Kenya

Country

Operational Plan

(COP) 2017

Strategic Direction Summary

April 21, 2017

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1.0 Goal Statement

Through strong partnerships with the Government of Kenya (GOK), civil society, the UN Joint Team on HIV/AIDS and bilateral stakeholders, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) in Kenya has made tremendous strides towards an AIDS- free generation. In 2004, only 7,800 Kenyans living with HIV (PLHIV) were on anti-retroviral treatment (ART); at APR16, nearly one million (969,433) are currently on ART. Kenya's additional successes since 2004 include: HIV testing services (HTS) for over 66 million persons; more than 800,000 HIV positive pregnant women received antiretroviral prophylaxis to reduce the risk of mother-to-child- transmission; voluntary medical male circumcisions (VMMC) for 1.5 million men; and in FY16, provided care to more than 740,000 orphans and vulnerable children and DREAMS beneficiaries.

Since 2004, health policy has continued to evolve with the epidemic. In 2014, UNAIDS rolled-out Fast-track targets ("90-90-90") to control the epidemic, and in 2015 the World Health Organization (WHO) released guidelines for "Test and Start". The GOK kept pace with these policy changes and developed national guidelines for same day treatment initiation for HIV infected persons, differentiated care models and task shifting to better meet patient needs and streamline service delivery. In 2016, PEPFAR successfully executed the GOK's new 90-90-90 guidelines – scaling up care and treatment efforts in counties which held 90% of the national HIV burden. The implementation of the "Test and Start" guidelines nearly doubled the number of new patients starting ART in quarter 4 compared to the average achievement in quarters 1 to 3.

Through expanded prevention and treatment activities in high burden counties, PEPFAR can build on maximum gains in COP17. To reach 90-90-90 targets, PEPFAR will focus on key and priority populations including young men and women under 30 years with critical HIV services: HIV testing and counseling including mobile and self-testing ('First 90'); same day initiation on treatment ('Second 90'); and adherence support while monitoring the response to ART to achieve optimal virologic control for all populations ('Third 90'). PEPFAR will refine testing strategies in Homa Bay and Siaya; expand activities for the Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS) to seven counties; better reach men by learning from civil society, innovative targeted interventions, and science; decrease the frequency of clinic visits and medication pickup for stable patients through the use of differentiated care models; provide community-based support for adherence and retention; scale up stigma reduction activities; and improve orphans and vulnerable children (OVC) outcomes by linking beneficiaries to DREAMS activities, clinical services and household economic strengthening. To identify priority gaps and generate quality data, PEPFAR Kenya will work alongside the GOK to improve key population size estimates and complete KENPHIA—Kenya's population-based HIV impact assessment. PEPFAR will also strengthen government financial contribution to HIV, county-level governance and supply chain systems and bridge DATIM and DHIS2 data systems for better decision-making.

In COP17, PEPFAR expects to test 13.2 million Kenyans, including 10.6 million adults, 1.3 children, and 1.3 million pregnant women (for case finding and prevention across all HIV testing modalities); initiate 274,680 new on ART in order to support 1,318,902 PLHIV current on treatment by end of September 2018; circumcise 300,000 men, focusing on 15-29 year old boys and men; reach 252,000 adolescent girls and young women with DREAMS services and serve an additional 670,374 OVC; and improve viral suppression rates to ≥90%. Once these goals are achieved by September 2018 – across gender and age-disaggregated populations – Kenya will have exceeded 87% national ART coverage and over 81% for both men and women in all age groups. With continued GOK leadership epidemic control is within reach, and through targeted efforts and strong partnerships, Kenya will expedite the end of the HIV/AIDS epidemic.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Kenya is a lower-middle income country with a population of 41.1 million and per capita gross national income (GNI) of $1,340 (KNBS 2009/2015 projection; World Bank 2015). Government Health Expenditure as a proportion of Total Government Expenditure increased from 6.1% in the Kenya fiscal year (KFY)2012/13 to 8% in KFY2015/16 with contributions to HIV/AIDS increasing from 18.8% in KFY2012/13 to 20.9% in KFY2015/16 (Draft 2015/16 National Health Accounts). Kenya demonstrates bold leadership in supporting Sustainable Development Goals (SDGs) as a co-facilitator in drafting the SDGs, and as the host for the second High-Level Meeting on the Global Partnership for Effective Development Cooperation in late 2016. The Kenya AIDS Strategic Framework (KASF) is fully aligned with the 90-90-90 global targets set by UNAIDS towards ending AIDS as a public health threat by 2030, and the GOK has fast- tracked key policy shifts that will enable attainment of these ambitious targets.

The most recent UNAIDS report estimates a total of 1,517,707 adult and pediatric people living with HIV (PLHIV) in Kenya (Kenya HIV Estimates 2015). With this new estimate, Kenya has approximately 77,647 new HIV infections and 35,800 HIV-related deaths per year. These new estimates also highlight a major revision to children living with HIV from 159,731 to 98,169 (Kenya HIV Estimates, 2015). The national adult prevalence is estimated at 5.9% (NACC 2015), and varies widely by geographic region, ranging from 0.4% in Wajir to 26.0% in Homa Bay (NACC, 2015). Ninety six percent of PLHIV are in 34 of the 47 counties, with the five highest burden counties (Nairobi, Homa Bay, Kisumu, Siaya and Migori) accounting for 45% of all PLHIV. Females, especially young women, are disproportionately affected with higher HIV prevalence compared to their male counterparts (8.76% vs. 5.96% respectively among those aged 25+ and 3.97% vs. 2.26% among those aged 15-24) (NACC, 2015; NASCOP, 2014). Among key populations (KP), high HIV prevalence rates persist, ranging from estimates of 18.2% among men who sex with men (MSM), 29.3% among female sex workers (FSW), and 18.7% among people who inject drugs (PWID) (NASCOP, 2015). Fisherfolk in the lake region of western Kenya constitute a priority population with an estimated ~26% HIV prevalence (KEMRI,

2015; NASCOP, 2014; FELTPAA, 2010). These demographic and epidemiological data are summarized in table 2.1.1 and 2.1.2 below.

Significant progress has been made in the number of PLHIV who know their status and are enrolled in care and antiretroviral treatment (ART). By the end of Fiscal Year 2016 (FY16), 12,332,607 individuals were tested and received their HTC results. Of those individuals tested, 239,054 were identified as HIV positive. Since 2004 through APR 16, a total of 969,586 HIV positive patients received ART services, of which a total of 176,883 patients were newly initiated onto ART in FY16. This was also due in part to the enhanced efforts in implementing the new Test and Start ART guidelines launched in July 2016, improved retention, and rapid results initiative (RRI) by the Ministry of Health. After the launch of the guidelines there was mop-up of patients who had been in care but had not been initiated on ART. Robust defaulter management systems are in place to minimize loss to follow up and maximize retention in care and treatment.

There has been continuous acceleration of the Government of Kenya's (GOK) efforts to ensure that the 90/90/90 targets are achieved by 2019 as outlined in the Kenya AIDS Strategic Framework (KASF). Of the 969,586 patients on treatment, 81,150 were pediatrics,
representing 8% of all the patients currently on ART. However, the estimates for children living with HIV have been revised downwards to 98,170; therefore, these achievements actually represent a national coverage of 83%.

With PEPFAR support, Kenya is on course to roll out the treatment guidelines, which includes Test and START and the eMTCT guidelines, differentiated service delivery models, and pre-exposure prophylaxis (PrEP).

By the end of FY 16, 1,205,995 women had documented HIV status. Notably, during COP 2016 planning, PEPFAR transitioned from PMTCT sites with less than four (4) positive mothers but retained the targets on the assumption of referral to PEPFAR supported sites. National level data demonstrated worse outcomes in transitioned sites as most clients were retained in those sites with MOH constrained support. Based on this background, strategies in Q4 included data use for decision making at all levels, tracking of missed opportunities, HEI screening at immunization and under-five departments (in- and out-patient departments) and optimized use of EID website down loads resulted in increased performance. Furthermore, in FY16, under the leadership of NASCOP, counties engaged in the development of the national eMTCT framework 2016-2021, involving significant county stakeholder meetings to review county PMTCT indicator results and gaps. The counties discussed with facility level staff challenges faced and how gaps could be addressed. The new national eMTCT framework will be launched in 2017. Overall, this continued support for important policy shifts will rapidly increase ART coverage and accelerate progress towards epidemic control.

Overall, Determined, Resilient, AIDS-free, Mentored, and Safe (DREAMS) Kenya has rolled out the implementation of all interventions. Notably, cash transfers have been late to start due to challenges in setting up the transferring institutions and modules. PrEP was not initiated in FY2016 as commodities had not been received in country as of the end of the fiscal year. However, communities were engaged

to create awareness and advocate for the future use of PrEP which will be launched in May 2017.

In FY16, PEPFAR Kenya supported sites surpassed the VMMC target of 240,000 by conducting 263,584 circumcisions, a major step towards the second national VMMC strategic plan (2014 – 2019). This is attributed to increased demand creation, availability, and uptake of static and mobile circumcision services. All VMMC priority counties are approaching or have achieved 80% coverage for males 15-29 years. In addition, to continued technical support towards the design and initiation of Early Infant Male Circumcision (EIMC) policy, PEPFAR Kenya continues to provide central support to government-led models of VMMC service delivery including the circumcising of annual cohorts of boys as they transition to the 10-14 year age band.

Key Populations (KP) in Kenya include female sex workers (FSW), men who have sex with men (MSM)/transgender population (TG) and people who inject drugs (PWID). In FY16, KP community engagement approaches employed by PEPFAR include funding of KP led organizations to deliver services to community members and quarterly Civil Society Organization (CSO) stakeholder engagement for program guidance. The KPs were reached with risk reduction peer outreach interventions to include condom use education and distribution, HTC, linkage to HIV treatment for KPs who test HIV positive and STI screening and treatment. Integrated health services including ART were provided in KP only sites (Drop-In Centers) and in select public health facilities by trained KP friendly service providers. Further, HIV services were regularly provided through outreach in KP hot spots locations utilizing peers to mobilize KP communities for service uptake. PWID were reached with community based outreach harm reduction services, access to needle and syringe programs supported by other partners, viral hepatitis vaccination, diagnosis and treatment.

Besides behavioral interventions of safer injecting practices, PWIDs were initiated on opioid substitution therapy (OST) in two service outlets. Inconsistent documentation of KPs served persists within public health facilities. PEPFAR Kenya continues to implement capacity strengthening activities to equip health care workers with essential skills to improve documentation in KP-friendly public health facilities. This effort will scale up service delivery while fostering county government and health provider ownership of a quality, integrated KP programming.

While Kenya is ensuring KPs who test positive link to care and treatment services, stigmatization and criminalization of KP behavior remains a major obstacle to successful HIV prevention, care and treatment. According to the most recent data from 2011, diagnosed

infections ranged from estimations of 30% among MSM to 60% among FSW in Nairobi, while ART coverage was markedly lower, ranging from 6% among MSM to 34% among FSW.[1] Similarly, qualitative interviews among a priority population, the fisherfolk community, suggest that stigma, misperceptions, and logistic barriers continue to contribute to high levels of HIV infection and low access to care and treatment (FELTPAA, unpublished).

Achieving sustained epidemic control will be predicated on optimal coverage of clinical and prevention interventions as well as a number of systemic processes falling into place along the 90-90-90 cascade. PEPFAR will address key programmatic gaps in the clinical cascade in the Country Operational Plan for FY 2018 (COP17) in the context of achieving HIV epidemic control, the national sustainability profile, and health systems investments.

Table 2.1.1 Host Country Government Results

	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	44,156,583		9,109,443		9,280,430		4,432,411		4,423,280		8,728,045		8,182,974		KNBS 2009 Census projection for 2015
HIV Prevalence (%)		5.9%[a]		0.90%[a]		0.90%[a]		3.97%[a]		2.26%[a]		8.76%[b]		5.96%[b]	[a]National HIV estimates 2015. [b]Disaggregated prevalence KAIS 2012
AIDS Deaths (per year)	35,800		2,500[c]		2,500[c]		1,925[c]		1,925[c]		13,475[c]		13,475[c]		National HIV estimates 2015. [c]Redistributed proportion
# PLHIV	1,517,707		49,085		49,085		179,057		89,529		690,603		460,402		National HIV estimates 2015.
Incidence Rate (Yr)		0.35%		n.a		n.a		0.58%		0.31%		n.a		n.a	EPP spectrum. Incident infection rates unavailable for

[1] NASCOP, Kenya. Epidemiologic and Programmatic Profile of HIV among Key Populations in Kenya. Final Report. Nairobi, NASCOP. March 2015

Table 2.1.1 Host Countr y Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
															<15 and 25+
New Infections (Yr)	77,647														National HIV estimates 2015.
Annual pregnancies	1.65 million														KNBS
% of Pregnant Women with at least one ANC visit		96.0%		n.a			n.a	n.a			n.a	n.a			KHDS 2014. Age disaggregation not available.
Pregnant women needing ARVs	79,475														National HIV estimates 2015.
Orphans (maternal, paternal, double)	740,384		242,114		211,778		164,732		121,136		n.a		n.a		25+ are no longer OVC Source: OVC program from DATIM (disaggregates are slightly less than sum total)
Notified TB cases (Yr)	75,418		3,053		3,365		5,816		7,528		19,504		36,152		National TB program (TIBU)
% of TB cases that are HIV infected	23,763	31.5%	754	24.7%	816	24.2%	1,255	21.6%	671	8.9%	9,137	46.8%	11,130	30.8%	National TB program (TIBU)
% of Males Circumcised		91.1%				n.a				87.7%				92.8%	KAIS 2012
Estimated Population Size of MSM*	57,321														
MSM HIV Prevalence		18.2%													
Estimated Population Size of FSW	138,665														

Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
FSW HIV Prevalence		29.3%					n.a.	n.a.			n.a.	n.a.			IBBS 2010-2011
Estimated Population Size of PWID	28,935														
PWID HIV Prevalence		18.7%													
Estimated Size of Priority Populations (Fisher folk, Prisoners, Military, Uniformed Population)	**All 577,865[d]:** Fisher folk 123,065; Prisoners 64,800; Uniformed Population 108,000; Military 30,000; AGYW 15-19, 117,096; AGYW 20-24, 134,904		n.a.		n.a.		n.a.		n.a.		n.a.		n.a.		[d]Data presented are for targeting purposes and may not reflect actual size. *Sources various including*: FELTP AA 2011, IBBS 2010-2011, NASCOP Consensus Report, KNBS 2009 Census projection for 2015
Estimated Size of Priority Populations Prevalence (specify)		n.a. for others; 26.2% for fisher folk; 10% for male prisoners		n.a.		n.a.		n.a.		n.a.		n.a.		n.a.	Age disaggregated estimates not available.

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate	HIV Prevalence	Estimated Total PLHIV	PLHIV diagnosed	On ART	ART Coverage (%)	Viral Suppression (%)	Tested for HIV	Diagnosed HIV Positive	Initiated on ART
	(#)	(%)	(#)	(#)	(#)			(#)	(#)	(#)
Total population	44,156,583	5.90%	1,517,707	1,099,510	969,433	64%	84%	12,360,964	239,213	176,507
Population less than 15 years	18,389,873	0.90%	98,170	100,291	81,150	83%	65%	2,362,765	16,954	11,705
15-24 year olds	8,855,691	3.12%	268,586	999,219	116,350	43%	61%	3,570,888	57,258	22,734
25+ year olds	16,911,019	7.40%	1,151,005		788,362	68%	86%*	6,506,325	165,404	139,773
MSM	29,829	18.20%	n.a.	n.a.	n.a.	n.a.	n.a.	Testing is done at both facility and outreach sites. Tools used for APR16 reporting did not capture Test & Start clients by their sub-population categorization, With MER 2.0, the disaggregates are capture going forward. All 577,865: AGYW 15-19, 117,096; AGYW 20-24, 134,904	All 44,929: AGYW 15-19, 196; AGYW 20-24, 6,206	All 40,611: AGYW 15-19, 176; AGYW 20-24, 5,585
FSW	132,928	29.30%	n.a.	n.a.	n.a.	n.a.	n.a.			
PWID	15,368	18.70%	n.a.	n.a.	n.a.	n.a.	n.a.			
Priority Pop (specify)	577,865	n.d. for others, 26.2% for fisher folk, 10% for male prisoners	n.a.	n.a.	n.a.	n.a.	n.a.			

[1] HTS numbers are from APR16 as accessed in DATIM on March 2, 2017; the tally of the age disaggregations (DSD+TA) is slightly higher (12,439,978) than the HTC_TST total (12,360,964, DSD+TA), likely due to data entry error

*These should be national data, if the data do not exist, PEPFAR data may be used if relevant.

Estimates for testing, treatment, retention and suppression for key and priority population groups (below grey line) should only be included if reliable data exists.

1,2 - Estimates are from Kenya HIV estimates 2015 (extrapolated from Table 1. National HIV estimates for 2015). Adult prevalence estimates based on a 15-49 age band

3 - Assumes a 5% of new on treatment are from previously diagnosed

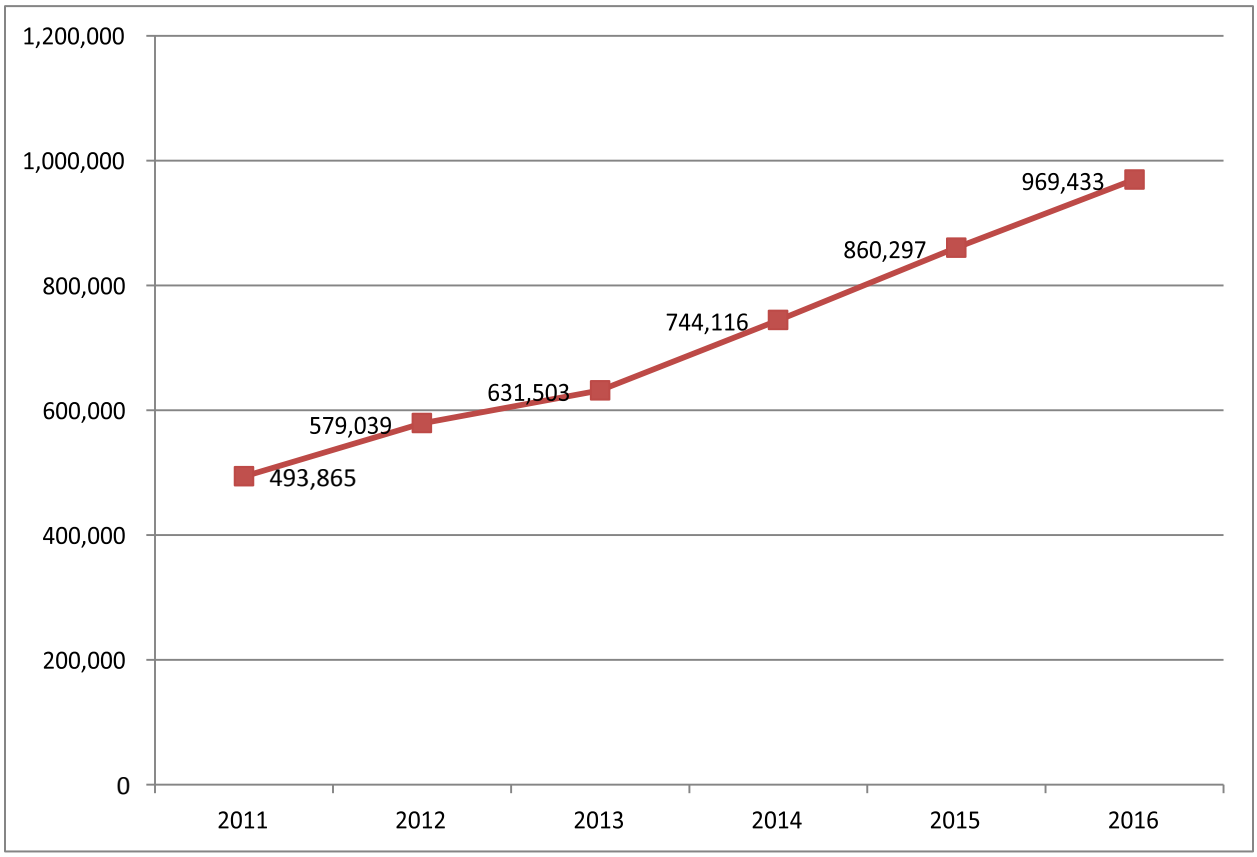
4 - Assumes a 95% retention rate

5 - Assumes a 90% linked to treatment

a – Estimated from Kenya AIDS Indicator Survey 2012

n.a. - no data

Figure 2.1.3 National and PEPFAR Trend for Individuals Currently on Treatment



2.2 Investment Profile

The GOK remains committed to ending AIDS by 2030 with specific objectives for ensuring strategic investment of health funds to maximize impact while increasing the domestic pool of resources to sustain the national HIV/AIDS response.

The present health financing landscape indicates an improvement in government financing to the health sector. Government Health Expenditure as a proportion of Total Government Expenditure increased from 6.1% in the Kenya fiscal year (KFY)2012/13[3] to 8% in KFY2015/16.[4] However, out-of-pocket spending remains a large source of health financing (26% of total health spending in KFY2015/16), placing vulnerable households at greater risk of incurring catastrophic health expenditures leading to impoverishment. Available fiscal space limits the expansion of funding to the health sector. The large proportion of government revenue used to finance debts and wages limits the capacity to expand health resources. The clamor for higher wages by public sector employees (resulting in ongoing nationwide health worker strikes) is expected to balloon the public wage bill, leaving few resources to be used for health or other services.

While public sector contributions to HIV/AIDS have increased from 18.8% in KFY2012/13 to 20.9% in KFY2015/16, donors remain the predominant source of HIV financing, contributing 69% of HIV expenditures in KFY2015/16. Kenya's contribution (as part of its Global Fund to Fight AIDS, Tuberculosis and Malaria – Global Fund) counterpart financing requirement as a lower middle income country) is $22 million for procurement of ARVs and test kits, an increase of $2 million from last year. However, donors continue to finance 92% of all ARV needs.

On average, county governments increased the proportion of their total budgets allocated to health from 13.9% in KFY 2013/14[5] to 25.2% in KFY2016/17,[6] reflecting the extent to which county governments prioritize health investments over other sectors. PEPFAR supported sub-analysis of county budget allocations in 26 counties shows counties prioritizing HIV with financial commitments to the HIV program totaling $4 million in KFY2016/17. But, anticipated increases in salary resulting from the ongoing labor disputes will be expected to significantly impact county revenues for KFY2017/18.

Given the current status, significantly greater domestic financing for health and HIV is required to reduce donor dependency and sustain progress made in controlling the HIV epidemic. Government budget alone is inadequate to offset uncertainties in donor support. Efforts to increase the fiscal space for health must be accompanied with measures to address inefficiencies in the use of available resources, including through health insurance reforms focusing on pre-payment schemes as well as other measures that could contribute greater financing towards HIV

[3] NHA 2012/13
[4] NHA 2015/16
[5] MOH National and County Health Budget Analysis.
[6] Ibid

care and treatment and ensure greater returns on investment. Innovative financing which engages private sector needs to be further explored as a means to expand uptake of HIV services, decongest the public sector and ensure long-term sustainability of the HIV response. (See also section 6.0 for COP17 sustainable financing and domestic resource mobilization activities.)

Table 2.2.1 Annual Investment Profile by Program Area (KFY2015/16)

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other Bilateral	% UN Agencies	% All Other International
Clinical care, treatment and support	$369,624,791	58%	8%	34%	0%	0%	0%
Community-based care, treatment, and support	13,153,253	100%	0%	0%	0%	0%	0%
PMTCT	46,135,326	50%	0%	48%	2%	0%	0%
HTS	70,880,183	60%	1%	39%	0%	0%	0%
VMMC	15,337,522	100%	0%	0%	0%	0%	0%
Priority population prevention	12,404,403	96%	4%	0%	0%	0%	0%
Key population prevention	12,444,763	70%	28%	0%	0%	1%	0%
OVC	81,732,843	48%	0%	0%	19%	32%	0%
Laboratory	42,471,805	61%	17%	22%	0%	0%	0%
SI, surveys and surveillance	25,301,671	54%	46%	0%	0%	0%	0%
HSS	7,691,706	97%	0%	0%	0%	0%	3%
Total	**$697,178,268**						

Table 2.2.2 Annual Procurement Profile for Key Commodities[7]

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	$159,729,722	41%	50%	9%	0%
Rapid test kits	22,381,266	62%	28%	11%	0%
Other drugs	6,015,508	67%	33%	0%	0%
Lab reagents	11,444,176	81%	16%	0%	3%
Condoms	12,843,711	0%	34%	0%	66%
Viral Load commodities	20,597,559	100%	0%	0%	0%
VMMC kits	1,361,546	47%	53%	0%	0%
MAT	3,387,707	91%	0%	9%	0%
Other commodities	5,065,342	49%	51%	0%	0%
Total	**$242,826,53**				

[7] Data sources for the tables 2.2.1 and 2.2.2: Draft National Health Accounts (NHA) 2015/16; Draft KNASA, 2016; National and County Health Budget Analysis, 2016/17 and HIV commodity gap analysis, 2016, EA report (2016) – PEPFAR expenditures. All expenditures include program costs

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration[8]

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	$14,200,000	$4,700,000	10	$0	Support quality services for Maternal and child health
USAID TB	$5,000,000	$4,869,000	1	$0	Improve TB diagnosis, care and treatment
USAID Malaria	$35,000,000	$23,717,328	7	$0	Support Malaria prevention and treatment in select high burden counties
USAID Family Planning	$26,000,000	10,311,845	12	$0	Support FP services in the country
USAID Nutrition	$4,000,000	$2,600,000	3	$0	Support nutrition interventions in the country
Quarantine	$303,000	$0	2		Surveillance of migrant populations and refugee camps
CDC DTRA	$369,725	$0			Disease surveillance, diagnostic of priority syndromic illnesses. Incidence and economic impact of Brucella. Non HIV- FELTP activities
Global Disease Detection and Emergency Response	$93,414		1		Building capacity, monitoring & detecting threats , responding to international emergencies and reconstructing health systems
Global Health Security Program Costs	$3,908,588	$1,149,508	1	$0	Help develop health systems that prevent avoidable epidemics, early threat detection and rapid and effective response
Global Public Health Capacity Development	$45,000	$0	2	$0	Global Health Protection research to KEMRI and MOH
Improving Program Effectiveness	$135,900	$0	1	$0	HIV AIDS clinical research
Malaria	$335,374	$0	1	$0	Malaria research
Pandemic Influenza	$857,884	$0	2	$0	Flu research
CDC OD	$1,319,127	$0	0	$0	Management Support
Total	**$91,568,012**	**$47,347,618**	**43**	**$0**	

[8] Data sources for the tables 2.2.1 and 2.2.2: Draft National Health Accounts (NHA) 2015/16; Draft KNASA, 2016; National and County Health Budget Analysis, 2016/17 and HIV commodity gap analysis, 2016, EA report (2016) – PEPFAR expenditures. All expenditures include program costs

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
DREAMS Innovation	$10,427,727	$3,165,935	$3,165,955	1	$7,250,936	Reduce new HIV infections among 15-24 years adolescents girls and young women by 40% in two years' time 2017)
VMMC – Central Funds	$1,792,000			7		Reduce risk of HIV infections
Other PEPFAR Central Initiatives	$11,026,044	$8,302,290	$8,302,290	10	$222,582,077	Various
Other Public Private Partnership	$7,500,000	$750,000	1	-	$500,000	Various
Total	**$30,745,771**	**$12,218,225**	**$11,468,246**	**18**	**$230,333,013**	

2.3 National Sustainability Profile Update

The sustainability index and dashboard (SID) process was completed in 2016 under the leadership of National AIDS Control Council (NACC) and remains a critical tool to strengthen the health and HIV agenda at both national and county levels. Through various platforms, the USG team in coordination with the GOK has been able to emphasize the need for a more methodical and data-driven dialogue with stakeholders on the sustainability of the HIV/AIDS response.

Key progress has made towards the vulnerabilities and priority areas for investment identified in the 2016 SID. These include:

Service Delivery: Test and Start policy and differentiated models of care were integrated into national ART guidelines launched in July 2016. The Ministry of Health (MOH) through the National AIDS and STI Control Programme (NASCOP) in collaboration with other stakeholders rolled out same day ART for all HIV infected and is currently expanding operational guidance for health care workers to implement the updated differentiated models of care policy, complemented by a practical guidebook targeting HIV managers and service providers. Full Implementation of each document to scale is anticipated to begin in June 2017.

Health Financing: PEPFAR focus counties were trained on Project Based Budgeting (PBB), which resulted in an additional $2 million in public allocations to HIV programming. In addition, counties have been provided national and county level budget analyses, a cost analysis of the new Test and Start guidelines and county health accounts to inform fiscal and program planning. As a result of domestic resource mobilization (DRM) advocacy at the county level, health plans expanded from 13% (KFY2013/14) of the total budget to 25% (KFY2016/17). However, over reliance on donor funding, low domestic allocations to health spending and high direct household out of pocket spending persists. Key interventions include replicating the PBB training in additional counties and ongoing domestic expenditure tracking to inform policy advocacy and resource allocation practices for sustainable DRM.

Human Resources for Health: County HRH management capacity building and complementary strengthening of pre-service institutions and professional bodies continue. The ongoing health worker strike has had a considerable impact on service uptake. If salaries are increased, this will also increase the financial allocations required to deliver services.

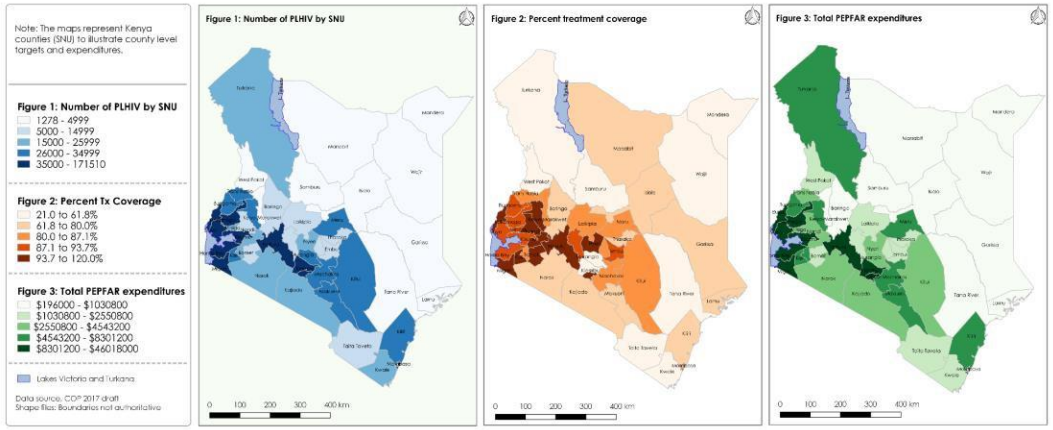
Commodities Security and Supply Chain: The Kenya HIV Supply Chain is integrated and managed by KEMSA and MOH/NASCOP. Increasingly both GOK and GF contribute to the commodity pool. Whereas PEPFAR is a major contributor to the supply chain, the use of local institution has greatly increased the sustainability profile of the Kenya HIV supply chain. KEMSA procures, warehouses and distributes commodities on behalf on USG, UNICEF, DANIDA, GF, JICA and GOK. The Global Fund has availed funds for expansion of the KEMSA warehousing capacity. A national supply chain assessment is ongoing in FY17 and will inform commodity management and logistics to maximize efficiencies and reduce stock-outs.

NACC in partnership with NASCOP continues to champion the engagement of county leadership in the SID process and has mobilized USG support to adapt the SID tool for the county level. The OGAC sustainability technical working group (TWG) is providing technical support for tool adaption, which will be incorporated into national level program monitoring.

2.4 Alignment of PEPFAR investments geographically to disease burden

Figure 2.4.1 compares PEPFAR expenditures in 2016 to burden of HIV disease and ART coverage by county. For COP17, PEPFAR analyzed its expenditures to inform investments, relying on EA16 as the primary data source to inform unit expenditures. On average, PEPFAR spent $243 per PLHIV in Kenya ranging from $151 to $667 by county. The variation in unit expenditure per PLHIV is due to different service delivery models between government-owned, non-government, and private facilities; higher cost in hard-to-reach areas; and patient density in high burden counties that reduces the total cost per PLHIV. Figure 2.4.1 presents a well aligned program response to the HIV epidemiology; total PEPFAR expenditure overlays with total PLHIV and ART coverage (Fig 3, 1 and 2, respectively, within Fig 2.4.1), while the cost per PLHIV (Fig 1 within Fig 1.4.2) is primarily higher in Kenya's remote counties with very low burden (Lamu, Mandera, Wajir and West Pokot) and in the geographically remote area of Turkana, which is a high HIV burden scale up county. While the total spending in the four low burden counties is low (light green shade in Fig 3 within Fig 2.4.1), PEPFAR has categorized these counties as sustained commodities for COP17. The PEPFAR team considered new disease burden estimates where there were significant changes in order to appropriately invest (e.g., Kiambu); however, the rank order of the national HIV burden estimates were relatively similar to those used in COP15 and COP16. The overall PEPFAR investment continues the success of the geographic alignment started in COP15, amplified in COP16, and ensures concentration of investments in the five highest burden counties (Nairobi, Homa Bay, Kisumu, Siaya, and Migori) to close the remaining ART gap as well as to accelerate progress towards attainment across all scale up scale up counties.

Figure 2.4.1 Map of: a.) Number of PLHIV by SNU, b.) Coverage of Total PLHIV with ART; and c.) Expenditure by SNU



2.5 5 Stakeholder Engagement

The PEPFAR interagency team consistently engages key external stakeholders (national and county government entities, the UN Joint Team on HIV/AIDS, Global Fund, civil society, private sector, and professional bodies) during COP development and throughout the implementation year to ensure coordination and alignment on strategic, programmatic, technical and policy issues. This engagement includes focused discussions with county health management teams and public administrators in high burden counties, including a series of high level discussions with Homa Bay County representatives. The PEPFAR interagency team meets quarterly with civil society organizations (CSO) to disseminate program results and information, and to obtain input on programs with specific considerations for human rights, gender, people with disabilities, key populations (KP), and PLHIV perspectives. The annual PEPFAR Civil Society Engagement Strategy Plan, which is under review by the CSO leadership, is an annex to the SDS. As part of the annex, a detailed matrix on the engagement with CSOs during and beyond COP development is included under supplementary documents section of COP17. This plan will also be used to inform the PEPFAR CSO Terms of Reference (TOR) still pending review by CSO leadership and their respective constituents.

