Kenya

Country Operational Plan

(COP/ROP) 2018

Strategic Direction Summary

April 10, 2018

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1.0 Goal Statement

Through strong partnerships with the Government of Kenya (GOK), Global Fund, civil society, the UN Joint Team on HIV/AIDS (UNJT) and bilateral stakeholders, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) in Kenya has made tremendous strides towards achieving epidemic control. In 2004, only 7,800 People living with HIV (PLHIV) in Kenya were on anti-retroviral treatment (ART); at APR17, 1.04 million people were on ART, including 47,522 pregnant women. Kenya's successes in FY17 include the launch of Pre-Exposure Prophylaxis (PrEP), assisted partner notification (PNS) and expansion of male-targeted and adolescent HIV services. Of the 1.04 million Kenyans on ARVs, 83% are virally suppressed.

The GOK has continued to be a leader in adopting health policies to address changes in the HIV epidemic. In 2014, UNAIDS rolled out Fast-track targets ("90-90-90 by 2020" and "95-95-95 by 2030") to control the epidemic, and in 2015 the World Health Organization (WHO) released guidelines for "Test and Start". As such, the GOK revised national guidelines for same day treatment initiation for PLHIV, differentiated models of care and task shifting to better meet patient needs and streamline service delivery. Notably, in the past two years, policies for Test and Start, PrEP, voluntary medical male circumcision (VMMC) and elimination of mother-to-child-transmission (eMTCT), as well as guidelines for key populations and self-testing were finalized and disseminated. PEPFAR Kenya has been fully implementing differentiated service delivery models since 2017.

Through aggressive, geographically aligned, gender and age-band focused targets, PEPFAR Kenya will accelerate progress toward epidemic control in all counties. To reach 95-95-95 targets, emphasis will be placed on key and priority populations as well as focused age-band high-yield testing and increased linkage, retention, and viral suppression of women aged 15 -24 and all men. PEPFAR will scale up prevention and treatment services and find innovative solutions to services in underserved informal settlements. Building upon current successes, PEPFAR will optimize case finding methods identified as high-yield and cost-efficient, such as Partner Notification Services (PNS) and integrated HIV testing services (HTS) and TB screening. PEPFAR will continue to support the Determined, Resilient, AIDS-free, Mentored, and Safe (DREAMS) program by identifying the most vulnerable through girl roster data, linking girls enrolled in orphans and vulnerable children (OVC) programs, and targeting pregnant adolescent girls and young women (AGYW) (ages 15-24 years) attending antenatal clinics (ANC). A client-centered market research approach will be initiated in order to improve VMMC uptake among prioritized age groups.

PEPFAR will use results from Kenya's Population-based HIV Impact Assessment (KENPHIA) to confirm performance gaps, refine testing strategies in the high burden areas of Homabay, Kisumu, Migori, Nairobi and Siaya, and better respond to any epidemic shifts in other counties. In order to assure the most effective use of funds, PEPFAR will work to assure partner funding aligns with targets and performance through enhanced monitoring.

In COP18, PEPFAR expects to test 8.2 million Kenyans, including 6.4 million adults, 411,043 children and 1.1 million pregnant women for case finding and prevention across all HIV testing modalities; initiate 182,811 new patients on ART to support 1,273,604 PLHIV current on treatment by end of September 2019; circumcise 300,000 men, focusing on 15-29 year old boys and men; reach 252,000 AGYW with DREAMS services (of which 154,464 are OVC) and serve 792,342 OVC (of which 157,464 will receive complementary support under DREAMS); and improve viral suppression rates to over 90%. Once these goals are achieved by September 2019—across gender and age-disaggregated populations—Kenya will have exceeded 84% national ART coverage.

With continued GOK leadership, epidemic control is within reach; and through targeted efforts and strong partnerships, Kenya will be on a path to sustain these gains.

