; PMTCT and pediatric mentorship activities; Integrated Support Supervision. Linkages with the KEMRI reference Laboratory will help improve the timely submission of EID results and the Clinton Health Access Inititiative will support the project to get access to the web based EID resutls for selected sites. Efficiencies will be achieved through coordination with the transport network of Care and treatment team in the DBS sample transportation; use SMS for DBS results notification; Integration of activities within MCH: PPFP, FP in ANC, Use online updates on latest PMTCT guidelines on new changes; Use of champions as mentors at facility level; Global E-learning on PMTCT/EID; Encourage SBA for PMTCT; by motivation e.g provision of mama packs to women; Mentor mothers for defaulter tracing; CMEs,and OJTs for newly recruited health workers; Mentoring SS; Transitioning to FBO; ARVs, Counseling time, CD4, Viral load, FBC, UECs, LFTs; TB & STI screening and treatment; Documentation; SS; Job aids and mobilization costs. Additional resources ($200,000) from Let's live Campaign (LLC) will be geared at training of HCW on maternal and newborn care, hence increase their skills in offering antenatal care, delivery and newborn services. This will help to improve the quality of services and ensure better health outcomes for HIV positive women and their new borns.. Activities will also aim at significantly increasing cervical cancer screening for high- risk women aged 30 - 49 .

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	642,700	0

Narrative:

An effort will be made to narrow the gap between the number of clients testing positive and those actually enrolling into care and treatment in both provinces. This will be done through various strategies that will include facilitated referral by non-clinical counsellors/ volunteers and CHWs within the facilities, use of community referral documents and through follow up of the clients testing positive. The clients testing positive will also be linked to support groups in their areas for psychosocial support as well as adherence counselling and defaulter tracing.

The project will continue to expand the integration of HIV services in the MCH, TB clinics and OPD. The project will also link with the ongoing pilot QI/QA intervention supported by URC and NASCOP in select districts of Nyanza province, and roll out best practices to other districts.
The decentralization of integrated services HIV/FP/RH/MCH will be supported by the rapid expansion of and continued support for the highly reliable, cost-effective laboratory network model i for the referral of specimens to

comprehensive laboratories in level 4 and 5 facilities from the lower level satellite facilities. A clinical systems mentorship (CSM) program jointly conducted by MOH mentors, Kenya Pediatrics Association in and the APHIAplus NAL mentors will continue to be expanded in the counties of Garissa, Wajir, Mandera, Tana River, Marsabit, Isiolo, Sambvuru and Turkana. The mentorship teams have a mutually agreed work plan/schedule of visits to health facilities which are shared with the recipient facilities well in advance.
Multi-disciplinary teams (MDTs) are the entry points.
The three main facets of clinical systems mentorship process are:
1. Preceptorship,
2. Chart reviews and
3. Clinical case discussions.

Clinical case discussions: challenging patient presentations serves to generate interesting cases to support learning and sharing of ideas (Case-based learning).

Supported defaulter tracing and prevention strategies include provision of HIV treatment literacy, adherence monitoring, and use of phone tracing.
DHMTs and the PHMTs will be supported to conduct quarterly integrated supportive supervision. This builds the capacity of MOH to manage services ensure there is sustainability- country managed project.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	89,138	0

Narrative:

APHIAplus will scale-up pediatric care and treatment in the region. In the next two years, all adult/adolescent CT sites will strengthen the delivery of pediatric CT services to ensure optimization of entry points into CT and improved follow-up through integration of pediatric HTC into MNCH services and in-patient pediatric care services. Identification of HIV exposed and infected children will be intensified through longitudinal follow-up of HEI and PITC for the infants with unknown status in the health facilities. Early infant diagnosis facilities will be scaled-up to ensure provider competence to collect quality DBS samples and transport samples to regional laboratories for HIV DNA PCR diagnosis. Mentorship teams will ensure providers minimize missed opportunities for HIV diagnosis among exposed children. OJT for service providers on collection of DBS samples will be conducted in the facilities to improve diagnosis of HIV among the HEI. Turnaround times for receipt of results will be analyzed for each facility and optimized through measures to reduce time waiting for and relaying results to mothers. Service providers will be mentored on the prompt initiation of ART for children less than two years old with confirmed HIV status, while access to CD4 and viral load testing will be facilitated through laboratory networks linking regional labs with the National HIV Reference Laboratory to enhance evaluation and monitoring of patients. APHIAplus will build the capacity of health service providers in pediatric HIV management through

targeted trainings and clinical mentorship to ensure that regimen dosing is age appropriate. Nutritional assessments of pediatric patients and therapeutic and supplemental feeding will be an integral part of their evaluation and monitoring. Access to all other immunization care, supplementation, and growth monitoring services will be undertaken in compliance with National Guidelines. *The use of the HEI register and mother-baby booklets will be promoted and data complied to assess HIV transmission rates every month. Other outcomes will be analyzed to enable the development of facility-based responses to address poor outcomes. This effort will be undertaken by the pediatric HIV care and treatment mentor based in the supported health facility in conjunction with the Quality Improvement Team.*