In addition to established coordination fora, PEPFAR convenes stakeholder meetings during COP development; data meetings for PEPFAR oversight and accountability response (POART), Semi- and Annual Program Results (S/APR); and planning for special initiatives such as DREAMS. In particular, UNAIDS, UNICEF, UNDP, WHO and UNFPA as well as NACC, NASCOP, and the Global Fund Kenya Coordination Mechanism (KCM), Principal Recipients and Local Funding Agent contributed to the COP17 discourse during the stakeholders retreat. PEPFAR engages with the Global Fund at multiple levels, and the Country Team's written feedback was incorporated into this plan. PEPFAR POART reports are presented to the HIV Interagency Coordination Committee (ICC), which is the technical committee of the KCM.

3.0 Geographic and Population Prioritization

The PEPFAR interagency team reviewed the HIV epidemiologic profile based on 2015 UNAIDS estimates. With the availability of the 2015 estimates, observed changes include an increase in the total number of PLHIV in Kenya from 1,366,771 to 1,517,707. Specifically, there was an increase in the number of adult PLHIV from 1,207,192 to 1,419,537 and substantial reduction in the estimated number of children (<15 years) living with HIV from 159,731 to 98,170. In addition, there were shifts in the number of PLHIV in different counties with the greatest increase occurring in the high burden counties prioritized in COP16. Importantly, the five counties prioritized in COP15 and 16 as having the highest HIV burden remained unchanged, accounting for nearly 45% of the national HIV burden.

The national ART coverage increased from 860,297 (57%) in FY15 to 969,433 (64%) in FY16.

Analysis by finer age and gender disaggregates revealed significant disparities: ART coverage among children was 82% compared to 63% among adults. ART coverage among women was 75% compared to 57% among men. Using FY17 Q1 analysis, ART coverage among young adults aged 15- 24 years is estimated at 43%. There were also significant differences in ART coverage across counties. Among those prioritized for scale up to saturation in COP16, ART coverage ranged from 47% in Kiambu to 103% in Uasin Gishu. ART coverage in Kiambu was affected by the revised estimates that more than doubled the number of PLHIV, lowering ART coverage from 106% to 47%. Uasin Gishu County is home to the Moi Teaching and Referral Hospital, and is one of only two national referral hospitals having the highest number of patients on treatment nationwide. Information from project records in the largest treatment programs in Uasin Gishu indicated that only 71% of patients were from the county, and HIV testing yield data indicated continued identification of large numbers HIV positive individuals, implying the need for continued scale up. Although 15 counties (11 scale up and four (4) sustained) were on the trajectory to achieve overall ART coverage >80%, only two sustained counties (Embu and Kericho) will have achieved this in priority subpopulations (men, women, and children) by APR17. Among the five highest burden counties, Homa Bay and Siaya lagged behind with ART coverage at 58%; this compares to 64%, 72% and 73% in Kisumu, Migori and Nairobi, respectively. The suboptimal coverage in these two counties has been attributed to lower than expected HIV positive testing yields, with adult positivity averaging 3% (compared to ~25% spectrum estimates) and suboptimal linkage to ART at 69% for Siaya, respectively. In FY17, facility-based and targeted community testing strategies are being implemented with additional focus on improving linkage to treatment. ART uptake among KP remains suboptimal. Available program data suggest that less than half of KP PLHIV are on ART. All focus counties except Turkana have achieved >80% VMMC coverage among 15-29 year old males. However, APR16 data indicated that even in the counties were the 15-29 age band had been saturated based on the available modeling data, more men in need of VMMC were identified putting a strong case for continued expansion and validation of the VMMC coverage estimates. Review of 2015 HIV estimates indicated that the four (4) counties selected for DREAMS Initiative in COP15 and 16 (Homabay, Nairobi, Kisumu and Siaya) continue to have disproportionately high number of new HIV infections, collectively accounting for 44% of the 268,586 incident HIV infections in the 15-24 year olds in Kenya. Three additional counties (Migori, Mombasa and Kiambu) also had high HIV incidence with 7%, 4% and 3% of national estimates, respectively.

Based on program performance and updated epidemiologic estimates, the PEPFAR interagency team refined the geographic and population prioritization strategy for COP17. This prioritization allows PEPFAR to more efficiently increase the number of patients on ART by 14% above the already ambitious COP16 targets, while maximizing impact towards epidemic control at the sub-national level in the 34 counties which account for over 96% of the national HIV burden and 95% of ART unmet need. These include 25 counties prioritized for scale up to saturation to achieve >81% ART coverage and close the coverage gap among men, children, youth 15-24 years old and KPs. In addition, nine (9) counties are prioritized for aggressive scale up, putting them on a trajectory to achieving ART saturation by FY19. In COP17, therefore, 274,680 new patients will be initiated on ART, bringing the net new patients on ART to 185,665, compared to 293,116 new and 192,719 net new in COP16. Targets for current on ART will be 1,318,902, including 417,442 adult men, 93,928 children and 214,869 youth (15-24 years). In line with the pivot, 95% of the ART

patients will be within the 34 counties prioritized for scale up to saturation, with the five highest burden counties accounting for 47%. Two of these high burden counties, Homa Bay and Nairobi, account for 23% of the total number of ART patients. Within prioritized counties, PEPFAR will target efforts to reach sub-populations at greater risk for HIV with higher HIV prevalence and with poorer access to services such as populations within any geographic hot-spot (towns, transport corridors, beaches, informal settlements, etc.); men; adolescent girls and youth (<30 years old); key populations including female sex workers (FSW), people who inject drugs (PWID), men who have sex with men (MSM); uniformed personnel, including the military; prison populations; and fisher-folk. In order to achieve these ambitious targets, both facility and targeted community testing approaches will be implemented, with innovative strategies for optimizing testing and reaching previously underserved populations. Additionally, special emphasis will be placed on creating synergies across prevention of mother-to-child transmission (PMTCT), OVC, voluntary medical male circumcision (VMMC), (KP) and DREAMS activities to ensure these are optimized and integrated with ART (including viral suppression) and HIV prevention services to break the cycle of transmission. PEPFAR will continue to provide technical and programmatic oversight to partners working in the prioritized counties to ensure achievement of set targets.

Based on the above aggressive targets, PEPFAR Kenya will support the country to achieve ART coverage of 87%. With gender and age- focused strategies, ART coverage will be increased to 80% for adolescents and young adults aged 15-24 years, 80% for men, 87% for women and 95% for children <15 years based on the estimated number of PLHIV by the end of FY18. With this prioritization, PEPFAR will have supported Kenya to reach sustained epidemic control ensuring that no one is left behind.

Table 3.1 Current Status of ART saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP17	# Current on ART (FY16)	# of SNU COP16 (FY17)	# of SNU COP17 (FY18)
Attained	27,523 (2%)	22,325	-	2
Scale up Saturation	1,214,876 (80%)	816,037	16	25
Scale up Aggressive	231,413 (15%)	109,447	11	9
Sustained	25,130 (2%)	11,221	13	4
Central Support	18,765 (1%)	7,317	7	7

4.0 Program Activities for Epidemic Control in Scale up Locations and Populations

4.1 Targets for scale up locations and populations

Targets in COP17 were set based on the revised 2015 estimates of PLHIV, APR16 achievements, and expected coverage in FY17. A cascade approach was employed in setting targets, which

considered identification of new HIV positive individuals, efficient linkage to treatment and expected loss to follow-up (estimated at 10% for new patients based on current program performance). Overall, COP17 aims to initiate a total of 274,680 on ART, bringing the total number of patients on ART to 1,318,902, 7% of whom are children below 15 years of age. This target represents a 16% increase from COP16. In support of the Kenya AIDS Strategic Framework (KASF) and aligned with UNAIDS 90-90-90 targets, PEPFAR will aim to achieve over 90% PLHIV diagnosed and 87% on ART in FY18. PEPFAR expects to achieve this increased number of new patients on treatment by completing the scale up of Test and Start and cost efficiencies gained through differentiated models of care.

Over 90% of the overall COP17 targets will be met in the 34 scale up counties (described in Section 3.0) where 264,666 adults and children living with HIV will be newly initiated on ART in FY18 (Table 4.1.1). The five highest burden counties will account for 153,491, (58%) of all the newly initiated PLHIV on ART in the 34 counties and 55% of all newly initiated PLHIV on ART nationwide. It is anticipated that in FY18, there will be 179,464 net new patients on ART and 1,262,553 current on ART in the 34 scale up counties, with a sub-set of 14 counties achieving >81% coverage among finer sex and age disaggregates. To reach the treatment coverage target in the 34 scale up counties, adult and pediatric patients will be identified and linked mainly through high yielding strategies such as provider-initiative testing and counseling (PITC), and eligibility screening in out-patient departments (OPD)and PMTCT settings as well as other tailored testing strategies as summarized in table 4.1.1. Equally important, PEPFAR prioritized diagnosis and ART initiation for HIV infected pregnant women. In COP17, 1,324,938 pregnant women will be offered an HIV test, 65,710 HIV positive women will be identified assuming a yield of 5% and of those identified as positive, 95% (62,430) will be linked to ART. Aligned to COP17 prioritization 95% of all targeted PMTCT women on ART will be in 34 priority counties.

Table 4.1.1 Entry Streams for Adult and Pediatric Patients Newly Initiating ART in Scale up Counties

Entry Streams for ART Enrollment	Tested for HIV (APR FY18) *HTS_TST*	Newly Identified Positive (APR FY18) *HTS_TST_POS*	Newly initiated on ART (APR FY 18) *TX_NEW*
Adults			
TB patients	45,269	8,284	7,456
Pregnant women	1,117,499	24,877	23,633
VMMC clients	180,000	650	585
Key populations			
MSM	29,829	5,378	4,840
FSW	132,928	38,147	34,333
PWID	15,368	2,791	2,512
Priority Populations			
Fisher folk	123,065	32,243	29,018
Prisoners	64,800	6,480	5,832
Uniformed Population	108,000		
Military	30,000		
AGYW 15-19	117,096	1288	1,159
AGYW 20-24	134,904	6,206	5,585
Other testing	9,291,237	134, 375	122,373
Previously diagnosed and/or in care			13,233
Total Adults	**11,389,995**	**260,719**	**250,559**
Pediatrics (<15 years)			
HIV Exposed Infants	59,515	3,273	3,273
Other pediatric testing	1,235,306	12,038	10,834
Previously diagnosed and/or in care			-
Total Pediatrics	**1,294,821**	**15,311**	**14,107**
TOTAL	**12,684,816**	**276,030**	**264,666**

VMMC target allocation by county and age group is discussed in Section 4.3, and summarized in table 4.1.2.

Table 4.1.2 VMMC Coverage and Targets by Age Bracket in Scale up Districts

SNU	Target Populations	Population Size Estimate (SNUs)	Current Coverage	*VMMC_CIRC* (in FY17)	Expected Coverage (in FY18)
Homa Bay	15-29yrs	196,521	95%	19,220	105%
Nairobi County	15-29yrs	615,968	N.A	9,660	N.A
Kisumu	15-29yrs	157,786	86%	14,040	96%
Siaya	15-29yrs	131,306	100%	16,926	113%
Migori	15-29yrs	159,601	101%	13,860	110%
Nakuru	15-29yrs	270,797	N.A	3,036	N.A
Busia	15-29yrs	81,517	N.A	3,564	N.A
Turkana	15-29yrs	91,393	52%	6,794	72%

Nandi	15-29yrs	198,988	N.A	3,273	N.A
Kericho	15-29yrs	151,623	N.A	3,090	N.A
West Pokot	15-29yrs	87,924	N.A	742	N.A
	Total/Average	**2,087,816**		**94,204**	

Key and priority population target allocation by county is discussed in Section 4.2, and summarized in table 4.1.3. National estimates based on the censuses report (2014) were triangulated with University of California, San Francisco (UCSF) modeled size estimates were used to calculate coverage targets for key populations (FSW, MSM and PWID) in COP17. Programs focused on FSW and MSM will be implemented in all scale up and attained counties. PWID harm reduction programs will similarly be offered across scale up and attained counties; however, targets for medically assisted therapy are limited to seven scale up counties (Kiambu, Kilifi, Kisumu, Kwale, Meru, Mombasa and Nairobi).[1] In total, 178,125 KP will be provided with a package of tailored services. Targets for community prevention interventions including DREAMS were set using the best size estimation data available and realistic coverage goals for priority populations in each of the geographic focus counties (Table 4.1.3).

Table 4.1.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (UCSF 2017)[9] (scale up SNUs)	Coverage Goal (in FY17)	FY18 Target
Key Populations			
FSWs	138,665	129,431	132,929
MSM	57,321	19,930	29,829
PWID	28,935	15,032	15,368
Priority Populations			
Fisher folk	122,088	102,554	149,225
Military	unknown	46,800	30,000
Uniformed forces	unknown	90,000	108,000
Prisoners	unknown	54,000	64,800
AGYW (10 -24 years)	7,118,314	180,000	252,000
TOTAL	**7,465,323[10]**	**637,747**	**782,151**

OVC targets incorporate the planned expansion of DREAMS and increased numbers of girls aged 10-17 years that will be brought into the program. OVC targets are summarized in table 4.1.4 and discussed in Section 4.10.

[9] The UCSF 2017 key population size estimates are higher than official Ministry of Health key population size estimate (NASCOP 2014).

[10] Population Sizes cannot be estimated for all key and priority populations. The reported figure is therefore an under-estimate of the real size.

[1] A scoping visit is planned in FY2017 to determine the appropriateness of expanding services in Lamu County.

Table 4.1.4 Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY18Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY18 Target) OVC***
Nairobi	98,954	127,085	114,377
Homa Bay	170,587	114,778	103,300
Kisumu	160,050	77,000	69,300
Siaya	107,301	66,280	59,652
Migori	97,457	47,590	42,831
Kisii	104,561	16,949	15,254
Nakuru	115,453	36,589	32,930
Kakamega	122,248	32,742	29,468
Mombasa	30,335	16,067	14,460
Kiambu	60,462	30,619	27,557
Turkana	26,739	4,845	4,361
Muranga	50,266	5,054	4,549
Machakos	45,563	9,483	8,535
Uasin Gishu	19,497	7,713	6,942
Bomet	62,853	4,305	3,875
Kilifi	69,849	43,950	39,555
Busia	117,922	23,707	21,336
Nyamira	72,867	3,031	2,728
Narok	50,164	6,208	5,587
Makueni	89,372	6,893	6,204
Transnzoia	95,822	1,931	1,738
Bungoma	58,898	20,300	18,270
Meru	53,110	15,351	13,816
Kajiado	38,165	8,146	7,331
Nyeri	27,911	9,711	8,740
Kitui	39,430	6,360	5,724
Kwale	87,921	5,313	4,782
Nandi	85,249	2,768	2,491
Kericho	50,257	17,633	15,870
Nyandarua	51,741	4,399	3,959
Kirinyaga	39,114	-	-
Embu	16,500	12,100	10,890
Vihiga	55,118	6,291	5,662
Taita Taveta	17,813	6,352	5,717
Baringo	19,767	3,377	3,039
Laikipia	16,773	4,085	3,677
Tharaka Nithi	24,339	12,633	11,370
West Pokot	67,967	1,965	1,769
Samburu	16,209	2,320	2,088
Elegyo Marakwet	9,234	1,237	1,113
Mandera	75,157	-	-
Garissa	19,200	-	-
Isiolo	11,374	-	-
Lamu	3,786	-	-
Marsabit	28,262	-	-
Tana River	9,662	-	-

Wajir	15,000	-	-
Military		374	374
TOTAL	**2,706,279**	**823,534**	**741,218**

Detailed description of the targets, results, and approaches to achieving targets and efficiencies are described in the program area summary section 4.2-4.10.

4.2 Priority population prevention

PEPFAR will invest in the provision of a comprehensive package of services tailored to priority populations. Kenya has adapted WHO Pre-exposure prophylaxis (PrEP) policy and is developing PrEP guidelines targeting key and priority populations (KP/PP). In the 34 scale up counties, PEPFAR in collaboration with all key partners will support intensified demand creation, targeted HTS, linkage to treatment and provision of PrEP for all eligible KP. Innovative approaches will include: enhanced monitoring for better tracking and retention; implementation of positive health, dignity, and prevention (PHDP); creation of PLHIV peer networks; setting convenient working hours; and sensitizing public health personnel to KP friendly service provision. Community strategies will be used to reach KP and other targeted groups via sexual network analysis and testing of index clients and reaching hard to reach populations especially men and young people <30 years. To increase linkage to treatment from 73% (APR16) and 82% in FY17 Q1 to 90%, PEPFAR will support client escorts, the use of telephone and short text message reminders and in person follow-up by peer educators. A bulk SMS system will be used for appointment reminders; clients receive prompts in advance of their scheduled clinic visit. Further, PEPFAR will actively engage KP/PP, CSOs, and local communities and other stakeholders to address stigma and discrimination, harmful gender norms and other barriers to accessing HIV. In addition, PEPFAR will routinely forecast site-specific commodity needs and work closely with the Kenya Medical Supplies Authority (KEMSA) to ensure service delivery points (SDPs) receive uninterrupted supplies, e.g. rapid test kits (RTKs), condoms, lubricants and methadone.

Key Populations

Services in COP17 will include: condom and lubricant promotion and distribution; HTS and linkage to ART; TB screening and treatment referral; provision of PrEP for all eligible KP; sexually transmitted infections (STI) screening and treatment; peer education and outreach; risk reduction interventions; violence prevention and post violence care; alcohol and substance abuse counseling; PHDP; and structural interventions that foster an enabling environment to access health services. KP at high risk of HIV infection will be recommended for quarterly testing; other KP are tested annually or semi-annually and social network testing will be expanded. Implementation research on KP self-testing was carried out in FY16 and a set of guidelines, operational procedures and advocacy materials are being developed to expand use among FSWs and their clients. KP are also eligible for PrEP as per national guidelines, especially those who frequently take PEP. Site Improvement through Monitoring System (SIMS) data will be used to monitor partner performance and enhance tracking of both KP prevention and treatment cascades through monthly data updates with a view to improving ART and viral load

(VL) testing coverage. PWID services will be scaled up by adopting a low-threshold model to increase access to high-risk injecting users. A human rights-based approach will be adopted to provide services to KP and their sex partners through stand alone and integrated drop in centers (DICE). Sexual network testing strategies will be employed to enhance hot-spot based outreach services, with a specific focus on reaching younger MSM and FSWs. Strategies to improve service uptake in this group includes recruitment of youth peer leaders, health worker sensitization, targeted outreach and use of social media. The KP program will also strengthen health care worker sensitivity and clinical skills in support of integrated services. Pilot differentiated care programs for KP who meet the criteria to be considered a stable patient as per national guidelines will receive three month prescriptions from DiCES; those KP who access services in non-specialized clinics will continue to receive standardized services. Index testing for KP living with HIV links family members to appropriate services, including referral of children to OVC programs.

National KP estimates based on the consensus report (2014) were reviewed against program performance data and expected size based on literature. These were triangulated with UCSF 2016 size estimates which took into account the initial estimates, and were updated using available program and epidemiological data, including for MSM which were considered implausibly low. This exercise led to a modest upward adjustment of the population size estimates from, 133,677 FSW, 20,185 MSM and 18,327 PWID to 138,665 FSW, 57,321 MSM, and 28,935 PWID. Services for FSW and MSM in the 25 scale up to saturation counties and two (2) attained counties are targeted to reach 100% of FSW and 54% of MSM. In the nine (9) aggressive scale up counties, 94% FSW and 42% of MSM are targeted for services. Based on these population size estimates, targets were increased to 29,829 MSM, 132,928 FSW, and 15,368 PWID. In total, 178,125 KP will be provided with HTS. Services offered to PWID will be provided in safe spaces and sites integrated within public health facilities in all target counties. Of the PWID targeted, 53% will be linked to harm reduction including needle and syringe programs (NSP – not PEPFAR funded) and condoms, and 27% will be offered methadone via medication assisted therapy (MAT). PEPFAR will not procure MAT in FY18; however, MAT sites will continue to receive mentorship, quality assurance and human resources. PEPFAR will also continue to support community mobilization and referral for MAT uptake

Priority populations

DREAMS activities will be expanded to increase coverage in the four existing DREAMS counties of Homa Bay, Kisumu, Nairobi and Siaya and introduced in Kiambu, Mombasa and Migori using a phased approach. In the initial phase a broad menu of prevention interventions is available focusing on the AGYW, her household and her community. The core package of services includes: social asset building; educational subsidies; cash transfers; combined socio-economic approaches (entrepreneurship support, financial capabilities, vocational training and job placement); community mobilization and norm change; parenting/caregiver programs; condom promotion and provision; expanded contraceptive method mix; HTS and linkage to ART; PrEP promotion and provision; characterization of male sexual partners (MSP) of AGYW ages 15-19 and 20-24; and linkage to HTS, VMMC and ART; school-based HIV and violence prevention;

and post-violence care. The second phase concentrates interventions primarily targeting AGYW, and in the final phase, the AGYW is transitioned through an exit program and herself becomes a mentor. PEPFAR is working with stakeholders to integrate and expand in-school behavioral interventions, violence prevention and response education. Services are offered through adolescent and youth friendly safe spaces, referral to health facilities and other community services. Demand creation for correct condom use is an integral part of the HIV prevention program in Kenya. PEPFAR supports health education on appropriate condom use via social marketing, interpersonal communication strategies and mass media. Condoms are easily accessible at health facilities, key population hot spots, outreach sites, and private sector outlets including chemist shops, bars and supermarkets. Fast track introduction of PrEP and Test and Start for AGYW is under way in the four initial DREAMS counties and will be expanded in COP17. To date, operational guidelines have been developed for PrEP, health workers have been oriented to the guidelines and commodities are available at all health system levels. Facilities have begun dispensing and reporting PrEP coverage, and the Ministry of Health is publicly launching pre-exposure prophylaxis in May 2017. Layering of DREAMS interventions for all eligible AGYW will be optimized and tracked to ensure achievement of desired goals. PEPFAR will support NACC and NASCOP and the respective county governments to strengthen coordination of AGYW programs and maximize synergies with other investments, including linkages to PEPFAR-supported OVC, VMMC and ART programs. DREAMS commodities including the PEPFAR HTS supply, USAID and MOH contraceptives, and PrEP medication will support program delivery. South-South exchanges will continue to help the in-country team make multiple and complex decisions to enable the accelerated rollout of DREAMS and facilitate networking for shared learning.

Adolescent and young people <30 years of age in the 34 priority counties will be targeted with combined prevention interventions. HTS will be provided, linking those infected with HIV to ART and referrals for VMMC, condoms and risk reduction interventions including PrEP for HIV negative individuals. Vulnerable HIV infected youth <18 years will be referred to OVC programs. Peer mobilization and outreach interventions targeting institutions of higher learning (secondary and tertiary institutions) in urban settings, informal settlements, and mobile populations (taxi drivers, truck drivers, fisher folk and motor bike riders). Outreach to fisher folk will be carried out in five (5) scale up to saturation counties (Busia, Homa Bay, Kisumu, Migori, and Siaya), targeting 70% of the population. Other priority populations include prisoners and uniformed personnel, including the military. To maintain quality services, program performance will be assessed regularly through SIMS and monitored through the DREAMS dashboard and DATIM.

4.3 Voluntary medical male circumcision (VMMC)

Given the overall male circumcision (MC) rate of 91% in Kenya (KAIS 2012), the national program focuses in non-circumcising communities in the former Nyanza region, parts of Rift Valley, and pockets of other counties. Kenya introduced a second national VMMC strategy in 2014 that targets 1,001,757 circumcisions, addressing cultural barriers to achieve 80% MC coverage in all

focus counties by 2019. Counties with MC coverage below 80% at the beginning of the second strategy were prioritized (Homa Bay 56%, Kisumu 59%, Migori 73%, Siaya 56%, Turkana 26%). Counties with MC coverage above 80% but which host pockets of non-circumcising populations were also prioritized (Busia, Kericho, Nairobi, Nandi, and West Pokot). Each of the focus counties excluding Nandi are among the 34 scale up counties prioritized for ART saturation.

PEPFAR will continue to support the GOK VMMC strategy by: applying county specific targets that address age groups where there is suboptimal coverage (e.g., greater emphasis on boys 10-14 years old in Homa Bay and Siaya); targeting boys in the 10-14 year old age band in all priority counties and those in the 30-34 year old age band in DREAMS counties; and achieve 80% coverage for males in the 15-29 year old age band. Kenya appears to have achieved >80% coverage among 15-24 year old males however, coverage among 25-29 year olds lags below 80% in most counties. Therefore, COP17 gives significant emphasis on 25-29 year old males. Demand creation among this "hard-to-reach" age band is anticipated to be more complex than routine circumcision services, and innovative outreach activities and service delivery models will be implemented, and thus higher costs are projected to drive demand for VMMC among older men in FY18.

PEFPAR Kenya has set an ambitious COP17 target of 300,000 VMMCs in 11 focus counties. Targets were set based on increased client demand in FY16, during which uptake of services exceeded expectations (264,490 MCs against a target of 240,000). This represents a 13% increase from COP16 in the five (5) VMMC focus counties, and an overall 25% increase. UNAIDS "Fast Track Goals" for VMMC (2016-2021) modeling data estimated VMMC coverage in Kenya at 72% among 10-29 year old males in 2015. An additional 290,000 MCs are needed in this age band to achieve and sustain 80% coverage by 2021; this changes to 500,000 for 90% coverage in the same period. This estimate contrasts with DMPPT2 modelling, which shows MC coverage above 80% for 15-29 year old males in all priority VMMC counties except Turkana, as well as data pack target calculations. Coverage data by age band will be validated in future years through the population HIV impact assessment.

Implementing partners will be managed to improve performance in an ongoing and timely manner through SIMS and post-operative follow up teams. Continuous quality improvement (CQI) interventions will: reorient providers to the MOH ME, reporting tools and the day seven (7) follow up according to the national VMMC package of care; remind providers to continue providing consistent and correct information at follow up; review client data and all records to ensure that data is correct and up to date; include mobile and outreach service staff to help increase follow up coverage; leverage and ensure continuity of activities supported through the VMMC central initiative; and validate coverage of the 15-29 year old age band in National VMMC Strategy focus counties.

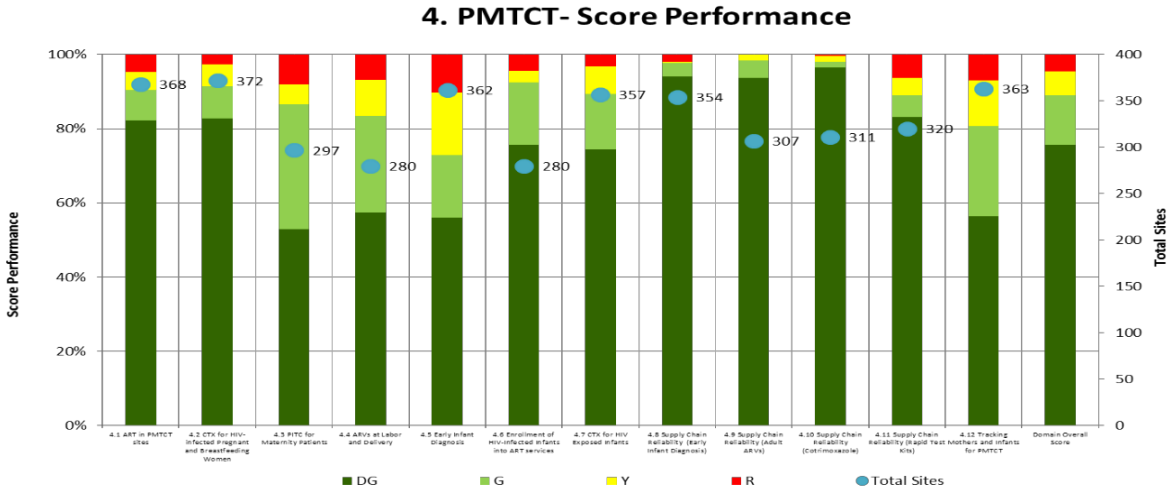
4.4 Preventing mother-to-child transmission (PMTCT)

PEPFAR Kenya supports the GOK in the elimination of mother-to-child-transmission (MTCT) as a lead technical partner to the MOH and through implementing partners serving approximately

80% (62,477) of the HIV infected pregnant population. Of these 91% (70% in saturation and 21% in scale up aggressive SNU) are in the 34 scale up counties and 9% in sustained counties. The package in scale up counties includes: sensitization, dissemination and operationalization of revised elimination (eMTCT) framework, M&E tools and guidelines; optimizing the implementation of the minimum service delivery package; community mobilization to boost antenatal care (ANC) attendance through community health volunteers, mentor mothers and maternal child health (MCH) outreach programs; health worker recruitment, capacity building and mentorship; support to high volume private facilities to improve access and quality of PMTCT care and reporting through District Health Information System (DHIS); improved data quality and reporting in supported public health facilities; optimizing retesting of HIV negative mothers as per revised guidelines to identify new and sero-convertors; the conduct of routine HIV-exposed infants (HEI) screening at immunization clinics and pediatric and in-patients wards with referrals for the follow up of mother-infant pairs; optimizing the retention and tracking of mothers and infants lost during follow up; early (same day) ART initiation for HIV infected pregnant and breastfeeding women with support for enhanced adherence, disclosure and retention including use of mentor mothers (peer support) at the facility and community level; and clinical quality of care monitoring of HIV infected pregnant women, including VL testing and targeted support for those with a detectable VL per revised national guidelines inclusive of enhanced adherence support, repeat VL testing and regimen adjustment.

In FY16, 1,205,995 (93%) of the approximately 1,291,554 pregnant women attending ANC in PEPFAR-supported health facilities were offered HTS, representing 86% (1,387,755) of ANC/L&D attendees. However, this translates to only 69% of national PMTCT_STAT coverage targets. A total of 61,517 (5% yield) were identified as infected with HIV, representing 82% of the estimated PMTCT need in Kenya. Of these, 56,695 (92%) were provided with ARV prophylaxis for PMTCT, representing a national coverage of 76%. In line with the current national PMTCT guidelines, nearly all of HIV infected pregnant and breastfeeding women identified were enrolled on ART, up from 98% in FY15. In FY16, 49,396 infants <12 months of age were tested for HIV in PEPFAR supported sites, contributing to 66% national coverage. PEPFAR focuses on reaching women accessing antenatal care services to identify HIV exposed children early and provide prophylaxis. Among those tested, 66% were tested within 6-8 weeks aligned with national policy. The majority of tests conducted among infants 2-12 months were confirmation tests or tests conducted at immunization points. Overall, 5.7% of the tested infants were HIV positive; the positivity rate in PEPFAR supported sites was 3.2% among those tested within 6-8 weeks and 9% among those tested between two (2) and 12 months of age. Consistent with this finding, a review of FY16 SIMS data identified gaps in uptake of HIV testing for women during delivery and postnatal period. In total, 4,822 HIV infected pregnant and breast feeding women identified at the facility missed ART. A significant proportion of these mothers declined to initiate treatment, while the balance represent missed opportunities due to errors in recording and reporting. Program data shows improved access and uptake of VL monitoring; however, those with a high VL experienced delays in the utilization of results. The late identification of HEI resulted in delayed action and increased Polymerase chain reaction (PCR) positivity, delayed release of results to caregivers and hampered the retention of mother-infant pairs. PEPFAR,

working through implementing partners, will provide targeted technical assistance to improve performance and address these implementation gaps.



The PEPFAR support for the 34 scale up counties accounts for 78% of the national PMTCT need (n=79,475), of which 40% (31,705) is within the five (5) highest burden counties and 39% (n=30,943) spans the remaining 29 counties. The COP17 target for pregnant women on ART in the 34 scale up counties represents a 12% (6,547) increase compared to the FY16 results in these counties. Improvements in the proportion of identified HIV positive pregnant and breastfeeding women and treatment targets will be achieved through a combination of increased testing and retesting coverage, partnership with private health facilities through technical assistance (TA) support, HEI screening at immunization and in patient wards, improved referrals and linkage including immediate ART initiation and retention of those identified.

PMTCT targets in 25 scale up to saturation counties were set to reach 100% of pregnant women attending ANC with HTS and initiate ART for 95% of identified HIV-infected women. In the five (5) highest HIV burden counties, in addition to above mentioned strategies, enhanced collaboration added to other community prevention interventions will increase identification (e.g. embedding PMTCT screening in community HIV testing strategies, OVC programs, family testing from index clients, referrals from traditional birth attendants, and key and priority interventions). These modalities will be implemented to increase identification and referral of pregnant women. Additional services will include: an enhanced package for male involvement/participation through partner notification, provision of HIV testing for sex partners, and non-communicable disease screening; VMMC services offered to male partners in non-circumcising communities; the identification of and psychosocial support for discordant couples and their children; PrEP offered to HIV negative women in sero-discordant relationships including those who are pregnant and breastfeeding; peer support groups and empowerment meetings for pregnant adolescent girls and young women; repeat HIV testing during late pregnancy and the postpartum period; and written facility-required written case audits for exposed infants who seroconvert, documenting the factors that may have contributed to transmission. Furthermore in these counties, family planning

(FP) services will be integrated at ART clinics to eliminate unmet need for FP among HIV infected women of reproductive age. This will be complemented with pregnancy intention assessments and FP support tools conducted routinely for all women of reproductive age enrolled in the HIV program to appropriately identify individual client needs. DREAMS partners will enhance prevention interventions targeting AGYW at risk of acquiring HIV, and ART will be initiated for all HIV positive individuals (Test and Start) as per national guidelines. Based on the success of PEPFAR program data reviews and piloted innovations (e.g. longitudinal HEI birth cohort reporting showed a retention rate of 86%), PEFPAR will continue to contribute to the improvement of revised PMTCT tools and guidelines.