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 44.2 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 2012/13[1] to 6.7% in 2015/16[2] and further increased to 7.6% in 2016/17 (MoH, 2016/17) with contributions to HIV/AIDS, increasing from 18.8% in Kenya fiscal year KFY2012/13 to 25.5% in KFY2015/16 (2015/16 National Health Accounts). Kenya demonstrates bold leadership in supporting the Sustainable Development Goals. The Kenya AIDS Strategic Framework (KASF) is fully aligned with the global 90-90-90 targets by 2020 and 95-95-95 by 2030 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 2016 UNAIDS report estimates a total of 1,517,707 adult and pediatric PLHIV in Kenya (Kenya HIV Estimates 2015). With this estimate, Kenya has approximately 77,647 new HIV infections and 35,800 HIV-related deaths per year, with an estimated 98,170 children living with HIV (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 (Homabay, Kisumu, Migori, Nairobi and Siaya) 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 years and 3.97% vs. 2.26% among those aged 15-24 years) (NACC, 2015; NASCOP, 2014).

[1] National Health Accounts (NHA 2012/13)
[2] National Health Accounts (NHA 2015/16)

More recent data suggest that the HIV burden may be lower than previously estimated. Preliminary SPECTRUM-based estimates from the accelerated UNAIDS Data 2018 indicate that 2016 and 2017 PLHIV estimates were 1,480,000 and 1,490,000, respectively. In addition, routine ANC (RANC) data for the former Nyanza Province (Hombay, Kisii, Kisumu, Migori, Nyamira and Siaya counties) suggested that the official estimated HIV prevalence for the region in 2015 was approximately 15% higher than expected. Given the high coverage of antenatal care (96%) and coverage of HIV testing in ANC (93%) [KDHS 2014], PEPFAR Kenya triangulated RANC results as compared to community serological surveys and explored the comparison of RANC with SPECTRUM estimates to understand the areas of divergence between sources. During COP17 and early COP18 implementation, the KENPHIA will be conducted. In order to assure that COP18 is fully responsive to the present-day HIV epidemic, a second phase of COP18 will be developed based on preliminary data from KENPHIA.

Overall, significant progress has been made in the number of PLHIV who know their status and are enrolled in ART. By the end of FY17, 1,159,325 PLHIV had been tested for HIV, and of these 1,041,326 were receiving life-saving antiretroviral therapy. This was largely facilitated by the strong collaboration between PEPFAR, GOK, Global Fund (GF) and other key stakeholders, accelerating Kenya's efforts to achieve 90-90-90 targets by 2020 as outlined in the KASF. Significant achievements include the rapid rollout of Test and Start guidelines, differentiated care models, robust defaulter management systems to minimize loss to follow-up and maximizing retention in care and treatment.

Elimination of mother-to-child transmission of HIV remains a key goal of Kenya's HIV epidemic response. In FY17, due to health workers strikes and extended presidential elections, Kenya recorded lower than expected achievements in PMTCT indicators: 69% PMTCT_STAT and 66% PMTCT_ART compared to FY16 of 75% and 76%, respectively. Despite this low performance, 98% of those attending 1st ANC knew their HIV status with a similar 98% initiating ART among those eligible. Overall, 85% (58,437/68,556) of HIV exposed infants (HEI) had an initial PCR test, of whom 3.5% (2,027/58,437) were HIV infected. The national eMTCT framework launched in 2017 provides an opportunity to close these gaps in COP18 through data use for decision making at all levels, tracking of missed opportunities, HEI screening at maternal child health clinics (in- and out-patient departments) and optimizing transmission and utilization of early infant diagnosis (EID) results.

