

Approved



Kenya

Country Operational Plan

FY 2014

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

COUNTRY CONTEXT

By year-end 2012, approximately 1.2 million adults were estimated to be living with HIV in Kenya. The estimated number of AIDS deaths in this population was 57,000, and the estimated number of new infections was 85,000. Among children younger than 15 years of age, approximately 200,000 children were living with HIV, with approximately 13,000 new infections occurring each year, primarily through mother-to-child transmission of HIV (APR, 2013).

Globally, Sub-Saharan Africa is the region most affected and infected by HIV/AIDS, accounting for 61% of all people living with HIV, 70% of all new infections, and 75% of all AIDS related deaths in 2012 (UNAIDS 2012). Kenya's epidemic started in 1984 when the first case of HIV was detected and, to date, the country ranks as the fourth largest HIV epidemic worldwide. There is substantial variation in HIV prevalence in Kenya. Preliminary results from the second Kenya AIDS Indicator Survey (KAIS 2012) reported HIV prevalence to be as high as 15.1% in Nyanza region and as low as 2.1% in Eastern North region. Women continue to carry a higher burden of HIV infection compared to men. Significant differences exist in HIV prevalence by age and sex, with rates among women peaking around aged 35-39 years, 10 years earlier than men, whose peak HIV prevalence is among those aged 45-49 years. Widowed women and men have very high rates of HIV infection, with one in five HIV-infected. Women who are separated or divorced are also vulnerable to HIV infection, with approximately 15% infected with HIV. Education and income appear to be inversely related with HIV prevalence, with persons of higher education and income less likely to be HIV infected than their counterparts (KAIS 2012).

The expansion of antiretroviral therapy (ART) programs in the country has led to drastic reductions in HIV-related mortality, from approximately 130,000 AIDS deaths 2001 to 57,000 in 2012 (KAIS 2012). With increasing coverage of ART among those that need treatment, HIV transmission has also decreased leading to reductions in new infections on a population level. Kenya's epidemic continues to be driven by heterosexual transmission, with the majority of new infections occurring among persons in marital or cohabiting relationships. Key populations at high-risk of HIV exposure have also been identified as drivers of the epidemic. Though the number of key populations may be low, the burden of HIV infection in these groups and potential for bridging to the general population is high. The lack of routine surveillance data among key populations have made it difficult to fully understand the HIV epidemic in these populations and the extent of bridging behaviors to the general population, limiting the effectiveness and reach of targeted programs for these groups.



The Kenyan national HIV/AIDS response has historically been coordinated by the National AIDS Control Council (NACC). Kenya National AIDS Strategic Plan 2009/10 – 2012/13 (KNASP III) has ended, and a mid-term review is in process. In April, the Government of Kenya (GOK) will begin the process of developing KNASP IV with a projected completion date of July 2014. The development of KNASP IV comes at a critical time for Kenya as the country transitions healthcare managed at the central level to the counties. Great opportunities and challenges emerge from this transition as the GOK and donors ensure service delivery remains uninterrupted. Along with other stake holders, the USG will provide technical support to the development of KNASP IV.

The United States is the predominant donor to the HIV response in Kenya. We recognize that opportunities exist within and across USG programs to ensure more integrated planning and coordination. At the request of the GOK, the USG team, both senior leadership and technical experts, plays a strategic role in participating in high level planning meetings in addition to being active members of national Technical Working Groups (TWG) that strengthen and leverage partnerships within USG and other donors. The USG participates on GOK Interagency Coordinating Committees (ICCs) dealing with HIV and other health issues as well as the multi-sectorial National AIDS ICCs and the National AIDS/STI Control Programme (NASCOP) working groups.

The Development Partners for Health in Kenya, (DPHK) in its current form has been in place since 2005. The DPHK meets monthly and there are currently 16 member agencies. The USG actively participates in the forum. The purpose of the DPHK is to provide a forum for development partners to share information, discuss key sector issues and reach consensus on positions where needed, coordinate support to the sector, and in general promote and facilitate adherence to the Paris Declaration principles. While the GOK is not a member of the DPHK, it is invited to DPHK meetings on a regular basis to participate in discussions.