From program data nearly two thirds of women in PMCT are already known positive, majority of whom have been in care and on treatment. Similarly, Viral suppression among pregnant and breastfeeding women is high, ranging from 80-90% across programs. As such, a reasonable number of PMTCT patients who are stable can be prioritized for differentiated care in order to improve efficiencies and decongest health facilities. Differentiated models of care will be adopted in PMTCT settings and structured to meet the unique needs of HIV pregnant and breastfeeding women. In line with current ART guideline stable patients will be prioritized for differentiated services including: facility based multi-month prescriptions, fast tracked patient flows and or community ART pickups where applicable. On the other hand, unstable PMTCT patients will be offered facility based services including, regular clinic follow ups, opportunistic infection and comorbidity management and intensified adherence support.

4.5 HIV testing services (HTS)

PEPFAR will support Kenya's implementation of the recently launched HTS guidelines, which offer guidance on: a) self-testing; b) re-testing for various sub-populations, including newly diagnosed PLHIV before enrollment into treatment; and c) referral (linkage) from testing to treatment and to other post-test services such as PMTCT, VMMC, FP, TB and other prevention interventions. The guidelines further lower the age to consent for HTS from 18 years to 15 years, which provides an opportunity for testing adolescents.

To ensure optimal performance, strategies will be implemented to address gaps identified through SIMS: capacity building for service providers on proficiency testing and quality assurance; improvement of the supply chain to eliminate testing interruptions in the scale up counties; scale up of approaches known to improve HIV+ yield; strengthening linkage to ART and adoption of WHO/National Test and Start Guidelines. In Homabay, Kisumu, Siaya and informal settlements in Nairobi City County, PEPFAR will expand new census-based testing strategies based on the SEARCH model inclusive of flexible facility hours and locations, targeted mobile testing and multi-disease health fair efforts. The 2016 gender analysis identified low (and late) HIV testing coverage for men and KP as a key gap. This is now being addressed through innovative strategies for early identification of HIV positive men through home and work place testing and multi-disease screenings for non-communicable diseases (NCD) and strategies for improving HTS

coverage for key populations. Using expenditure analysis (EA) data, the 2016 average expenditure per test was $3.11 in facilities and $9.21 for community-based HTS (Appendix B). Kenya conducted a forecasting and quantification exercise in 2016 to determine the HIV commodity needs beyond 2017, and PEPFAR Kenya engages continuously with GOK and Global Fund to ensure sufficient funding and commodity security at national, county and facility level. The HIV commodity supply chain is well integrated and managed by KEMSA, providing the GOK better visibility on commodity usage and requirements.

Targets for HTS were calculated based on an analysis of the cascade to meet the targeted number of new on treatment requirements in the 34 scale up counties (Section 4.1). This calculation factored: county data on HTS positivity; linkage to enrollment in HIV treatment (90%); and estimates of loss to follow-up (LTFU) (5% for newly enrolled patients). The approach to coverage and scale is tailored to the geographical prioritization strategy. Targeted HTS community testing within the 34 priority counties will reach: 906,268 people in the 25 scale up to saturation and two (2) attained counties; and 47,257 people in the nine (9) aggressive scale up counties. PEPFAR will support the following in the 25 scale up to saturation counties: universal PITC in all supported sites; home-based HTS in high density and higher prevalence areas; testing of PLHIV family members; and HTS outreach to key and priority population hotspots. In the nine (9) aggressive scale up counties, PEPFAR will support: prioritized PITC in health facilities among high-yield populations; expanded high-yield index patient-partner and patient-family testing; and targeted HTS outreach to key/priority populations in hotspots. In the five (5) highest burden counties, PEPFAR will target priority populations such as men, fisher folk, and their families in hard to reach areas and informal settlements with community testing and effective linkage.

As PEPFAR continues to prioritize high burden and high incident counties and populations and increase ART coverage, greater numbers will need to be tested in order to identify the remaining PLHIV. At APR16, the overall HTS yield stood at 2.0%, down from 3.3% and 3.6% in FY15 and FY14, respectively. PITC in different health facility settings continues to produce the highest yield across all priority counties and is the most cost-effective testing strategy. PEPFAR will support modalities to institutionalize PITC and ensure that HTS is offered as a routine service in all health facilities in priority counties.

Program reports (APR16) show a high HIV positivity (1.0% - 3%) among both males and females aged 15-24 years as compared to other age cohorts in the 34 priority counties. Adolescents and young people will be aggressively targeted with HTS in these counties. Younger children will be reached through PMTCT, OVC, pediatric in-patient wards and sick child care, index testing and specialized clinics such as nutrition clinics. Information on HTS for children is recorded in patient registers; supportive supervision and health worker coaching will be provided to address documentation and improved case management. Linkage strategies for children and their care givers include treatment clinic escorts to promote same day ART initiation, confirmatory referrals where inter-facility services are offered, SMS reminders for newly diagnosed clients, linkage officer follow up and peer support groups facilitated by mentor mothers to facilitate enrollment and adherence. HTS will focus on the identification of new positives with same day treatment

linkage and the linkage of negative individuals to VMMC, PrEP, condoms and risk reduction prevention services. Targeted HTS strategies aimed at testing less and achieving a high yield will include: mobile outreach campaigns and incentives for testing in informal settlements, colleges, and Lake Basin communities; social and sexual network analysis; partner notification; integrated HIV and NCD screening and testing outreach campaigns; targeted local media campaigns through radio and TV advertisements; youth friendly services and hours including evening and weekend clinics; and self-testing. The following strategies will be applied to improve linkage to ART among adolescents and young people: peer to peer counseling/treatment buddies; facilitated disclosure through counselling; self or assisted disclosure to significant others including parents, caregivers, and teachers; the use of social media platforms and an adolescent hotline to provide information on the importance of immediate treatment, location information for youth-friendly treatment facilities, and referrals; and peer youth living with HIV (YLHIV) support groups that incorporate adherence support.

Targeted HTS will employ the following strategies to increase identification among males: mobile outreach campaigns and incentives for testing in informal settlements, colleges, and Lake Basin communities; social and sexual network analysis; partner notification; self-testing; evening and weekend HIV testing services; targeted local media campaigns through radio and TV advertisements; and integrated HIV and non-communicable disease screening and outreach campaigns. Linkage to treatment will be expedited through: same day treatment linkage; peer to peer counseling/treatment buddies; treatment counselling, psychosocial support and patient escort services; SMS reminders; peer Men LHIV support groups that incorporate adherence support and evening and weekend clinics.

4.6 Facility and community-based care and support

Kenya launched its ART guidelines for treatment and prevention in 2016. The updated guidelines focus on two key areas in which PEPFAR will prioritize and work with GOK: a) linkage and retention to treatment; and b) expansion of differentiated care models. All PLHIV are eligible for treatment. Data reveal that linkage to treatment has been sub-optimal at 74% (APR16) and efforts are needed to improve engagement in care. Kenya will enhance intensive post-test counseling and also use case managers to ensure all those identified positive initiate treatment. Kenya will also innovate by using mHealth technologies to track and trace patients who have disengaged from care through text messaging, which has been shown to be effective for those entering or already in care. Strategies to enhance ART linkage for patients identified HIV positive in facility and community settings will include use of patient escorts, same day ART with continued adherence support (as recommended in the new Kenya ART guidelines), use of linkage officers and registers, and continued follow up of patient cohorts who do not link immediately and support linkage within three to six months. These strategies will improve linkage to treatment to over 90% and retain at least 95% of patients on treatment.

PEPFAR is supporting a MOH policy framework to operationalize differentiated care. In addition,

treatment literacy will be offered to stable patients on the differentiated models including multi-month prescriptions, fast tracked patient flows and the option of community ART pick up. Differentiated care models will help to reduce the transaction costs for patient travel to facilities, increase peer support and community involvement, reduce workload from the health worker's perspective and maintain and improve patient outcomes. PEPFAR will work to ensure there is adequate linkage between the facility and communities for both data capture and referral systems. Community health worker referral tools including linkage registers will be used to track and facilitate follow up. Complementary support will also be provided to develop monitoring and evaluation instruments including ART distribution forms, fast-track forms and registers.

PEPFAR will provide both facility and community care services in the two (2) attained, 25 scale up to saturation and nine (9) scale up aggressive counties as part of COP17. Kenya has prioritized: test and start implementation; support expansion of differentiated care models; adherence and retention strategies especially to men <30 years in care and pregnant and breastfeeding women; pharmacovigilance; human resource capacity especially to enhance linkage to treatment; and viral load access and suppression through demand creation and optimized use of viral load for patient management. Kenya will also continue to provide nutrition assessment counseling and support (NACS) and therapeutic feeding for severe acute malnutrition (SAM), provision of cotrimoxazole, cryptococcal screening, ART monitoring as per national 2016 guidelines and PHDP promotion. In addition Kenya will prioritize TB prevention and treatment through optimized TB screening, improved diagnostics using GeneXpert and enhanced Isoniazid preventive therapy (IPT) uptake among all eligible PLHIV.

4.7 TB/HIV

Kenya is a high TB burden country with an estimated prevalence of 120/100,000 and 80% case detection rate for all TB cases.[11] In FY16, 76,987 of the 110,000 WHO estimated incident TB cases were notified and 32% of these were HIV positive, including 16,710 newly testing positive. The majority (87%) of co-infected TB/HIV cases are within the 34 counties that account for 95% of PLHIVs. In Kenya, 97% of identified TB patients are tested for HIV and 96% of TB/HIV patients are on ART during TB treatment (Kenya TB program data FY16). Kenya recently completed data collection for a national TB prevalence survey to determine the burden of TB, assess the health seeking behavior of individuals with TB, inform TB control policy and assess progress towards achieving international TB control targets. The survey was national in scope and conducted among eligible individuals aged 15 years and above in 99 randomly selected clusters from July 2015 to July 2016. The survey is in the final stages of report writing and the final official report is expected to be released on world TB day, March 24, 2017.

While TB and HIV services are integrated in 90% of PEPFAR-supported ART sites and TB screening has been institutionalized in PEPFAR-supported ART sites, the low yield (2%) and double the estimated prevalence from the recently concluded national TB survey suggest the need to improve screening and diagnostic evaluation. The GeneXpert® mycobacterium TB and

rifampicin resistance (MTB/RIF) test was made the initial diagnostic test for PLHIV presumed to have TB. A total of 146 GeneXpert® machines (including 42 PEPFAR-procured) have been installed across Kenya and a specimen referral network was established to cover all HIV treatment sites countrywide. Efforts are underway to optimize machine utilization from the current 65% to 80%. There has been marked improvement in implementation of TB infection prevention and control (IPC) at site level with 90% of sites meeting expectation during SIMS.

TB Preventive Therapy (TPT) for PLHIV was officially launched nationally in March 2015 and recommends a six month course of isoniazid (INH) for asymptomatic PLHIV aged 12 months and older or less than 12 months with a known TB contact. To date 465,000 PLHIV have been initiated on TPT using INH procured by Global Fund, the MOH and PEPFAR. PEPFAR played a critical role in developing and operationalizing TPT policy documents, engaging implementing partners and monitoring the integration of TPT into the standard package of HIV care in various service delivery models. In COP17, Kenya will continue to scale up TPT nationally to 90% coverage of all eligible PLHIV and build the capacity of site level staff in identifying, managing and reporting adverse drug reactions and other events. PEPFAR will continue to support forecasting and quantification for TPT commodities, printing of TPT tools, advocating for the inclusion of IPT outcome indicators in the DHIS, piloting the shorter 3HP regimen and evaluating the impact of IPT on the HIVTB epidemic. GF will continue to procure INH for TPT.

To improve the quality of TB screening and case detection, PEPFAR will train staff on reading and interpreting CXR x-rays while continuing to scale up previously supported activities including: universal HIV testing for patients with presumed or diagnosed TB, and timely access to ART for those with HIV infection; integration of ART in TB clinics in priority/scale up counties to overcome persistent challenges with linkage to care and retention; strengthen TB IPC in health care settings in anticipation of higher numbers of patients in care as well as conducting surveillance of TB among health care workers; support TB screening, contact tracing and active case finding in HIV, MCH and prison clinics and other hospital settings, diagnostic work-up and appropriate management as per the national TB guidelines; strengthen and expand the specimen referral network for GeneXpert testing to ensure early TB case detection and management among PLHIVs including drug resistant TB surveillance; strengthen and expand continuous quality improvement for use of GeneXpert, smear microscopy and TB culture through external quality assurance including proficiency testing; monitoring and evaluation, including integration of the TB web-based surveillance system with the existing electronic medical record (EMR) systems.

[11] TIBU, the national TB surveillance database

4.8 Adult treatment

Kenya has made significant progress in increasing the number of adults living with HIV on ART in the past 10 years. By the end of FY16, 969,433 (64%) out of the estimated PLHIV of 1,517,707 (UNAIDS 2015) were on ART; this represents a 13% (109,136) increase from APR15 (860,297) of patients on treatment. COP17 is in line with COP16 geographic prioritization where 45% of total patients on treatment were in five (5) high burden counties and >80% in the 34 scale up counties. In FY18, PEPFAR aims to increase the total number of children and adults on ART to 1,318,902, to achieve an overall ART coverage of 87%; >80% in males, 89% in females and 95% in children 0-14 years. To attain epidemic control, PEPFAR aims to achieve >89% ART coverage in the five (5) high priority counties, and >80% in all scale up to saturation counties. To accomplish these ambitious targets, Kenya will initiate 274,680 new on ART, 56% of which will be from the five (5) high burden counties, and achieve a net new ART of 185,665.

New ART guidelines were adopted in FY16, which recommend immediate ART initiation for those diagnosed with HIV. All patients on care were transitioned to treatment; this involved line listing patients, calling them back to facilities and subsequently preparing them for ART. Between APR15 and APR16, PEPFAR added a net new of 109,136 on ART. As a result of these successful mop-up activities, approximately 96% of all patients on care are currently benefiting from treatment. Although overall ART coverage is at 64%, gender and age disparities persist. Male treatment coverage remains at 57%, female coverage is at 75% and only 43% youth (15-24 years) living with HIV are on treatment. Going forward, PEFPAR will build on the momentum of FY16 and project reaching 1,044,350 adults on treatment in FY17 and 1,224,974 in FY18. This will increase the adult coverage of PLHIV to 73.5% in FY17 and 86% in FY18. Because of difficulty in reaching the men and young adults, special emphasis will be put on this population. To reach the men, targeted mobile testing combined with demand creation for men- sports (football, boat sports, etc.) will be employed as well as men friendly hours and services. Differentiated care services specifically targeting the men will also be expanded. Site Improvement through Monitoring System (SIMS) data will be used to monitor partner performance and enhance tracking of treatment cascades by sub-population including priority age groups with a view to improving Test and START coverage and improved viral load (VL) outcomes.

In FY16, Kenya performed 857,530 (VL website) VL tests among the 969,443 PLHIV on ART, giving VL coverage of 88%. In 2016, 85% of adults (>25 years), 63% adolescents (10-19 years) and 57% of children (<15 years) accessing VL testing were virally suppressed. In FY16, Kenya strengthened its VL capacity by hiring additional staff, increased the availability of testing equipment within laboratories, improved VL networks by expanding and strengthening sample transport and return of results, and strengthened the NASCOP VL database used to monitor uptake and suppression. In order to support achievement of 90% viral suppression in FY18, the focus will shift to: enhancing clinic-based quality assurance systems to increase patient access to viral load testing; increasing use of the web-based database to streamline sample–results management (remote sample log-in and printing of

result at peripheral site level); and expanding clinical mentorship including the application of the multidisciplinary clinical case management model (with emphasis on pediatric and adolescent patients), which includes peer leaders, and facility and community health workers. Specific strategies to address viral suppression in pediatric (<15 years) and youth (15-24 years) include use of improved treatment literacy and drug formulations (e.g. dispersible pediatric formulations, introduction of DTG, LPVr pellets, single dose ABC/3TC), close monitoring and dose adjustments for pediatric patients, adolescent support groups, adolescent friendly services, home visits and stigma reduction in schools.

FY16 program data from 14 DICE targeting KP in Western Kenya showed ART coverage of 74% and 48% among FSW and MSM, respectively. This increased from an estimated national coverage of 34% and 6% in FY15. In FY18, Kenya will expand the peer-based and DICE models to reach additional KP and ensure those identified as HIV positive are initiated on ART.

Data Summary as of September 2016 (All WK Partners)

	Total Reached with Services	Total HIV Pos Ever identified	Total Active on ART
FSW	16,082	5,924 (37%)	4,402 (74%)
MSM	1,161	161 (14%)	77 (48%)

4.9 Pediatric Treatment

The HIV estimates for pediatric patients (<15 years) in Kenya have drastically decreased from 159,731 (2014) to 98,169 (UNAIDS 2015); consequently, ART coverage in CLHIV is 82% as of APR16. The implementation of the FY15-FY16 Accelerating Children's HIV/AIDS Treatment Initiative (ACT) led to an additional 19,000 net new and a total of 81,019 children on treatment. Even though Kenya has reached ≥80% ART coverage in high burden counties, there remains a substantive number of new infections in HIV exposed infants (<1 year) and treatment gaps remain among those infected with HIV. Similarly, the estimated ART unmet need for adolescents remains high at 49%. There has been significant improvement in the quality of pediatric care in FY16 as identified through SIMS visits, especially pediatric testing, ARV dosing and monitoring and improved access to adolescent services; however, linkage to community services remains suboptimal.

In FY18, PEPFAR in collaboration with the MOH will implement targeted, high impact interventions across pediatric and adolescent clinical cascades. Momentum gained through the ACT Initiative will be leveraged to reach 93,928 CLHIV and attain 95% ART coverage among HIV infected children. To achieve this ambitious goal, high yield pediatric testing will be expanded through: use of the geographic and patient-clinical probability index; family and index testing; screening of HIV exposed infants and early infant diagnosis (EID); in-patient testing; universal HIV screening for all eligible OVC; and prioritized out-patient screening. Early identification and linkage to ART for HIV infected infants will be enhanced through

optimized exposure screening in immunization settings, where service uptake within two (2) months of birth is >90% and enhanced mother-infant pair follow up through longitudinal cohort tracking (HEI and HITS). Expanded treatment packages for pediatric and adolescent patients include: psychosocial support systems; nutritional support; opportunistic infection (OI) screening and prevention with universal provision of cotrimoxazole (CTX) and IPT; and defaulter tracking systems to improve retention. PEPFAR will support implementation and expansion of adolescent and youth friendly services promoting demand and uptake of testing and treatment services, reproductive health services and adherence. Meaningful engagement of young people living with HIV will be realized through trained adolescent and youth peers to facilitate, identify, engage and retain patients in care. To improve treatment outcomes, bi-directional referrals with DREAMS and OVC programs will be enhanced. Unmet pediatric ART need will be addressed in close collaboration with county governments through robust case identification and linkage strategies: EID strengthening and scale up, universal IPD/OPD coverage for all eligible and family testing for all enrolled family members. The OVC platform will be utilized for HIV testing, psychosocial and adherence support at the community level. The majority of HTC for OVC is provided at outreach sites; separate HTC outreach registers will be used to document OVC testing during outreach.

Currently, viral suppression among children and adolescents is at 65% and 61%, respectively. As 95% of children and adolescents are on NNRTI-based regimens, they are at greater risk of developing drug resistance mutations with suboptimal virologic control. Therefore, treatment monitoring will be strengthened through: routine VL testing; enhanced, age appropriate adherence assessment and counselling for children and adolescents; prompt shifts to second line treatment for all who are eligible as per the guidelines; and consistent availability of child friendly regimens and fixed dose combinations. Appropriate regimens and dosage monitoring will be optimized in order to facilitate the achievement of viral suppression in this population.

PEPFAR continues to support the GOK to optimize pediatric ARV regimens consistent with the inter-agency task team (IATT) Optimal Formulary List. There have been no reported ARV stock outs for the last two years. In FY18, Global Fund will support procurement of 1st and 2nd line pediatric ARV, and the GOK will provide 3rd line ARVs for children in conjunction with Janssen pharmaceuticals. LPV/r pellets are anticipated to be available by FY17 and full roll out is anticipated in FY18.

4.10 OVC

Kenya has an estimated 2.6 million orphans and vulnerable children (OVC) (KAIS 2012), 660,000 of whom are due to AIDS related deaths (UNAIDS 2015). PEPFAR OVC programs are focused in counties where the HIV burden and OVC unmet need is greatest. In FY18, PEPFAR will reach 758,663 children and adolescents in the 34 scale up to saturation and scale up aggressive counties. PEPFAR will continue to apply family-centered approaches to mitigate the impact of HIV/AIDS and ensure that children and adolescents remain: AIDS free, healthy, safe, stable and schooled. The program will target the mother and child, adolescent girls, community, facility/clinical systems and the social welfare workforce, with an emphasis on adolescents (10-17 years) and HIV

positive children in high HIV burden areas. Children with an unknown HIV status will be screened using a risk assessment and all eligible OVC will be referred for HIV testing, treatment and care services as required. The OVC earmark will be apportioned to interventions spanning finer age band disaggregates. Intervention packages for children are developed appropriate to their age specific needs. As children grow older the cost of schooling and other interventions increases substantially. Investments broken down by age band are as follows: children under five years of age (<1%), young children aged 5-14 years (8%), adolescents age 15-17 years (75%) and economic strengthening activities for young adults (≥18 years) and caregivers (17%). The DREAMS partnership further extends services to vulnerable AGYW (10-24 years), increasing the OVC resource envelope by 44%.

PEPFAR will integrate efforts to reach CLHIV with health, nutrition, education and social protection services. The program will support: targeted mobilization and sensitization of vulnerable groups; protection of the rights of children, adolescents and their families; reduction of stigma and discrimination; and institutionalization of policies, guidelines and quality standards. PEPFAR will continue to strengthen linkages between the community and health systems to improve health outcomes for OVC, including ART adherence and retention in treatment and care for the HIV infected child. Community link desks will improve bi-directional clinical referrals to OVC programs for children and adolescents with poor retention, particularly in high volume health facilities. Families will be sensitized to the benefits of HIV testing for children and age-appropriate disclosure for caregivers to build their skills in parenting and the care of HIV-affected, infected and exposed children and adolescents. Health education and psychosocial support will be intensified for OVC, including grief counseling, disclosure and positive living for index clients and their families, including sex workers whose children are at risk of HIV. Education support will be provided to OVC by addressing barriers to enrollment, attendance, and progression, particularly for adolescent girls.

Children under five years of age will be reached with combined OVC and MCH interventions delivered at PMTCT, child health and early childhood development (ECD) sites in high burden communities. Local partners will connect to a designated focal person in each clinic to link HIV exposed and infected infants to OVC services. The program will facilitate this through the line listing of index clients, social network mapping, and building the capacity of local partners and community volunteers (e.g., mentor mothers, lay counselors and social workers) to coordinate with clinical partners. Other interventions will include home visits using the mentor mother model.

PEPFAR will continue to build linkages to DREAMS activities and employ community mobilization strategies to identify vulnerable adolescent girls in- and out-of-school and facilitate their access to health, HIV and other social services such as education, gender-based violence (GBV) protection and economic strengthening. Referral networks to reproductive health and other social services will be strengthened and girls will be coached to advocate for their own needs and rights. OVC caregivers and adolescents will be supported to be more resilient to financial shocks through group savings and loans, as well as referrals and enrollment in social

protection programs. As part of rights-based and gender transformative programming, PEPFAR will improve responses to violence and exploitation by supporting child protection as outlined in the National Violence Against Children (VAC) Response Plan. GBV targets have been set to encourage partners to address and increase reporting of GBV cases; rates of physical and sexual violence were estimated using national survey (KDHS 2014, VAC 2012, IBBS 2010/11) and peer reviewed literature. Post-GBV care is supported at facility level (e.g. sensitivity and response training for health providers, HTS, PEP, etc.) with referral to law enforcement and other social welfare agencies. At community level, community health workers are trained to identify and link clients to services and to sensitize community members to GVC issues and prevention. In addition, paralegal training is leveraged for key and priority populations including adolescents and youth.

Finally, the program will use data for OVC programming through integrated data reviews. PEPFAR will continue to strengthen the national and county level child protection Management Information System (MIS) in collaboration with the Department of Children's Services (DCS) and other stakeholders. The MIS flags cases for additional follow-ups, and that empowers local leadership with timely data for decision making. Stakeholder orientations will sensitize target counties on data for decision making including local resource mobilization.

4.11 Addressing COP17 Technical Considerations

Sustained epidemic control will be achieved through optimal coverage of clinical and prevention interventions, client centered approaches, gender and age-disaggregate focused services and innovative service delivery models as outlined in the 2017 COP technical considerations. To achieve the ambitious 90-90-90 targets and enhance quality, the MOH with support from PEPFAR launched and rolled out 2016 Kenya ART guidelines to include Test and Start. The updated guidelines stipulate that all identified patients should be started on ART on the same day, as feasible, and include differentiated service delivery models. Innovative approaches will ensure strategic scale up of treatment in priority locations and populations and will make significant contributions to the achievement of Test and Start.

Within the 34 scale up counties, prevention and care services will be intensified for adolescents and youth <30 years. These services will include: targeted combination prevention; peer-mobilized outreach offering HTS and linkage to treatment for individuals testing HIV positive; risk reduction counselling; condom promotion and distribution; referrals for VMMC and HIV testing during VMMC; and PrEP. These services will be provided in urban informal settlements, colleges, beaches, fishing bays, town centers and sports and entertainment hang-outs of young men. In addition, PITC will be offered at health outpatient and in-patient health facility clinics. Social and sexual network testing combined with self-testing (when kits become available) will be employed for optimal identification of young people living with HIV (YLHIV). Peer escorts and mobile text messages and telephone reminders will be used to link YLHIV to treatment. Health

care providers will be trained to offer youth friendly services with extended hours on weekends. Adolescent friendly reproductive health services will be supported in high volume facilities to offer: comprehensive sexual and reproductive health information including risk reduction counselling; HIV testing; STI treatment and ART; condoms; and PrEP. Targeted local media campaigns will also be implemented to create demand for HIV services among those 15-30 years old.

High yield facilities combined with targeted community testing approaches will be employed with the objective of testing fewer individuals and maximizing yield of newly identified HIV positive individuals. An HIV test and re-test screening tool based on the Kenya HIV testing and counselling guidelines (MOH 2015/2016) will be implemented to identify and test only those eligible individuals: who report an exposure to HIV; report multiple partner relationships; and have never tested, tested over a year ago, and/or report minimal risk to HIV. To improve linkage to treatment, HIV testing will be prioritized in HIV treatment facilities, physical escort by HTS providers and peers for treatment, enhanced post-test counselling, referral tracking and follow up by peers, phone calls, and SMS reminders beyond three months; a strategy that was initiated in Q4 of FY16 with increased linkage results. The PEPFAR Gender Analysis shows that 57% of adult PLHIV on ARV are male compared to 74% female (APR16). PEPFAR will utilize community mobilization strategies targeting men (including lessons learned from the SEARCH Study) and adolescents through establishing a Public-Private-Partnership (PPP) to use NCD platforms, and other community focused opportunities for comprehensive and integrated services to better reach men, and leverage DREAMS to improve ART coverage for adolescents and young women. PEPFAR will also employ peer-based models and the DICE model to reach more key populations.

Both MOH and PEPFAR will continue to support the nationwide expansion of differentiated care models and an MOH policy framework to operationalize this. PEPFAR will support the development of accurate methods to monitor ART delivery through newer models of care such as community-based delivery, less frequent (3-6 month) intervals for drug refills, and use of programs such as community adherence groups (CAGs) in which one patient collects medications refills for multiple patients.

HIV viral suppression is critical for the reduction of HIV related morbidity and mortality and prevent HIV transmission. Current suppression rates stand at 84% for adults and about 65% for pediatrics. There are many factors contributing to low viral suppression rates among PLHIV. Some could be attributed to the individual missing one or many appointments, not following the care plan, missing a dose or doses of medicine, sharing medicines with other people, stopping medicine for a day or many days, taking medicines at the wrong time or taking medicines without following instructions about timing or food intake. Other factors can be attributed to the health services and include youth-friendliness of services, level of confidentiality, referral systems, provider attitudes, cost of health services, existence of drug stock-outs, existence of support groups, distance/transport costs, space for private counseling, convenience of clinic hours, patient record and tracking systems and the number and type of health care workers. Patient literacy will

continue to be enhanced to in order to address adherence challenges related to individual patients, and health services are being improved to make them more patient friendly. Provider attitudes are also being addressed through clinical mentorship on patient centered care and other factors affecting adherence including pill burden, dose timing, pill size, etc. are under review. The MOH-led current commodity security management systems have ensured zero stock outs of ARV drugs.

To achieve high VL suppression rates, high retention rates are required. From the cohort analysis, retention in care at 12 months for adults was estimated at 83%. To further improve retention and adherence, viral suppression and the overall quality of the program, client centered approaches will be implemented, including: stigma reduction; patient literacy; implementation of PHDP interventions; age and gender appropriate support groups; targeted home visits; and timely defaulter tracing. In FY18, linkage for patients identified HIV positive will be enhanced to achieve the 90% target and robust tracing mechanisms will be put in place to draw back for those who have defaulted on treatment.

Program Area 4.12: Commodities

Kenya has a robust and well integrated supply chain system for HIV commodities. The system is coordinated by NASCOP, and KEMSA manages the logistics on behalf of all partners: the GOK, GF and PEPFAR. NASCOP as the chair of the Commodity Security Committee convenes stakeholders monthly to review the pipeline and take appropriate action. Over the years, Kenya has experienced no national stock outs of its major commodities. Kenya has a well-functioning ARV distribution system made up of ordering and satellite facilities. There have been challenges with the allocation and distribution of RTKs in the past, but this was addressed by increasing county and service delivery partners' involvement in RTK management.

PEPFAR together with NASCOP will continue to strengthen the supply chain by building the capacity of commodity security teams at the national, county and facility level to effectively oversee systems for improved quantification, pipeline monitoring and ordering, tracking and reporting of commodities. At the national level, PEPFAR will continue to support KEMSA and NASCOP to ensure optimal national forecasting, quantification, pipeline management and timely distribution. PEPFAR working with NASCOP will continue to strengthen the county-based distribution model to ensure rational use, reporting and accountability. Counties will be allocated RTK quantities based on the geographic prioritization strategy, and they will be responsible for ensuring proper utilization. In line with the devolution of health in Kenya, counties have taken a greater role in the supply chain. PEPFAR will continue to strengthen the capacity of county commodity security teams to effectively oversee supply chain management systems and eliminate facility level stock-outs. At the site level, implementing partners will coordinate closely with health facilities to bolster timely and accurate reporting, receipt and appropriate use of RTKs and

other commodities. The country will also continue to use electronic reporting tools to monitor usage and resupply so as to achieve each "90." This will ensure that there are adequate stocks in the country, and that there are no unforeseen funding gaps to address ARV requirements in FY18.

Adequate supply of VL testing commodities including VL and EID re-agents is key to achieving the third "90". PEPFAR aims to support 100% of viral load and EID commodities while enhancing the MOH's capacity for national coordination of distribution and reporting within lab networks. Rational use of VL and EID supplies will be monitored continuously through DHIS2 and the online NASCOP EID/VL website, where each user facility directly inputs their data. Through the NASCOP EID/VL website each is accounted for electronically and PEPFAR will continue to support the website since it provides timely and accurate information for VL and EID reagents.
Overall, the HIV commodity supply chain is well integrated and managed by KEMSA, providing the GOK, GF and PEPFAR better visibility on the total commodity usage and requirements, and the country has effective supply chain monitoring systems which PEPFAR will continue to support. Stock outs are not anticipated in FY18. The PEPFAR Kenya team has carefully analyzed the current commodity pipeline, expected GF and GOK resource allocations and the requested PEPFAR budget request, and the plan proposed here is adequate to support scale up.

Program Area 4.13: Collaboration, Integration and Monitoring

PEPFAR continues to strengthen its collaboration with a range of government, civil society and private sector stakeholders in Kenya, both to solicit feedback to the fiscal year program cycle and as a way to spur greater accountability of the national HIV control program. PEPFAR engages across critical fora – the MOH Advisory Committee on HIV and AIDS and Kenya Global Fund Coordination Mechanism – and convenes a PEPFAR-CSO stakeholder working group. Key engagement result areas will include better alignment and collaboration in HIV national response. Further, there will be increased participation in annual country operational planning; alignment with Global Fund activities; POART reviews; thematic technical working groups (e.g. DREAMS, PMTCT, pediatric HIV, etc.); S/APR reviews; routine monitoring; and special studies. To identify priority gaps and generate quality data, we will work alongside the GOK to improve key population size estimates. Through this engagement, PEPFAR will seek to maintain alignment with other stakeholder activities including Global Fund and address priority issues, including building consensus around national key population size estimates, assuring quality service delivery and completing KENPHIA – Kenya's cross-sectional, population-based HIV impact assessment. KENPHIA is funded by PEPFAR and is both led and implemented by the MOH. Preparation and training for KENPHIA commenced in FY17 and data collection will be initiated in FY18. Completing KENPHIA in partnership with the GOK is envisioned as an important process to validate current PLHIV estimates, evaluate HIV prevention and treatment program successes and to inform new strategies for responding to the epidemic.

Implementing partner (IP) management and monitoring will be strengthened through routine SIMS and other field visits, regular management meetings and monthly-to-quarterly performance reviews (programmatic and financial) with individual and groups of IPs. In addition, quarterly meetings will be held with all IPs to foster an environment of cross-fertilization, promote experience exchange and facilitate the sharing of innovative local solutions, and challenges. During these meetings, results will be disaggregated and discussed in quorum to effectively monitor performance across the cascade. This will allow PEPFAR to overcome barriers to achieving targets and improve impact within a short time frame. Further, PEPFAR will coordinate jointly with the GOK to monitor program performance via routine monitoring activities benchmarked with regular performance review meetings. National and county government-led meetings further serve as a venue to address policy or systems issues impeding program implementation, such as improved integration of key health system interventions and improving efficiencies of service delivery through the expansion of differentiated models of service delivery.