To address HIV prevention needs for AGYW, Kenya scaled up implementation of interventions through DREAMS. At the end of FY17, 144,821 AGYW (ages 10-24 years) were cumulatively enrolled in the four initial DREAMS sub-national units (SNU) (Homabay, Kisumu, Nairobi and Siaya, combined accounting for 44% of new infections) against a target of 180,000. During FY18, coverage is expanding in these counties as well as to three new SNU (Kiambu, Migori and Mombasa combined account for 14% of new HIV infections). This will bring the total number of AGYW enrolled to 252,000. Beyond enrollment, a key focus of the DREAMS initiative is both HIV

prevention and risk avoidance for AGYW through a combination and layering of age-appropriate evidence based interventions. Preliminary analysis of APR17 data demonstrated a 25-40% decline in new HIV diagnoses among young (ages 15-24 years) pregnant women in three of the four original DREAMS SNU. COP18 provides an opportunity to build on this success to optimize coverage.

Based on the overall VMMC rate in Kenya of 91% (KAIS 2012), the national program targets non-circumcising communities in the former Nyanza Province, parts of Rift Valley, and pockets of other counties. Kenya introduced a second national VMMC strategy in 2014 targeting 1,001,757 circumcisions, addressing cultural barriers to achieve 80% coverage in all focus counties by 2019. Counties with VMMC 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 VMMC coverage above 80%, but which host pockets of non-circumcising populations, were also prioritized (Busia, Kericho, Nairobi, Nandi, and West Pokot). Nine of the VMMC focus counties are also prioritized for ART scale up to saturation while two are in the sustained category (Nandi and Kericho), which have large pockets of non-circumcising communities requiring VMMC services for epidemic control. Kenya has continuously met VMMC targets, largely through an enabling policy environment, 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 continue technical support towards the design and initiation of Early Infant Male Circumcision (EIMC) policy, PEPFAR 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.

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). High HIV prevalence rates persist among KP, ranging from estimates of 18.2% among MSM, 29.3% among FSW, and 18.7% among PWID (NASCOP, 2015). Fisherfolk in the lake region of western Kenya constitute a priority population (PP) with an estimated 26% HIV prevalence (KEMRI, 2015). These demographic and epidemiological data are summarized in table 2.1.1 and 2.1.2 below. The PEPFAR-supported KP program provides a comprehensive package of biomedical and behavioral package of services for prevention, diagnosis and treatment of HIV, sexually transmitted diseases and viral hepatitis. Despite availability of services, uptake remains suboptimal, largely because of stigmatization and criminalization of KP behavior. 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% to 34%, respectively. To address these gaps, PEPFAR invests in the sensitization of health workers and relevant authorities, as well as KP community engagement approaches including funding of KP led organizations to deliver services directly to community members and regular Civil Society Organization (CSO) stakeholder engagement for program guidance. To sufficiently respond to KP needs, PEPFAR in collaboration with GOK and other stakeholders will carry out a KP size estimate study and an integrated

biological and behavioral survey (IBBS). Targets and resource allocation may be adjusted during phase 2 of COP18 to better meet the needs of these important populations.

In COP 2017, PEPFAR Kenya Key Population program embarked on institutional and organizational capacity building of key population led organization with for increased capacity to implement health programmes and ability to fundraise for own projects. Currently 7 Key population organizations namely Health Options for Young Men on AIDS and STIs (HOYMAS, Nairobi), Bar Hostess Empowerment Support Program (BHESP, Nairobi), Men Against AIDS Youth Group (MAAYGO, Kisumu), Nakuru Youth Development Education Support Organization (NYDESO, Nakuru), Mamboleo Peer Empowerment Group (MPEG, Kiambu), Busia Survivors (SSG, Busia) and Tamba Pwani (Kilifi) to increase capacity to develop and implement HIV and AIDS, and violence prevention and response programs in addition to fundraising for own developed programs. Preliminary assessment work is going on for capacity building of the following Key Population led organizations in COP 2018; SAPTA in Nairobi, Nyarwek in Kisumu, Nyanza RHS in Kisumu, ISHTAR MSM in Nairobi, NOSET in Nairobi and KISWA in Kisumu.