Implementing Mechanism Details

Mechanism ID: 14034	**Mechanism Name: The OVC Scholarship and Leadership Program**
Funding Agency: U.S. Agency for International Development	Procurement Type: Grant
Prime Partner Name: Equity Group Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,324,656	
Funding Source	**Funding Amount**
GHP-State	1,324,656

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The OVC Scholarship Program is a five year Global Development Alliance Partnership between USAID, Equity Bank (EBL), Equity Foundation (EGF), and their other partners to support Kenyan OVC scholars to access secondary, tertiary and university education. The total estimated cost of the program is $17,426,213. The activity will offer comprehensive scholarships, leadership and mentoring to the remaining 488 beneficiaries of the USAID Kenya OVC project for the period 2011-2013. In addition, the program will select and fund a cohort of an additional 1,678 academically gifted children from needy backgrounds to join the EGF's flagship Wings to Fly Program. Based on HIV prevalence rates and a higher number of OVC burden in Nyanza and Rift Valley Provinces

and in keeping with EGF selection criteria, subject to the availability of funds, at least $10 million of USAID funding will be utilized to select scholars as follows: 30 percent will come from Nyanza Province, the next 30 percent will come from the Rift Valley Province and the remaining 40 percent will be selected from across the country, especially those areas where the Equity Bank has a presence. The scholarship component will provide a comprehensive package covering basic scholars' needs while at their academic institutions (tuition, room, board, books, supplies, uniform, cost of practicum, stipend, etc). It will then complement this with leadership development and mentoring which EGF currently provides to scholars under its Wings to Fly Program. The mentoring component of the USAID-EGF Program will focus on achieving academically-orientated goals as well as provision of psychosocial support to the scholars. This activity supports GHI/LLC and is completely funded with pipeline funds in this budget cycle.

Cross-Cutting Budget Attribution(s)

Education	1,300,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection

Budget Code Information

Mechanism ID:	**14034**
Mechanism Name:	**The OVC Scholarship and Leadership Program**
Prime Partner Name:	**Equity Group Foundation**

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HKID	1,324,656	0

Narrative:

The OVC Scholarship Program is a five year Global Development Alliance Partnership between USAID, Equity Bank (EBL), Equity Foundation (EGF), and their other partners to support Kenyan OVC scholars to access secondary, tertiary and university education. The activity will offer comprehensive scholarships, leadership and mentoring to the remaining 488 beneficiaries of the USAID Kenya OVC project for the period 2011-2013. In addition, the program will select and fund a cohort of an additional 1,678 academically gifted children from needy backgrounds to join the EGF's flagship Wings to Fly Program. Part of the selection criteria will be based on HIV prevalence Based on HIV prevalence rates and a higher number of OVC burden in Nyanza and Rift Valley Provinces. The scholarship component will provide a comprehensive package covering basic scholars' needs while at their academic institutions (tuition, room, board, books, supplies, uniform, cost of practicum, stipend, etc). It will then complement this with leadership development and mentoring which EGF currently provides to scholars under its Wings to Fly Program. The mentoring component of the USAID-EGF Program will focus on achieving academically-orientated goals as well as provision of psychosocial support to the scholars.

Implementing Mechanism Details

Mechanism ID: 16450	**Mechanism Name: Global Give Back Circle**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Kenya Community Development Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 445,866	
Funding Source	**Funding Amount**
GHP-State	445,866

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Reprogrammimng $157,229. The Price Waterhouse Coopers project came to an end in November 2011. The priority

activity currently is the Global Give Back Circle (GGBC) which is an OVC girls empowerment program that transitions the beneficiaries from poverty to prosperity through provision of educational scholarships, mentorship and life skills training.

Cross-Cutting Budget Attribution(s)

Education	400,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**16450**		
Mechanism Name:	**Global Give Back Circle**		
Prime Partner Name:	**Kenya Community Development Foundation**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	445,866	0
Narrative:			
August 2012 Reprogrammimng $157,229.			

Implementing Mechanism Details

Mechanism ID: 16643	**Mechanism Name: Nursing Capacity Building Program**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services	Procurement Type: Cooperative Agreement

Administration	
Prime Partner Name: Columbia University Mailman School of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 100,000	
Funding Source	**Funding Amount**
GHP-State	100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Global Nursing Capacity Building Program will strengthen the knowledge, skills and abilities of nurses that deliver care to people affected and infected by HIV/AIDS and co-morbidities, as well as the capacity of in-country nurse leaders, organizations and institutions. This will involve bridging pre-service and in-service HIV/AIDS nursing training and education, fostering continuous professional development, cultivating nursing leadership and recognition, expanding scopes of practice and updating national nursing strategies. Specific objectives include 1) perform a situation analysis to determine the current roles of nurses in HIV care, including the status of nurse-initiated management of ART (NIMART) in Kenya, 2) support establishment of an expanded scope of practice for nurses within HIV management, 3) define essential competencies for NIMART, 4) determine steps required to establish government-endorsed NIMART in Kenya, and 5) pilot the implementation of NIMART in identified MCH clinics.