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

As part of COP17 planning, PEPFAR carefully considered program activities towards the 90-90-90 goals to achieve HIV epidemic control in attained and sustained locations and populations. Foundational to the planning in these geographic areas and respective populations, the technical working groups (TWG) carefully considered the partnership with GOK as well as other donors and public health actors; further, the TWGs considered the minimum package of services or interventions to be provided including quality assurance, as these areas and populations are to be primarily covered by non-PEPFAR entities. As presented in Tables 5.1.1 and 5.1.2, targets are modest relative to PEPFAR's commitment in COP17 scale up counties, but with clear impact on Kenya's HIV epidemic. Detailed description of the targets, results, and approaches to achieving targets and efficiencies are described in sections 5.2-5.10.

5.1 Targets for attained and sustained locations and populations

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Attained Support Counties*

Attained Support Volume by Group		Expected Result APR 17	Expected Result APR 18
HIV testing (all populations)	*HTS*	45,890	160,490
HIV positives (all populations)	*HTS_POS*	1,296	2,786
Treatment new	*TX_NEW*	3,112	3,307
Current on ART	*TX_CURR*	22,652	26,410
OVC	*OVC_SERV*	30,276	29,733
Key populations	*KP_PREV*	776	2,166

*Calculations for targets for clinical services should be based on maintaining 80% ART coverage levels in the Attained counties. [Current Retention + (Passive HTC_POS * Linkage)]/PLHIV = 80% ART Coverage

Table 5.1.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Counties

Sustained Support Volume by Group		Expected result APR 17	Expected result APR 18
HIV testing in PMTCT sites	*PMTCT_STAT*	59,819	52,801
HTS (only sustained ART sites in FY17)	*HTC_TST/HTS_POS*	143,457 (1,878)	192,801 (2,721)
Current on ART	*TX_CURR*	13,441	15,458
OVC	*OVC_SERV*	14,751	14,014

Program Area Summaries 5.2-5.10

5.2 Priority population prevention

The GOK HIV prevention program aims at drastically reducing new HIV infections through a population-focused combination prevention approach that takes into consideration geographical disparities, KP and priority population vulnerabilities (Kenya HIV Prevention Revolution Road Map, 2014). PEPFAR will collaborate closely with the GOK to maintain support to KP for treatment in low burden counties through procurement and distribution of HIV services commodities including ARVs, condom promotion and direct support to government for HIV programming.

5.3 Voluntary medical male circumcision (VMMC)

In compliance with 2017-2021 WHO framework for VMMC and the GOK's National VMMC Strategy, PEPFAR Kenya will support increasing MC coverage to 90% among males 15-29 of age in Nandi. Activities in this focus county will target boys in the 10-14 year old age band and achieve 80% coverage for males 15-29 years of age. In addition, PEPFAR Kenya provides central support to government-led models of VMMC service delivery including the circumcising of annual cohorts of boys as they transition to the 10-14 year age band and newborn males aged 0-60 days.

5.4 Preventing mother-to-child transmission (PMTCT)

Attained and sustained counties receive support for facility-based interventions only, where the PMTCT package will include: HTS for pregnant and breastfeeding women presenting in PEPFAR-supported high yield sites; ART for those testing HIV positive while tracking missed opportunities for identification; adherence and retention support including use of mentor mothers (peer

counselors) and case management; strategies to improve retention of the mother-infant pair, EID and linkage to ART for HIV positive infants; optimizing retesting as per revised national guidelines to identify new and sero-convertors; and the conduct of routine HEI screening at immunization clinics and pediatric (in-patient) wards with referrals for mother-infant pair follow up. The expected volume of patients in these areas was calculated based on county estimates and FY16 achievements. PEPFAR sites will receive support for QA/QI to ensure that national standards are maintained. Existing condom distribution will be maintained, however, local programs will be discontinued. Central support counties will be able to access commodities and national level quality assurance activities. However, in COP17, these services will ride on existing county government resources for health care that includes community strategy, Beyond Zero campaigns, and community outreach to optimize access and uptake of services.

In FY15, 2,803 PMTCT sites had zero positive and 14 sites with 1-4 positive, including sites transitioned during COP14. PEPFAR Kenya will support the GOK goal to eliminate MTCT (eMTCT), operationalize the revised eMTCT framework, guidelines and M&E tools while ensuring that efforts are aligned with OGAC guidance and the pivot for epidemic control. Direct service delivery will be transitioned to the GOK by the end of FY17, at which time these sites will be supported only with commodities. A site yield analysis was completed and will be reviewed alongside the results of a planned site audit in FY17; facilities with low yield may be closed based on the results of these analyses. Best practices from ongoing program learning in transitioned sites will be applied, including the best models for technical support and lab networking including inter-facility courier services. The PEPFAR inter-agency technical team will work closely with national and county governments to ensure the continuity of high quality service delivery during this transition period.

5.5 HIV testing services (HTS)

In FY14-15 PEPFAR transitioned HTS services at 2,245 sites to the GOK and will continue this in sites where yield is <5 HIV+ individuals per year (taking into consideration any RTK stock outs). PEPFAR Kenya is committed to ensuring HTS is focused at high yield sites to maximize efficiencies of high quality services. The transition of low HIV+ yield (<5 positives) to GOK will continue and facility monitoring in these sites will be provided by the GOK. The team is working closely with national and county level governments to ensure the continuity of high quality service delivery during and following this transition.

5.6 Facility and community-based care and support

In attained counties both facility and community based services will be maintained to ensure high ART coverage, high retention rates and optimal viral suppression. The package of services will include: enhanced appointment management through SMS reminders and same day patient phone calls for those who miss appointments; facility based treatment adherence and

psychosocial support for new and existing patients in care as per national guidelines; community based adherence for individuals with treatment failure; use of mobile technologies and physical tracing for defaulter tracking; and encouraging patients to return for regular appointments.

In sustained counties, a facility based package of services will be provided to ensure a high quality of care for all identified PLHIV. The service package will include: enhanced appointment management through SMS reminders and same day patient phone calls for those who miss appointments; facility based treatment adherence and psychosocial support for new and existing patients in care as per national guidelines; and facility based defaulter tracking.

5.7 TB/HIV

In both attained and sustained counties a package of quality services will be offered to ensure TB prevention, early diagnosis including DST (drug susceptibility testing), appropriate treatment and monitoring, and hence reduced morbidity and mortality among TB and TB/HIV co-infected patients. This package will include: 100% TB screening among PLHIV and GeneXpert testing for symptomatic and TPT for asymptomatic patients; universal HIV testing for all TB patients; and 100% ART uptake among TB/HIV co-infected patients. Strengthening of laboratory quality assurance and the TB surveillance system will be integrated in this package.

5.8 Adult treatment

In both attained and sustained counties adult treatment services of quality will be provided in line with the national ART guidelines. The package of services will include timely ART initiation, client centered services and routine ART monitoring. Test and Start will be optimized across all SNU with same day ART initiation for those eligible to assure optimal benefits to the patient. Client centered services will be provided for all patients including multi-month dispensing for adherent patients on treatment for >12 months and community based ART, where applicable. Sick, newly enrolled (≤12 months) and patients with high viral load (VL≥ 1000 copies) will be closely monitored at the facility with psychosocial and adherence support and management of OI's. ART monitoring will be provided as per national guidelines: at six (6) months for newly enrolled patients, annually for existing patients and targeted viral load testing for patients with virologic failure (VL≥ 1000 copies). Quality of care for adult treatment will be assessed through scheduled SIMS visits.

5.9 Pediatric Treatment

In both attained and sustained counties, quality pediatric and adolescent treatment services will be provided in line with national ART guidelines. The package of services as per national ART guidelines will include: timely ART initiation; appropriate ART dosing and regimens; child and

adolescent friendly services; routine ART monitoring; and appropriate shifts to second line. Test and Start will be optimized for children and adolescents in all SNU with same day ART initiation for those eligible to assure optimal benefits to the patient. Client centered services will be provided for all children including multi-month dispensing aligned with school holidays for well patients on treatment >12months and community based ART where applicable. Sick, newly enrolled (≤ 12months) children and adolescents as well as those with high viral load (VL≥ 1000 copies) will be closely followed up at the facility for psychosocial and adherence support, care giver treatment literacy and management of OI's. ART monitoring will be done as per guidelines: at six (6) months for newly enrolled patients; annually for existing patients; and targeted viral load testing for patients with virologic failure (VL≥ 1000 copies). Quality of care for pediatric treatment and adolescent services will be assessed through scheduled SIMS visits.

5.10 OVC

Aligned with S/GAC guidance, further reductions in the number of OVC receiving support will occur in sustained counties in FY18 to enable scale up of targets in priority counties. PEPFAR will provide technical support to selected counties and local partners to expand and replicate best OVC strategies, practices and lessons learned from current work in central support counties in preparation for future transition and graduation of OVC. Best practices will include: implementing effective case plans and processes for assessing economic vulnerabilities of target households; tools that determine households' capacity to support basic needs of their children; identifying households that require referrals to non-PEPFAR social protection and other resources; and supporting the establishment of county transition committees overseen by the GOK (Department of Children's Services). The program will build the capacity of local partners and target counties to develop costed sustainability plans and cost–effective mechanisms to monitor graduated households and ensure progress is sustained after graduation. The program will support the use of case conferencing to improve referrals among health and social service providers through improved GOK and local partner coordination.

Program Area 5.11: Establishing service packages to meet targets in attained and sustained districts

At the beginning of FY18, two (2) SNU's – Embu and Kericho - meet the criteria for attained with ≥81% ART coverage among both males and females and across priority age bands (<15 years; 15-24 years; and >25 years). These SNUs will be maintained at high ART coverage levels with ≥90% of patient viral suppression to achieve the desired impact. Passive HIV testing services will be offered to symptomatic adults, children and adolescents, confirmed or presumptive TB patients or upon request. PEPFAR will not support aggressive demand creation for prevention services in the general population. However, HIV negative prevention programs will be targeted to at risk populations based on surveillance and epidemiologic data, including a comprehensive KP package

of services including outreach, prevention, testing, care and treatment with an ultimate goal of achieving ≥81% ART coverage and ≥90% viral suppression. Surveillance and laboratory services will be strengthened in attained counties to identify high risk populations for prioritized prevention services. Case-finding and outbreak investigation methods will be used to identify any networks with on-going or new transmission in order to break the cycle of transmission. PMTCT services will include HIV testing for pregnant and breastfeeding women and provision of ART for all eligible women. Longitudinal follow-up of the mother-infant pair will be supported to ensure high HIV-free survival for HEI, linkage of all infected infants to ART and high ART retention rates for PMTCT clients. Age and gender specific retention strategies will be adopted ensure ART coverage remains ≥81% even with passive HTS and linkage. Program monitoring and quality assurance activities will be implemented to maintain high performance standards in HIV services.

In attained counties, passive HTS testing will be offered to 160,490 clients. There will be an anticipated modest (7%) increase in number current on ART from 24,773 to 26,410 (FY18) translating to an average ART coverage of 95% ART coverage in the two counties. There will be a 4% decrease in OVC served owing to the graduation and transitioning out of eligible OVC.

Based on APR16 performance, 13 sustained counties have been reviewed and categorized as follows: seven (7) are now categorized as aggressive scale up SNU; two (2) achieved attained status; and four (4) remain in the sustained category. In sustained counties, HTS will only be provided to symptomatic patients presenting in PEPFAR-supported high yield sites, presumptive TB cases as well as partners and families of HIV infected individuals, and patients requesting a test. Existing condom distribution programs will be maintained; however, promotion activities will be limited to clinical counseling settings in FY18. Services for KP, HIV prevention, STI screening and HIV care and treatment will be transitioned to the national and county governments, with a focus on health system integration for efficiency and sustainability. All PEPFAR supported sites in these areas will receive QA/QI support to ensure that national performance standards are maintained. The PMTCT package will include: HIV testing of pregnant and breastfeeding women presenting in PEPFAR supported high yield sites; ART for those identified as HIV positive; adherence and retention support including the use of mentor mothers (peer counselors); and strategies to improve retention of mother baby pair, EID and linkage to ART for HIV infected infants. Both existing and passively enrolled PLHIV will be provided a minimum package of care as per national guidelines which include: CTX prophylaxis; TB screening; IPT prophylaxis; PHDP services; fluconazole; and ART.

PEPFAR will invest modest resources in sustained counties to support passive enrolment and oversight while engaging the GOK to transition support for activities such as HRH (ongoing), training and supervision with the exception of high burden sub-counties and high volume facilities. Enrolment in these GOK national acceleration plan areas is expected to exceed 5%. PEPFAR Kenya will encourage county governments and other stakeholders to provide ongoing support in these areas.

As a result of shifts in the sustained category; program area targets have reduced. HTS testing is increased to 113,060 in the four (4) sustained counties while HTS in PMTCT will reach 52,801. Passive enrollment in PEPFAR supported ART sites are expected to yield 15,458 current on ART. PMTCT estimates are derived from the noted assumptions, while the expected current on ART was calculated using historical program data for anticipated passive enrollment and retention. Targets are summarized in table 5.1.1.

Table 5.11 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained SNU

Sustained Support Volume by Group	Expected result APR17 13 (4) sustained	Expected result APR18 (4) sustained	Percent increase (decrease)
HIV testing in PMTCT sites	**203,136 (61,915)**	**52,801**	**(15%)**
HTS (only maintenance ART sites in FY18)	**442,505**	**113,060**	**(75%)**
Current on ART	**95,119 (13,441)**	**15,458**	**15%**
OVC	**90,921 (24,054)**	**14,014**	**(42%)**

There will be no active enrollment of new children and families in PEPFAR supported OVC programs. To support currently enrolled beneficiaries, key interventions include: linkages for HIV positive children and adolescents to other HIV and social services; education support; psychosocial support for families; and close monitoring of OVC outcomes. PEPFAR will accelerate graduation and the transition of beneficiaries in order to redirect resources within scale up counties. To that end, PEPFAR will support the capacity building of local OVC partners, communities and county governments to increase local resources to social protection programs, intensify appropriate linkage and referrals to health services, and identify and graduate children and families showing progress towards reduced economic vulnerability. Consequently, the number of OVC served in sustained counties has decreased from 34,533 in COP16 to 14,014 in COP17. In the new attained SNU category, the number of OVC served has also decreased, from 30,276 in COP16 to 29,733 in COP17.

Program Area 5.12: Commodities

Kenya has a robust and well integrated national supply chain management system for HIV commodities as described in section 4.12. The supply of commodities to attained and sustained counties is coordinated by NASCOP and managed by KEMSA, and the system is demand driven nationwide. There are no commodity stock-outs anticipated in these SNU categories, and PEPFAR together with NASCOP will continue to provide technical support to attained and sustained counties to assure a seamless supply chain system for HIV commodities.

Program Area 5.13: Collaboration, Integration and Monitoring

PEPFAR continues to strengthen its collaboration with a range of government, civil society and private sector stakeholders in Kenya. In sustained and attained counties, this engagement will improve implementation and reinforce core components of the GOK's minimum/standard package of services for people living with HIV/AIDS with a focus on essential HIV treatment services and commodities. Joint stakeholder planning forums at county will be convened to strengthen current and future county HIV/AIDS responses. Key result areas include: support for annual joint county work planning and budgeting to mobilize resources for health financing; program performance monitoring to ensure new and current patients on treatment are provided ART, CTX prophylaxis and TB screening per national guidelines; and support for institutionalization of QA/QI per national standards. PEPFAR will support lab networking system to assure quality and timely HIV testing, EID, VL and CD4 testing. PEPFAR will continue working across sustained counties to support the transition and graduation of OVC beneficiaries and local partners. Individual IP management and monitoring will be strengthened through routine SIMS and other field visits, regular management meetings and monthly-to-quarterly performance reviews (programmatic and financial). In addition, quarterly meetings will be held jointly with all IP to foster an environment of cross-fertilization, promote experience exchange and facilitate the sharing of innovative local solutions. In addition, PEPFAR will build capacity of priority counties to use county HIV response monitoring systems for sustained epidemic control.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps and 6.2 Critical Systems Investments for Achieving Priority Policies

In COP16, PEPFAR Kenya identified system investments required to bolster the clinical cascade in achieving the 90-90-90 targets for sustained epidemic control. The three key programmatic and one cross-cutting gaps identified were: 1) weak commodity and logistics management; 2) limited county human resource management capacity; 3) sub-optimal use of viral load results; and 4) inadequate domestic resource mobilization at county and national levels to sustain program gains and achieve epidemic control. An interagency team conducted a thorough review to determine the three year outcomes to address system barriers and the benchmarks that required modification in light of progress made. For COP17, no system barriers changed but certain outcomes, benchmarks and commensurate activities were modified to better align with the

current context. The areas below provide a brief description on progress to date and proposed interventions to maximize PEPFAR's investment in these health systems functions.

Commodity and logistics management (Table 6.1.1): An uninterrupted supply of RTKs remains critical to achieving the first "90". In COP17, Kenya has set an ambitious testing target of 13,243,938 individuals (including PMTCT). Further, the country plans to provide treatment to 1,318,902 PLHIV and will therefore require an efficient commodity management system. With a current SID score of 4.8 (yellow), improvement efforts are underway in COP16 to transition RTK allocation and other commodities from the national to the county level, and APR16 results revealed that all counties received adequate RTKs to achieve testing targets with minimal stock-outs reported. In addition, a national supply chain assessment is underway to better understand and ameliorate all elements of the system from commodity allocation, distribution and storage to consumption and reporting. In COP17, the barriers to RTK allocation and distribution and timely commodity reporting remain unchanged for COP17 as continued investment is critical. Activities proposed include supporting a commodity management advisor at national level to enhance coordination between the national and county level, forecasting and quantification at both levels, facility level mentorship on stock management and reporting, stakeholder coordination and implementing findings from the supply chain assessment.

Human Resource Capacity (Table 6.1.2): Substantial progress was made in COP16 to: 1) expand the number of graduates in key cadres required for epidemic control; 2) strengthen training institutions' systems and capacity to deliver accredited trainings; 3) support regulatory bodies to ensure quality of HW training and performance; and 4) improve county capacity to utilize Human Resource Information System (iHRIS) data to inform HRH planning and resource mobilization as well as manage health workforce needs. New COP17 benchmarks are proposed to show continued progress in these areas and demonstrate a gradual transition from PEPFAR support to local institutions and systems. Additional actions are proposed to analyze emerging HRH issues such as task shifting under differentiated models of care, track deployment of PEPFAR-supported graduates, and uptake of institutionalized trainings and transition of PEPFAR-contracted staff to government payrolls. Weaknesses in the current HRH management systems have resulted in labor disputes at national and county level, resulting in health worker strikes that have significantly affected service delivery and further constrained health budgets. Further, as COP17 implementation will coincide with nationwide elections. Anticipated changes in county health leadership and staffing will require sensitization and capacity building for new county health teams. COP17 resources will thus continue to strengthen county HRH management systems in a bid to minimize future disruptions to service delivery.

Viral Load (Table 6.1.3): Significant progress has been made towards accessing VL with >80% of ART patients completing at least one annual VL test (APR 16). However, the turn-around time (TAT) is below 20 days in most labs and none have achieved an average of <14 days, the annual benchmark. During COP16 implementation, at least 40% of the labs will achieve this target with the implementation of remote data entry, where patient details are entered into the system at the facility instead of the testing lab. For viral suppression, Kenya is on a trajectory to reach the year

one benchmark of 85%, as program data indicates a suppression rate of 83% for year 2016 (National VL website). Timely action on detectable VL remains a key barrier; continuing to reinforce the lab-clinical interface and enhance health worker capacity will be strengthened in COP17. Interventions will include mapping VL/EID lab referral networks and related hubs, supporting lab operations, strengthening information systems and strengthening the lab-clinical interface. In addition, Kenya has excelled in utilizing information technology for VL/EID management: a national user-friendly website provides easy and real-time access to results. Ongoing work to improve the interface of this system with all existing EMRs and mobile phone technology will continue, so that the system auto-generates messages (SMS) to health workers, clinicians and patients.

Domestic Resource Mobilization (Table 6.1.4): Progress in COP16 included completion of analytics and evidence generation to inform HIV advocacy, planning and resource allocation in the 26 counties targeted for health financing support across SNU categories. As an outcome of PEPFAR-supported training and mentoring launched in COP15, targeted counties are utilizing Program Based Budgeting (PBB) to develop county plans – including a program line item for HIV – with resultant commitments to HIV equivalent to $4 million in KFY2016/17. New benchmarks are introduced in COP17 to track progress in PEPFAR-supported health financing activities, including support to the private sector (e.g., ARV financing and insurance uptake) and to national/county planning and resource allocation. Various analyses undertaken as part of the Sustainable Financing Initiative (SFI) have contributed to an increase in the national budget allocation for HIV commodities, helped to estimate resource requirements for Test and Start factored into the new funding request to Global Fund, and assisted NACC in quantifying new sources of domestic funding for HIV from social mitigation activities required under government infrastructure contracts.

6.2.1 Test and Start

In COP16, PEPFAR Kenya focused its investment in systems that strengthen the clinical cascade to achieve the 90-90-90 goals for sustained epidemic control. Three key programmatic gaps impacting the clinical cascade were: 1) Lack of policy, strategy and national guidelines on Test and Start; 2) Inadequate commodity supply and/or weak supply chain at the county, sub-county and remote lower sites; and 3) Gaps in HRH numbers and capacity to support patient literacy and adherence counselling. For COP17, system barriers did not change; however, certain outcomes, benchmarks and commensurate activities have been modified to better align with the current context. The areas below provide a brief description on progress to date and proposed interventions in COP17.

1) Lack of policy, strategy and national guidelines on Test and Start: Test and Start guidelines in Kenya were launched in July 2016, including same day initiation of treatment and

innovative service delivery models. By end of FY16, sensitization of the revised guidelines and 10 regional trainings had been conducted. The new guideline enabled immediate transition of PLHIV from pre-ART to ART enabling PEPFAR Kenya to achieve 75% of the TX_NEW FY16 annual target. Based on APR16 and FY17 Q1 results, a significant proportion of facilities are already implementing Test and Start. An assessment of select high volume facilities from sampled IPs indicates that approximately 60% of newly identified individuals are starting treatment on the same day of diagnosis. In COP16, PEPFAR is continuing to roll out the revised guidelines down to lower level facilities. Given that the COP17 treatment target is ambitious – 1,318,902 PLHIV on treatment – continued implementation of Test and Start in all PEPFAR supported sites will be crucial. COP17 proposed activities include continued countywide rollout and implementation of the revised guidelines, training/orientation in all supported facilities, and roll out and distribution of tools and SOPs.

2) Inadequate commodity supply and/or weak supply chain at the county, sub-county and remote lower sites: With the implementation of Test and Start and differentiated care models, an uninterrupted supply of ARVs at all the levels is necessary to achieve epidemic control. This requires an effective and efficient commodity management system for commodities to consistently maintain 100% availability of ARVs. PEPFAR supports national and county forecasting and quantification to estimate the level of HIV/AIDS and TB commodities needed. Proposed COP17 activities include: expanding drug availability and ARV storage capacity to hold at least three months of stock to support multi-month (e.g., 3-6) ARV scripts; support county commodity security teams to accurately estimate commodity needs; and build the capacity of pharmacy staff in commodity management.

3) Gaps in HRH numbers and capacity to support patient literacy, and adherence counselling: As part of Test and Start guidelines and differentiated care models, intensification of post-test counseling is needed to provide same day ART initiation, develop robust tracing mechanisms for defaulters and provide patients and caregivers with comprehensive treatment literacy through health education. This requires an increased number of staff, particularly lay workers at the facility and community level. Certain IPs have deployed lay workers to support linkage to treatment, adherence counselling, defaulter tracing, and treatment literacy; however, there is neither a national nor standard deployment protocol nor training package for this cadre. As this barrier remains relevant, PEPFAR Kenya will support the development of a standardized training and orientation package for lay workers by end of year one and implement the package by the end of year two.

6.2.2 ew and Efficient Service Delivery Models

In COP17, system barriers did not change but certain outcomes, benchmarks and commensurate activities were modified as Kenya introduces differentiated models of care. The areas below provide a brief description on progress to date and proposed intervention to maximize PEPFAR's investment in these systems in COP17.

1) Lack of policy to support alternative service delivery models: As part of the Test and Start guidelines, innovative service delivery models are outlined to encompass: appointment spacing (multi-month scripting); fast tracking stable patients for drug refills; community ART distribution points; formation of community ART groups; and facility or community based adherence support groups at the time of drug pick up. Medical teaching hospitals and some high volume facilities are implementing express care as a means to decongest high volume facilities and address staff shortages; however, at a national level, implementation of differentiated care models remains a new concept. Consequently, a national technical working group (TWG) was recently established to spearhead the roll out and development of tools for national dissemination. The TWG will cascade down to county level, starting with priority counties. Based on FY17Q1 reports from select IPs, a significant proportion of partners are already implementing multi-month scripting and fast tracking ART refills. It is expected that 50% and 100% of the high volume facilities will be implementing differentiated care models by the end of FY17 and FY18, respectively. In COP17, activities proposed to address this barrier include support policy framework and TWG at both the national and county levels, operationalization of innovative community-based and facility-based service delivery models, and task-shifting and broader utilization of lay health workers and peer cadres to ensure there are adequate community-facility linkages for referrals and program monitoring.

6.3 Proposed system investments outside of programmatic gaps and priority policies

The activities in Table 6.3 (Appendix C) encompass other system investments not comprised in Tables 6.1 and 6.2. It includes activity based interventions at above site and service delivery level proposed for COP17 including treatment support, strategic information, VMMC, prevention, OVC, KP, laboratory, and PMTCT. These are the activities critical to supporting the COP17 geographic prioritization strategy to sustainably control HIV. These activities bolster SID elements where scores are either yellow or red, and thus require continuous PEPFAR attention for advancement. Clear measurable and SMART outcomes and annual benchmarks were developed to monitor progress in coming years.

An interagency team conducted a thorough review of each activity based intervention both in-country and during the D.C. management meeting (DCMM). The review sought to identify duplication or ascertain whether any activities could be better represented as targets with UEs for greater accountability, such as DREAMS interventions. Decisions from the DCMM are incorporated in Table 6.3; the USD amount in Table 6.3 represents the lump sum allocated to each IM to implement the specific activity, inclusive of PM costs.

7.0 Staffing Plan

The COP17 staffing plan analysis reflects the geographic prioritization strategy and focus on impact through the identification of skill sets and technical gaps required to achieve HIV epidemic control. Agencies agreed upon a common baseline for level of effort (LOE) by program, business and administrative staff and jointly reviewed the interagency LOE analysis prior to submission.

The PEPFAR interagency leadership remains committed to streamlining or repurposing positions to meet the needs of PEPFAR's directed program impact; reviews occur as vacancies emerge due to regular staff turnover or changes in agency structure. The number (full time equivalents) of PEPFAR Kenya staff and percent of time allocated remain closely aligned to activities described in the SDS. All agencies are addressing the need to maintain coverage for business processes and intra-agency partner management through additional trainings at the inter- and intra-agency level, as well as routine sharing of best practices across agency structures. The interagency management team discussed and agreed upon all proposed positions for COP17.

Long-term Vacant Positions: All agencies with vacant positions have reviewed and updated position descriptions and job description help sheets to facilitate the re-advertisement of the position through U.S. Embassy Human Resources (HR) or USAID HR offices. Nevertheless, given the volume of work at the US Mission to Kenya—the largest U.S. presence in the region—processing HR actions typically takes more than six months to be completed prior to recruitment. Agencies have addressed this in different ways, including utilizing standardized job descriptions and other pre-classified position descriptions to expedite the placement and hiring of new staff.

Proposed New Positions: There are no new requests for staff positions by Peace Corps and the PEPFAR Coordination Office in COP17. However, a return of Peace Corps volunteers is anticipated and the State LNA PEPFAR Coordinator position recruited during COP16 is fully in position.

For CDC, four additional local hires are requested. The first is for a Senior Cooperative Agreement (CoAg) Specialist due to increased requirements to monitor partners for improved performance and the geographic pivot towards high burden counties, all of which requires additional resources. The Senior CoAg Specialist will assume additional responsibilities to train, create, and lead strategies within the team and across the division to improve CoAg management for partners, a function that is needed and desired. Two additional positions are the SEB and LAB Locally Employed Staff (LES) Deputy Branch Chief Positions to provide supervision and coordination of teams as well as to support the Branch Chief given increased requirements for partner monitoring and enhanced coordination. An LES leadership position in the branch will also assist with management. The fourth position is the Quality Improvement (QI) Advisor who is critical to achieving the Government of Kenya and PEPFAR's mutual goals towards HIV epidemic control. The QI Advisor will strengthen CDC's partnership with the MOH and the PEPFAR interagency team towards mutual goals in improving quality in health care, working across multiple technical areas, and implementing interventions according to established standards

ensuring program outcomes and impact are achieved.

In COP17, DOD proposes a 25% FTE to support the new civilian Director's time under the U.S. Army Medical Research Directorate-Kenya (USAMRD-K). This FTE will provide leadership and strategic guidance to the DOD PEFPAR program and to the interagency PEPFAR team.

USAID proposes two new positions as it repurposes the soon-to-depart TCN Clinical Sub-Team Lead. These include: 1) a local hire Pharmacist position that will manage the sizeable contract with the Kenya Medical Supplies Authority; and 2) a local hire Clinical Sub-Team Lead position to replace the TCN. USAID is still determining the best use of the existing local hire Program Management Assistant FTE. It is likely that this will be reviewed and reclassified as a local hire Prevention specialist who will focus on DREAMS and OVC programs given the expansion in this area.

APPENDIX A

SNU Prioritization

Table A.1[12]

SNU	COP 15 Prioritization	APR16 Achievement	COP 16 Prioritization	Expected Achievement by APR17	COP 17 Prioritization	COP 17 Target: (APR18)
Nairobi County	Scale up Sat	73%	Scale up Sat	80%	Scale up Sat	94%
Homa Bay	Scale up Sat	58%	Scale up Sat	70%	Scale up Sat	89%
Kisumu	Scale up Sat	64%	Scale up Sat	74%	Scale up Sat	89%
Siaya	Scale up Sat	58%	Scale up Sat	67%	Scale up Sat	89%
Migori	Scale up Sat	72%	Scale up Sat	86%	Scale up Sat	96%
Kiambu	Scale up Agg	47%	Scale up Sat	55%	Scale up Agg	60%
Mombasa	Scale up Sat	75%	Scale up Sat	86%	Scale up Sat	88%
Kakamega	Scale up Agg	70%	Scale up Agg	85%	Scale up Sat	92%
Nakuru	Scale up Agg	78%	Scale up Agg	95%	Scale up Sat	100%
Busia	Scale up Sat	78%	Scale up Sat	90%	Scale up Sat	95%
Kisii	Scale up Agg	76%	Scale up Sat	93%	Scale up Sat	97%
Machakos	Scale up Agg	66%	Scale up Sat	75%	Scale up Sat	82%
Kilifi	Scale up Agg	65%	Scale up Agg	76%	Scale up Agg	80%
Bungoma	Sustained	71%	Scale up Sat	86%	Scale up Sat	92%
Makueni	Scale up Agg	51%	Scale up Sat	60%	Scale up Sat	80%
Kitui	Sustained	60%	Scale up Sat	70%	Scale up Sat	81%
Murang'a	Scale up Agg	38%	Scale up Agg	43%	Scale up Agg	61%
Uasin Gishu	Scale up Sat	103%	Scale up Sat	118%	Scale up Sat	120%
Trans Nzoia	Sustained	50%	Scale up Sat	59%	Scale up Sat	86%
Meru	Sustained	66%	Scale up Sat	75%	Scale up Sat	85%
Nyamira	Scale up Agg	50%	Scale up Agg	63%	Scale up Sat	85%
Kwale	Sustained	31%	Scale up Agg	38%	Scale up Agg	50%
Turkana	Scale up Agg	28%	Scale up Agg	37%	Scale up Agg	60%
Kajiado	Sustained	52%	Scale up Agg	67%	Scale up Agg	80%
Vihiga	Sustained	65%	Sustained	82%	Scale up Sat	90%
Nyeri	Sustained	81%	Sustained	90%	Scale up Sat	98%
Narok	Scale up Agg	44%	Scale up Agg	58%	Scale up Agg	76%
Nyandarua	Sustained	72%	Sustained	82%	Scale up Sat	90%
Kirinyaga	Sustained	68%	Sustained	78%	Scale up Sat	85%
Nandi	Sustained	84%	Scale up Agg	96%	Scale up Agg	100%
Bomet	Scale up Agg	83%	Scale up Agg	99%	Scale up Sat	100%

[12] Source: UNAIDS 2015 PLHIV estimates and PEPFAR program data.

SNU	COP 15 Prioritization	APR16 Achievement	COP 16 Prioritization	Expected Achievement by APR17	COP 17 Prioritization	COP 17 Target: (APR18)
Tharaka Nithi	Sustained	65%	Sustained	72%	Scale up Sat	80%
Laikipia	Sustained	59%	Sustained	69%	Scale up Agg	84%
Elgeyo Marakwet	Sustained	55%	Sustained	74%	Scale up Sat	85%
Kericho	Sustained	86%	Sustained	94%	Attained	100%
Taita Taveta	Sustained	42%	Sustained	49%	Sustained	55%
Baringo	Sustained	54%	Sustained	67%	Sustained	80%
Embu	Sustained	74%	Sustained	84%	Attained	90%
West Pokot	Sustained	45%	Sustained	54%	Sustained	60%
Samburu	Sustained	37%	Sustained	46%	Sustained	55%
Mandera	Sustained Com	14%	Sustained Com	17%	Sustained Com	21%
Tana River	Sustained Com	32%	Sustained Com	39%	Sustained Com	47%
Isiolo	Sustained Com	58%	Sustained Com	63%	Sustained Com	80%
Garissa	Sustained Com	43%	Sustained Com	54%	Sustained Com	65%
Lamu	Sustained Com	49%	Sustained Com	58%	Sustained Com	67%
Marsabit	Sustained Com	50%	Sustained Com	56%	Sustained Com	66%
Wajir	Sustained Com	17%	Sustained Com	20%	Sustained Com	23%

Table A.2 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY 17)	Additional patients required for 80% ART coverage	Target current on ART (APR FY18) *TX_CURR*	Newly initiated (APR FY 18) *TX_NEW*	ART Coverage (APR 18)
Attained	27,253	24,773	0	26,410	3,307	96%
Scale up Saturation	1,214,876	952,144	0	1,106,610	228,372	91%
Scale up Aggressive	231,413	130,945	31,731	155,943	36,295	67%
Sustained	25,130	13,425	4,646	15,458	3,184	62%
Sustained Commodities	18,765	8,528	4,726	10,286	2,654	**55%**
Military Kenya	0	3,422	298	4,196	870	90%
Total	**1,517,707**	**1,133,237**	**41,402**	**1,318,902**	**274,680**	**87%**

APPENDIX B

B.1 Planned Spending in 2017

Table B.1.1 Total Funding Level		
Applied Pipeline	**New Funding**	**Total Spend**
$US 57,809,299	**$US $510,243,557**	**$US 568,052,856**

*Data included in Table B.1.1 should match FACTS Info records, and can be checked by running the "Summary of Planned Funding by Agency" report.