Focus in FY 2014

In COP14, PEPFAR will continue to support HIV services in line with GOK treatment priorities. In FY15, Kenya aims at increasing the number of new patients initiating ART to 140,000, resulting in a net annual increase of approximately 100,000 patients. Under the eMTCT framework, the Kenya team will support the GOK by providing technical assistance through capacity building, implementing new guidelines to provide ART for pregnant and breastfeeding HIV positive women, strengthening linkages and referrals between facilities and community and supporting implementation of prevention of mother-to-child (PMTCT) services in the private sector. The Kenya team will also work with the GOK on the national voluntary medical male circumcision (VMMC) strategy and guidelines revisions to lower the age cut off for circumcision from 15 years, evaluate new VMMC devices, task shift service provision and advance early infant male circumcision (EIMC). Capacity building of health care workers to offer VMMC services will be supported through continued monitoring and supervision. Kenya was successful in securing central funding



for VMMC, enabling additional VMMC targets to be reached. One of the major shifts in HIV prevention is the determination of priority populations for HIV prevention as opposed to targeting all individuals. The planned scale up for key populations has been increased to over 80% for sex workers and men who have sex with men.

Taking into consideration current budget realities, the Kenya team closely reviewed our current portfolio and activities that, while important, have not contributed as significantly to reducing incidence of HIV and getting people living with HIV into treatment. Accordingly, we are adjusting our funding [REDACTED]. These activities include:

- Cervical cancer screening and funding of broader maternal health services
- Construction and renovation of facilities and laboratories
- Broad support to the community strategy (refocusing our efforts on the community linkages to care and treatment)
- Refocusing on key populations most at risk of acquiring HIV
- General Population Health Communication
- Non-HIV specific laboratory support

Kenya Team response to the funding level letter from OGAC

The Expenditure Analysis (EA) was one of the tools used by the team to inform budget decisions. In FY15, Kenya aims to bring the total number of patients currently on ART to 730,000 in FY14 and 830,000 in FY15. The main priorities for the PMTCT program are improving access to quality testing for pregnant women and their partners and increasing linkages to the prevention and treatment programs. VMMC program has been scaled up to reach over 60% of all uncircumcised men aged 10-29 in traditionally non-circumcising communities and the ITT will work with the country VMMC task force to support EIMC-related formative/policy work for development of national sustainable strategies for long-term male circumcision coverage. In line with PEPFAR's commitment of increasing health workers globally by 140,000, USG will continue working with medical training institutions, regulatory bodies and the private sector to expand the numbers of health workers graduating with the requisite skills, knowledge and attitudes for delivering prevention, care and treatment services.

The PEPFAR Kenya interagency team rigorously evaluated its investments in 2013 to ensure that activities proposed and program budget levels set for COP14 provide the greatest value for proposed interventions. Some critical exercises undertaken included portfolio reviews, detailed review of program area costs using EA data as well as other costing studies, ensuring coordination with the GOK, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GF) and other donors in order to avoid duplications, and cutting out and or reducing activities deemed non-core. The exercise resulted in funding reductions from COP13 in the



following programs areas including: Prevention (20%), Care and Support (13%), Health Systems Strengthening (HSS)/Strategic Information (SI) (2.75%); in addition, our management and operations (M&O) budget was reduced by 6.1%. Slight increases were had in the treatment/lab programming area. An estimated \$85 million in pipeline resources and \$375 million new funds requested will go towards focused activities identified for COP14. With these resources, we will still achieve the primary goal of saving lives while demonstrating the interagency team's commitment to supporting the GOK to achieving an AIDS-free generation in the country.

Progress and future

Between 2009 and 2013, the USG team alongside the NACC has monitored the progress of the set objectives and goals of the Partnership Framework (PF) and the accompanying Partnership Framework Implementation Plan (PFIP). The PF and PFIP were aligned to the KNASP III.

With the PF, PFIP and KNASP III ending in 2013, the end term review for KNASP III is in the final stages and the KNASP IV development process is due to begin in early 2014. USG is an integral part of both processes. As Kenya takes note of the gains made and gaps from KNASP III, the GOK and key stakeholders will be identifying new targets and priorities, building on the gains and addressing the gaps. One key area of focus for the USG will be to continue to encourage and increase domestic HIV financing under the auspices of critical Blueprint principles; namely, shared responsibility and advancing country ownership.