This program will support the GHI strategy of increasing impact through strategic efficiencies by building capacity of nurses to expand their scope in ART management. This task-shifting effort will not only facilitate expanded access to quality ART services but also significantly reduce costs by reducing the workload on the few available clinicians. Through this project, CU-ICAP will build the capacity of National Nurses Association and National Nursing Council to promote ownership and sustainability.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	80,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**16643**		
Mechanism Name:	**Nursing Capacity Building Program**		
Prime Partner Name:	**Columbia University Mailman School of Public Health**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXS	100,000	0

Narrative:

Columbia University-ICAP, through the Global Nursing Capacity Building Program, will a)provide pre-service and in-service HIV/AIDS training to professional nurses, nurse educators and students through on-site clinical and on-campus didactic mentoring as well as curricula review and development, b) develop wellness programs and centers for health workers infected or affected by HIV/AIDS and co-morbidities, c) facilitate networking of nurses across institutions and countries, d) support development of national nursing strategy and e) promote and conduct nursing research. This will strengthen the knowledge, skills and abilities of nurses that deliver care to people affected and infected by HIV/AIDS and co-morbidities and build the capacity of in-country nurse leaders and institutions, such the National Nurses Association and National Nursing Council.

Implementing Mechanism Details

Mechanism ID: 16644	Mechanism Name: UNICEF
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: United Nations Children's Fund	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 400,000	
Funding Source	**Funding Amount**
GHP-State	400,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goals of this mechanism are first to target prisoners and prison staff with all HIV prevention, care and treatment services and second to build the capacity of Prison's services authorities for eventual running of wervices by the authority. Limited care and treatment services will be provided to the surroudning community based on exigency of critical HIV services.

Specific objectives:

1. Provide appropriate HIV combination prevention services including HIV education, HIV testing and counseling, linkage to care, male circumcision, STI screening and treatment, Positive Health Dignity and Prevention, ARV-based prevention, sexual violence itnerventions for both the perpetrator and victim, PMTCT, newly recommended HIV prevention innovations and appropriate evidence based behavioral interventions (EBI) to prison staff and their families, and to all prisoners as categorized in the prison population HIV transmission/acquisition risk groups; and also according to Kenya's laws and regulations.

2. Provide HIV care and treatment services, including tuberculosis and cervical screening, in accordance to

Kenya's care and treatment guidelines to prisoners, prison staff and families and emergency services for the surrounding community.

3. Provide technical assistance and capacity building to allow program transition to Kenya Prisons Services institutions through incremental transitioning of tasks and funding to full transition by 2018.

Cross-Cutting Budget Attribution(s)

Gender: GBV	400,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increasing women's legal rights and protection

Budget Code Information

Mechanism ID:	**16644**
Mechanism Name:	**UNICEF**
Prime Partner Name:	**United Nations Children's Fund**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	400,000	0

Narrative:

In collaboration with Government of Kenya and other stakeholders, UNICEF will use results of the 2010 Kenya Violence against Children Survey (VACS) and other data on violence against children to inform the design and launch of a national and regional advocacy and communication strategy to promote prevention of sexual violence against children and service use among child survivors of sexual violence.

The key objectives are to 1) Create a VACS communication and advocacy tool kit comprised of tailored, tested messages and tools that can be adapted and used in varied settings with varied audiences to A) create awareness of the extent of sexual violence among children and adolescents based on data from VACS, and B) support prevention strategies and provide information on support services for children and adolescents who have experienced sexual violence. 2) Conduct a demonstration campaign and a short-term evaluation in a few selected areas. 3) Develop and implement a plan to disseminate the messages and tools to stakeholders in all the counties. 4) Develop a plan to monitor and evaluate use of the toolkit by stakeholders to inform ongoing activities and future communication interventions.

Advocacy and communication messages in the toolkit will primarily target children through the school system and through ongoing HIV prevention interventions targeting children and youth. The school-based campaign will reach at least 3,000 primary schools. Parents, policy makers, law enforcement, and healthcare workers will be additional targets for a broader mass media campaign to raise awareness and reinforce the messages targeting children.

UNICEF will leverage existing communication initiatives and partnerships to ensure the campaign 1) complements ongoing PEPFAR and non-PEPFAR supported work, 2) creates cost-efficiencies by actively engaging partners and stakeholders in using the messages developed within their own program activities and communication and advocacy materials, and 3) supports future transition of activities to the Kenyan government and local organizations.