Table B.1.2 Resource Allocation by PEPFAR Budget Code (new funds only)

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	**$23,025,616**
HVAB	Abstinence/Be Faithful Prevention	**$4,828,802**
HVOP	Other Sexual Prevention	**$44,615,849**
IDUP	Injecting and Non-Injecting Drug Use	**$2,205,375**
HMBL	Blood Safety	**$2,500,000**
HMIN	Injection Safety	**$1,500,000**
CIRC	Male Circumcision	**18,632,471**
HVCT	Counseling and Testing	**$49,752,076**
HBHC	Adult Care and Support	**$11,648,843**
PDCS	Pediatric Care and Support	**$1,318,426**
HKID	Orphans and Vulnerable Children	**$45,887,140**
HTXS	Adult Treatment	**$169,944,311**
HTXD	ARV Drugs	**$91,496,720**
PDTX	Pediatric Treatment	**$13,603,348**
HVTB	TB/HIV Care	**$3,617,988**
HLAB	Lab	**$13,115,892**
HVSI	Strategic Information	**$26,260,000**
OHSS	Health Systems Strengthening	**$8,000,000**
HVMS	Management and Operations	**$36,100,000**
TOTAL		**$568,052,856**

*Data included in Table B.1.2 should match FACTS Info records, and can be checked by running the "Summary of Planned Funding by Budget Code" report

B.2 Resource Projections

Describe what inputs and methods were used to calculate required resources to sustain program activities in the coming implementation year. Describe data sources and adjustments made. Detail should be sufficient so an HQ reviewer can replicate the calculations.

APPENDIX C

Section 6.0 Tables: Program Support Necessary to Achieve Sustained Epidemic Control

Section 6.0 Tables have been saved as an Excel Workbook and submitted to the document library.

Section 6.0: Systems Investments

Included Activities	Excluded Activities
Human Resources for Health (HRH): Systems/Institutional Investments	
Pre-service training; in-service training systems support and institutionalization; HRH performance support/quality; HRH policy planning and management; HR assessments and information systems; other HRH activities not classified as above	N.A
Human Resources for Health (HRH): Personnel Costs for Service Delivery	
In-service training; all HRH support at sites and community across all program areas	Other site-level investments such as purchase of vehicles, equipment and furniture, construction and renovation, and site-level recurrent categories such as ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, building rental and utilities
Governance	
Technical area-specific guidelines, tools, and policy; general policy and other governance; other governance activities not classified as above	N.A
Finance	
Expenditure tracking; efficiency analysis and measurement; health financing; costing/cost modeling; other health financing activities not classified as above	N.A
Systems Development	
Supply chain systems; health information systems (HIS); laboratory strengthening; other systems development activities not classified above	ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, freight for transport of commodities to sites and other supply chain costs incurred at the site-level
Institutional and Organizational Development	
Civil society and non-governmental organizations (NGOs); government institutions; social welfare	N.A

systems strengthening; other institutional and organizational activities not classified above	
Strategic Information	
Monitoring and evaluation; surveys; operations research; geographic mapping, spatial data, and geospatial tools; surveillance; other strategic information activities not classified above	N.A
Laboratory	
Quality management and biosafety systems; implementation and evaluation of diagnostics (POC and VL monitoring); laboratory information and data management systems; laboratory workforce; quality management system; sample referral systems; accreditations; technical assistance to assure or improve quality of laboratory services	Vehicles, equipment and furniture, construction and renovation for site labs, and recurrent categories from site labs such as lab reagents an supplies, travel and transport, building rental and utilities will not be included

Appendix C: Table 6.1 Programmatic Gaps

Table 6.1.1 Key Programmatic Gap #1: Weak supply chain commodity and logistic management

Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
1. Non-alignment of HIV Rapid Test Kits (RTKs) distribution to Kenya pivot	National commodity allocation committee using projected RTKs allocation and data for **100% of PEPFAR supported** sites .	~~**100%** RTK allocations released to counties and facilities based on estimated data~~	~~**100% achieved RTK allocations released to counties and facilities based on estimated data**~~	% of PEPFAR supported sites allocated RTKs as per COP target based on results of national supply chain assessment	**1. Support a laboratory commodity management advisor to work with county and sub-county logisticians and the national level to closely monitor and track lab commodities through all supply pipelines from procurement , allocation to use.**	OHSS	$137,000	UMB (17950)	Element: Commodity security and supply chain (4.86)

	100% of counties have county-level distribution systems established to support quarterly distribution of	25% of counties have functional RTK distribution system to facilities	**60%** of counties have functional RTK distribution system to facilities	SIMS Facility module Supply Chain Reliability CEE results. National program reports.	1. Improve timely distribution of RTKs 2. Strengthen lab commodity security from national to county levels 3. **Support county and sub-county laboratory coordinators to provide facility-based mentorship on laboratory commodity management.**				8.1.-8.6: Commodity security and supply chain (4.86)
						HLAB	$150,000	UMB (17950)	
2. Lack of timely and/or complete reporting by facilities.	**100%** of facilities and counties submitting timely **and accurate** commodity reports ~~requests quarterly~~ to the	**90% of facilities and counties submitting timely and accurate commodity reports to the national commodity allocation committee**	**100% of facilities and counties submitting timely and accurate commodity reports to the national commodity allocation**	**Percentage of facilities and counties submitting timely and accurate results as reported in HCMP, DHIS**	1. Support quantification ,forecasting and reporting ,centrally and at facility level**. 2. Facility level dissemination of tools, mentorship on use of**	**HLAB**	**$148,000**	**UMB (17950);**	*Laboratory Score 2.08*
							$289,000	**GIS (17954);**	
							$80,000	**AMREF (17947);**	

	national commodity allocation committee		**committee**		**tools, linking LMIS and LIMS 3. streamline reporting systems, TA on forecasting and quantification**		**$79,000**	**FHI 360 (17951)**	
							$4,000	**EGPAF**	

3. Weak commodities management capacity to ensure availability of quality HIV/AIDS commodities in response to the pivot	~~Evidence-based strategic and operational plan that responds to HIV program supply chain system strengthening assessment by the end of YR 3~~ **Strengthened sustainable and efficient national pharmaceutical supply chain systems.**	**Assessment to identify gaps and support interventions in the supply chain and commodity management systems in focus counties. This will assess quantification, ordering, storage, inventory management, commodity information systems, and patient safety measures, differentiated by type of commodity where possible, including HIV laboratory commodities.**	**Develop a flexible, tailor-made package of support for county and facility levels that can be replicated and scaled up to other counties and sub-counties**	**Percentage of health facilities within the focus counties that submit timely and accurate information into DHIS2 on commodity utilization reporting rate** **Percentage of HIV commodities stocked according to set stock management parameters /plan to avoid overstocking and expiration while ensuring availability**	**Implement the package of supply chain services in selected sub-counties** **Routine commodity audits a/o end use verification to establish and respond to gaps** **Establish and build oversight capacity of commodity working groups at county and sub-county level for strengthened coordination of HIV program commodity management in focus**	OHSS HLAB	$895,000 $150,000	Kenya Supply Chain Systems Strengthening (KSCSS) - 18281 APHIAPlus-HCM (13868)	Commodity Security and Supply Chain Score: 4.86

				in health facilities. **Number of commodity management supportive supervision visits undertaken by the county commodity TWG**	**counties**				
Sub-Total							**$1,862,000**		

Table 6.1.2 Key Programmatic Gap #2: Low county health system capacity to meet the needs for scale up, transition and a sustained response									
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP/ ROP16) Annual Benchmark**	**Year Two (COP/ ROP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP/ROP 2017 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Implementing Mechanism**	**Relevant SID Element and Score (if applicable)**

1. Insufficient numbers of skilled health workers to support treatment scale up	1. Pre-service training institutions increase graduates of critical cadres required for epidemic control by ~~5%~~ graduating at least 900 PEPFAR supported students every year for next three years	**At least ~~5%~~ least 900 students who have benefited from PEPFAR support graduated from training collages. (the number is based on the historical data and anticipated number of graduates that are PEPFAR supported)** **- currently we have 1107 PEPFAR-supported graduates with COP 15 support for cadres relevant to HIV 90-90-90 strategy (*expected for COP 16 1163 PEPFAR supported graduates*)**	**At least ~~5%~~ 900 students who have benefited from PEPFAR support graduated from training colleges.**	**Number of PEPFAR-supported graduates available for deployment in the high burden counties to meet the PEPFAR 90-90-90 strategy.** **POART call issue: deployment of graduates for HIV service delivery**	Facilitate access to pre-service training through - Tuition fees support - Epidemiologist Fellowship Programs Pre-service faculty development Curriculum review, accreditation and dissemination Training content conversion to online modules **Track deployment in high burden areas**	OHSS HTXS OHSS OHSS	$850,000 $300,000 $850,000 $320,000	HRH Kenya (17709) University of Nairobi (16670) MoH (13061)	Human Resources for Health: 6.50

	2. Increase the ~~proportion~~ number of training institutions offering in-service trainings by 4 institutions every year for the next three years	Increased number of training institutions accredited to provide in-service trainings **by ~~5%~~ 4 form the current 16 which were in place by end of COP 15.** **(The current IMs target based on available resources is addition of 4 per year)** **Regulatory bodies supported to accredit institutions providing HIV/related in-service training** **In-service training data system rolled out in to all PEPFAR supported accredited training institutions to track HIV/AIDs related trainings and link to CDP points**	**Continue supporting** training institutions accredited to provide PEPFAR supported in-service trainings **In-service training data system rolled out in all PEPFAR supported training institutions to track HIV/AIDs related trainings and link to CDP points**	**No. of institutions supported by PEPFAR to offer accredited in-service trainings** **No. of in-service trainings conducted in the training institutions** **No. of IMS utilizing accredited institutions and data tracking system**	~~Expand support to the additional~~ **Continue supporting training** institutions to offer PEPFAR supported in-service training through institutional capacity assessment, strategic/ action plan development, capacity development for institutionalization, implementation and transition of activities to the supported institution. Support accreditation of training	OHSS HTXS	$250,000 $200,000	HRH Kenya (17709)	

					institutions to provide approved in-service courses Support use of HRIS train system to track PEPFAR supported HIV training and link the same to regulatory boards for CPD **Monitor IP use of in-service trainings at accredited institutions**				

	3. Support at least 20 county health management teams using evidence-based approaches and HRIS for workforce planning & budgeting, attraction and retention by the end of YR 3	**20 County HRH units established (Each Unit comprised of County HRH manager, County Executive officer of Health, Employee representative, County Finance manager, County health board representative and others as may be co-opted from time to time) HRIS installation and use supported in 20 counties108 HR Managers trained3 HRH mgmt courses developed with Institute for HR Development3 HRH coordination meetings supported for each of the 9 county clusters**	**Functioning County HRH units post-election 20(Functional Unit has full members in place, meet regularly, plans of action in place and tracked)Continue strengthening HRIS data use in 20 counties**	**No. counties with functioning HRH units/HRH managersNo. counties with improved budgetary allocations for HRH**	Review HRH management gaps in remaining priority countiesStrengthen HRH management skills for 20 county health teams Support 20 counties to rationalize workforce and budget allocation for HIV/AIDs related HRH	OHSS	$1,700,000	HRH Kenya 17709	

	4. Engage up to eight regulatory boards to strengthen their regulatory systems to ensure quality training and performance of health professionals over the next three years.	**Regulatory functions strengthened to ensure quality of care** **Coordination function improved to ensure uniformity in course accreditation and CDP** **Regulatory data system and regulatory guidelines developed to ensure quality of training and performance**	**Regulatory functions strengthened at the county level to ensure quality of care** **Coordination function improved national to county level to ensure uniformity in course accreditation and CDP** **Regulatory data system and regulatory guidelines developed to ensure quality of training and performance**	**No. regulatory bodies with guidelines developed and disseminated** **No. of critical regulatory functions in priority regulatory boards transitioned as per the Matrix plans** **Utilization of regulatory data systems for decision making by the various stake holders namely GoK, Regulatory bodies, developme**	Continue supporting use of CPD systems (HRH-Train) to track in-service trainings for CPD and re-licensure by key regulatory bodies. Continue to support the 8 regulatory bodies to ensure quality of training and service delivery	OHSS OHSS	$250,000 $595,000	HRH Kenya (17709) Palladium-Emory (13179)	

				nt partners and regulatory bodies					

	5. Support County Health Teams to ensure clinical staff numbers are rationalized, deployed according to planned targets, and retained in appropriate sites. **Support task shifting interventions to ensure higher access of PEPFAR supported services**	**Clinical staff numbers rationalized and deployed aligning to county planned targets by skilled county health teams**	**20 counties supported to meet identified HRH gaps** **Sensitization of MCAs in 20 counties on HRH resource needs**	**HRH assessments report County HRH reports** **Staffing gaps in PEPFAR priority counties** **No. PEPFAR staff transitioned to County payroll**	Ensure implementation of MoH - Donor Supported Contracting Guidelines. Track progress with HRH contracting and transitioning across all USG agencies. Conduct HRH analyses to address key workforce gaps, assess strategies for attraction and retention, trends and emerging issues i.e. task shifting related to differentiated models of care	OHSS HTXS	$270,000 $200,000	HRH Kenya 17709	

					Support community level health workforce for HIV/AIDs guidelines development .				

2. Inadequate domestic resource mobilization (DRM) to sustain program gains and epidemic control in the absence of donor financing	1.- ~~Increased participation of private sector i.e. increased commercial sector participation in provision of ARVs, above current baseline~~ **100,000 PLHIV accessing ARVs in the private sector by the end of YR 3**	**Assessment is on-going; findings to inform activities and benchmarks for PLHIV able to access ARVs in the private sector:Detailed description of private sector supply chain models, including price, place, product, promotion and quality; and private sector role in procurement, supply chain, service delivery, financing/insurance Identification/prioritization of key success factors and critical hurdles for private sector to provide these offerings**	**Total number of PLHIV accessing ARVs through private sector (increased from baseline)**	**Total number of PLHIV accessing ARVs through private sector**	Activities to strengthen private sector engagement in health financing and provision of ARVs informed by assessment	Sustainable Financing Initiative (SFI) Funded	Funding TBD	KSCSS 18281	Financial/ Expenditure Data Score: 4.17DRM: 5.28

	2. Budget line retained for HIV commodities at current level of $20M or greater in national budget each year	**Budget line for HIV commodities retained at $22M in national budget allocation for Kenya fiscal year 2016/17** **Budget execution for HIV commodities line item = 70%**	**Budget line retained for HIV commodities at $25M in national budget allocation for Kenya fiscal year 2017/18** **Budget execution for HIV commodities line item = 100%**	**Total allocation for HIV commodities in national budget** **Budget execution level**	High level advocacy for increased allocations to health and HIV in national budget Ensure timeliness and transparency in procurement planning and financial reporting to influence budget execution Monitor trends in domestic financing. Support NACC and NASCOP to generate evidence to inform domestic resource mobilization	SFI Funded	Funding TBD	Health Policy Plus 7139	

					(e.g. cost effective differential models of care, health/non-health sources of domestic financing, actuarial analysis)				
	3. ~~10 percent of ARVs for members~~ HIV services for PLHIV paid by **National Health Insurance Fund and/or private**	**PLHIV accessing their services via health insurance schemes (baseline TBD)**	**Increased numbers of PLHIV accessing their services via health insurance schemes**	**Total number of PLHIV accessing HIV services through NHIF and/or private sector**	Implement priorities from analyses of HIV in benefit package to be paid by NHIF Link to private sector work as above.	OHSS Co-funded by SFI	$200,000 Funding TBD	Health Policy Plus 7139	

	health insurance by the end of YR 3								
	4. Average county budget allocations to health and HIV increased or retained at current levels of 21.5% across **26 targeted counties** ~~at least 22 county budgets~~ by the end of year three	**Average county budget allocation to health as percent of total county budget is 26% across 26 targeted counties**	**Average county health budget allocation as percent of total county budget is greater than or equal to 2016 level**	**Average county health budget allocation as a percent of total county budget across 26 counties**	1. Analytics to inform health and HIV resource allocation at county level 2. County budget analysis, updated county health accounts, expenditure tracking 3. **Monitoring free maternity services for uptake of PMTCT and other HIV services** 4. Facilitate stakeholder coordination and inter-	OHSS	$400,000	Health Policy Plus 7139	

					county/inter-governmental policy dialogue on health and HIV financing				
	5. Demonstrated county capacity in- ~~at least 22~~ **26 counties** to undertake program based budgeting resulting in improved health and HIV resource allocation by the end of YR 3	**$4M allocated to HIV/AIDS across 26 focus county health budgets** **26 counties assisted to produce sector reports (incl. HIV requirements) to inform Treasury allocations to health**	**$6 M allocated to HIV/AIDS across 26 focus county health budgets** **26 counties assisted to produce sector reports to inform Treasury allocations to health**	**Total allocated to HIV/AIDs (as a program line item for HIV/AIDS) across 26 focus county health budgets**	Capacity building and mentoring County governments in Program Based Budgeting: - 12 initial SFI counties - 14 additional counties **Expand advocacy capacity of members of County Assemblies; influence performance**	OHSS Co-funded by SFI	$600,000 Funding TBD	Health Policy Plus 7139	

					of budget execution **Special emphasis on financing and transition issues in 6 'deep dive' counties (SFI only)**				
Sub-Total							**$6,985,000**		

Table 6.1.3 Key Programmatic Gap #3: Low access to viral load results and low suppression rates									
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP/ ROP16) Annual Benchmark**	**Year Two (COP/ ROP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP/ROP 2017 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Implementing Mechanism**	**Relevant SID Element and Score (if applicable)**
1. Low access	**1. 100% of**	~~YR 1 : 70%~~	~~YR 2: 90%,~~	**Number of**	~~1. Hire~~	HLAB	$3,028,73	UMB	Laboratory

to Viral Load with long turn-around time	**HIV patients on ART have at least one VL result per year**	**90% of HIV patients on ART have at least one VL result per year 80% of all ART sites networked to a VL lab directly or through a hub**	~~YR 3:100%~~ **100% of HIV patients on ART have at least one VL result per year 100% of all ART sites networked to a VL lab directly or through a hub**	**HIV patients on ART have at least one VL result per year as documented in Facility registers LIS, EMR , DHIS2, MER2.0 and DATIM (TX_Viral) Percent of ART sites reported in national VL website**	~~laboratory supply chain advisor at national level~~ 1. Support VL/EID lab operations, quality assurance, M$E and infrastructure improvement 2. support HRH including lab techs, data clerks and IT staff 3. strengthen and increase VL hubs		9	(17950)($1,633,537) DOD-TBD ($200,000) AMPATHPlus (14012)-VL-$422,686; APHIA-PlusPwani (17719) $200,127; CLSI-$75,000; TBD-DOD-SRV-(18491)-$464389; KEMSA-$33,000	Score 2.08
	2. 100% of the VL testing laboratories have a TAT of at most 14 days	40% of the VL testing laboratories have a TAT of at most 14 days	~~• YR 2: 70%~~ 80% of the VL testing laboratories have a TAT of at most 14 days	Percent of VL labs with an average TAT of at most 14 days as documented in the national VL website	1. Strengthen and improve coordination of sample referral networks through mapping of facilities and labs	HLAB, HTXS	$463,137	APHIAPlus HCM (13868)-$126,470; UMB (17950)-$16,667	

					2. Implementation of remote logging of patient information at VL hubs 3. Continue strengthening the use of LIS for lab management, commodity management and return of results			APHL (9110)- $100,000; Clinical IPS- $220,000	
2. Low HRH capacity in VL use and interpretation	**100% of eligible ART patients have a VL within the last one year**	90% of eligible ART patients have a VL within last one year	100% of eligible ART patients have a VL within last one year	Percent of eligible ART patients with VL within last one year as reported in DATIM, SIMS (ART monitoring indicator)	1.Develop job aids and provide ongoing clinical mentorship in utilization of VL results	HTXS, PDTXS, HLAB	$435,251	PEPFAR Clinical IMs- $100,000	Service Delivery Score 4.21
					2. Strengthen the lab/clinical interface in sample management and access to results			UMB (17950)- $69,104; FHI (17951)- $47,069; GIS (17954)- $135,269; AMREF (17947)- $44,017; EGPAF- $3,416; TBD-	

								DOD-SRV (18491)- $9,375	
	90% of ART patients virally suppressed	85% of ART patients virally suppressed	90% of ART patients virally suppressed	1. Per cent of ART patients that are virally suppressed as reported in DATIM TX_Undetect, VL Website; 2. Percent of patients transitioning from 1st line to 2nd line treatment from program data	1. Develop job aids and provide ongoing clinical mentorship in utilization of VL results. 2. **Clinical alert for detectable viral loads in facilities with EMR. Establish a regional clinical mentorship hub using the ECHO platform**	HTXS, PDTXS,	$425,000	ICAP-NTRH , PEPFAR Clinical IMs	HRH Score 6.5
	Patients with a second confirmed detectable VL are switched to second line	Patients with a second confirmed detectable VL are switched to second line regimen within 30 days as per the treatment guidelines	Patients with a second confirmed detectable VL are switched to second line regimen	Routine review of VL register and patient records	1. Register all patients with high VL for more intensive follow-up particularly for key populations,	HTXS, PDTX, PDCS, HBHC, HLAB	(These activities will be covered under $436,375 amount)	PEPFAR Care and Treatment IMs	Service Delivery Score 4.21

	regimen within 14 days as per the treatment guidelines		within 21 days as per the treatment guidelines		infants, and pregnant women 2. **Clinical alert for high VL in facilities with EMR and flagging of high VL in the VL register with active notification to the clinician 3. Designating a VL champion at facility level.**				
Sub-optimal utilization of information technology	~~100% of VL labs use LIS for relaying on results~~	~~70 % of VL labs use LIS for relaying on results~~	~~100% of VL labs use LIS for relaying on results~~	~~VL/EID Website, EMR~~	~~1. Support utilization of Laboratory Information System for relay of results **by linking with existing VL website**~~	~~HTXS, PDTXS, HLAB~~	~~$0~~	~~17950 UMB, PEPFAR care and Treatment Ims~~	~~Epidemiological and Health Data Score 5.36~~
	~~100% of VL labs use LIS for commodity management~~	~~25% of VL labs use LIS for commodity management~~	~~50 % of VL labs use LIS for commodity management~~	~~Percent of VL labs using LIS for commodity management~~	~~Upgrade the LIS to include logistics management function **and linking with existing LMIS**~~	~~HTXS~~ HLAB	$0	~~APHL~~	~~Epidemiological and Health Data Score 5.36~~

					~~for accurate VL commodity tracking~~				
	Improved clinical decision making through utilization of VL within 2 week of receipt by clinician by the end of YR 3	**Action by clinician within 30 days of receipt of VL results**	Action by clinician within 21 days of receipt of VL results	File review and VL Service Quality Assessment	**1. Improve utilization of electronic medical records for timely VL results and outcomes to patients through API to link VL website with EMRs**	HTXS, PDTX	$200,000	PEPFAR Care and Treatment IMs	Epidemiological and Health Data Score 5.36
Sub-Total							**$4,552,127**		
TOTAL TABLE 6.1							**$13,399,127**		

Appendix C Table 6.2. Policy Gaps

Table 6.2.1: Test and START									
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP/ ROP16) Annual Benchmark**	**Year Two (COP/ ROP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP/ROP 2017 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Implementing Mechanism**	**Relevant SID Element and Score (if applicable)**
1. Lack of policy, strategy and national guidelines on "Test and START"	1. Test and START national strategy and guidelines adopted by end of YR 1	~~Achieved (Test and start guidelines and implementation of differentiated care models Launched before end of Yr. 1)~~	Continued Implementation of Test and Start guidelines	~~2016 ART guidelines developed, Launched and Rolled out~~	~~Support MOH to develop Test and START policy and guidelines Collaborate with MOH to roll-out the implementation of Test and START guideline focusing on five highest burden and scale up counties initiated by July 2016~~	HTXS HTXD PDTX PDCS	$0 (activity completed)	18213 MOH, 13346 WHO PEPFAR IMs in Care and Treatment	Policies and Governance Score 6.66
	2. Completed roll out of the revised guidelines through trainings and orientation by end of year 1	Completed roll out of the revised guidelines through trainings and orientation by end of year1	Continued implementation of Test and Start guidelines	Number of facilities offering Test and Start	**Continued countywide rollout and implementation of Test and Start guidelines (same day initiation of**		$2,120,000		

					treatment). Training of TOTs and 10 regional trainings in high volume sites completed. PEPFAR IMs to continue offering orientation and training on the new guidelines to staff at lower level facilities				
	3. Roll out and distribution of Tools and SOPs supporting Test and Start	All PEPFAR supported facilities to have Tools on Test and Start by Year 1	Continued implementation of Test and Start guidelines	SIMS (Availability of tools and SOPs supporting Test and Start)	**Continued distribution of tools and SOPs supporting Test and Start policy**		*$50,000*		
2. Inadequate commodity supply and/or weak supply chain at the county, sub-county and remote lower sites	100% availability of ARVs to support Test and Start across all levels	100% availability of ARVs to support Test and Start and differentiated care models across all levels	100% availability of ARVs to support Test and Start and differentiated care models across all levels	National 1 pager generated monthly from the facility ARV consumption reports	**1. Expand drug availability through mentorship at national, county and sub-counties on ARV and other drug inventory reporting, including**	HTXD HTXS PDTX PDCS	*$1,000,000*	18213 (MOH) 13701 (KEMSA)	Commodity Security and Supply Chain Score: 4.86

					ordering				
					2. Support national Forecasting and Quantification exercise at national and county levels to ensure accurate commodity estimation (through the County Commodity Security Teams).			18213 (MOH) 13701 (KEMSA) and PEPFAR Care and Treatment Partners	
					3. Continued orientation and capacity building of pharmacy staff in commodity management.			13061 & 18213 (MOH) 13701 (KEMSA)and PEPFAR Care and Treatment Partners	
	~~Increase ARV storage capacity in sub-county and lower level ART sites to hold~~	~~Lower level facilities holding one month (1 month)~~	~~Lower level facilities holding 3 months of stock and~~	~~Number of sub county and lower levels facilities~~	~~1.Identify alternative storage models from the county to sub~~	-	~~*$2,000,000*~~	~~*3061 & 18213 (MOH) 13701 (KEMSA)*~~	

	~~at least 3 months stock depending on the level of facility~~	~~stock of ARVs~~	~~ordering sites holding at least 6 months of stock~~	~~with 3-6 months stocks level~~	~~county levels to support 3-6 month scripting/ARV refill . 2. Support minor renovations to improve storage of ARVS~~			~~*PEPFAR IMs in Care and Treatment*~~	
3. Gaps in HRH numbers and capacity to support patient literacy, and adherence counselling	**1. Develop standard package for deployment, training and orientation of Lay workers**	**Standardized package for training and orientation of Lay workers developed by end of Year 1**	**Package for training and orientation of lay workers developed and fully rolled out by end of Year 2**	**Availability of standard package for providing training and orientation to lay workers**	1. Work with MOH to standardize training and orientation package for lay workers, building on the Community strategy Training package **2. Ensure adequate HRH to support test and start and implementation of differentiated care models. This includes: Peer counselors, expert patients, data officers,**	HTXD, HTXS, PDTX	$100,000	18213 (MOH) and PEPFAR IMs in Care and Treatment	Service Delivery Score: 4.21

					linkage & tracing officers, Clinicians and nurses.				
	2. All the non clinical cadres (lay workers) receive a standard package of training/orientation on linkage, adherence, viral suppression and retention.	At least 60 % lay workers trained/ oriented	100% lay workers trained and oriented	Number of lay workers trained/ oriented.	Build capacity of non clinical cadres on linkage, adherence, viral suppression and retention and the community based model of care.				
Sub Total							**$3,270,000**		
Table 6.2.2: New and efficient service delivery models									
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP/ ROP16) Annual Benchmark**	**Year Two (COP/ ROP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP/ROP 2017 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Implementing Mechanism**	**Relevant SID Element and Score (if applicable)**

1. Lack of policy to support alternative service delivery models	~~National differentiated service delivery models accepted by MOH through revised policies by the end of YR 3~~	~~Achieved (Test and start guidelines and implementation of differentiated care models Launched before end of Yr. 1)~~	~~Achieved (Test and start guidelines and implementation of differentiated care models Launched before end of Yr. 1)~~	~~Availability of Revised Guidelines in all the facilities~~	~~1. Provide technical assistance to MOH to develop and implement differentiated service delivery approaches building on evidence-based models such as SEARCH and other promising facility and community approaches. Certain models will be included in the GOK's Test and START guidelines.~~	~~*HTXS HBHC PDTX*~~	*$0*	18213 (MOH) PEPFAR IMs in Care & Treatment	Policies and Governance Score: 6.66
	1. Differentiated Care TWGs formed and in operation at national and county level (starting with priority counties)	**Differentiated Care TWGs formed and in operation at national and county level by end of Year 1**	**County level TWGs in operation**	**Number of Differentiated care TWGs formulated and in operation**	**Support policy Framework for operationalization of Differentiated care models TWG at both the national and county levels (Priority counties).**	HTXS HBHC PDTX PDCS	*$50,000*		

	2. PEPFAR supported facilities implementing efficient service delivery models	**50% of the high volume facilities implementing at least 2 models of differentiated care**	**100% of high volume facilities implementing at least 2 models of differentiated care**	**Number of facilities implementing at least 2 differentiated care models (SIMS)**	**Operationalization of community-based and facility-based new, innovative and efficient models of service delivery (Multi month scripting, express care, community ART distribution points e.g. dispensaries, formation of community ART groups etc.)**		$1,675,696		
					Task-shifting and broader utilization of community health workers cadre and peers to ensure there's adequate linkage between facility and community in				

					terms of data capture and referral systems				
	3. Differentiated care models tools developed, disseminated and in use in priority counties.	Development of differentiated care model tools developed by MOH through the TWG	Dissemination and sensitization on the differentiated care tools	M & E Tools for differentiated care available at county and facility level (SIMS)	Support development and dissemination of tools for monitoring and evaluation; ART distribution forms, fast track forms , registers etc.				
~~2. Lack of supporting evidence for successful, cost-efficient approaches in Kenya~~	~~At least one PHE conducted to demonstrate evidence-based quality and cost-efficient service delivery approaches by FY 19~~	~~*baseline data collected*~~	~~PHE demonstrating evidence based quality and cost efficient service delivery approaches, conducted~~	~~Studies and operational research on the success and efficiency of differentiated care Models~~	1. Conduct expanded monitoring against routine indicators for determining practical service delivery models in collaboration with IMs and NASCOP ~~2. Proposed PHE on effectiveness and cost effectiveness of differentiated~~		0	18213 (MOH) PEPFAR IMs in Care & Treatment	Epidemiological and Health Data Score: 5.36 Service Delivery Score: 4.21

					~~care models~~				
Sub-Total							**$1,725,696**		
TOTAL TABLE 6.2							**$4,995,696**		

Appendix C: Table 6.3: Other Proposed Systems Investments

Table 6.3 Other Proposed Systems Investments									
System Barrier	For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.	Outcomes expected after 3 years of investment	Year One (COP/ROP16) Annual Benchmark	Year Two (COP/ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Inst & Org Development									

Kenya Prisons – capacity development: **lack of organizational capacity , and strategic program management to implement high quality, evidence-based HIV services**	**1. Support sustained epidemic control through following activities: Train Leadership in financial management , and USG grant management to increase Human and financial resources for HIV/AIDS Management** **2. Mentor, train Program management staff in program management capacity**	**1. 75% of the HIV/AIDS Project's Human resources and 55% of financial resources are directly managed by the Kenya Prisons** **2. 100% of Program staff have program management capacity to plan, expend and report on program funds in a timely and accountable manner impact of system development evidenced by**	**45% of Kenya Prison services institutional capacity strengthened to increase coverage of HIV treatment and prevention services from 23 to 27 counties** **50% of program staff trained in comprehensive management of HIV and TB service** **50% of leadership trained in financial management and in USG grant**	**60% of Kenya Prison services institutional capacity strengthened to increase coverage of HIV treatment and prevention services from 23 to 27 counties** **65% of program staff trained in comprehensive management of HIV and TB service** **50% of leadership trained in financial management and in USG grant management** **Transition of 90% HIV &TB services delivery programs to Kenya Prison National and County structures.**	**Proportion of HIV and TB Services delivery transitioned to Kenya Prison National and County structures.** **Number of leadership and program staff trained in strategic management of HIV &Tb services.** **Number of ACUs established by the end of year 3 .**	OHSS	$160,000	Health Strat 16687	6.66 (Policies and governance)

	to plan, expend and report on program funds in a timely and accountable manner by year 5 of the Project **3. Establish eight regional Sub-ACU structures aligned to County and prisons governance structures, including establishment of strong, transparent financial management system**	**improved clinical management of patients with positive effects such as increased VL suppression among prisoners from 85% to 90%**	**management** **Transition of 75% HIV & TB services programs to Kenya Prison National and County structures.**						

	(All three 90s)								