Achieving sustained epidemic control will be predicated on achieving optimal coverage of clinical and prevention interventions as well as a number of systemic processes falling into place along the 95-95-95 cascade. PEPFAR addresses key programmatic gaps in the clinical cascade in the Country Operational Plan for FY 2019 (COP18) in the context of achieving HIV epidemic control, strengthening the national sustainability profile, and leveraging transformative health systems investments.

Standard Table 2.1.1 Host Country Government Results

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		201,440		67,147		696,457		454,493		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

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	%	
															<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)	2.6 million		979,000		1,042,000		291,000		286,000						KAIS 2012
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														

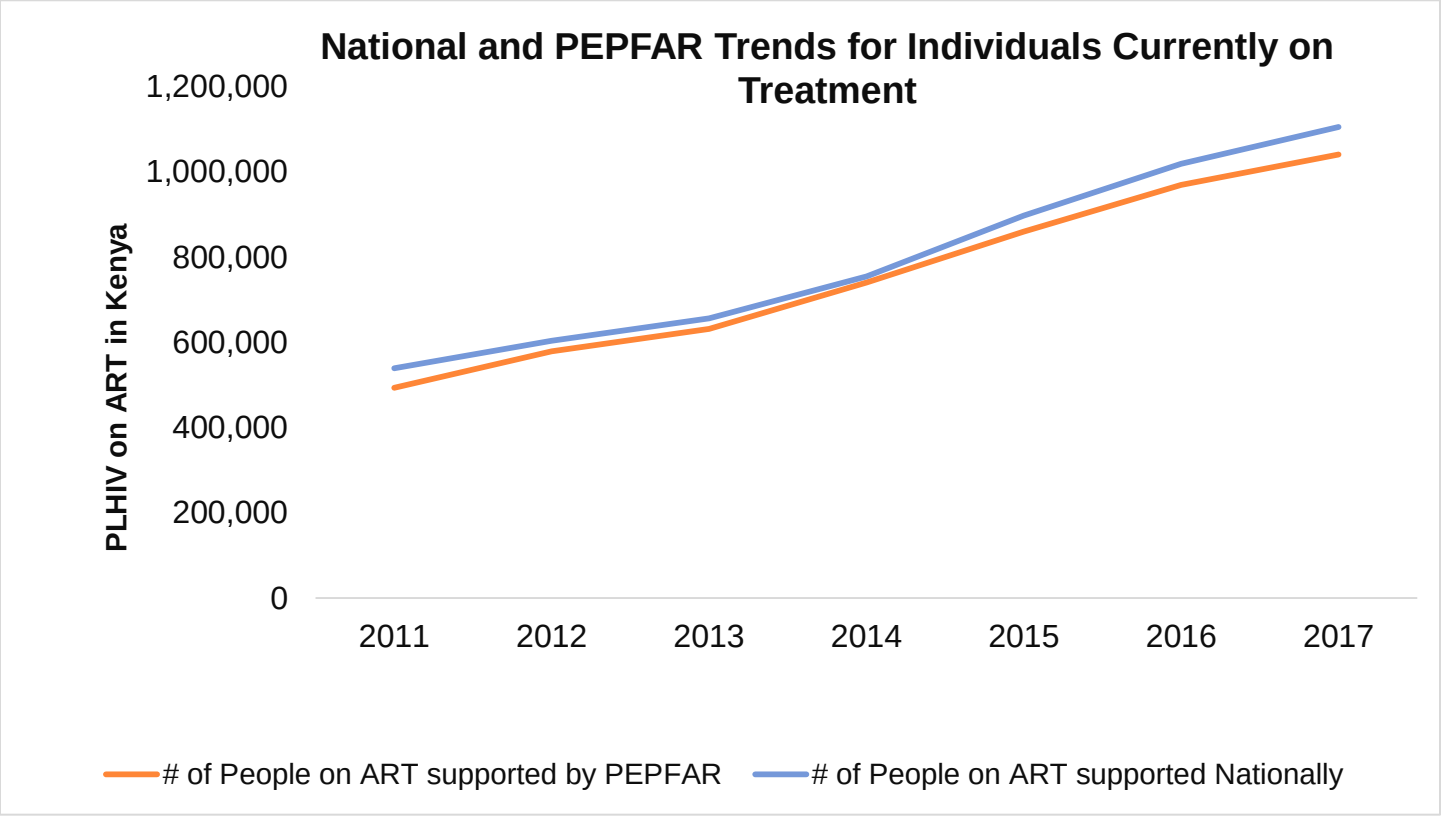
Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
FSW HIV Prevalence		29.3%					n.a.	n.a.			n.a.	n.a.			IBBS 2010-2011; NASCOP, 2015
Estimated Population Size of PWID	28,935														
PWID HIV Prevalence		18.7%													
Estimated Size of Priority Populations (Fisherfolk, Prisoners, Military, Uniformed Population)	**All 577,865**[d]**:** Fisherfolk 123,065; Prisoners 85,273~200,000; Uniformed Population 108,000; Military 30,000; AGYW 15-19, 117,096; AGYW 20-24,		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.