Kenya is moving towards sustainability and advancing its efforts towards country ownership. Current ongoing technical discourse and legislative processes to this regard include a Cabinet memo on the establishment of a Trust Fund for HIV and non-communicable diseases; the establishment of technical teams on the Investment Case and Trust Fund for HIV specific efforts; and the efficiency and effectiveness studies conducted to inform the KNASP IV process. The outcome of the KNASP IV will also inform the development of the PEPFAR Kenya Country Sustainability Plan. With UNAIDS, the USG team has been engaged with the Ministry of Health (MOH)/NACC team leading on the investment case. More one-on-one technical and strategic meetings are planned ahead as the Investment Case conceptualization for Kenya takes shape.

PROGRAM OVERVIEW

Clinical Services

Kenya has made tremendous progress in the coverage of ART for eligible people living with HIV (PLHIV) over the past decade. The KAIS 2012 preliminary results showed that among HIV-infected persons aged 15-64 years, 58% were eligible for ART. The number of new patients on ART has stabilized at about



110,000 while the total number of patients on ART stood at 631,503 as per the annual progress report (APR) 2013. The major barrier to ART uptake is lack of awareness of one's HIV status. The coverage of HIV testing and counseling (HTC) among adults has increased over the years, from 34% in 2007 (KAIS 2007) to 72% in 2012 (KAIS 2012). Despite this, many HIV infected Kenyans do not know their status and therefore cannot access treatment.

In order to accelerate the treatment coverage and attain a tipping point, in FY15 Kenya aims to increase the number of new patients initiating ART and attain a retention level of 85%. In addition to strengthening existing activities, PEPFAR Kenya will support the adoption and national dissemination of the 2013 World Health Organization (WHO) treatment guidelines (ART for patients with a CD4 count of less than 500 cells/mm³; all HIV infected children less than 10 years of age; HIV-infected pregnant and breastfeeding women as lifelong treatment; and the HIV-positive partner, at any CD4 count, in a sero-discordant relationship) which will result in an increase of an additional estimated 50,000 patients.

In line with the 2013 WHO recommendations, Kenya will implement a simplified first line ARV regimen, consisting of tenofovir, lamivudine and efavirenz, for use by adults, pregnant women, those on anti-TB medication, and those with hepatitis B co-infection. Patient response to ART will be monitored using viral load testing, while CD4 will continue to support assessment for ART eligibility. Once finalized, the guidelines will be disseminated through sensitization meetings with program managers and health care workers. Capacity building and sensitization will be done through mentorship and supportive supervision from county health teams.

PEPFAR will continue to focus on strategies to decentralize pediatric HIV services. The PEPFAR program through its implementing partners (IP) will also continue to scale up adolescent friendly services to all ART sites. The new NASCOP developed adolescent friendly standard package of HIV services has been piloted and dissemination is planned for June 2014. PEPFAR will support the MOH to evaluate the impact of implementing the adolescent package of care in FY15. PEPFAR will continue to support the MOH to integrate gender into HIV programs, and promote integration of gender throughout its own prevention, care, and treatment programs with the goal of reducing HIV risk, mitigating its impact, and increasing access to services for men and women.

Kenya has made great strides in TB services. About 95% of TB patients are screened for HIV while 54% of HIV patients are screened for TB. About 74% of the TB/HIV co-infected patients initiated on treatment. In FY15, we expect to reach about 85% of HIV patients with TB screening and initiate more than 90% of the TB/HIV co-infected patients on HIV treatment. Isoniazid Preventive Therapy is given to children with TB exposure and to adults in selected health facilities.



In Kenya, there is a National HIV Commodities' Security Committee that meets monthly to review the performance of the supply chain and take the necessary corrective actions. This committee prepares an HIV commodity monthly report commonly referred to as the "2 pager" that is shared with the relevant stakeholders. The report gives a summary of the active patients on treatment, broken down by regimen, current stocks at central level and facility level, expected stocks from suppliers and new patients enrolled on treatment during the month. Currently, Kenya has a stock sharing mechanism where stocks are shared between the two ARV pipelines – those procured by the USG and those procured by the GOK. As the USG procurement mechanism comes to a close, the USG will work with the GOK to ensure a smooth transition. The interagency PEPFAR Team will strategically plan for this transition over the next several months and make the appropriate movement of funds to accommodate this process. The laboratory commodity reporting by the facilities has been a challenge over the years; however, the GOK has designed electronic tools to be used for reporting and tracking lab commodities, especially CD4 reagents and HIV test kits. The early infant diagnosis (EID) and viral load reagents are reported and tracked on the NASCOP websites, which is also used for program reporting.