Kenya Disciplined Services (ZUIA) **lack of organizational capacity , and strategic program management to implement high quality, evidence-based HIV services**	**1. Support sustained epidemic control through following activities: Train Leadership in financial management , and USG grant management to increase Human and financial resources for HIV/AIDS Management** **2. Mentor, train Program management staff in program management capacity**	**75% of the HIV/AIDS Project's Human resources and 55% financial resources are directly managed by the Kenya Disciplined services** **100% of Program staff have program management capacity to plan, expend and report on program funds in a timely and accountable manner by year 5 of the Project** **70% of**	**45% of Uniformed services institutional capacity strengthened to increase coverage of HIV treatment and prevention services from 23 to 27 counties** **50% of program staff trained in comprehensive management of HIV and TB service** **50% of leadership trained in financial management and in USG grant manageme**	**60% of Uniformed services institutional capacity strengthened to increase coverage of HIV treatment and prevention services from 23 to 27 counties** **65% of program staff trained in comprehensive management of HIV and TB service** **50% of leadership trained in financial management and in USG grant management** **Transition of 90% HIV &TB services delivery programs to Uniformed services National and County structures. Transition of 90% HIV & TB services delivery programs**	**Proportion of HIV and TB Services delivery program management transitioned to Kenya Disciplined Services National and County structures.** **Number of leadership and program staff trained in strategic management of HIV &Tb services .** **Number of ACUs established by the end of year 3.** **Evidence of Accreditation of**	OHSS	$190,000	Kenya Disciplined Services: EGPAF ZUIA - 16684	6.66 (Policies and governance)

	to plan, expend and report on program funds in a timely and accountable manner by year 5 of the Project 3. Establish eight regional Sub-ACU structures aligned to County Disciplined services governance structures, including establishment of strong, transparent financial management system	Uniformed services institutional capacity strengthened to increase coverage of HIV treatment and prevention services from 23 to 27 counties Establishment of eight regional Sub-ACU structures aligned to County Disciplined services governance structures, including establishment of strong, transparent financial	nt Transition of 75% HIV & TB services programs to Kenya Disciplined services National and County structures. Monthly financial reviews related to transition of project management responsibilities to Disciplined services program staff to support implementation are conducted		National ACUs obtained by the National Youth Service and Kenya Forestry service by NACC				

	(All three 90s)	**management system** **Impact of system development is evidenced by improved clinical management of patients with positive effects such as Increased viral load suppression among uniformed officers and family members from 80% to >90% by 2018** **75% of program personnel Trained, mentored and**							

		provided with continuous technical support to implement high quality, evidence-based HIV services Accreditation of National ACUs for National Youth Service and Kenya Forestry service by NACC Training, mentorship and continuous technical support to program personnel to implement high quality, evidence-							

		based HIV services Provide monthly financial reviews with related transition of project management responsibilities to Prisons program staff to support implementation							
Inst & Org Sub-Total							**$350,000**		
Laboratory									

1. Weak quality assurance program to support massive HIV testing to achieve the first "90"	**1. Implement RT-CQI through increased production and distribution of HIV PT panels to HIV testers (First "90")**	**100% of HIV testers are enrolled, participate in PT program and achieve at least 90% satisfactory results**	**80% of HIV testers are enrolled, participate in PT program and achieve at least 90% satisfactory results**	**90% of HIV testers are enrolled, participate in PT program and achieve at least 90% satisfactory results**	**Proportion of HIV testers are enrolled, participate in PT program and achieve at least 90% satisfactory results as reported in program reports, facility SIMS-HTS quality assurance and DATIM-PTCQI indicator**	**HLAB/OHSS**	**$1,044,000**	**AMREF-$755,000; APHL (9110) - $279,000; MoH (18213) - $10,000**	Laboratory Score 2.08
	2. Support staff/quality corps, county sensitization, refresher training of testers, results management through a web portal and SMS and assessment of HTS sites (First "90")						**$1,625,113**	AMREF (17947)-$352,560; FHI (17951)-$470,080; GIS (17954)-$470,080; UMB (17950)-$332,393; EGPAF	

								(18203)-$58,760;	
Weak lab quality improvement initiatives to ensure accurate and timely diagnostics	**1. Improving lab operations, lab biosafety control, commodity management at site level (First, second and third "90")**	700 labs in 27 scale up counties and a few selected labs in sustained counties are enrolled in continuous quality improvement (CQI) activities	475 labs in 27 scale up counties and a few selected labs in sustained counties are enrolled in continuous quality improvement (CQI) activities	600 labs in 27 scale up counties and a few selected labs in sustained counties are enrolled in continuous quality improvement (CQI) activities	Number of laboratories enrolled into the CQI activities based on program reports	HLAB, HMIN, HMBL	$1,613,247	AMREF (17947)-$294,400; FHI (17951)-$255,327; GIS (17954)-$1,063,520; UMB (17950)-$544,640; EGPAF (18203)-$14,720	Laboratory Score 2.08

	2. Implementing the stepwise quality improvement process towards accreditation (First, second and third "90")	130 labs enrolled and achieve minimum acceptable level towards attainment of international accreditation	67 enrolled and achieve minimum acceptable level towards attainment of international accreditation	83 enrolled and achieving minimum acceptable level towards attainment of international accreditation	Number of labs enrolled and achieving minimum acceptable level towards attainment of international accreditation as reported in program reports as per the EPMP		$1,017,375	AMREF-$138,000; FHI-$127,000; GIS (17954)-$182,000; UMB (17950)-$226,000; CLSI (13919)-$55,000; MoH (18213) -$63,000; KAVI (18512)-$187,000, TBD-DOD-SRV-$39,37	

								5(18491)	
	3. Support SLIPTA complimentary trainings and auditors training (First, second and third "90")	4351 HCW receive complimentary trainings conducted to support SLIPTA	1657 HCW receive compliment ary trainings conducted to support SLIPTA	3086 HCW receive complimentary trainings conducted to support SLIPTA	Number of HCW receiving compliment ary trainings conducted based on program reports		$445,525	CLSI (13919)	
							$100,000	ASLM (17948)	
	4. Enrollment of labs into EQA, maintain database and web portal(1st, 2nd and 3rd "90")	100% of labs enrolled into EQA for HIV achieve at least 80% satisfactor y score	80 % of labs enrolled into EQA for HIV achieve at least 80% satisfactory score	90 % of labs enrolled into EQA for HIV achieve at least 80% satisfactory score	Percent of labs enrolled into EQA for HIV achieve at least 80% satisfactory score as reported in DATIM	HLAB	$76,825	APHL (9110)	

	5. Enrollment of sites into EQA including Gene Xpert. Review EQA results and conduct corrective action and preventive action (CAPA) to failing sites by the county lab quality assurance coordinators and the partner TA (First "90" and second "90")	100% of sites conducting review EQA results and conduct corrective action and preventive action (CAPA)	90% of sites conducting review EQA results and conduct corrective action and preventive action (CAPA)	95% of sites conducting review EQA results and conduct corrective action and preventive action (CAPA)	Proportion of sites conducting review of EQA results and conducting corrective action and preventive action (CAPA) based on program reports and EPMP	HLAB	$757,600	AMREF (17947)-$305,244; FHI-$172,326; GIS (17954)-$172,326; UMB (17950)-$86,163; EGPAF-$21,541;	

3. Poor infection control, blood safety and waste management practices at service delivery sites	**Improve infection control and quality blood utilization at site level (First, second and third "90")**	100% of sites are implementing TB and other infection control measures including blood safety	90% of sites are implementing TB and other infection control measures including blood safety	100% of sites are implementing TB and other infection control measures including blood safety	Proportion of sites are implementing TB and other infection control measures including blood safety and waste management as assessed through facility SIMS	HMIN/HMBL	$1,840,000	AMREF (17947)- $278,171; FHI (17951)- $305,184; GIS (17954)- $790,763; UMB (17950)- $445,882; EGPAF (18203)- $20,000	Laboratory Score 2.08
4. Limited capacity for coordination of quality assurance for lab services, infection control and blood safety	Coordination of lab and infection control services at national level **(1st and second**	Well coordinated lab and infection control services, with quarterly national TWGs and	Well coordinated lab and infection control services, with quarterly national TWGs and	Well coordinated lab and infection control services, with quarterly national TWGs and quarterly support supervision	Program report and quarterly monitoring review meetings	HMBL/HLAB	$280,001	MoH (18213) - $76,000; UMB (17950)- $204,001	

	90)	quarterly support supervision	semia-annual support supervision						
	Implement quality management systems in the blood safety program to ensure no HIV is transmitted through blood transfusion and link infected donors to treatment **(1st and 2nd "90")**	100% of blood transfusion centers are accredited by AFSBT standard	50% of blood transfusion centers are accredited by AFSBT standard	80% of blood transfusion centers are accredited by AFSBT standard	Program reports on number of sites accredited and above-site SIMS	HMBL	$1,060,000	KNBTS (17711)-$850,000; UMB (17950)-$210,000	Laboratory Score 2.08
5. Emergence of HIV Drug resistance	Conduct HIVDR surveillance **(3rd 90)**	Annual HIVDR conducted to identify resistance patterns	Annual HIVDR conducted to identify resistance patterns	Annual HIVDR conducted to identify resistance patterns	Annual HIVDR resistance reports from the program	HLAB	$50,000	APHL (9110)	Laboratory Score 2.08

6. Weak equipment management programs and lab information systems	1. Implement an equipment management program at national and county level 2. implement lab information management system (LIMS) 3. Biosafety cabinet certification and maintenance of TB safety hood **(First, second and third "90")**	An effective equipment management program at national and scale-up counties	setting up a national equipment maintenance and calibration center	Use the national center to support a few selected scale-up counties	Program reports and SIMS reports on testing interruptions	OHSS, HLAB, HMBL	$1,028,842	AIHA (9108) - $458,000; APHL (9110) - $270,842;AMREF (17947)- $20,000; FHI (17951)- $19,750; GIS (17954)- $72,250; UMB (17950)- $1187,000; EGPAF (18203)- $1,000	Laboratory Score 2.08
Laboratory Sub Total							**$10,938,528**		
Strategic Information (SI-CDC)									

Lack of efficiency in the provision of HIV/AIDS service delivery in a paper based process. Information not always readily available for clinical decision making	Strengthen the use of EMRs from implementation to integration and sustainability by collaborating with Service Delivery and getting their buy in an support to invest in EMR maintenance. **(All 90s)**	1. EMRs that are integrated into the operations of facilities and are used for clinical decision support resulting in improvements in clinical outcomes and clinical management of patients with HIV/AIDS.	1. Increased use, acceptance and adoption of EMRs among the health care workers based on comparison to the base line over time	1. Increased number and percentage of facilities use the EMRs as POS and are paperless 2. There is a systematic and timely process in place to monitor and track the progress of sites along the continuum via dashboards and performance metrics and a process for CQI	1. % of facilities in priority counties that have EMRs that are integrated and sustained as defined by the EMR continuum 2. Extent to which there is MOH and county and facility level buy in and ownership in the integration and use of the EMRs	HVSI	$700,000	Palladium and 18214	5.36 (epidemiological and health data)
The need for timely and accurate data to drive programmatic, clinical and population based decisions at the facility, county, sub county and national levels.	Enhancing the HDW by including data from other sources beyond EMRs, ensuring access at the	1. The availability and use of timely, accurate and relevant data at the facility, county, sub county and	1. Data from all EMRs are added into the DWH and tools for data visualization and mapping are being used to	1. Data from LIS, ADT and HRIS are integrated into the dataware house and used for analysis and reporting. 2. Access to the DWH is available at the county, sub county and facility level 3. DWH is enhanced to meet the needs for	1. % of counties and sub counties that have access to DWH for analysis and reporting 2. Extent to which the DWH has	HVSI	$700,000	Palladium and 18214	5.36 (epidemiological and health data)

	national, county, sub-county, and site level and integrating data visualization and dashboards to ensure access at the national, county, sub-county, and site level. **(All 90s)**	national level to drive clinical, programmatic decision making	analyze the data	case based surveillance	been enhanced to meet the needs for Case Based Surveillance 3. % of identified and usable data sources that have been integrated into the DWH				
There is a need for interoperability between the different HIS products to facilitate the seamless flow of data exchange, reduce redundancy and improve availability of data in the care and treatment process	Developing an interoperability framework and establishing data exchange between HIS products (EMR, DHIS II,	1. The data between EMRs, ADT, LIS and data warehouse can be electronically exchanged and used	1. Establishment of an interoperability framework that is agreed upon by all major stakeholders and signed off by the MOH	1. Implementation of the interoperability technology and tools as per the policy framework in high priority counties with a focus on improving exchange of information between EMRs, LIS and ADT as well as with the DWH	1. At least 70% of sites in high priority counties have interoperability between EMRs, ADT and LIS (where available 2. At least	HVSI	$500,000	Palladium and 18214	5.36 (epidemiological and health data)

	LIMS, ADT, Data warehouses (HDW) etc.) **(All 90s)**				70% of data from EMRs is sent electronically to the DWH and not thru manual processes				
There is a lack of a unique identifier to match patients across facilities, systems and counties as they go thru the treatment cascade. This is needed for improved patient management, data analysis and accurate reporting	Operationalization of the National Patient Unique Identifier by implementing it in EMRs **All 90s**	NUPI is used in all of the EMRs that have been implemented and /or maintained by Palladium in high burden/priority counties	NUPI successfully piloted in at least 3 of the 5 high burden/priority counties and based on the lessons learned appropriate enhancements made to refine the process	NUPI successfully implemented in at least 3 of the 5 high burden/priority counties	1. % of facilities in priority counties that have NUPI successfully implemented 2. % of data in the DWH that uses NUPI as the unique identified	HVSI	$500,000	Palladium and 18214	5.36 (epidemiological and health data)
There is a need to more accurately capture, monitor and track data on HIV/AIDS testing from clinical and non clinical, community based settings	Develop and implementation Innovation in the use of HTC modules and	An HTC mobile application developed and implemented in clinical and non clinical	Exploration of potential technological options for the HTC application	Development of configuration of the HTC application and piloting in 3 of the 5 high priority counties	1. % of testing facilities in high priority/burden areas where testing data is captured	HVSI	$700,000	Palladium and 18214	5.36 (epidemiological and health data)

	mobile applications in clinic and non clinic based settings **First 90**	settings			electronically 2. Extent to which these data are used for county, and national level decision making				
There is a need to enhance LIS infrastructure particularly in high burden/priority counties to facilitate the availability of viral load data for clinical decision making, for case based surveillance and to improve the availability of timely information across the treatment cascade.	Strategic scale up of LIS in high burden facilities **(2nd and 3rd 90)**	LIS has been implemented and in use in high burden/priority counties and integrated with EMRs	Formation of a Lab Informatics workgroup that is chaired and owned by the MOH and is and development of a strategic scale plan that is agreed upon by all stakeholders.	Implementation of LIS and other lab informatics tools (e.g. Mlab) by Palladium and partners based on the agreed upon strategic scale up plan	1. % of facilities in high burden/priority counties that have a lab informatics tool to facilitate timely use of viral load data for clinical decision support	HVSI	$300,000	Palladium and 18214	5.36 (epidemiological and health data)
There is a need to conduct timely and relevant evaluations that can be shared with the larger public health community and also drive system and program improvements	Conduct process and outcome evaluations on relevant HIS	At least 5 evaluations completed on salient HIS initiatives	Evaluation protocol has been approved and cleared	At least 3 of the 5 evaluations have been completed and published	1. Five HIS evaluations have been completed and published	HVSI	$500,000	Palladium and 18214	5.36 (epidemiological and health data)

	initiatives including EMRs, DWH and LIS to drive program and process improvements and add to the body of knowledge (**All 90s)**								
There is a need to integrate the HRIS in the functions of all 7 regulatory bodies to facilitate the licensing of health care professionals and use the data for decision making at the county and sub county levels	In collaboration with the regulatory bodies, integrate and transition the rHRIS into their licensing operations **(All 90s)**	rHRIS has been fully transitioned into the operations of all 7 regulatory boards and data are used for decision making at the county and sub county levels	rHRIS has been transitioned to at least 6 of the boards	rHRIS has been transitioned to all 7of the boards	1. % of the 7 regulatory boards where the use of the rHRIS has been fully transitioned 2. % of counties that use the rHRIS data for strategic decision making	OHSS	$300,000	Palladium and 18214	5.36 (epidemiological and health data)

There is a need to integrate the HRIS systems that deal with the supply and demand side. Currently these are separate systems which makes it difficult to track the health worker from certification to training and service	Integrate the rHRIS and iHRIS **(all 90s)**	The rHRIS and iHRIS are fully integrated and implemented	Begin design and development plan for the integration of rHRIS and iHRIS	Complete the integration and begin implementaiton efforts at the boards and facilities	1. Has the integration between rHRIS and iHRIS been completed (Yes/No) 2. % of facilities where the integrated product has been implented and in use	OHSS	$295,000	Palladium and 18214	5.36 (epidemiological and health data)
There is a need to understand the full breath and scope of HIS initiatives implemented in Kenya both to support HIV/AIDS and health care in general to identify synergies, duplication and opportunities for collaboration	Conduct an environmental scan of existing HIS systems and infrastructure to facilitate the development of a national HIS landscape (As-Is state) **All three 90s**	Completed environement scan and landscape assessment and greater understanding of the full scope of HIS investments in Kenya	Development of the paper based and electronic tool and identification of data collection strategy	Completion of data collection efforts and analysis in progress	1. Has the landscape assessment been completed (Y/N). 2. What is the extent of which the assessment is used to inform strategic HIS decision making	HVSI	$200,000	International AIDS Education and Training Center (I-TECH) and 18259	5.36 (epidemiological and health data)

Here are numerous HIS initiatives in the Kenyan landscape and no organized and systematic way to leverage their development, application and use. As a result, there is a need to establish a certification and governance framework to ensure transparency and accountability in the use of HIS investments and promote strategic resource use	Develop a governance and certification framework **All 90s**	Established governance and certification framework that has been made into a policy by the MOH	The certification and blue print for governance are in development and being refined	The certification and blue print for governance are in place and efforts underway to make them into a policy. Also efforts underway to develop the relevant strcutures to support the governance	1. Has the governance and certification framework blue print been completed (yes/no) 2. Is the framework made into policy (yes/no)	HVSI	$150,000	International AIDS Education and Training Center (I-TECH) and 18260	5.36 (epidemiological and health data)
There is a need to improve the timeliness in the availability of viral load results at the facility level to promote viral suppression	Develop and implement the mLab module in facilities that have no other way to receive viral load results **(3rd 90)**	Mlab application has been developed and implemented in atleast 50% of areas in high burden/priority facilities where no other methods are available to receive viral load	Mlab application is developed and enhanced based on stakeholder feedback	Mlab application pilot has been completed and roll out has begun in targeted sites	1. % of targeted sites where Mlab roll out has successfully been completed 2. The TOT for viral load results in facilities where Mlab has been implemented	HVSI	$250,000	MHealth Kenya and 17945	5.36 (epidemiological and health data)

		results							
There is a need to use of mobile technology to facilitate the prevention of HIV/AIDs among health care workers thru accidental exposures when providing care, as well as to provide other wellness messages to improve their overall wellbeing	Development and implementation of the C4C (Care for Caregiver) mobile applicatioi n **(2nd 90)**	The C4C module has been implemented in atleast 80% of high burden/priority facilities	Complete development/refinement of the C4C application and begin sensitization and implementation efforts	Continue the strategic scale up of the C4C application and relevant trainings to promote its use	1. % of sites in high burden/priority counties where the C4C application is in use	HVSI	$120,000	MHealth Kenya and 17945	5.36 (epidemiological and health data)
There is a need to improve communication between providers and patients on ARV treatment using mobile technology to enhance patient outcomes	Development of a SMS based application called T4A- text for adherence that can be used to send out reminders, and wellness checks to patients on ARVs **(2nd and**	The T4A application has been rolled out in three of the five high burden counties and is in active use	The development and piloting of the T4A application is complete and it has been refined based on end user feedback	The roll out of the T4A application in the high burden /priority areas has begun and 50% complete	1. % of sites where the T4A application has been implemented and integrated into the care and treatment model 2. % change in adherence rates and % improvements in lost to follow up	HVSI	$270,000	MHealth Kenya and 17945	5.36 (epidemiological and health data)

	3rd 90)				after the introductio n of the T4A application				
There is a need to improve the efficiency in the commodities management system for ARVs by using mobile technology or the internet to improve the bi directional flow of order requests and deliveries across facilities, counties and KEMSA at the national level	Developm ent, implement ation and integratio n of the mKEMSA applicatio n **(all 90s)**	The MKEMSA application has been developed and implement ed at the county, facility and national levels and the ownership has been transferred to KEMSA with no reliance from Mhealth	Complete any addiitonal enhanceme nts needed to the MKEMSA application	Complete handing over the ownership for MKEMSA to the counties and KEMSA	1. Has the ownership of MKEMSA completely transitioned to KEMSA? (Yes/No). 2. Have all requested enhanceme nts to the MKEMSA application been completed? (Yes/No)	HVSI	$110,000	MHeal th Kenya and 17945	5.36 (epide miolog ical and health data)

There is a need to conduct timely and relevant evaluations that can be shared with the larger public health community and also drive system and program improvements	Conduct process and outcome evaluations on relevant HIS initiatives including EMRs, DWH and LIS to drive program and process improvements and add to the body of knowledge (**All 90s)**	At least 3 evaluations completed on salient HIS initiatives	Evaluation protocol has been approved and cleared	At least 2 of the 3 evaluations have been completed and published	1. There Mhealth evaluations have been completed and published or disseminated to key stakeholders	HVSI	$100,000	MHealth Kenya and 17945	5.36 (epidemiological and health data)
Need for more accurate/localized assessment of HIV prevalence, incidence and mortality	Siaya 90-90-90 Surveillance System -- Continue case-based surveillance linked to community census in 5 sites and expand	Near-complete mapping of HIV diagnosis and treatment uptake in high-prevalence sub-county; ability to	Linkage of demographic surveillance to facility records in five facilities, systems established, initiation of electronic HTS records	Routine surveillance reports; system functional & integrated for use by service delivery partners in Gem sub-county.	No of sites included in surveillance system, no. of records captured in electronic HTS systems; No. of patients linked from service	HVSI ($500) & HTXS ($600)	$1,100,000	University of Maryland Baltimore - TAPHIK (18216)	5.36 (epidemiological and health data)

	towards 100% coverage in Gem sub county **(All 90s)**	distinguish geographic care-seeking patterns, more accurate assessment of LTFU vs mortality; assessment of incidence	and linkage to demographic surveillance		delivery pt to community census; no. of dashboard reports disseminated and No. of users				
Limited prevalence and cascade data on key and priority populations	Activity: Fisherfolk bio-behavioral surveillance: Lab testing, Data management and analysis **(All 90s)**	Accurate assessment of HIV prevalence among fisherfolk on islands in Lake Victoria with action plan for addressing unmet needs for HIV services and prevention	Protocol approved and fieldwork/data collection completed	Report and manuscript writing (Report and 1 manuscript published)	No of FFX participating in serosurveillance; Dataset available for analysis; Report published /recommendations made	HVSI	$350,000	University of Maryland Baltimore - TAPHIK (18216)	5.36 (epidemiological and health data)

Need for field-validation of estimates to improve estimates process / Lack of local-level prevalence and incidence data in high burden counties	Activity: Longitudinal HIV Bio Behavioral Surveillance (LBBS): 4th round of house-hold based serosurveillance and risk survey, linking over time permits assessment of incidence cases in high-burden area (**All 90s**, unique data toward #1)	Improved measurement of service coverage and uptake in a high burden setting; More accurate inputs for modeling of prevalence and incidence in western Kenya; Indicators of incidence and mortality in high burden county post - implementation of "treatment for all," Better elucidation of factor associated	Surveillance reports available for County MOH and program use to inform service delivery improvement strategies; Completion of Round 1-3 incidence comparisons	Round 4 data collection complete in late FY18. Analysis and dissemination of data from FY16-Round 3 and previous 2 rounds	No. persons surveyed; No lab tests run; Dataset available for analysis; No of reports published;	HVSI	$550,000	University of Maryland Baltimore - TAPHIK (18216)	5.36 (epidemiological and health data)

		with HV infection and HIV service utilization							
Need for data interoperability vis-à-vis EMRs	Activity: Development of interoperable data tools for HIV Case-Based and other surveillance applications **(all 90s)**	Development of tools to allow sharing of selected data elements between EMR, LIS and repository systems	Adoption of EMR-to local county database for sharing of clinical 'sentinel event' data	Availability of system tools to facilitate interoperability of EMR and LIS systems with national and regional databases and dashboards	No. of EMR records integrated into national case-based surveillance via interoperable tools; No. of sites reporting to regional and national databases	HVSI	$200,000	University of Maryland Baltimore - TAPHIK (18216)	5.36 (epidemiological and health data)

Need for more accurate data along the clinical cascade, and new approaches that move beyond aggregate data	Implementation of HIV case-based surveillance (CBS) as per NASCOP strategy **(all 90s)**	Near-real-time county and national access to more accurate, de-duplicated data linked to key indicators of HIV service utilization along the entire clinical cascade; more accurate assessment of 90-90-90 cascade among KPs leading to improved prevention models and improvements in service delivery for KPs	Dissemination of report from pilot western Kenya implementation of case-based surveillance, Adaptation of data-collection system and refinement of system requirements, Assessment of suitability of EMR systems for CBS reporting indicators; Development of systems for CBS among key populations especially those accessing KP Drop-In	Implementation of CBS in NASCOP-designated counties, Routine use of data by county and national MOH officials; Stood up systems for monitoring the 90-90-90 cascade among key population members	CBS rolled out to at least 2 high burden counties, No. of cases reported into CBS, No of county and national MOH staff accessing/using CBS data	HVSI	$450,000	University of California-San Francisco- SI (17712)	5.36 (epidemiological and health data)

			Centers						
Need for more accurate key population size estimates	Development of/implementation protocol for expanded/ national KP size estimation **All three 90s**	Accurate estimates for MSM, FSW and PWID (and potentially FFX) for Kenya	Not funded in COP16, will pursue redirection of funds (within UCSF COP16 funding) for protocol development, stakeholder meetings, design etc.	Execution of fieldwork for KP size estimation, Report writing and dissemination	KP population size estimates updated to match current epidemic	HVOP and HVSI	550,000	University of California- San Francisco- SI (17712)	5.36 (epidemiological and health data)

Need for more accurate measures of HIV-associated mortality	Technical assistance and implementation for mortuary surveillance in 2 sites and collaboration with NASCOP and CDC in formation of national HIV mortality surveillance strategy (Primarily last 90, though more accurate data on mortality also helps to adjust overall estimates and refine targets) **All 90s**	Established national strategy for HIV-associated mortality surveillance in mortuaries	Implementation of mortuary surveillance in western Kenya, Dissemination of report	Drafting and finalization of national strategy, Implementation of mortuary surveillance in targeted areas as per NASCOP designation	National strategy adopted; Mortuary surveillance rolled out to additional sites; Report disseminated and recommendation for program made	HVSI	450,000	University of California- San Francisco- SI (17712)	5.36 (epidemiological and health data)

Need to address gaps along the 90-90-90 cascade to better understand barriers to service delivery	Technical assistance to national and county MOH in epidemiology and surveillance to define specific gaps which may include improved understanding of migration, analysis of those who are not diagnosed /not linked (esp. <30 years olds), barriers to adherence and retention; Development and execution of epidemiol	Increased capacity of MOH to conduct epidemiologic and surveillance activities that address gaps in the clinical cascade, Improved understanding of barriers among specific populations that affect service utilization, PLHIV identification, linkage, adherence, retention and optimal clinical outcomes	Execution of loss-to-follow-up study and report disseminated; Execution of adherence study and dissemination of report/recommendations; Collaboration with MOH to analyze national data warehouse and lab data to develop and issue recommendations	Execution of specific studies as per needs indicated with county and national MOH and through data warehouse and other sources; Develop and issue recommendation for improved service quality and strategies	Reports disseminated and MOH/partner staff sensitized to gaps along clinical cascade, No. of programmatic adaptations made to address gaps	HVSI	350,000	University of California- San Francisco- SI (17712)	5.36 (epidemiological and health data)

	ogical studies related to HIV risk, service utilization, coverage and other issues related to the clinical cascade; use of national data warehouse and lab data systems to evaluate cascade. **All 90s**								
Need to improve program data use and interpretation at all levels of government and among PEPFAR partners	Capacity building of MOH staff and PEPFAR partners through conceptual models, analysis, manuscript writing training sessions	MOH and PEPFAR partner staff with increased ability to analyze service delivery data and disseminate lessons-learned; Increased	Training sessions held with national and county MOH and partner staff, Analyses conducted and product disseminated by trained staff	Training sessions held with national and county MOH and partner staff, Analyses conducted and product disseminated by trained staff	Availability of published journal peer-reviewed articles and other programmatic scientific products including key reports from	HVSI	250,000	University of California-San Francisco- SI (17712)	5.36 (epidemiological and health data)

	resulting in wider disseminat ion of scientific products to inform HIV programm ing. **All 90s**	replication and diffusion of "best practices" for improved service delivery toward 90-90-90 outcomes			surveys and public health evaluations Increased knowledge and skills in use and epidemiolo gical interpretati on of HIV data				
Need for better understanding of incidence among young women	Activity: DREAMS-developed surveillanc e for recent HIV infection among AGYW attending ANC - LaG Avidity. **Primarily first 90, with implicatio ns for other 90s**	Improve characteriz ation of incident infections among AGYW, and developme nt of appropriati on prevention and identificati on strategies	Not funded in COP16, will pursue redirection of funds (within UCSF COP16 funding) to facilitate implementa tion in FY 17 in collaboratio n with HQ	Continued implementation as surveillance strategy/protocol, report writing dissemination for R1 of surveillance/data collection	Structures developed to facilitate at health service delivery level, No. samples collected and successfully analyzed, Report developed and disseminate d, Recommen dations made	HVOP	400,000	Univer sity of Califor nia-San Franci sco- SI	5.36 (epide miolog ical and health data)

Lack of comprehensive data for violence against children to inform programmatic approaches to reduce HIV incidence and other covariates for HIV acquisition among children in Kenya	By identifiying children at risk for HIV due to violence, it will enable us to have a more focused HTS strategy, linkage to care, and ultimately support for viral suppression **All 90s and epi control**	Improved understanding of the HIV epidemic among children and precise data in regards to the impact of behaviors and violence	Protocol submitted and approved by KEMRI and CDC IRBs	Fieldwork will have completed and initial analysis will have been conducted with findings disseminated in multiple scientific and program fora	Protocol submitted (Y/N), Protocol approved (Y/N), Number of abstracts, presentations, or manuscripts written	HVSI	$3,000,000	University of California- San Francisco- SI (17712)	5.36 (epidemiological and health data)
Need for better characterization of the role of HIV drug resistance (DR) as a barrier to achieving treatment outcomes and viral suppression	Development and submission of protocol for surveillance of pre-treatment drug resistance (PDR) and acquired drug resistance	Development of strategy for sustainable surveillance of HIV DR, Execution of protocol as approved; Characterization of HIV drug	Submission of HIVDR protocol (PDR/ADR in adult and peads)	Protocol for HIVDR approved by relevant ethics authorities, stakeholder sensitized in selected counties and facilities; liaison with laboratories and system for specimen transfer developed; initial data collection steps undertaken	Approved protocol for HIVDR; Development of execution strategy	HVSI	$100,000	Ministry of Health /NASCOP	5.36 (epidemiological and health data)

	(ADR) among both pediatrics and adults. **Third 90**	resistance and development of mitigation strategies							
Need for more accurate data along the clinical cascade, and new approaches that move beyond aggregate data	National strategy documents produced and active leadership for HIV Case-Based Surveillance **All 90s**	Near-real time county and national access to more accurate, de-duplicated data linked to key indicators of HIV service utilization along the entire clinical cascade; more accurate assessment of 90-90-90 cascade among KPs leading to	Dissemination of report from pilot western Kenya implementation of case-based surveillance, Adaptation of data-collection system and refinement of system requirements, Assessment of suitability of EMR systems for CBS reporting indicators;	Implementation of CBS in NASCOP-designated counties, Routine use of data by county and national MOH officials; Stood up systems for monitoring the 90-90-90 cascade among key population members	CBS rolled out to at least 2 high burden counties, No. of cases reported into CBS, No of county and national MOH staff accessing/using CBS data	HVSI	$50,000	Ministry of Health /NASCOP (18213)	5.36 (epidemiological and health data)

		improved prevention models and improvements in service delivery for KPs	Development of systems for CBS among key populations especially those accessing KP Drop-In Centers						
Need for more accurate and localized estimates of PLHIV by key disaggregates	Participation in production of sub-national HIV estimates **All 90s**	More accurate and useful HIV estimates; confidence in and use of sub-national estimates for planning at county and local levels	Participation in HIV Estimates workgroup leading to creation of national and subnational estimates report	Participation in HIV Estimates workgroup leading to creation of national and subnational estimates report; Participation in development of innovations to further develop estimations process, as appropriate	Availability of national and sub-national HIV estimates	HVSI	$25,000	Ministry of Health /NASCOP (18213)	5.36 (epidemiological and health data)
Need for more accurate data on HIV-associated mortality	Formulation of national policies for HIV-related mortality	Established national strategy for HIV-associated mortality surveillanc	Coordination with county governments to create support for implementa	Leadership in finalization of national mortality surveillance strategy, designation of areas for mortuary	National strategy adopted; Mortuary surveillance rolled out to	HVSI	$50,000	Ministry of Health /NASCOP (18213)	5.36 (epidemiological and health data)

	surveillance (mortuary) and active participation in up to 2 ongoing sites **All 90s**	e in mortuaries	tion of mortuary surveillance in western Kenya, Participation in and dissemination of mortality surveillance report	surveillance	additional sites; Report disseminated and recommendation for program made				
Need for improved systems to track MTCT outcomes	Development of Mother-to-Child Transmission (MTCT) active surveillance and pregnancy register **All 90s, and prevention**	Improved surveillance of MTCT and data on pregnancy-related indicators	Development of strategy for MTCT active surveillance and pregnancy register , Outreach to stakeholders; Development of protocol	Execution of strategy for active MTCT surveillance and pregnancy register , Dissemination of initial results	Available data on HIV prevalence in pregnant women, HIV transmission rate in children	HVSI	$75,000	Ministry of Health /NASCOP (18213)	5.36 (epidemiological and health data)
Need for improved systems to track MTCT outcomes	MTCT outcome generation and eMTCT validation system **All 90s**	Improved data on MTCT outcomes	Development of strategy for MTCT outcome measurement and validation , Outreach to	Reports from MTCT outcomes monitoring disseminated and adopted as routine data source	MTCT outcome monitoring reports made available and used by stakeholders	HVSI	$100,000	Ministry of Health /NASCOP (18213)	5.36 (epidemiological and health data)

			stakeholders; Development of protocol						
Need for better routine measurement of HIV infection in ANC, Need to refine HIV estimates through more current ANC sentinel data	Establishment of modified routine antenatal care (ANC) surveillance **First 90**	Routine availability of ANC sentinel surveillance using approved national protocol; Contribution to improved HIV estimates process through better data availability	ANC protocol developed to accommodate current requirements for return of results, and submitted for appropriate ethical review	ANC surveillance approved and executed is protocol-designated sites	# of sites reporting into ANC surveillance; Availability of ANC prevalence indicators	HVSI	$270,000	Ministry of Health /NASCOP (18213)	5.36 (epidemiological and health data)
Gaps in achieving identification and diagnosis of PLHIV (First 90)	Operations Research (OR) re. HIV Testing Services (HTS) expansion (in collaboration with M&E)	Identification of successful strategies for HIV Testing Services in order to reach and maintain he 1st 90	Development of protocol and stakeholder input for OR regarding HTS expansion	Approval and implementation of OR protocol; Initial report to stakeholders and service providers	no of operational variables identified for adaptation through execution of OR investigations and # of changes	HVSI	$150,000	Ministry of Health /NASCOP (18213)	5.36 (epidemiological and health data)