Implementing Mechanism Details

Mechanism ID: 16670	**Mechanism Name: HIV Fellowship Program**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Nairobi	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,081,584	

Funding Source	Funding Amount
GHP-State	1,081,584

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Goals and objectives:

The purpose of this program is to build and strengthen the capacity of local organizations and health professionals in Kenya to develop, implement, monitor, and manage HIV/AIDS programs and strategic information management activities that align with Kenya National AIDS Strategic Plan. This program aim at to support the continued transition of the Kenya HIV program to local organizations under PEPFAR by progressively strengthening and institutionalizing capacity for local organizations in a sustainable manner through strategic mentoring relationships.

Specific objectives of the program include;

- *Implement a pre-service two-year senior fellowship program in at least three tracks: HIV/AIDS science Epidemiology, HIV program management; Health Informatics and Economics.*

- *Support organizations implementing HIV and other public health programs*

to plan and evaluate programs, develop pilot interventions, strengthen health-information management systems, and develop HIV/AIDS and related public health policies and implementation guidelines.

- *Implement customized short courses and fellowship targeting middle to senior level public health managers in HIV and related public health programs.*

Cost-efficiency strategy: The program is expected to utilize the state of art technologies such as web based systems, Skype, video links, and other systems for the delivery of the training programs. These technologies will substantially reduce costs associated with residential trainings and increase geographic coverage of the training program.

Transition to country partners: The program is expected develop a strategy for the sustainability of the program beyond the project period.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	1,081,584

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	16670		
Mechanism Name:	HIV Fellowship Program		
Prime Partner Name:	University of Nairobi		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	1,081,584	0

Narrative:

Target population: The HIV Fellowship program aims to expand capacity for leadership and management in HIV programs at the national level. The fellowship will targets middle to senior level public health managers in HIV and other related public health programs. The fellowship will also provide support to local organizations to improve the HIV and public health service delivery and support the transition of HIV programs in Kenya to local organizations.

Approaches: The program will utilizes both didactic and web based approaches to delivering the training activities. The fellows will also undergo an experiential training which will see them take on a specific project, conceptualize and implement the projects.

Targets and achievements: By the end of the last budget, the program has graduated 27 fellows and supported over 30 local organizations supporting HIV programs in Kenya. In FY12 will be expected to graduate additional 6 fellows in the two year program and 40 fellows in the short term fellowship program which last for six months. The program continues to provide targeted short term training program and has so far trained over 1000 health care workers in leadership and management, health communication, financial and economics, HIV epidemiology, biostatistics, efficiency and resource mobilization. In FY13 the program will support 10 two year fellows, 60 short term fellows, and support at least 10 organizations directly. The program is also expected to train at least 600 health care workers in the short courses

program. . Monitoring and evaluation: The program will hire a monitoring and evaluation expert to keep track of the courses offered, quality, report the achievements, and develop a concrete M&E plans to ensure the quality of the program.

Implementing Mechanism Details

Mechanism ID: 16679	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16682	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16684	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16687	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16698	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16699	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16700	**Mechanism Name: OVC Child Protection Research**
Funding Agency: U.S. Agency for International Development	Procurement Type: Grant
Prime Partner Name: United Nations Children's Fund	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 500,000	
Funding Source	**Funding Amount**
GHP-State	500,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

A critical task in supporting vulnerable children, including children affected by HIV/AIDS, is to build national child protection systems that prevent and respond to different forms of vulnerability. In Kenya, where children face enormous risks associated with orphaning, sexual abuse and exploitation, HIV/AIDS, and trafficking (among many others), the challenges to building national child protection system are vast. Practitioners who work on social services and HIV/AIDS in different parts of the country indicate that there is a significant gap between community-based child protection mechanisms (CBCPMs) and the government led national child protection system. Existing research indicates that CBCPMs are more effective and sustainable when there are strong connections with the national system that enables referrals, capacity building, and provision of necessary resources. There need to develop models for connecting community mechanisms with formal and national system. The four-year program and training activities will enable urban and rural communities in Coast and Nyanza Provinces develop their own interventions for strengthening connections with the national child protection system. The project also includes extensive capacity building needed for mapping existing CBCPMs, facilitating an inclusive process through which the community develops appropriate interventions, monitoring and documenting the process through which the

linking interventions are implemented, and using the lessons learned to encourage policy leaders and other stakeholders to develop stronger community linkages as part of efforts to strengthen the national child protection system. The expected results will benefit vulnerable children across Kenya with respect to both prevention and response.