Through joint planning and collaboration, GOK, GF and PEPFAR resources are coordinated to avoid duplication and improve efficiency under the leadership of the MOH through NASCOP. PEPFAR will continue to support the specific service delivery components including additional health care workers, technical support and mentorship at health facility, capacity building, HIV commodities and health systems strengthening.

Community Care and Support Services

Sustained scale up of HIV care has ensured provision of services to PLHIV in Kenya. By September 2013, 831,000 (86,000 children) were receiving care while 630,000 (62,000 children), were receiving ART, which is 83% of the FY13 target. Kenya has reached about 70% of PLHIV with care services, based on the KAIS 2012 estimate of 1.2 million PLHIV nationally. In FY15, the number of children receiving EID will be increased to 90,000.

According to KAIS, of the 1.2 million PLHIV in Kenya, 42% overall are accessing care and 90% among those who know their status are accessing care. Kenya targets to reach 1 million (90,000 children) and 1.1 million (100,100 children) PLHIV with care services in FY14 and FY15 respectively. In FY13 PEPFAR Kenya provided 94% of the 238,778 identified malnourished PLHIV with therapeutic food support and targets to reach 220,000 malnourished PLHIV and OVC in FY14.

KAIS 2012 estimated the orphans and vulnerable children (OVC) population at 2.6 million, with over a third aged 10-14 years. PEPFAR's OVC approach is aligned with the National Policy on Children, a holistic framework for addressing children's rights and welfare as well as the OVC National Plan of Action



2007/2010. In FY15, the program targets to reach 680,000 OVCs with essential services. OVC priorities will include: 1) supporting family-centered services that are responsive to the individual needs of OVC and households; 2) strengthening the Children's Department MIS including standardization of OVC tools, rollout and harmonization of the OVC longitudinal management information system with the GOK National Child Protection Management Information System and capacity building of County and IPs to collect, analyze, manage and use data and support for a biennial survey for OVC outcomes and impact; and 3) partners ensuring 80% of all OVC and caregivers know their HIV status and if positive, are linked to care. OVC program will retain the children currently enrolled with no enrollment of new children beyond the target.

Maternal, Newborn and Child Health (MNCH)

The HIV prevalence rate among pregnant women is 6.2% (with regional variation in prevalence; the highest being in Nyanza with 13.9% and the lowest in North Eastern at 0.9%). The Kenya County HIV profiles report estimates the need for ART among pregnant women to be 92,228. According to our APR, PMTCT ART Coverage is 69%.

The main priorities for the program are improving access to quality testing for pregnant women and their partners and increasing linkages to prevention and treatment programs. Voluntary family planning (FP) will be integrated in the facility with other PMTCT and ART services, and non-PEPFAR partners will be leveraged to increase FP commodities and monitor uptake. Access to ART will be improved through integration of ART in MNCH, supporting the retention and monitoring of mothers on ART once initiated, and tracking mother infant pairs until the end of the breast feeding period. HIV positive mothers will be linked to psychosocial support at the facility and in the community in an effort to reduce stigma and discrimination, gender-based violence, and to mainstream gender and human rights services.

As a shift from the past, the PMTCT team categorized the counties into three tiers. Tier one had high burden, high prevalence counties. Tier two had medium prevalence, high unmet need and tier three had low burden counties. Target setting and funding was allocated based on the category of county. This will ensure that resources are allocated to counties where they will have optimal impact.

Upon adoption of the new WHO guidelines, the program will transition to lifelong ART for all pregnant and breastfeeding women, thus emphasizing the need to invest in quality improvement systems to ensure retention for women and their infants. The MOH will foster a strong joint MNCH/eMTCT partnership at national and county levels, including those for harmonized planning, budgeting, data analysis and program review processes, and leverage technical and financial resources to address the greatest MNCH/eMTCT bottlenecks in a coordinated manner.