	First 90				implemented				
Need to assess continuing role of stigma and discrimination in limiting the achievement of 90-90-90 and adversely affecting the lives of PLHIV	Planning and execution of a national survey to assess stigma and discrimination against PLHIV **Sustained Epi Control**	Development and rollout of strategies to address HIV-related stigma in Kenya, leading to reduced role in stigma as a barrier to care-seeking	Not funded in COP16, however initial planning activities and stakeholder engagement will occur	Planning and execution of stigma and discrimination index survey	Completion of survey fieldwork; Dissemination of report and strategies adopted.	HVOP, HVSI	TBD	Ministry of Health /NASCOP (18213)	5.36 (epidemiological and health data)
Need for more accurate and localized estimates of PLHIV by key disaggregates; Availability of data visualization tools to improve understanding and utilization of data	Annual HIV national and subnational estimates in collaboration with national and international	Improved national and subnational planning for the HIV sector; More accurate and useful HIV estimates; confidence in and use	Improved methodology, processes and dissemination products to generate sub-national HIV estimates	Improved methodology, processes and dissemination products to generate sub-national HIV estimates; Improved dissemination products/apps/figures	Number of in-person and electronic meetings held to ensure that county and national partners are able to use denominator data from	HVSI	$200,000	UNAIDS (18262)	5.36 (epidemiological and health data)

	partners, as well as development of novel data visualization approaches to help stakeholders understand, interpret and use the data effectively **Sustained Epi Control**	of sub-national estimates for planning at county and local levels			the HIV estimates; N umber of graphs, maps and other images ("data visualizations") that show better and more intuitive understanding of sub-national HIV monitoring data, including PLHIV denominators				

Lack of coordination and capacity to fully implement optimal TB control interventions in high TB-HIV burden regions	Intensified TB Control Initiative in Kisumu: **1st 90** (increased identification of TB/HIV co-infected), **2nd 90** (ART initiation among co-infected), 3rd 90 (improved viral suppression through optimal management of comorbidities.)	Fully functional, comprehensive active TB control program in Kisumu County and decreased TB case notification. Intensified TB Control Initiative to include active case finding, comprehensive diagnostic evaluation, including GeneXpert, and mycobacterial culture and drug susceptibility testing when indicated, and comprehe	Active case finding system and comprehensive TB prevention strategies implemented in Kisumu County in targeted sites; Preliminary findings and reports available to County MOH and program to inform service delivery strategies.	Continued implementation of the intensified TB control system. System reports, dashboards, and regular analysis available to inform County MOH and program service delivery improvements.	No. of sites included in the system; No. reports dissemination; Rate of decline of TB case notification rate in Kisumu County from 2016-2020 ;	HTXS, HVTB	$500,000	University of Maryland Baltimore - TAPHIK (18216)	5.36 (epidemiological and health data)

		nsive TB prevention strategies (early initiation of antiretroviral therapy (ART) and isoniazid preventive therapy (IPT) for people with HIV)							
Limited laboratory capacity to address high-volume TB diagnostic service needs	Improved viral suppression through optimal management of comorbidities **3rd 90**	Reference laboratory in Western Kenya model of excellence in TB services and support to peripheral labs in a high HIV and high TB burden region.	GeneXpert and MDR-TB diagnostic services fully functioning at optimum throughput and quality; improved TB laboratory services for accurate and efficient TB diagnostics.	Continued provision of high quality, efficient TB diagnostic services (GeneXpert, MDR-TB) and improved capacity of the regional reference laboratory to support the region.	Number of GeneXpert and MDR-TB tests performed	HTXS, HVTB	$250,000	University of Maryland Baltimore - TAPHIK (18216)	5.36 (epidemiological and health data)

Low capacity in monitoring and evaluation of HIV programs among national and sub-national MOH staff through training and mentorship.	Develop and Implement M&E Training Tracking Tool. Convert training materials into e-learning format. Provide continuous mentorship on revised M&E tools at all levels. **All 90s**	All National , County, Sub-county and Facilities across Kenya will be using complete set of HIV tools	Work with service delivery partners to cascade training to sub-county and health facility levels	All 47 counties will have received all tools at all sites, training of HCWs will have been executed, and all program data and associated reports will be generated from use of the new tools	# of counties within Kenya where county health workers have been trained on the new tools. # of sites within counties reporting using the new tools. Ability to report at the national, county, and site levels using the new data (e.g., use of new disaggregation's)	HVSI	$565,000	University of California- San Francisco- SI (17712)	5.36 (epidemiological and health data)

Need for high quality data for use in decision making, support MOH in coordination and implementation of RDQAs/RDQIs in all counties	In Partnership with MOH, coordinate harmonization, and implementation of RDQA/RDQI tools and implementation of RDQAs/RDQIs A**ll 90s**	Improve the quality of data in all facilities across Kenya	All facilities in high burden counties will have receive DQA and all data expected to have improved	50 % of all facilities in Kenya a will have received data quality assessment and any improved required will be n working progress	# facilities where the DQA has been conducted. # Facilities with improved quality of data	HVSI	$65,000	University of California- San Francisco- SI (17712)	5.36 (epidemiological and health data)
Need to Monitor clinical cascade, partner with MOH to increase capacity to conduct cohort analysis at national and sub-national levels	Define cohorts and how effectively can handle cohorts in routine reporting, Strengthen cohort analysis in routine reporting, Conduct trainings, Stakeholder engagement, E-Learning	increased capacity to conduct cohort analysis at national and sub-national and Facility levels	All 34 PEPFAR scale-up and aggressive scale-up counties be able to conduct cohort analysis accurately	75% of facilities across Kenya able to conduct analysis cohort analysis accurately	# Staff trained on cohort analysis; # Facility reports accurately reported on cohort analysis. # counties with staff able to conduct cohort analysis	HVSI	$100,000	University of California- San Francisco- SI (17712)	5.36 (epidemiological and health data)

	All 90s								
Need for continuity to monitor the clinical cascade and changing data needs to monitor the HIV epidemic, partner with MOH to support roll out of revised M&E tools and analysis program data	Provide technical support to the county TOTs during the cascade process to ensure the quality set by NASCOP is maintained Support the cascade of revised M&E tools to sub-county levels through provision of UCSF TOT where gaps are	All National , County, Sub-county and Facilities across Kenya will have received complete set of tools	All 34 PEPFAR scale-up and aggressive scale-up counties will have received all tools at all sites, training of HCWs will have been executed, and all program data and associated reports will be generated from use of the new tools	All 47 counties will have received all tools at all sites, training of HCWs will have been executed, and all program data and associated reports will be generated from use of the new tools	# of counties within Kenya where county health workers have received the new tools. Ability to report complete set of tool set the national, county, and site levels using the new data (e.g., use of new disaggregation)	HVSI	$60,000	University of California- San Francisco- SI (17712)	5.36 (epidemiological and health data)

	identified Development of job aids for training Take lead in further revisions of data collection tools and training materials based on participant input and consensus with NASCOP Document the tools roll-out process and disseminate the findings to the key stakeholders **All 90s**								

Need to support alternative learning platform for easier reference to complement the face-to-face training	The e-learning content, establish mode of Delivery, Tracking eLearning, establish credit system **All 90s**	Expect a fully working e-learning module covering all applicable areas	Covering the e-learning content and testing through the appropriate mode of delivery	75% of counties sensitized on the e-learning content	# Facilities accessing the e-learning content	HVSI	$305,000	University of California-San Francisco- SI (17712)	5.36 (epidemiological and health data)
Need to document evidence about the effectiveness in reaching program objectives, partner with MOH to Implement evaluation of HIV program evaluations	Structure the feedback system (National/ County), Tracking reporting rate, Track new MOH tools, Track MOH tool requests Track Targets/results, performance **All 90s**	Improve evidence documentation through interventions and services provided by MOH	Continue conducting the Activities in B81	Continue conducting the Activities in B81	# Evaluations conducted and findings disseminated	HVSI	$100,000	University of California-San Francisco- SI (17712)	5.36 (epidemiological and health data)

Need to evaluate effectiveness of UCSFs performance on technical assistance and capacity building activities	Stakeholder engagement; Protocol development; determine appropriate evaluation design; conduct analysis, reporting and dissemination of results **All 90s**	Conduct mid term review to evaluate Improved technical assistance and capacity building activities as a result of	Continue conducting the Activities in B82	Continue conducting the Activities in B82	# Evaluations conducted and findings disseminated	HVSI	$100,000	University of California-San Francisco- SI (17712)	5.36 (epidemiological and health data)
Weak knowledge in Geo spatial mapping and Mapping of HIV burden	Establish GIS community of practice and support in adoption and integration of GIS in data collection, strategic and program	Improve better understanding of HIV epidemic	Conduct a needs assessment on mapping	Train eligible staff on mapping across different levels	# Staff trained on GIS.	HVSI	$20,000	University of California-San Francisco- SI (17712)	5.36 (epidemiological and health data)

	Planning **All 90s**								
Low support data reviews, dissemination, and utilization forum	Lead and support data review and triangulation exercise; Develop and disseminate a national data review and triangulation reports or briefs. Support dissemination of evaluation findings and development of results	Improve quality of data and enhance data use for decision making at National and County levels	Support for data reviews at National Level	Support for data reviews at County and Sub-county Levels	# counties conducted data reviews; # Counties demonstrating use of data for decision making	HVSI	$95,000	University of California- San Francisco- SI (17712)	5.36 (epidemiological and health data)

	All 90s								
Poor Laboratory Mid term reviews	Conduct desk reviews, conduct partner visits; Analysis, report writing and data dissemination **All 90s**	Assess the effectiveness of Lab support to the ART cascade in Eastern, Coast, Rift Valley, Nyanza and Western regions.	Continue conducting the Activities in B85	Continue conducting the Activities in B85	# Lab Evaluations conducted and findings disseminated	HVSI	$100,000	University of California-San Francisco- SI (17712)	5.36 (epidemiological and health data)
Lack of information systems for tracking and reporting OVC MER Outcome results.	OVC MER outcome measurement: **1st 90**	MER OVC Outcome Assessments and Impact survey results reported to OGAC	Constitution of survey teams and completed plan ready for execution by the partner	Survey conducted and results disseminated	PEPFAR Kenya Number of MER OVC Outcome assessments years completed	HVSI, HKID	$200,000	Measure Evaluation IV 17964	12. Technical and Allocative Efficiencies: 6.105
Quality Improvement collaboratives and data dissemination	Implement a CQI collaborative toimprove	Implementation of a change package to inform the	Develop a change package to inform the national	Scale-up the change package to inform the national program in improving the 3rd	Proportion utilization of VL results by HCW as	HVSI	$50,000	ICAP (18261)	12. Technical and Allocative

	utilization of viral load results in 30 facilities in Siaya county. **3rd 90**	national program in improving the 3rd 90. 100% of health workers utilize VL results	program in improving the 3rd 90. 60% of health workers utilize VL results	90. 80% of health workers utilize VL results	assessed through 6 monthly file reviews as per the KHQIF model				Efficiencies: 6.106
There is a need for improved coordination between the MOH and the Ministry of Interior to facilitate implementation of NUPI	Convene meetings with the Ministry of Interior and other stakeholders to lay down the legal frameworks that will enable the implementation of National Unique Patient Identification for the health sector **All 90s**	A policy for the use of NUPI in the health care sector will be in place and the technical implementation will be in progress	At least 3 meetings are convened with the appropriate stakeholders to develop a MOU and policy around the use of NUPI in health	Blue print for the operational use of NUPI in the health care space is completed and in the process of implementation	1. Is a blue print for the implementation and use of NUPI in the health care space in place (yes/no). 2. Do HIS implementing partners have clear guidance on the use of NUPI in the health care space (Y/N)	HVSI	$40,000	Ministry of Health /Division of Health Informatics, M&E, and Research (18213)	5.36 (epidemiological and health data)

There is a need to better understand the full scope and breath of HIS initiatives in the Kenyan landscape for improved coordination	Provide leadership and direction for the development and execution of a survey that will comprehensively detail the national HIS landscape and ensure a sustained status update **All 90s**	A land scape assessment of all HIS projects and initiatives will be completed and actively used for HIS governance and decision making	Survey instrument for the landscape assessment in completed and signed off on by the MOH	Data collection efforts for the landscape assessment have been completed under the oversight of the MOH	1. Is there a survey instrument in place for the landscape assessment (Y/N) 2. Is the data collection effort complete (Y/N)	HVSI	$40,000	Ministry of Health /Division of Health Informatics, M&E, and Research (18213)	5.36 (epidemiological and health data)
Need for improved coordination among stakeholders to facilitate the formation of structures to implement certification frameworks	Convene meetings with appropriate stakeholders to ensure the completion, buy in and accessibility of national	The governance structure for certification will be in place	The certification framework has been made into policy	The blue print for the governance structure for certification is in place	1. Is the governance structure for certification in place (Y/N). 2. Has the certification framework been made into policy (Y/N) 3. Have staff	HVSI	$40,000	Ministry of Health /Division of Health Informatics, M&E, and Research (18213)	5.36 (epidemiological and health data)

	HIS standards and guidelines and ensure structures for their implementation through effective certification frameworks **All 90s**				been identified to do the governance for certification (Y/N)				
There is a need to bring together all of the different HIS policies under a framework to promote the implementation and use and remove redundancies	Carry out activities that ensure the establishment of a comprehensive HIS policy framework that all relevant stakeholders have bought into and are aware of All 90s	Establishment of a HIS policy framework completed and in use by appropriate stakeholders	All relevant policies that are under the framework have been identified and a draft framework document is in place	The framework document is completed and is being vetted and approved by relevant stakeholders and there is sensitization in progress	1. Have all relevant stakeholders been sensitized about the policy framework? (Y/N) 2. Has the policy framework been signed into policy (Y/N)	HVSI	$40,000	Ministry of Health /Division of Health Informatics, M&E, and Research (18213)	5.36 (epidemiological and health data)

A number of HIS initiatives are implemented and not coordinated leading to lack of transparency, inefficient use of resources and lost opportunities for synergies	Provide oversight to ensure that all HIS activities are effectively coordinated to ensure there are optimal synergies and no redundancies **All 90s**	Improved coordination of HIS initiatives in the Kenyan space and opportunities for synergies and collaboration are leveraged	At least 3 initiatives have been instituted to improve coordination of HIS initiatives	All known and relevant HIS initiatives have been linked up and sensitized and there are numerous synergies in place as a result of these efforts	1. Are there at least 5 examples of improved synergies of HIS initiatives as a result of improved coordination (Y/N)- Please describe	HVSI	$40,000	Ministry of Health /Division of Health Informatics, M&E, and Research (18213)	5.36 (epidemiological and health data)
A number of lab informatics initiatives are implemented and not coordinated leading to lack of transparency, inefficient use of resources and lost opportunities for synergies	Provide leadership and direction for convening appropriate stakeholders to ensure the development and implementation of a well aligned lab informatics road map **All**	Improved coordination of lab informatics initiatives resulted in better synergies and resource usage	A lab informatics workgroup is convened on a bi monthly basis to improve coordination and collaboration	A blue print strategy for lab informatics is in place for the Kenya space with identified opportunities for collaboration across HIS partners	1. Is there a road map in place for lab informatics for Kenya (Y/N) 2. Are the relevant lab informatics partners working together to achieve relevant synergies (Y/N)	HVSI	$25,000	Ministry of Health /NASCOP (18213)	5.36 (epidemiological and health data)

	90s								
There is a need to do active monitoring of current EMR implementations to ensure EMR use is strengthen and optimized	Provide oversight in strengthening the implementation and integration of EMRs along the continuum by conducting site visits **All 90s**	A larger number of EMRs are integrated into the operations of facilities and there are improved clinical outcomes	At least 25% of sites with poor EMR integration are visited and remedial action is taken as evidenced by the dashboards	At least 50% of sites with poor EMR integration are visited and remedial action is taken as evidenced by the dashboards	1. % of facilities with EMRs in high priority/burden areas that have EMRs that are integrated into their operations 2/ % of sites where EMRs are owned by service delivery partners	HVSI	$25,000	Ministry of Health /NASCOP (18213)	5.36 (epidemiological and health data)
Number of HIS projects in the Kenyan space but they are not always well coordinated leading to lost opportunities for synergies	Convene meetings of appropriate implementing partners in	Improved coordination of HIS initiatives in the Kenyan space for HIV/AIDS	Meetings convened with HIS partners in the HIV/AIDS space and a blue print in	Strategies outlined in the blue print for collaboration are accepted by partners and implemented	1. % of strategies for fostering collaboration implemented in the	HVSI	$25,000	Ministry of Health /NASCOP (18213)	5.36 (epidemiological and health data)

	the HIS space to ensure the alignment and coordination of HIS projects and initiatives, particularly in the area of HIV/AIDS and TB A**ll 90s**	and TB and opportunities for synergies and collaboration are leveraged	place to foster future collaborations		field				
The use of the DWH needs to be expanded and optimized to facilitate decision making for clinical, public health and programmatic needs	Provide technical direction and oversight of the ongoing development and implementation of the DWH to ensure its use for programmatic activities and for case based surveillanc	DWH is used for case based surveillance, clinical decision support and programmatic decision making	1. A technical and operational plan is in place to use the DWH for CBS. 2. The data from all EMRs are in the DWH with regular data quality checks	1. The technical and operational plan for using the DWH for CBS is implemented under the direction of the MOH	1. Is the DWH able to generate required reports and outputs to support CBS (Y/N) 2. Is 100% of EMR data in the data warehouse (Y/N) 3. Has the DWH database been transferred to NASCOP ownership? (Y/N)	HVSI	$25,000	Ministry of Health /NASCOP (18213)	5.36 (epidemiological and health data)

	e **All 90s**								
Need to distribute all revised M&E Tools and train counties for Test & Start and other 90-90-90 priorities to all counties in Kenya	Formulation of national policies in regards to and distribution and training at county level for all monitoring & reporting tools for the HIV program **All 90s**	All facilities within counties will be using the Test & Start tools with routine training for new and continuing staff to ensure data quality	All 34 PEPFAR scale-up and aggressive scale-up counties will have received all tools at all sites, training of HCWs will have been executed, and all program data and associated reports will be generated from use of the new tools	All 47 counties will have received all tools at all sites, training of HCWs will have been executed, and all program data and associated reports will be generated from use of the new tools	# of counties within Kenya where county health workers have been trained on the new tools. # of sites within counties reporting using the new tools. Ability to report at the national, county, and site levels using the new data (e.g., use of new disaggregati	HVSI	$200,000	Ministry of Health /NASCOP (18213)	5.36 (epidemiological and health data)

					ons)				
Need to support the MOH (both NASCOP and NACC) to facilitate data analytics and visualization for optimal monitoring, surveilling, and evaluation of the HIV epidemic towards the 90-90-90 goals	Establishment of a data analytics hub. Coordination and implementation of advanced program analytics and visualizations from multiple data streams, including the formal establishment of a data analytics hub to support routine and	A mature data analytics hub with established governance, with data hub instances in the counties, coordinating the multiple actors and partners working with NASCOP and the HIV sector, ability to respond to routine and ad hoc queries, and continued	Quarterly HIV program and cohort reports are generated and data are readily available to program managers and other stakeholders for HIV program monitoring and planning from DHIS2 and other program databases, including DWH	Data hub is able to generate expenditure, quality, program, epidemiologic data in analytic formats with publically available datasets through DHIS2 and/or the NASCOP website. Sophisticated routine program and epidemiologic reports are generated as are ad hoc abstracts and manuscripts for various scientific fora	#of epi/data scientist staff and at what %effort; number of reports generated; number of county instances of data hub; datasets available on DHIS2 and/or NASCOP website	HVSI	$150,000	Ministry of Health /NASCOP (18213)	5.36 (epidemiological and health data)

	nonroutine program/epidemiologic data calls. This would be complimentary to the UNAIDS/NACC HIV Situation Room and would require the hiring of a senior epidemiologist/data scientist to oversee existing data managers. **All 90s**	data use for program improvement							
Need to ensure data collected and reported for PEPFAR and MOH is of the highest quality possible	Development of a harmonized data quality protocol and tools to be used by all	Timely, accurate and consistent data reported for both MOH and PEPFAR in	Harmonized DQA protocol developed, pilloted and adopted for Kenya.	All counties using the harmonized protocol for DQA with a greater focus on priority counties.	Number and proportion of DQAs conducted using the harmonized protocol	HVSI	$80,000	Ministry of Health /NASCOP (18213)	5.36 (epidemiological and health data)

	stakeholders for HIV. **ALL 90s**	Kenya							
CDC SI Sub Total							**$16,205,000**		
Strategic Informaion (SI-DoD)									
Weak M&E systems impeding accurate, timely and complete data	Provide on-site training and mentorship to health care workers (HCW) on correct use of revised national (MOH) HIV M&E tools to accurately capture data. **All 90s**	Accurate HIV data being collected and utilized for patient care by having trained and mentored 1,000 HCW on national HIV revised tools	500 HCW (military and non-military) trained and mentored on national HIV M&E tools to include cohort analysis to ensure accurate data collection, data aggregation, analysis and reporting	500 HCW (military and non-military) trained and mentored on national HIV M&E tools to include cohort analysis to ensure accurate data collection, data aggregation, analysis and reporting	Number HCW trained and mentored	HVSI	$90,000	$30,000 TBD KW (18490) $30,000 TBD SRV (18491) $30,000 TBD KDoD (18492)	13. Epidemiological and Health Data: 5.36

Inaccurate interpretation, collection and collation of data at facility level	Conduct DQA/DQI at the facility level to improve data quality which includes correct definition and interpretation and utilization of indicators in both paper based and electronic data collection systems **All 90s**	300 facilities/sites with improved data quality reflected both DQA conducted in 300 sites	DQA/DQI conducted and corrective actions adopted in 150 sites	DQA/DQI conducted and corrective actions adopted in 150 sites	Number of sites with a complete DQA/DQI conducted	HVSI	$80,000	$10,000 TBD KW 18490 $40,000 TBD SRV 18491 $30,000 TBD KDoD 18492	13. Epidemiological and Health Data: 5.36
Weak EMR system that does not adequately support data collection for finer age disaggregation required to for program decision making for epidemic control	Provide on-site mentoring to HCW on utilization of existing EMR of all HIV service delivery	180 existing EMR facilities strengthened and fully functional encompassing all HIV	60 existing EMR facilities strengthened and functional in all HIV service delivery point	120 existing EMR facilities strengthened and functional in all HIV service delivery point	Number of Sites with fully functional EMR system addressing the clinical cascade	HVSI	$80,000	$20,000 TBD KW (18490), $30,000 TBD SRV (18491),	13. Epidemiological and Health Data: 5.36

	points address. **Sustained Epi Control**	service delivery points for improved patient management of care						$20,000 TBD KDoD (18492)	
Poor data dissemination channels for program use	Improve coordination of data dissemination through regular data review meetings, best practices forums, data synthesis to strengthen data demand and utilization. **All 90s.**	12 quarterly data review meetings and three (3) best practices forums attended by	4 quarterly data review meetings, 1 best practices forum attended	8 quarterly data review meetings, 2 best practices forums attended	Number of quarterly data review meetings held and number of best practices forum held	HVSI	$100,000	$20,000 TBD KW (18490), $40,000 BD SRV (18491), $40,000 TBD KDoD (18492)	13. Epidemiological and Health Data: 5.36
Poor TB case detection in high burden sub-counties of Kisumu West and Seme	Implement and coordinate TB case finding data	To determine whether a comprehensive set of active	Complete study IRB approvals and study implementation	Study implementation and data analysis	TB case notification rate	HVSI	$150,000	TBD KW 18490	13. Epidemiological and Health Data:

	collection in two high-burden counties: Kisumu West and Seme sub-counties. **Second and third 90s.**	case-finding and TB prevention interventions have a sustained population-level effect on TB case notification rate.							5.36
Poor size estimation of fisherfolk population	HDSS will conduct a prospective population-based surveillance platform which collects longitudinal health, demographic and social information to support PEPFAR program	Fisherfolk size estimation in Seme sub-county conducted to have a denominator for calculating HIV incidence/ prevalence rates	Mapping out of landing sites, identify migratory patterns and conducting census	Mapping out of landing sites, identify migratory patterns and conducting census. Data analysis and dissemination	Denominator of fisherfolk population in Seme sub-county	HVSI	$150,000	TBD KW 18490	13. Epidemiological and Health Data: 5.36

	activities. This includes mapping out target Fisherfolk population in Seme sub-county using GPS to identify landing sites. **First and second 90s.**								
Low access to and uptake of HIV services among fisher folk population	Conduct a three year implementation evaluation (IE) to assess impact of multi-month scripting and mobile platform self check-in on retention rates and viral	Completed the fisher folks IE with findings to be applied to priority population interventions for improved adherence, retention, and viral suppression among the fisherfolk population	Study design completed and protocol develop and approved by IRB	Study interventions implemented and evaluation started	Appropriate regulatory study paperwork; progress reports	HVSI	$400,000	TBD KW 18490	13. Epidemiological and Health Data: 5.36

	suppression among the fishing communities in Seme sub-county. **Second and third 90s.**								
Lack of understanding of eMTCT status within military population	Develop and conduct a study to measure the current eMTCT status within the military population. This activity will evaluate routine cohort analysis in EMR and non EMR military facilities. **Second 90.**	EMTCT findings incorporated into PMTCT service delivery with the military to improve program for achieving eMTCT	Study design completed and protocol approved	Study conducted and results disseminated and findings incorporated to improve PMTCT services within military	Completion of study through final report; plan to implement findings into service delivery	HVSI	$55,000	TBD KDOD 18492	13. Epidemiological and Health Data: 5.36

Insufficient utilization of data in DHIS 2	Provide on-site refresher training and mentoring of HCW on how DHIS2 can be used to manage patient care. **All 90s**	300 facilities optimally utilizing DHIS 2 to improve patient care and improve quality of services provided	150 facilities utilizing DHIS 2 for monitoring patient care	150 facilities utilizing DHIS 2 for monitoring patient care	Number of sites using DHIS 2 optimally	HVSI	$20,000	TBD SRV 18491	13. Epidemiological and Health Data: 5.36
DoD SI Sub Total							**$1,125,000**		
Strategic Information (SI-USAID)									
Lack of data exchange platform between DHIS2 and numerous critical subsystems	Establish an Integrated National Health Information system (DHIS2, KMHFL2, KEMSA Health Commodity Information Management System,	100% of critical subsystems successfully exchanging data with DHIS2 Critical sub-systems: KMHFL2, KEMSA Health Commodity Informatio	Systems Integration plan developed. Interoperability between KMHFL2 and DHIS2 successfully completed. 45% of Applications Programs Interface developed. 45% of critical	75% of critical subsystems successfully tested and exchange data with DHIS2	Number of new HIS systems integrated to the NHIS, Number of health facilities accessing comprehensive data on DHIS2 platform	HVSI	$480,000.00	Health IT (University of Nairobi Enterprises Services) 17959	13. Epidemiological and Health Data: 5.36

	MCUL, EMR/EHRs, LMIS, DSL and DATIM4U, Viral Load Database). **All three 90s**	n Management System, HRIS, MCUL, EMR/EHRs, LMIS, DSL and DATIM4U, Viral Load database)	subsystems successfully tested and exchange data with DHIS2. ,						
Lack of data exchange platform between DHIS2 and DATIM/DATIM4U	Establish a data exchange platform between National reporting system DHIS2 and PEPFAR reporting system DATIM4U/ DATIM. **All three 90s**	A fully functional Data Exchange Platform between DHIS2 and DATIM/DATIM4U established.	Data exchange protocol, data mapping and testing between DHIS2 and DATIM established. Data exchange protocol, data mapping and testing between DHIS2 and DATIM4U established.	A fully functional Data Exchange Platform between DHIS2 and DATIM/DATIM4U established.	Number of complete and accurate reports (Quarterly) successfully submitted to OGAC from the data exchange module	HVSI	$140,000	Health IT (University of Nairobi Enterprises Services) 17959	13. Epidemiological and Health Data: 5.36

Lack of portal that supports PEPFAR partners attribution.	Enhance and upgrade the Joint Partners Reporting portal (JPRP) for use by stakeholders and MOH. **All three 90s**	A fully functional Joint Partners Reporting Portal with partner attribution of results in KMHFL2-DHIS2 system	75% mapping of PEPFAR partners through JPRP completed and reports successfully generated	100% JPRP mapping of PEPFAR partners completed and complete and accurate reports successfully generated.	Number of PEPFAR partners with correct health facilities attribution in JPRP system	HVSI	$150,000	Health IT (University of Nairobi Enterprises Services) 17959	13. Epidemiological and Health Data: 5.36
Lack of systematic platform for enforcing standards-based health informatics systems development	Setup a functional Test Environment within University of Nairobi/School of Computing and Informatics and publicize with Implementing Partners. **Sustained Epi Control**	MOH-standard Health Informatics Test Environment for Integrated National Health Information System fully functional	Test Environment Requirements Specifications completed. Setting up of ICT Infrastructure for the Test Environment completed and publicized through HIS Interagency Coordinating Committee.	A fully functional test environment established, available and accessible to public and private sector systems developers.	Number of HIS systems and EMRs / EHRs successfully tested in the environment	HVSI	$125,000	Health IT (University of Nairobi Enterprises Services) 17959	13. Epidemiological and Health Data: 5.36

Lack of in country capacity at national and county levels to manage the evolution of DHIS2-KMHFL2	Raise awareness and strengthen HIS capacity of Local institutions and County governments to use and support integrated National Information System (DHIS2, KMHFL2, EMR/EHRs, MCUL, LMIS, DSL and DATIM), Training on Integrated NHIS and Pilot with in-county Universities, county governments (CHMTs)	Capacity of regional-county based public and private universities strengthened to effectively manage evolution of DHIS2-KMHFL2	At least 3 public universities competitively selected, Memorandum of Understanding developed and ratified between them and University of Nairobi to support DHIS2-KMHFL2 in the HIV High burden region of Western Kenya.	At least all the 3 public universities complete revision of their health informatics training curriculum. 50% of faculty of the 3 universities trained on DHIS2-KMHFL2 Module Curriculum development and implementation. At least 1 university introduce new DHIS2-KMHFL2 module.	Number of local institutions with capacity to support HIS activities	HVSI	$400,000	Health IT (University of Nairobi Enterprises Services) 17959	13. Epidemiological and Health Data: 5.36

	and health facilities in three (3) counties. **All three 90s**								
No system for generating new knowledge on health informatics	Research findings incorporated on Health Informatics to support health sector: **Sustained Epi Control**	Identifying key HIS research questions with stakeholders that can contribute to improved measurement of outcomes and thus impacting the HIV program response in the country	Conduct research to inform the process of making health systems integrated and interoperable, Carry out research to inform data analytics and data mining and disseminate findings to stakeholders	Incorporated findings on Health Informatics to support health sector	Number of new cases research findings relevant to DHIS2 used to inform service provision	HVSI	$80,000	Health IT (University of Nairobi Enterprises Services) 17959	13. Epidemiological and Health Data: 5.36