Cross-Cutting Budget Attribution(s)

Education	100,000
Gender: GBV	300,000
Gender: Gender Equality	100,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection

Budget Code Information

Mechanism ID:	**16700**		
Mechanism Name:	**OVC Child Protection Research**		
Prime Partner Name:	**United Nations Children's Fund**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	500,000	0
Narrative:			
The funds will support the continuation and completion (next phase) of the Kenya Child Protection Study			

(lead researchers from Columbia University). The four-year program and training activities will enable urban and rural communities in Coast and Nyanza Provinces develop their own interventions for strengthening connections with the national child protection system. The project also includes extensive capacity building needed for mapping existing CBCPMs, facilitating an inclusive process through which the community develops appropriate interventions, monitoring and documenting the process through which the linking interventions are implemented, and using the lessons learned to encourage policy leaders and other stakeholders to develop stronger community linkages as part of efforts to strengthen the national child protection system. The expected results will benefit vulnerable children across Kenya with respect to both prevention and response.

Implementing Mechanism Details

Mechanism ID: 16705	**Mechanism Name: IDU - HIV Combination Prevention**
Funding Agency: U.S. Agency for International Development	Procurement Type: Grant
Prime Partner Name: United Nations Office on Drug and Crime (UNODC)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,765,844	
Funding Source	**Funding Amount**
GHP-State	1,765,844

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Through a partnership with United Nations Office on Drugs and Crime – UNODC –, USAID/Kenya wants to improve the HIV/AIDS response in the country. The immediate purpose of the project is to enhance the capacity of government institutions and NGOs to prevent HIV infection among injecting drug users (IDUs). The project will be implemented in Nairobi and the Coast regions, targets to reach at least 25 % of the estimated population of IDUs in those provinces (16,619 persons). The main elements of the project strategy include: a) National level support for policy review, guidelines review and development, strong coordination and implementation of an effective HIV and

AIDS combination prevention for IDUs, b) Integrating Opiod Substitution Therapy (including Methadone and Medication Assisted Therapy), c) Linkages to Needle and Syringe Exchange Programs (NSP) and other drug dependence treatment into IDU prevention programs, without the procurement of the commodities for the program, d) Enhancing the technical skills of staff working with IDUs to design and implement HIV/AIDS prevention programs among IDUs, g) Improve outreach programs to better reach male and female IDUs with services, h) Provide HIV prevention services and referral for ART and tuberculosis screening and treatment for IDUs living with HIV, their partners and children, i) provide HIV counseling and testing (HTC), Sexually transmitted Infections management, j) Condom programming, k) provide targeted HIV prevention information, education and communication for IDUs and their sexual partners.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Increasing women's legal rights and protection
Mobile Population
End-of-Program Evaluation
Family Planning

Budget Code Information

Mechanism ID:	**16705**
Mechanism Name:	**IDU - HIV Combination Prevention**
Prime Partner Name:	**United Nations Office on Drug and Crime (UNODC)**

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	IDUP	1,765,844	0

Narrative:

United Nations Office (UNODC) Injecting Drug User (IDU) HIV combination Prevention program aims at enhancing the capacity of government institutions and NGOs to prevent HIV infection among IDUs in Nairobi and Coast regions. The IDU program will support Policy, Advocacy and Coordination efforts for increased access to evidence based interventions for IDUs. The project will support the Ministry of Health (MOH), The National Campaign Against Drug Abuse Authority (NACADAA) and other stakeholders' to in cooperate effective approaches of medically assisted treatment (MAT) and Needle and Syringe Exchange program (NSPs) in policy documents and guidelines to facilitate implementation.

To facilitate provision of HIV and AIDS combination prevention services to IDUs in both public and private health facilities including NGO rehabilitation centers, training and mentorship of health professionals on drug dependence treatment will be provided at the selected facilities in areas with high injecting drug users and HIV prevalence. Support will also be provided to upgrade 2 drug dependence treatment centers of excellence in Nairobi and Coast regions to improve the quality of health care to drug users.

The project, in collaboration with the procurement agency will provide technical assistance to facilitate the quantification, procurement, import, storage, dispensing and control of methadone for the treatment of opioid dependent people and NSP in line with the international guidelines established by international Narcotics Control Board (INCB) and any other regulations that will be developed by the Kenyan Government.

UNODC will support strengthening of community level outreach activities by organizations working with drug users for increased community and family acceptance and utilization of services by IDUs. Injecting drug use is a problem that is not well understood by the community and any efforts to address the problem are misconstrued to supporting the activities. UNODC will work to improve comprehensive understanding of NSP and MAT by implementing partners, the larger community and family within which these interventions will be provided. UNODC will provide Information Education and communication (IEC) about NSP and MAT programs targeting journalists, religious leaders and other community opinion leaders in communities where the programs will be implemented.

UNODC will provide HIV counseling and testing (HTC), sexually transmitted Infections management, Condoms promotion and distribution and referral of IDUs living with HIV for ART and tuberculosis screening and treatment. UNODC will work with both GOK and all other partners to coordinate HIV prevention and treatment services to People who inject drugs (PWID) to minimize overlap and maximize results.