Prevention



PEPFAR Kenya's prevention efforts are aligned with KNASP III, NASCOP and NACC, in collaboration with international partners and local organizations, have drafted an HIV Prevention Revolution 2030 Roadmap. This roadmap will be critical in shaping the prevention activities and landscape in Kenya for many years to come. More importantly, the roadmap has determined which populations are considered priority in Kenya for HIV prevention, based on a restrained resource environment and available scientific evidence.

The PEPFAR Kenya HIV prevention program continues to intensify HIV prevention by increasing coverage of several standard packages of services for specific priority target populations throughout the country. The program strives to improve quality and enhance program efficacy through a combination of bio-medical, behavioral and structural interventions. Priority populations for HIV prevention include key populations (sex workers, men who have sex with men, people who inject drugs), PLHIV, discordant couples, uncircumcised males aged 10-29, pregnant women, fisher folk, truck drivers, military populations, disciplined services, young women aged 15-24 from high and medium prevalence counties, pre-risk youth (10-14 years) in the nine high prevalence counties, and out- and in-patients at health facilities. The priority of the blood safety program is to produce safe and adequate blood and blood products and to promote its appropriate use.

The prevention ITT also prioritized efficiency through leveraging investments of the GOK, GF, the private sector, and other stakeholders. An example of this leveraging is the \$14.8 million in GF for procurement of condoms and lubricant in 2014–2017. The prevention team has used data from recent surveys, including KAIS 2012 and known level of coverage and disease burden estimates in various counties, to determine the level of effort that needs to be directed in each region and ensure minimal overlap and duplication of efforts. The COP14 decisions are therefore informed by these considerations, current scientific evidence, and the drivers of the HIV epidemic in Kenya.

One of the major shifts in HIV prevention for Kenya in COP14 is the determination of priority populations for HIV prevention as opposed to targeting all individuals. The second shift is the geographical prioritization of prevention activities to focus only on counties with the highest HIV incidence and prevalence. An example is interventions for the pre-risk group will be done in the nine high HIV prevalence counties. For interventions that target the general population, PEPFAR will only be focusing on the nine high and 31 medium HIV prevalence counties. Other significant changes for COP14 include the prioritization of HTC services to only focus on approaches and settings with higher potential of identifying HIV positive individuals. These include focusing on key populations and other high risk groups as well as on provider initiated testing and counselling (PITC) in health facilities where it has been demonstrated to have a better yield and also lower implementation costs.

The scale of coverage for the prevention interventions among the priority populations has also been of particular importance in COP14. Prevention interventions have limited impact if they are not implemented in



a scale that is sufficient enough. In this regard, information regarding size estimates, based on the most recent data, for the priority populations has been used in target setting. Methadone programs are being introduced in three counties and will be scaled up to reach a significant number of people who inject drugs. HTC programs will target settings and approaches with the highest yield of identifying HIV positive individuals who are not aware of their status. VMMC programs have been scaled up to reach over 60% of all uncircumcised men aged 10-29 in traditionally non-circumcising communities and the ITT will work with the country VMMC task force to support (EIMC) related formative/policy work for development of national sustainable strategies for long-term male circumcision coverage.

Health Systems Strengthening

Expansion of HIV service provision is threatened by the lack of adequate human resources for health (HRH). Kenya's health care system continues to face critical HRH demands: shortages of essential cadres; problems in attracting and retaining staff; inequitable distribution of health workers affecting rural areas; poor working conditions and other performance management issues. Under devolution there is varying capacity among counties to effectively plan, manage and finance the health workforce. USG will continue working with medical training institutions, regulatory bodies and the private sector to expand the numbers of health workers graduating with the requisite skills, knowledge and attitudes for delivering prevention, care and treatment services. The main focus will be on supporting those from rural and high disease burden counties to access training in order to expand coverage and facilitate better retention of health workers in those regions. Support to in-service training will include use of innovative cost efficient approaches that reduce health workers' time away from facilities and improve quality of care i.e. use of integrated curriculum and medical training facilities, e-learning modes, leveraging resources from private sector and local authorities. USG will continue promoting equity in workforce distribution by contracting health workers, especially in poorly resourced high disease burden regions, but utilizing processes to enable these to be eventually transitioned to GOK payroll. PEPFAR will help build capacity of counties to manage human resources by rolling out an integrated HRH information system for better forecasting and distribution. Areas to be minimized or phased out include trainings that do not contribute directly to increased treatment numbers, as well as support to non-key cadre regulatory bodies, and community health workforce initiatives that do not contribute directly to PEPFAR goals.