Lack of an accredited e-learning platform for health care workers on health informatics in Kenya.	Develop and Pilot an online e-learning for CHRIOs, COs and Nurses as part of continuing professional development: **Sustained Epi Control**	MOH-Accredited e-learning platform for CHRIOs, COs and Nurses fully operational, reduced number of hotel-based trainings.	ICT Infrastructure for e-learning platform established. Online course contents developed, reviewed and approved by relevant boards. E-learning platform piloted and platform approved by MOH for continuing professional development.	E-learning platform fully operational, University of Nairobi and MOH jointly set up accreditation mechanism for learners.	Number of Health workers completing accredited courses by cadre.	HVSI	$125,000	Health IT (University of Nairobi Enterprises Services)17959	13. Epidemiological and Health Data: 5.36
Monitoring data not adequate to inform mid term implementation and management adjustments	Mid term review for Afya Pwani: **Sustained Epi Control**	Key performance and management mid-term adjustments are informed by	Mid-term review planned and conducted. Key findings, conclusions and recommend	Project management team, USAID KEA leadership and county health management teams use validated mid term review results to improve project implementation.	Mid-term review report completed, results shared and used by stakeholders	HVSI	$250,000	Program Support Services 16679	13. Epidemiological and Health Data: 5.36

		evidence.	ations validated by key focal county stakeholders.						
Weak institutional capacity to implement and evaluate effectiveness of existing policies, guidelines and standards.	Support counties to develop and update HMIS/M&E Policies, guidelines and standard protocols: **Sustained Epi Control**	At least 75% of focal counties implementing existing policies, guidelines and standards. County Policy Implementation Monitoring system in place.	At least 75% of focal counties implementing 75% of existing policies, guidelines and standards.	At least 75% of the focal counties implementing 75% of the existing policies, guidelines and standards. At least 30% of focal counties have evaluated/reviewed effectiveness of implemented policies, guidelines and/or standards.	% of counties effectively implementing existing policies, guidelines and/or standards. % of implemented policies reviewed and adjusted.	HVSI	$200,000	County Measurement, Learning and Accountability/TBD18499	13. Epidemiological and Health Data: 5.36
Weak stakeholders' coordination mechanisms	Support stakeholder engagement on relevant issues: **Sustained Epi Control**	Functional County HIV Stakeholders' Coordination Framework in place.	50% of focal counties complete assessment of existing coordination structures. 50% of focal counties	75% of focal counties hold quarterly HIV stakeholders coordination meetings regularly. 75% of county HIV stakeholders regularly participate in the quarterly coordination meetings.	Number of HIV stakeholders' coordination meetings held per year.	HVSI	$200,000	County Measurement, Learning and Accountability/TBD 18499	13. Epidemiological and Health Data: 5.36

			complete HIV stakeholders mapping exercise. 50% of focal counties conduct at least one HIV stakeholders coordination meeting.						
Weak/non existence of county HIV Learning and Results Accountability Forums	Develop a framework for county and subcounty priority outcomes measurements systems, build and sustain county capacity to implement and use MLA systems, use data and act to	Strategies and mechanisms for strengthening and/or establishing county learning and accountability systems in place. Functional county learning and results accountability forums in place	Strategies and mechanisms for strengthening and/or establishing county learning and accountability systems developed. 50% of focal counties have functional learning and results accountabili	75% of focal counties have functional learning and results accountability forums. 50% of focal counties using learning and accountability forums for increasing use of HIV response data in HIV program planning, management and decision making in resources allocations and targeting.	Number of counties with functional learning and accountability forums.	HVSI	$650,000	County Measurement, Learning and Accountability/TBD 18499	13. Epidemiological and Health Data: 5.36

	improve HIV programs and outcomes. **Sustained Epi Control**	and being used at all focal counties.	ty forums.						
Limited use of ICD10 at focal counties and facilities	Expand AIDS specific death registration coverage at facility level through ICD 10 training, mentorship, support supervision, data quality improvement and data use: **Sustained Epi Control**	75% of focal counties adopt ICD10 training and implementation at health facilities.	50% of focal counties complete ICD10 training, start reporting in DHIS2	75% of focal counties complete ICD10 training, use AIDS specific death data in managing county HIV response. At least 75% of health facilities in focal counties report complete and accurate data ICD10 in DHIS2.	% of health facilities by focal county reporting complete and accurate ICD10 reports in DHIS2.	HVSI	$575,000	County Measurement, Learning and Accountability/TBD 18499	13. Epidemiological and Health Data: 5.36

Lack of common county data analysis framework to guide regular and predictable data analysis	Development of data need and analysis framework, training and mentoring CHMTs on data analysis and visualization techniques: **Sustained Epi Control**	Data analytical framework on priority HIV outcome indicators by focal county in place. County HIV data visualization dashboards in place.	HIV priority outcomes data needs analysis framework developed. 50% focal counties produce quarterly HIV county profiles regularly.	75% of focal counties produce quarterly HIV county profiles regularly. At least 50% focal counties produce semi-annual scorecards on priority HIV outcomes.	% of focal counties regularly producing HIV county profiles. % focal counties regularly producing semi-annual scorecards on priority HIV outcomes.	HVSI	$650,000	County Measurement, Learning and Accountability/TBD 18499	13. Epidemiological and Health Data: 5.36
Lack of common county data demand and data use/framework guidelines to guide regular and predictable data use	Development of data demand and use framework, adaptation of DDU products developed at the national level, training	Data demand and data use plan for county HIV/AIDS and STI Coordinators (CASCOs) in place. At least 75% of CASCOs from focal counties demonstra	County data demand and use framework developed. At least 25% of CASCOs from focal counties use HIV response data in planning and rational county	At least 50% of CASCOs from focal counties use HIV response data in program planning and rational county health budget estimates development.	% of focal counties achieving increased county budget allocations by county assembly for HIV programming.	HVSI	$250,000	County Measurement, Learning and Accountability/TBD 18499	13. Epidemiological and Health Data: 5.36

	and mentoring CHMTs on data demand and use: **Sustained Epi Control**	te increased use of HIV county response data in planning and rational county health budget estimates development.	health budget estimates development.						
Weak institutional capacity to implement and evaluate effectiveness of existing policies, guidelines and standards.	Support counties to develop and update HMIS/M&E Policies, guidelines and standard protocols: **Sustained Epi Control**	At least 75% of focal counties effectively implementing existing policies, guidelines and standards. County Policy Implementation Monitoring system in place.	At least 75% of focal counties implementing 75% of existing policies, guidelines and standards.	At least 75% of the focal counties implementing 75% of the existing policies, guidelines and standards. At least 30% of focal counties have evaluated/reviewed effectiveness of implemented policies, guidelines and/or standards.	% of counties effectively implementing existing policies, guidelines and/or standards. % of implemented policies reviewed and adjusted.	HVSI	$550,000	Palladium/County Measurement, Learning and Accountability Program 18318	13. Epidemiological and Health Data: 5.36

Weak/non existence of county HIV Learning and Results Accountability Forums	Develop a framework for county and subcounty priority outcomes measurements systems, build and sustain county capacity to implement and use MLA systems, use data and act to improve HIV programs and outcomes. **Sustained Epi Control**	Strategies and mechanisms for strengthening and/or establishing county learning and accountability systems in place. Functional county learning and results accountability forums in place and being used at all focal counties.	Strategies and mechanisms for strengthening and/or establishing county learning and accountability systems developed. 50% of focal counties have functional learning and results accountability forums.	75% of focal counties have functional learning and results accountability forums. 50% of focal counties using learning and accountability forums for increasing use of HIV response data in HIV program planning, management and decision making in resources allocations and targeting.	Number of counties with functional learning and accountability forums.	HVSI	$450,000	Palladium/County Measurement, Learning and Accountability Program 18318	13. Epidemiological and Health Data: 5.36

Limited use of ICD10 at focal counties and facilities	Expand AIDS specific death registration coverage at facility level through ICD 10 training, mentorship, support supervision, data quality improvement and data use: **Sustained Epi Control**	75% of focal counties adopt ICD10 training and implementation at health facilities.	50% of focal counties complete ICD10 training, start reporting in DHIS2	75% of focal counties complete ICD10 training, use AIDS specific death data in managing county HIV response. At least 75% of health facilities in focal counties report complete and accurate data ICD10 in DHIS2.	% of health facilities by focal county reporting complete and accurate ICD10 reports in DHIS2.	HVSI	$600,000	Palladium/County Measurement, Learning and Accountability Program 18318	13. Epidemiological and Health Data: 5.36
Lack of common county data analysis framework to guide regular and predictable data analysis	Development of data need and analysis framework, training and mentoring CHMTs on data analysis	Data analytical framework on priority HIV outcome indicators by focal county in place. County HIV data visualizatio	HIV priority outcomes data needs analysis framework developed. 50% focal counties produce quarterly HIV county profiles regularly.	75% of focal counties produce quarterly HIV county profiles regularly. At least 50% focal counties produce semi-annual scorecards on priority HIV outcomes.	% of focal counties regularly producing HIV county profiles. % focal counties regularly producing semi-annual scorecards	HVSI	$750,000	Palladium/County Measurement, Learning and Accountability Program	13. Epidemiological and Health Data: 5.36

	and visualization techniques: **Sustained Epi Control**	n dashboards in place.			on priority HIV outcomes.			18318	
Lack of common county data demand and data use/framework guidelines to guide regular and predictable data use	Development of data demand and use framework, adaptation of DDU products developed at the national level, training and mentoring CHMTs on data demand and use: **Sustained Epi Control**	Data demand and data use plan for county HIV/AIDS and STI Coordinators (CASCOs) in place. At least 75% of CASCOs from focal counties demonstrate increased use of HIV county response data in planning and rational county health budget	County data demand and use framework developed. At least 25% of CASCOs from focal counties use HIV response data in planning and rational county health budget estimates development.	At least 50% of CASCOs from focal counties use HIV response data in program planning and rational county health budget estimates development.	% of focal counties achieving increased county budget allocations by county assembly for HIV programming.	HVSI	$500,000	Palladium/County Measurement, Learning and Accountability Program 18318	13. Epidemiological and Health Data: 5.36

		estimates development.							
Weak leadership and governance capacity at MOH/ MERDHI	Support Div. MEHRDI by building their capacity on Health Informatics Leadership & Governance: **Sustained Epi Control**	Health Informatics /M&E Leadership and Governance Modular Program developed by Kenya School of Government. Train 125 (45 from national and 80 from focal counties) health informatics and monitoring & evaluation managers on effective leadership and	Kenya School of Government completes development of leadership and governance program. 100% of targeted managers complete 50% of required modules. Health Informatics /M&E Investments Framework developed and adopted by donors investing in health informatics.	100% of targeted managers complete 100% of required modules and receive certification on effective leadership and governance in public sector. 100% of health informatics partners align their investments to MOH priorities. MOH achieve 100% harmonization of partners annual work plans with MOH/DivMERDHI's annual work plans.	% of targeted national and county managers who receive effective leadership and governance certification for national and county health informatics /M&E systems from Kenya School of Government.	HVSI	$450,000	Palladium/Health Informatics Governance & Data Analytics 17958	13. Epidemiological and Health Data: 5.36

		governance. TORs for Health Informatics Interagency Coordinating Committee (HI ICC) developed and ratified. Functional HI ICC in place. Improved coordination/ harmonization of donor investments in health informatics.							

Weak institutional capacity to implement and evaluate effectiveness of existing policies, guidelines and standards.	Update and operationalize current HMIS policies, strategies, guidelines, standards & protocols and develop an implementation plan: **Sustained Epi Control**	Capacity of MOH/Div MERDHI to implement the current policies, strategies, guidelines, standards & protocols strengthened/improved. (OCAT). Policy implementation monitoring system fully functional. At least 75% of existing policies, guidelines and standards effectively implemented.	At least 50% of existing national HMIS/M&E policies, guidelines, standards & protocols effectively implemented at national and focal counties. Policy implementation monitoring system tracks progress and reports semi-annually.	At least 75% of existing national HMIS/M&E policies, guidelines and standards effectively implemented at national and focal counties. At least 50% of implemented policies, guidelines and/or standards reviewed/evaluated and reviewed results used for implementation adjustments and learning.	Number of existing HMIS/M&E policies, strategies, guidelines, and/or standards implemented. Policy implementation mentoring systems operational.	HVSI	$600,000	Palladium/Health Informatics Governance & Data Analytics 17958	13. Epidemiological and Health Data: 5.36

Lack of national interoperability framework for effective governance	Support the division to institutionalize the Systems Standards & Interoperability of Health Information systems: **Sustained Epi Control**	National MOH-approved Health Systems Standards & Interoperability Framework developed. National Systems Interoperability Governance Committee in place.	Kenya National Inter-operability Framework and Standards Developed and endorsed by all key health informatics stakeholders. Governance structure for systems interoperability functional. At least 30% of sub-systems integrated into DHIS2	Harmonized and transparent information exchange specifications in use by public and private system developers nationally. At least 50% of sub-systems (Critical subsystems: KMHFL2, KEMSA Health Commodity Information Management System, HRIS, MCUL, EMR/EHRs, LMIS, DSL and DATIM4U, Viral Load database) integrated into DHIS2.	% increase in number critical subsystems that exchange information with DHIS2-KMHFL2 platform	HVSI	$450,000	Palladium/Health Informatics Governance & Data Analytics 17958	13. Epidemiological and Health Data: 5.36

Weak data analytics capacity at national and county levels	Capacity building of national HIV programs (NASCOP& NACC) and Division of RMNCH/Nutrition programs in data analytics: **1st 90 & 2nd 90**	National data analytics framework that standardizes analytical work on priority HIV/AIDS and RMNCH/Nutrition outcomes in place. Data analytics and visualization ICT infrastructure set up and functional for HIV/AIDS and RMNCH/Nutrition programs. At least 50% of relevant staff trained in	National Integrated Data Analytics Framework developed. 50% of targeted staff trained in data analytics and visualization.	100% of targeted staff trained in data analytics and visualization. National programs generate dashboards from available data. National programs present information products at annual Health Congress.	Number of staff trained in data analytics and visualization. No. of information products developed and shared annually on HIV outcomes.	HVSI	$450,000	Palladium/Health Informatics Governance & Data Analytics 17958	13. Epidemiological and Health Data: 5.36

		data analytics and visualization techniques.							
Limited use of data for program management, planning and policy formulation/evaluation	Activity: Support National and County governments to embrace the use of data analytics in decision making, program planning and policy implementation monitoring, evaluation and learning: **Sustained**	100% National and county HIV programs demonstrate increased use of data in policy development including advocacy for increased budget allocations. Rational budget development for HIV program.	50% of targeted staff trained in use of data for policy development including in budget advocacy.	100% of targeted staff trained in use of data for policy development and budget advocacy. 30% - 45% increase in domestic financing for HIV program including associated health informatics/M&E activities as a result of increased capacity to use data.	Number of counties demonstrating increased use of HIV/AIDS and RMNCH/Nutrition data in policy development.	HVSI	$250,000	Palladium/Health Informatics Governance & Data Analytics 17958	13. Epidemiological and Health Data: 5.36

	Epi Control								
Lack ICT infrastructural capacity for monitoring HIV national and county response	Activity: Support the HIV componen t of the National situation room - Monitorin g HIV National Response: **Sustained Epi Control**	100% Use of One Country M&E System by all HIV stakeholde rs (Kenya HIV and Health Situation Room) at national and Nairobi, Homabay, Kisumu, Migori, Mombasa, Nakuru and Mombasa focal counties	100% ICT infrastructu ral deployment at national and focal counties. 100% Situation Room System fulltime availability and accessibility at national and focal counties. At least 50% acceptance and usage rate of the situation room	100% Situation Room System fulltime availability and accessibility at national and focal counties. At least 75% Acceptance and Usage rate of the situation room platform HIV statistics.	Number of people accessing and using HIV statistics from the situation room platform for planning and decision making.	HVSI	$650,000	Palladi um/H ealth Inform atics Gover nance & Data Analyt ics 17958	13. Epide miolog ical and Health Data: 5.37

			platform HIV statistics.						
USAID SI Sub-Total							**$9,975,000**		
VMMC									**Relevant SID Element and Score (if applicable)**

Improve coverage and quality of VMMC services	1). Support a survey to validate VMMC coverage by age band and subnational units and revised WHO Manual for Male Circumcision under Local Anaesthesia, 2nd Edition 2). Support Kenya's VMMC program is advancing program quality, safety and sustainability as a model for other countries in the	MC coverage by age group by SNU; Sustainable adolescent VMMC model adopted; Local capacity to use WHO PQ devices; revised WHO Manual for Male Circumcision under Local Anaesthesia	TTCV Policy for Kenya; framework for introduction of devices for VMMC; supporting compliance with DS MC guidance	1. VMMC policy on TTCV developed 2. Survey to establish VMMC coverage and service need conducted 3. adopted WHO Manual for Male Circumcision under Local Anaesthesia	# of SNU with validated MC coverage data/report; # of SNU implementing sustainable models of VMMC; # of HCW trained on device-based MC	CIRC	$970,000	JHPIEGO 13868	4.21 (SERVICE DELIVERY)

	region. 3). Strengthen local knowledge and capacity for VMMC implementation including the use of WHO prequalified MC devices. (**First 90)**								
	Support development and review of national guidelines for VMMC including a technical advisor who supports program implementation, serves as an in-country	Adoption and use of WHO/NUNAIDS 2017-2021 framework for VMMC	WHO/NUNAIDS 2017-2021 framework for VMMC adopted	1. VMMC guidelines developed 2. Survey to establish VMMC coverage and service need conducted	WHO/NUNAIDS 2017-2021 framework for VMMC	CIRC	$50,000	WHO 13346	4.21 (SERVICE DELIVERY)

	resource person and point of contact for collaboration with WHO in adoption of normative guidelines for VMMC. **Sustained epi control**								
	Support coordination of national VMMC program, develop/review guidelines for service and support compliance with standards for VMMC service delivery. Strengthe	1. Implementation guided by 2nd edition of guidelines for VMMC under local anesthesia 2. Full compliance with directive for dorsal slit circumcision for boys 10-14yrs.	Transitioning from catch up to sustainable phase guided by first edition of WHO manual for VMMC which is being phased out. Suboptimal compliance with directive for dorsal slit circumcisio	1. VMMC guidelines disseminated 2. Supervision of counties' compliance with VMMC guidelines	Number of counties implementing VMMC according to the national guidelines;	CIRC	$80,000	MOH 18293	4.21 (SERVICE DELIVERY)

	n MOH structures to facilitate integration of VMMC in routine health care services for long term sustainability. **Sustained epi control**		n for bys 10-14yrs						
Low uptake of VMMC services by male age 20-29 years	Develop and execute targeted communication campaign to create demand for VMMC services among male 20-29 years. **First 90**	30% Increased uptake of VMMC services by male age 20 -29 in non-circumcising communities in Busia, Kisumu, Nairobi, Nakuru, and Turkana	Targeted communication campaign developed and executed through appropriate media	30% increase in uptake of VMMC services by male age 20-29 in target counties	No of males aged 20-29 receiving VMCC package	CIRC	$1,000,000	Health Communication and Marketing, 13868	SID score 4.21 under Service Delivery

Lack of VMMC coverage data to inform program planning	Develop VMMC coverage modeling tools and train in-country VMMC stakeholders on the use of tools to inform planning and program evaluation. **First 90**	VMMC DMPPT 2, Site Capacity/Site Utilization and GIS Dashboard Online tools available and in use by in-country stakeholders to inform program planning	VMMC DMPPT 2, Site Capacity/Site Utilization and GIS Dashboard Online tools available and in use by in-country stakeholders to inform program planning	This activitity will be completed in year 1	Online tools available at national and site level to estimate VMMC program coverage. Stakeholders ability to accurately set targets at national and site level	CIRC	$300,000	Avenir Health, 17960	SID score 4.21 under Service Delivery
VMMC Sub Total							**$2,400,000**		
OVC									

Weak coordination and networking of child protection county systems and structures including data for decision making thus affecting quality & sustainable service delivery	Provide technical support to Department of Children Services (DCS) and LIPs in 7 counties (Taita Taveta, Mombasa, Kilifi, Nairobi, Kiambu, Turkana & Samburu) through training and mentorship to improve County coordination of OVC activities, and strengthen systems and structures to deliver sustainable services.	Improved DCS coordination and networking of stakeholders at the county-level through strengthened systems and structures, including the County Area and Locational Advisory Councils (AAC/LAACs). LIPs & CHVs have accurate knowledge and skills to support OVC & HHs case management and plans (identifying, enrolling, assessing,	Seven counties supported through training and mentoring on coordination and networking, case management tools/package, documentation and reporting	Seven counties leverage & perform core child protection services more efficiently, effectively and sustainably	Number of social welfare workforces trained and mentored e.g., CHVs, social workers, Local Implementing Partners (LIPs) & DCS	HKID	$300,000	Nilinde OVC program & TBDS	12. Technical and Allocative Efficiencies: 6.99

	Build the capacity of DCS & LIPs on case management tools/package and approaches to facilitate better planning, advocacy and data management including case files. **All 90s**	planning, referring & monitoring) service delivery in a timely, contextualized and family-centered approach. Accurate data collected and utilized for OVC & HHs care plans, targeted monitoring and effective case closure.							

Inadequate capacity to provide, refer and promote access to & utilization of services that support graduation or transfer of OVC & their HHs from PEPFAR support plan & services	Support capacity building activities that promote access to services, enhance referrals and facilitate graduation and transfer of enrolled OVC households from PEPFAR support through use of Household vulnerability assessment data & graduation readiness tools and HHs case plans through a phased approach.	LIPs and DCS have the requisite knowledge and skills to facilitate planning for graduation and transition process, effective referrals, including case conferencing among health and other social service providers. LIPs implement Household economic strengthening (HES) plans. Clearer roles and responsibilities of OVC	DCS, LIPs & others stakeholder meetings, Household including HES case plans, county costed-sustainability plans	Operationalization of county transition mechanism, linkages and referrals to appropriate services for individualized OVC & Households (HHs)	Number & type of meetings held, Households that have been successfully graduated and or transitioned, counties with operational costed-sustainability plans	HKID	$1,050,000	Nilinde OVC program & TBDS	12. Technical and Allocative Efficiencies: 6.100

	Second & Third 90	households and that of DCS in the graduation and transfer process. Key OVC actors have improved capacity to advocate internally and externally for resources for children programming & enhanced ownership. Functional County-specific transition structures/ committees and implementation of County costed-							

		sustainability plans.							
Weak County mechanisms to track bi-directional referral & linkages to other existing County resources for most-at-risk OVC & HHs	Assessment of the existing mechanisms to health and other social services for OVC and their household	Effective bi-directional referral and linkage mechanisms between LIPs, health and other social	Trained and mentored DCS, LIPs, bi-directional referral and linkage mechanisms established	Clear/functional referral & linkage including tracking of complete bi-directional referrals implemented	Progress reports	HKID	$200,000	Nilinde OVC program & TBDS	12. Technical and Allocative Efficiencies: 6.101

	s, including mapping & capacity. **Second and third 90s.**	services. Implementation of case management tools, Job-aids and documentation including best practices.							
Lack of a functional national child protection information management system (for all children including orphans and vulnerable children services) in the country.	Conduct ICT infrastructure audits and assessments in Kisii, Busia, Bungoma and Vihiga. Deploy ICT infrastructure **Sustained Epi Control**	100% functionality of CPIMS in Kisii, Busia, Bungoma and Vihiga counties.	ICT infrastructure audits and assessments completed including costing of the infrastructure. Deployment, testing and commissioning of ICT infrastructure, in 50% of the targeted counties completed.	Deployment, testing and commissioning of ICT infrastructure completed in 100% of the targeted counties.	Number of additional counties effectively using CPIMS	HKID	$400,000	Palladium/County Measurement, Learning and Accountability Program 18318	12. Technical and Allocative Efficiencies: 6.102

Weak institutional capacity to manage implementation and use of Child Protection Information Management System (CPIMS)	Conduct trainings on CPIMS use at Department of Children Services (DCS) and the focal counties. (Kisumu, Migori, Homabay, Kakamega, Murang'a, Machakos, Kilifi, Nairobi, Nakuru, Siaya, Kisii, Busia, Bungoma and Vihiga) **Sustained Epi Control**	Train 300 DCS, county, sub-county and PEPFAR implementing partner staff on CPIMS use	100% of DCS and 50% focal county staff complete CPIMS modular trainings.	100% of all targeted staff (DCS and county) complete CPIMS modular trainings and receive system use competency certification.	% of CPIMS users demonstrating system use competency skills.	HKID	$300,000	Palladium/County Measurement, Learning and Accountability Program 18318	12. Technical and Allocative Efficiencies: 6.103

Weak capacity to demand and use data for policy making, program planning, and management.	Support the DCS and 14 focal counties to increase demand for and use of CP data through regular data reviews, production, and dissemination of reports during the quarterly data review. Develop and institutionalize CPIMS mentorship programs on basic data analysis, presentati	Children Services Data Demand and Use (DDU) framework in place and institutionalized at all levels. 100% (300) of staff at DCS and focal counties demonstrate increased use data for policy making, planning and program management.	DDU framework developed, reviewed and endorsed by key stakeholders at national and focal counties. 100% of DCS staff and 25% of focal county staff complete DDU modular curriculum.	100% (300) of all targeted staff (DCS and county) complete DDU modular curriculum and receive DDU competency certification.	% of focal staff who have successfully completed DDU modular training and received certification.	HKID	$300,000	Palladium/County Measurement, Learning and Accountability Program 18318	12. Technical and Allocative Efficiencies: 6.104

	on, and interpretation skills. **Sustained Epi Control**								
Lack of information systems for tracking and reporting OVC MER Outcome results.	OVC MER outcome measurement: **1st 90**	MER OVC Outcome Assessments and Impact survey results reported to OGAC	Constitution of survey teams and completed plan ready for execution by the partner	Survey conducted and results disseminated	PEPFAR Kenya Number of MER OVC Outcome assessments years completed	HVSI, HKID	$200,000	Measure Evaluation IV 17964	12. Technical and Allocative Efficiencies: 6.105
OVC Sub-Total							**$2,750,000**		
Prvention									
Low HIV risk perception among young people under 30 year	Demand creation and advocacy for risk reduction and reduce high risk behaviour	Increased HIV risk perception among young people under 30 years by 15%	Increased uptake of HIV prevention products and services among young people by	Increased uptake of HIV prevention products and services among young people by 10% under 30 years	Delayed sexual debut, increased uptake of HTS, VMMC, and increase risk perseption	HVAB	$3,257,353	HCM, 13868	SID score 4.21 under Service Delivery

	s. **First 90**		5% under 30 years						
High HIV incidence among AGYW	Primarily target AGYW ages 10-24 years at the highest risk of HIV infection with a comprehensive package of evidence based interventions. These include orphans and vulnerable children, young people who are head of their households, girls and young women	Reduced risk of HIV acquisition, increased use of SRH and HIV services, reduced sexual violence,	6,890 AGYW reached with evidence based prevention interventions	Saturate this intervention in the selected subcounty in Nairobi informal settlements.	Number of AGYW receiving a comprehensive package of evidence based HIV prevention interventions	HVAB	$1,571,448	HOPE 12054	SID score 4.21 under Service Delivery

	who have been sexually abused, girls who have dropped out of school, and will also work closely with parents and families of AGYW, schools, and communities. **First 90**								
Weak quality (QI) service systems	Review and strengthening of national quality improvement guidelines and policies. **Sustained EPI Control**	Strengthened national and county quality improvement guidelines policies and systems	Revised national guidelines on policies and systems for QI	This activity will be reviewed	National revised guidelines on policies and systems for QI disseminated	HVOP	$117,647	ASSIST 7305	SID score 4.21 under Service Delivery

Limited integration and Implementation strengthening for combination prevention programs for Key and prority populations	Improved identification of HIV infected and PrEP: A**chievement of first 90, Sustained EPI Control**	Optimal coverage of high quality combination prevention interventions for Key and Priority populations in all focus counties. Strethening integration of services; identification of HIV infected target populations, retention on ART and viral suppression; scale up of PrEP. 90% of Key and prority populations tested 90% on	Support for implementation of strategies that enhance service delivery for Key and Priority populations, CSOs involvement, legal enhancement and County Governments. 80%of Key and prority populations tested 71% on ART 85% virally suppressed. 3 KP TWG and coordination meetings held.	Improve efficiencies in implementing high quality HIV combination prevention interventions for Key and Priority Populations. Increasing access by strethening integration. 90% of Key and prority populations tested 80% on ART 90% virally suppressed.4 KP TWG and coordination meetings held.	Number of KP TWG and coordination meetings held. % of KPs and PPs tested, on ART and virally suppressed	HVOP	$582,353	MOH 18213	SID score 4.21 under Service Delivery

		ART 90% virally suppressed . 4 KP TWG and coordination meetings held.							
Lack of policy frame work HTS strategies and weak national coordination of quality assurance of HIV Testing services	Support National coordination and policy formulation to enhance service delivery of HIV testing services towards. A**chievement of the first 90**	Increased knowledge of HIV status in the population and coverage of PLHIV enrolled into HIV treatment services	Support formulation of policy framework and roll out HIV self-testing and partner notification services (Index client contact testing) to increase HTS coverage and identificatio	Support National coordination and standardization of HIV testing services to enhance quality of HIV testing services	Guidelines for HIV self-testing and Partner Notification services developed. Panel testing Uptake among HTS providers. Accreditation of training HTS institutions.	**HVCT**	**$300,000**	MOH 18213	SID score 4.21 under Service Delivery

			n of PLHIV.						
Weak national coordination of policy and Implementation of programs for People who inject drugs (PWID).	Support for national coordination of policy and Implementation strengthening of programs for People who inject drugs (PWID). **Sustained EPI Control**	Optimal coverage of high quality MAT services and related harm reduction services to PWID in Counties with a high IDU burden. 40 county health managers and 67 Service Providers supporting Harm Reduction programs	Support for implementation strategies that enhance interface between PWID communities and service delivery systems including clinics, CSOs, families of PWID, legal enhancement and County Governments. 15 county health managers and 25	Improve efficiencies in implementing high quality Harm Reduction programs, including Medically Assisted Treatment Programs (MAT). Increase the number of service providers and county health managers supporting Harm Reduction programs. 20 county health managers and 33 Service Providers supporting Harm Reduction programs	Guidelines for supporting a low-threshold-high impact service delivery model for MAT among PWID.	**IDUP**	**$300,000**	MOH 18213	

			Service Providers supporting Harm Reduction programs						
Prevention Sub-Total							**$6,128,801**		
MNCH									

Improve coordination of PMTCT services, PMTCT coverage and quality clinical services	Support to National PMTCT program - NASCOP for policy development and capacity building. **Sustained epi control** Support coordination of national PMTCT program, develop/review guidelines for service delivery and support compliance with standards for service delivery**.** **Sustained epi control** - Improve Lab-	1. Development and desimmination of revised edition of PMTCT guidelines and emtct framework 2 .Improved coordination of PMTCT services both at the National & County level 3. Greater involvement of the private sector to support PMTCT services and reporting. 4.PMTCT ART Increased coverage to 95%	- 100% implemenation of the revised PMTCT guidelines & emtct framework. Well coordinated PMTCT services, with routine national TWGs and support supervisions - 90% of HIV + pregnant women receive ART - 75% of HIV patients on ART have at least one viral load result per year - Reducing breakthrough infection, trends	- 100% implemenation of the revised PMTCT guidelines & emtct framework. Well coordinated PMTCT services, with routine national TWGs and support supervisions --95% of HIV+ pregnant women receive ART. - - 85% of HIV patients on ART have at least one viral load result per year - Less than 50/100,000 or less than 5 % (ref. EMTCT framework)	Number of counties implementing revised PMTCT guidelines - No. of National PMTCT TWG meetings held in a Year -Number of HIV + pregnant women on ART. - Number of HIV patients on ART with at least one viral load result per year as documented in the Laboratory Information System (LIS) -No.of HIV infected infants at 24 months of birth	MTCT	$1,514,706	MOH 18213	SID score 4.21 under Service Delivery

	Clinical interface, strengthen and address all gaps within the viral load testing spectrum. - **3rd 90**	5. Lower country transmission rates or absolute number of infected children (whichever comes first). Current national transmission rate at 8.3% 6. 95% of HIV patients on ART have at least one viral load result per year	towards year 2 outome						
Limited coordination of sample transportation from facility to the central testing laboratories, leading to long turn around times and delays in the identification of HIV infected infants.	Support the National PMTCT Program in the coordination and Transport of EID samples from the	A well coordinated EID sample transport system with reduced turn around time between	75% of facilities reporting positive pregnant women networked to the central testing labs and facilitated	95% of facilities reporting positive pregnant women networked to the central testing labs and facilitated to query results by use of sms short code	100% of facilities reporting positive pregnant women networked to the central testing labs and facilitated	**MTCT**	**$400,000**	Aphia Plus HCM - 13868	SID score 4.21 under Service Delivery

	facilities to the testing laboratories and return of results to ensure prompt identification and intiation on Treatment of all HIV infected infants.	sample collection and return of results.	to query results by use of sms short code		to query results by use of sms short code. Turn around time reduced to ≤ 2 weeks				
MNCH Sub-Total							**$1,914,706**		
TB									
Limited co-ordination of HIV/TB services and limited use of data for program management, planning and policy formulation/evaluation	Activity: Support to strengthen HIV/TB services co-ordination and reporting platform and ensure improved co-ordination and program	100% National and county HIV/TB programs demonstrate coordinated HIV/TB services and increased use of data in planning, management and	50% National and county HIV/TB programs demonstrate coordinated HIV/TB services and increased use of data in planning, management and policy	75% of counties hold quarterly HIV/TB stakeholders coordination meetings regularly	Number of counties effectively implementing coordinated HIV/TB services and using HIV/TB program date for planning and management. Number of HIV/TB	HVTB	$1,500,000	Centre for health Solutions (CHS) Kenya / TBARC	4.21 (SERVICE DELIVERY)

	data is used in management, planning and policy formulation: **Sustained Epi Control**	policy development for HIV/TB program.	development for HIV/TB program.		stakeholders' coordination meetings held per year.				
Weak national coordination of policy and Implementation of surveillance, diagnosis of HIV associated TB and drug resistant TB programs among People living with HIV.	Support for national coordination of policy and Implementation of surveillance and diagnosis of HIVTB and and Drug resistant TB towrads, case identification Treatment and viral suppressions among TB	100% integrated HIV and TB casefinding across HIV and TB cascades, universal HIV testing and ART for TB patients and drug succeptability testing for TB and presumed TB patients. - 100 % Gene Xpert uptake among eligibles - 100 %	Development and dissemination of policy, guidelines and tools for HIV TB Surveillance and screening across testing and treatment cascades. - 60% Gene Xpert uptake among eligibles - 97% ART uptake among HIVTB patients	Support policy implementation for improved HIVTB surveillance - 90% Gene Xpert uptake among eligibles - 100% ART uptake among HIV TB patients	% of PLHIV with presumed TB getting Gene Xpert test and % ART uptake among HIV TB patents. Data source: MER indicator, SIMS and program data.	HVTB	$470,588	MOH 18213	4.21 (SERVICE DELIVERY)

	patients and PLHIV. **Sustained Epi Control**	ART uptake among HIVTB patients							
TB Sub Total							**$1,970,588**		
TOTAL TABLE 6.3							**$53,757,623**		

Table 6 Total: **$72,152,446**