UNODC will develop a monitoring and evaluation tool, in collaboration with other partners. This information will be fed in the national surveillance system and will be disaggregate the IDUs by age cohort, Men who Sex with Men (MSM), Commercial sex worker and other vulnerable categories including truckers.

Implementing Mechanism Details

Mechanism ID: 16709	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16710	**Mechanism Name: Expanding Health Insurance Coverage**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Equity Group Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

USAID/Kenya as part of its sustainability strategy intends to help grow the percentage of Kenyans covered by Health Insurance and also help increase the services covered to include HIV/AIDS. Towards this end USAID/Kenya through a Global Development Alliance (GDA) intends to partner with Equity Group Foundation to increase the number of Equity Bank's member covered with health insurance.

Currently Equity has about 7 million members of whom only 30,000 have health insurance. Equity Bank estimates that ill health contributes significantly to their bad debt portfolio estimating the loss at US$ 172 million (Kshs 15 billion). USAID/Kenya and Equity therefore have a common interest in expanding health insurance to Equity members. For USAID/Kenya its part the sustainability agenda and for Equity it's to lessen their bad debt portfolio. Equity Group Foundation proposes to increase uptake of a comprehensive health insurance package to 25% of the bank's 7 million members by 2017. This will be achieved through three objective areas:

1) Provider reforms – Equity will take a High Volume/Low Margin approach through developing standardized health care services; and also utilizing franchising to ensure rapid scale up and thus increase access to this affordable high quality out-patient services.
2) Client reforms – to increase health literacy and health insurance literacy amongst clients.
3) Payer reforms – by developing and scaling up affordable comprehensive health insurance products.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**16710**
Mechanism Name:	**Expanding Health Insurance Coverage**
Prime Partner Name:	**Equity Group Foundation**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	0	0

Narrative:

This activity will help to increase the breadth and depth of health insurance amongst Equity Bank to 25% of the bank's 7 million members. This will contribute to USAID/Kenya's sustainability strategy which aims at growing the number of individuals covered with health insurance and increase the services covered to include HIV/AIDS. This activity will be via a GDA with Equity Group Foundation. This activity is funded out of pipeline funds.

Implementing Mechanism Details

Mechanism ID: 16711	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16712	**Mechanism Name: OVC Vocational Training**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Housing Finance Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,000,000	
Funding Source	**Funding Amount**
GHP-State	1,000,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Orphans and Vulnerable Children (OVC) Vocational training Program is a new program that will be implemented as a public private partnership with Housing Finance Foundation to provide vocational training for OVCs who are not able to complete secondary edcation for a variety of reasons. Through partnership with Housing Finance Foundation (HFF), Housing Finance Ecosystems, and USAID Office of Population and Health, the project will seek to provide technical and vocational training and create jobs for 3000 OVCs in the next 5 years by churning out graduates at certificate levels (2 years) and diploma levels (2 years). The purpose of the project as a private public partnership is to support the development of an army of trained and qualified artisans in the next five years. The proposed activity attempts to fill in the existing gaps by reviving all the national and county polytechnics to absorb the students annually. Through this initiative, the deficit in skilled labour will be significantly reduced whilst at the same time creating more opportunities for employment in the construction industry. HFF is targeting the OVCs currently supported by APHIAplus projects nationally who do not have access to vocational training. They will be enrolled into tertiary institutions to get technical skills and get linked to the job market for

opportunities as well as get entreprenuership training and mentorship. The core objective is enhancing the skills of the OVCs and creating employment and entrepreneurship opportunities hence economic strengthening of the OVC households.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**16712**		
Mechanism Name:	**OVC Vocational Training**		
Prime Partner Name:	**Housing Finance Foundation**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	1,000,000	0

Narrative:

The Orphans and Vulnerable Children (OVC) Vocational training Program is a new program that will be implemented as a public private partnership with Housing Finance Foundation to provide vocational training for OVCs who are not able to complete secondary edcation for a variety of reasons. Through partnership with Housing Finance Foundation (HFF), Housing Finance Ecosystems, and USAID Office of Population and Health, the project will seek to provide technical and vocational training and create jobs for 3000 OVCs in the next 5 years by churning out graduates at certificate levels (2 years) and diploma levels (2 years).

The purpose of the project as a private public partnership is to support the development of an army of

trained and qualified artisans in the next five years. The proposed activity attempts to fill in the existing gaps by reviving all the national and county polytechnics to absorb the students annually. Through this initiative, the deficit in skilled labour will be significantly reduced whilst at the same time creating more opportunities for employment in the construction industry. HFF is targeting the OVCs currently supported by APHIAplus projects nationally who do not have access to vocational training. They will be enrolled into tertiary institutions to get technical skills and get linked to the job market for opportunities as well as get entreprenuership training and mentorship. The core objective is enhancing the skills of the OVCs and creating employment and entrepreneurship opportunities hence economic strengthening of the OVC households.