Standard Table 2.1.2: 90-90-90 cascade: HIV diagnosis, treatment and viral suppression

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	5.91*	1,517,707	1,159,235	1,041,326	68.6%	85%	12,998,823	190,247	149,963
Population <15 years	18,389,873		98,170	91,847	81,346	82.9%	65%	2,267,108	10,698	10,092
Men 15-24 years	4,423,280	2.26	67,147	33,645	33,645	50.1%	73%	1,504,515	9,446	5,490
Men ≥25 years	8,182,974		454,493	269,802	269,802	59.4%	87%	2,357,883	51,660	40,592
Women 15-24 years	4,432,411	3.97	201,440	84,991	84,991	42.2%	80%	2,490,086	26,382	20,792
Women ≥25 years	8,728,045		696,457	572,194	572,194	82.2%	87%	3,467,666	75,419	73,004
MSM	57,321									
FSW	138,665									
PWID	28,935									
Priority Pop (specify)										

* Numbers subject to change once the Kenya disaggregate tool is completed and approved.

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment
(Source: PEPFAR Annual Program Reports 2011-2017; NASCOP ART Reports 2011-2017)



2.2 Investment Profile

The GOK remains committed to ending AIDS by 2030, making strategic investments in health to maximize impact while increasing domestic resources to sustain the national HIV/AIDS response. Further, the GOK's prioritization of affordable healthcare for all as a

key economic pillar will advance progress made to ensure equitable and affordable access to essential health services, particularly for the disadvantaged, vulnerable and poor in Kenya, and including people living with or affected by HIV.

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 Kenya Fiscal Year (KFY) 2012/13[3] to 6.7% in 2015/16[4] and further increased to 7.6% in KFY 2016/17 (MoH, 2016/17). However, Out-of-Pocket spending remains a large source of health financing (26% of total health spending in 2015/16), placing vulnerable households at greater risk of incurring catastrophic or impoverishing health expenditures (estimated at 6.2% in 2013). Available fiscal space continues to limit the expansion of funding to the health sector. The large proportion of government revenue used to finance debts and wages, coupled with slow economic growth and demand from other competing sectors limit the capacity to expand health resources. The clamor for higher wages by public sector employees resulting in ongoing nationwide health worker strikes has contributed to the ballooning public wage bill (52% of government revenues in KFY 2017/18), leaving few resources to be used for health or other services.

While public sector contributions to HIV/AIDS have increased from 19.8% in KFY 2012/13 to 25.5% in KFY 2015/16[5], donors remain the predominant source of HIV financing, contributing 62% of HIV expenditures in KFY 2015/16. Kenya's contribution as part of its GF counterpart financing requirement was $22 million in 2016/17 for procurement of ARVs and test kits and is expected to increase by $4 million in KFY 2017/18. This is further expected to increase to $31 million by KFY 2020/21. However, donors continue to finance the majority (86.4%[6]) of all ARV needs in Kenya.