Kenya's supply chain and logistics systems continue to face many challenges. One of these is the lack of a single coordinating office for procurement and supply chain within the MOH to guide national strategy development or address capacity-building of new county systems. The supply chain and logistics systems also suffer from inadequate regulation and quality assurance of health commodities, and limited supply chain workforce. The GOK's funds for procurement were devolved to counties at a time when commodity management systems and capacity at the facility/county levels were already limited, and few counties had the right skills to forecast and quantify commodities to facilitate procurement. PEPFAR support prioritizes



development of a country owned commodity procurement, storage and distribution system. USG will implement interventions to strengthen governance, logistics information systems, inventory tracking, warehousing and distribution, and improve pharmaceutical services and commodity management at national/county/facility levels. USG support for the logistics system remains a major focus and has resulted in successful procurement of HIV commodities on behalf of the entire program over the past year. However, challenges arising from devolution necessitate continued support to enable it to operate efficiently in this new environment.

The health sector has consistently received inadequate budgetary allocation over the last several years. The GOK budget for health was just 6.8% of the total budget in 2011/12. HIV spending in Kenya accounts for 24% of total health expenditure. The majority of HIV resources come from donors (51%) and private sources (28%), although government has increased its share from 7% (2005/06) to 21% (2009/10). As HIV/AIDS remains a leading cause of deaths (29%) and disability-adjusted life years lost (24%) (GOK, 2010 report), improved efficiency in the HIV sector could make major contributions to the sustainability of health financing in Kenya. However, HIV financing and integrating the response into the overall health agenda remains challenging. PEPFAR support will help strengthen GOK's capacity to use financing data to improve management of resources for HIV treatment and related services by supporting detailed costing analyses, strategic and operational planning at the national and county levels, and national surveys to help effectively mobilize, coordinate and efficiently utilize resources. PEPFAR support will also engage with NACC to undertake costing and prioritization within KNASP IV. Building on market analyses and other costing work done by the private sector, USG will also develop public private partnerships that could increase HIV service coverage, especially for higher income earners through new, strengthened, and expanded private healthcare financing mechanisms. These initiatives will serve to offset donor and government financing of the HIV response in future and thus advance the sustainability aims of the PEPFAR program.

Strategic Information/Informatics

PEPFAR will support a more strategic and integrated monitoring and evaluation (M&E; quality, outcomes, cost, and impact), strengthen surveys and surveillance across programs, and align with the National Health Information System to improve management and use of data.

PEPFAR will continue to support the GOK in strengthening National M&E systems, support MOH in its effort to improve data quality through institutionalization and scale-up of routine data quality assessments. The PEPFAR SI team will continue to work collaboratively to build the capacity of MOH staff on M&E, data management, analyses, and reporting. To strengthen the data dissemination and use at the national and sub-national level, PEPFAR will continue to support supervision and mentorship visits at all supported health facilities, facilitate M&E stakeholders meetings with an objective of bringing together all the M&E players in data sharing and cross-learning through dissemination and feedback forums.



Support to the MOH will be expanded to ensure the use of integrated systems as well as efficient tracking of indicators, strengthening systems for measuring effective referrals and linkages, rolling-out information communication technology infrastructure, deployment and use of a national integrated web-based district health information system (2), maintenance and use of electronic medical record systems, upgrading and rolling-out of logistics management information systems, evaluation of mHealth solutions on health care worker efficiencies and for health outputs and outcomes, as well as towards determination of national unique persons identifier to enhance patient linkages between points of service.