Implementing Mechanism Details

Mechanism ID: 16713	**Mechanism Name: Health Media Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Internews	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 533,233	
Funding Source	**Funding Amount**
GHP-State	533,233

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Health Media Project was awarded to Internews in Kenya under USAID Cooperative Agreement No. AID-615-A-13-00002 in January 2013. The overall objective of the Health Media Project is to create a more supportive social environment for preventing and mitigating the impact of HIV and AIDS, through an enlightened and committed local journalism community in Kenya. The Health Media Project incorporates carefully designed strands of activities to ensure that the program builds sustainable skills that contribute to the overall viability of media outlets while simultaneously enriching, informing and diversifying the information environment around HIV and AIDS and other target health issues. One intention of the program is to secure the commitment of news media

managers and owners in the battle against HIV and AIDS. The program also aims to strengthen journalists' skills and provide them with on-going resources needed to expand and improve their reporting ad programming on HIV and AIDS, child survival, family planning and reproductive health. Through the Health Media Project, journalists gain the knowledge and vocabulary to weave constructive and accurate messages about HIV and AIDS into their daily programs.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**16713**		
Mechanism Name:	**Health Media Project**		
Prime Partner Name:	**Internews**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	180,264	0
Narrative:			
This project supports workshops, roundtable meetings and travel grants for journalists. During the workshops, Internews equips journalists with skills and knowledge to tell compelling stories that give people the news and information they need about HIV			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Prevention	CIRC	30,374	0

Narrative:

This project supports workshops, roundtable meetings and travel grants for journalists. During the workshops, Internews equips journalists with skills and knowledge to tell compelling stories that give people the news and information they need about HIV and AIDS. Through roundtable meetings, Internews links journalists with experts in HIV and people living with HIV to discuss topical HIV issues. Internews travel grants and mentored travel grants provide journalists with means and guidance to travel to different parts of the country to tell critical HIV stories.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	172,595	0

Narrative:

This project supports two workshops. During the workshops, Internews equips journalists with skills and knowledge to tell compelling stories that give people the news and information they need about HIV and AIDS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	100,000	0

Narrative:

This project supports workshops, roundtable meetings and travel grants for journalists. During the workshops, Internews equips journalists with skills and knowledge to tell compelling stories that give people the news and information they need about HIV

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	50,000	0

Narrative:

This project supports workshops, roundtable meetings and travel grants for journalists. During the workshops, Internews equips journalists with skills and knowledge to tell compelling stories that give people the news and information they need about HIV

Implementing Mechanism Details

Mechanism ID: 16728	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 17190	Mechanism Name: Wezesha Project
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Life Skills Promoters	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

$151,030 October reprogramming.

One of the OVC RFA- Support to Nyanza and Rift Valley awards was made to Life Skills Promoters (LISP). The award targeted local organizations in Kenya to carry out orphans and vulnerable children (OVC) activities, and thus directly supports PEPFAR's goal of working with local organizations and USAID's Implementation of Procurement Reform (IPR) Objective 2 - Local Capacity Development, which focuses on building partnerships with new and local partners in development to improve the capacity and sustainability of the local community thereby improving aid effectiveness.

With funding from USAID, Wezesha Project mobilizes and scales-up community-based responses to meet the needs of Orphans and Vulnerable Children (OVC). The project works with local implementing partners, including non-governmental, faith- and community-based organizations as well as relevant Government of Kenya Ministries including the Ministries of Labor, Social Security and Services, Health, Education, Agriculture, Livestock and Fisheries. The Wezesha project uses a sustainable and family-centered approach to meeting the basic needs of OVCs, regardless of faith. The project supports community health workers to conduct local needs assessments and develop realistic plans for improving household incomes, which allows families to better serve as primary caregivers to OVCs. Community health workers provide counseling, health information, referrals and resources to

address health needs.

Complementary activities strengthen child protection structures in targeted communities that improve psychosocial care in schools and increase vocational skills.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Child Survival Activities

Budget Code Information

Mechanism ID:	**17190**		
Mechanism Name:	**Wezesha Project**		
Prime Partner Name:	**Life Skills Promoters**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	0	0
Narrative:			
With funding from USAID, Wezesha Project mobilizes and scales-up community-based responses to meet the needs of Orphans and Vulnerable Children (OVC). The project works with local implementing partners, including			

non-governmental, faith- and community-based organizations as well as relevant Government of Kenya Ministries including the Ministries of Labor, Social Security and Services, Health, Education, Agriculture, Livestock and Fisheries.

Implementing Mechanism Details

Mechanism ID: 17191	**Mechanism Name: Watoto Wazima Initiative)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Reformed Church of East Africa	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

October 2013 $151,031.

One of the OVC RFA- Support to Nyanza and Rift Valley awards was made to Reformed Church of East Africa (RCEA). The award targeted local organizations in Kenya to carry out orphans and vulnerable children (OVC) activities, and thus directly supports PEPFAR's goal of working with local organizations and USAID's Implementation of Procurement Reform (IPR) Objective 2 - Local Capacity Development, which focuses on building partnerships with new and local partners in development to improve the capacity and sustainability of the local community thereby improving aid effectiveness.

With funding from USAID, Watoto Wazima mobilizes and scale-up community-based responses to Orphans and Vulnerable Children (OVC) to enable them live a normal life. The project aims to empower OVCs and their families with skills that enhance their productivity and improve livelihoods to meet the needs of caregiving. Activities include: Improving essential services for OVCs through: Identifying and assessing the needs of OVCs and their

families, scaling up essential services such as education, health, birth registration, psychological support, housing and legal protection and mobilizing county leaders and stakeholders to respond to needs. Strengthening community-based institutions will focus on: Training community health volunteers and community institutions on child protection, OVC needs and OVC support and Community mobilizations to raise awareness of OVC needs and rights. Building household and school capacity to respond to OVC needs will include: Training caregivers on psychosocial support, counseling skills, and entrepreneur skills, Providing small grants to households to initiate income-generating activities and Forming support groups and clubs to engage OVCs.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Child Survival Activities

Budget Code Information

Mechanism ID:	**17191**		
Mechanism Name:	**Watoto Wazima Initiative)**		
Prime Partner Name:	**Reformed Church of East Africa**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	0	0
Narrative:			

With funding from USAID, Watoto Wazima mobilizes and scale-up community-based responses to Orphans and Vulnerable Children (OVC) to enable them live a normal life. The project aims to empower OVCs and their families with skills that enhance their productivity and improve livelihoods to meet the needs of caregiving. Activities include: Improving essential services for OVCs through: Identifying and assessing the needs of OVCs and their families, scaling up essential services such as education.

USG Management and Operations

Assessment of Current and Future Staffing.

Redacted

Interagency M&O Strategy Narrative.

Redacted

USG Office Space and Housing Renovation.

Redacted

Agency Information - Costs of Doing Business

U.S. Agency for International Development

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Computers/IT Services		169,414		169,414
ICASS		350,500		350,500
Management Meetings/Professional Developement		196,287		196,287
Non-ICASS Administrative Costs		840,359		840,359
Staff Program Travel		313,783		313,783
USG Staff Salaries and Benefits		3,607,239	0	3,607,239
Total	**0**	**5,477,582**	**0**	**5,477,582**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-State		169,414
ICASS		GHP-State		350,500
Management Meetings/Professional Developement		GHP-State		196,287
Non-ICASS Administrative Costs		GHP-State		840,359

U.S. Department of Defense

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Computers/IT Services		37,070		37,070
ICASS		43,843		43,843
Institutional Contractors		767,056		767,056
Management Meetings/Professional Developement		49,661		49,661
Non-ICASS Administrative Costs		108,200		108,200
Staff Program Travel		64,170		64,170
USG Staff Salaries and Benefits		30,000		30,000
Total	**0**	**1,100,000**	**0**	**1,100,000**

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-State		37,070
ICASS		GHP-State		43,843
Management Meetings/Professional Developement		GHP-State		49,661
Non-ICASS Administrative Costs		GHP-State		108,200

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of	GAP	GHP-State	GHP-USAID	Cost of Doing

Doing Business				Business Category Total
Institutional Contractors		0		0
Staff Program Travel		452,177		452,177
USG Staff Salaries and Benefits	5,415,044	1,300,904		6,715,948
Total	**5,415,044**	**1,753,081**	**0**	**7,168,125**

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

U.S. Department of State

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
ICASS		188,493		188,493
Management Meetings/Professional Developement		161,017		161,017
Non-ICASS Administrative Costs		32,000		32,000
Staff Program Travel		35,000		35,000
USG Staff Salaries and Benefits		520,000		520,000
Total	**0**	**936,510**	**0**	**936,510**

U.S. Department of State Other Costs Details

Category	Item	Funding Source	Description	Amount
ICASS		GHP-State		188,493
Management Meetings/Professional Developement		GHP-State		161,017
Non-ICASS Administrative Costs		GHP-State		32,000

U.S. Peace Corps

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Computers/IT Services		1,300		1,300
Management Meetings/Professional Developement		9,200		9,200
Non-ICASS Administrative Costs		19,800		19,800
Peace Corps Volunteer Costs		579,900		579,900
Staff Program Travel		26,500		26,500
USG Staff Salaries and Benefits		287,300		287,300
Total	**0**	**924,000**	**0**	**924,000**

U.S. Peace Corps Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-State		1,300
Management Meetings/Professional Developement		GHP-State		9,200
Non-ICASS Administrative Costs		GHP-State		19,800