PEPFAR will continue to support investments in epidemiologic studies to ensure that the HIV epidemic is appropriately monitored, public health programs are evaluated for efficiency and efficacy, and that data are readily available to formulate policy and to program decision-makers for immediate use. In this new strategic period, Kenya will build upon the strengths of its existing surveillance system by introducing new and improved components of monitoring and evaluation in efforts to provide a comprehensive epidemiologic profile of the HIV/AIDS epidemic at the national and sub-national level. Central to the success of the response to the HIV epidemic will be provision of technical support in building the capacity of program managers at the national and sub-national level to plan, implement, analyze, and use surveillance and epidemiologic data for informed decision making. PEPFAR Kenya will use the strength of known evaluation partners and call on other PEPFAR IPs providing clinical or prevention services to develop their own operations research questions and approaches to improve service provision and address barriers to services. PEPFAR Kenya, with support from the Office of Research and Science (ORS), will undertake three agency led-Impact Evaluations covering the:

- Impact of implementation of a novel standardized national package of services for adolescents living with HIV in Kenya (USAID)
- Impact of using the National EID Network on the linkage and retention to care of the HIV exposed and infected infants in Kenya (CDC)
- Effectiveness of implementing Option B+ under routine conditions with and without the PMTCT Patient Coordinator Program: A site-randomized impact evaluation among maternal and child health centers supported by the South Rift Valley PEPFAR program in Kenya (DOD)

The USG team continues to work with the GOK, GF, and the United Nations family to ensure overall HIV targets are met. The USG team will continue to provide technical guidance and contributions to key and relevant policy processes through its engagement with the GF and the ICC-HIV committee at NACC which also hosts other multilateral partners. The USG will continue to meet with the GF to a better align coordination, planning and programs. Commodities (ARVs, condoms, CD4 and other lab reagents, HIV test kits), community support, key populations and nutrition program issues will remain core to the discussions



and the revamped relationship with multilateral partners especially the GF, UNAIDS, United Kingdom Department for International Development, Deutsche Gesellschaft für Internationale Zusammenarbeit and the World Food Programme.

Kenya's original Global Health Initiative strategy focused on health systems strengthening, integrated service provision, and creating awareness to create demand for available services. These broad areas are embedded in the principles by which we operate in Kenya and will achieve measurable health benefits in substantially reducing unacceptably high rates of maternal, neonatal and child mortality and morbidity.

In close collaboration with OGAC, PEPFAR Kenya's proposal for central funds for VMMC has been approved. The additional funds for VMMC will be used to achieve activities described in our proposal. Additional VMMC targets have been set. The team will ensure these targets are met and reported in 2014 APR.

Other Key Considerations

Kenya's Constitution 2010 established a devolved system of governance with one national government and 47 county governments. Kenya has been in transition since the promulgation of the new constitution with most administrative changes taking place after the March 2013 elections. The transition process includes a restructuring of government that continues to evolve under the new legal framework. There have been changes in leadership and other senior positions throughout the MOH.

At the onset of the transition, PEPFAR's primary interest was to ensure that there was no interruption to vital HIV care and treatment services to Kenyans. Our engagement with the government has shifted and become much broader as we are now called upon to interact not only at the central level but with 47 autonomous counties. This comes with both challenges and opportunities, as capacity, readiness for this transfer, their willingness to prioritize health, and HIV in particular in their plans and budget varies by county.

As the MOH settles into its new role following the merger of the previous two Ministries of Health, the PEPFAR Kenya team will continue to work with our Front Office to intensify the dialogue between our Ambassador and the Cabinet Secretary for Health as well as county Governors. A key message to the GOK will be to increase its direct funding to the critical components of Kenya's AIDS program. Later this year, the Kenya team will develop a Sustainability Plan in close collaboration with the GOK and key partners. This plan will be in alignment with KNASP and will serve as our roadmap for the next 3 to 5 years.

As we begin planning for COP15 in April, the Kenya team has many important steps to take. In order to be transparent and responsible, it is incumbent upon us to inform the GOK of our future funding level as soon

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as possible; especially if it is considerably lower than our funding for COP14. The recent GF allocations for Kenya were lower than expected. With PEPFAR's future funding also potentially lower, there is an urgent need for us to inform the GOK of this and provide adequate time to plan accordingly. As part of this process, clarity of expectations from OGAC on the future direction of the Kenya program and level of financial support is paramount.