On average, county governments increased the proportion of their total budgets allocated to health from 13.9% in KFY 2013/14to 25.2% in KFY 2016/17[7] 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 increasing financial commitments to the HIV program totaling $4 million in KFY 2016/17. Anticipated increases in salary increments resulting from the ongoing labor disputes are expected to significantly impact county allocations to health. However, current efforts to rationalize staff and cleanup payroll will help contain the wage bill (currently 70.6% of county allocations in KFY 2016/17) thereby freeing up resources to finance drugs, medical supplies or other critical service delivery inputs.

[3] National Health Accounts (NHA 2012/13)
[4] National Health Accounts (NHA 2015/16)
[5] HIV Sub Account/NHA 2015/16
[6] Global Fund application 2017
[7] MoH National and County Health Budget Analysis (2016/17)

Given the above, significantly greater domestic financing for health and HIV is needed to reduce donor dependency and sustain progress made in controlling the HIV epidemic. Increased 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 health insurance reforms and other measures that could ensure greater returns on investment. Innovative financing such as those which engage private sector will continue to be explored as a means to expand uptake of HIV services, de-congest the public sector and ensure long-term sustainability of the HIV response.

Standard Table 2.2.1: Annual Investment Profile by Program Area

Table 2.2.1 Annual Investment Profile by Program Area

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	397,868,457.80	54.90%	7.70%	34.30%	0.00%
Community-based care, treatment and support	13,153,253.00	100.00%	0.00%	0.00%	0.00%
PMTCT	46,227,124.10	49.90%	0.00%	48.30%	1.80%
HTS	70,903,570.60	60.00%	0.70%	39.40%	0.00%
VMMC	15,337,522.00	100.00%	0.00%	0.00%	0.00%
Priority population prevention	12,450,020.90	95.60%	4.40%	0.00%	0.00%
AGYW Prevention	839,003.00	0.00%	100.00%	0.00%	0.00%
Key population prevention	12,387,097.10	70.30%	28.60%	0.00%	1.10%
OVC	81,382,545.60	48.20%	0.00%	0.00%	51.80%
Laboratory	42,518,378.00	60.90%	17.20%	21.90%	0.00%
SI, Surveys and Surveillance	25,314,130.30	54.00%	46.00%	0.00%	0.00%
HSS	7,721,900.80	96.60%	0.00%	0.00%	3.40%
Total	726,103,003.30				

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Standard Table 2.2.2: Annual Procurement Profile for Key Commodities

Table 2.2.2 Annual Procurement Profile for Key Commodities					
Commodity Category	**Total Expenditure**	**% PEPFAR (a)**	**% GF (b)**	**% Host Country (c)**	**% Other**
ARVs	115,883,863	51%	40%	8%	
Rapid test kits	21,885,865	39%	29%	33%	
Other drugs	8,439,000	99%	1%	0%	
Lab reagents	6,557,502	45%	55%	0%	
Condoms	5,115,585	0%	100%	0%	
Viral Load commodities	21,956,123	100%	0%	0%	
EID	897,752	97%	3%	0%	
Program Management	7,000,000	100%	0%	0%	
Other (equipment)	3,106,981	100%	0%	0%	
Total	**190,842,671**	**59%**	**32%**	**9%**	

(a) USAID KEMSA Medical Commodities Program, FY2017

(b), (c), MOH, appropriation accounts for FY 2016/17

Standard Table 2.2.3: Annual USG Non-PEPFAR Funded Investments and Integration

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	Non-PEPFAR Resources Co-Funding PEPFAR IMs	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
	Non-PEPFAR Resources				
USAID MCH	16,000,000	1,361,678	5	126,735,080	Supporting quality services for maternal and child health, supply chains, strategic information, and other health system components
USAID TB	5,000,000	4,835,073	1	1,500,000	Improving TB diagnosis, care and treatment
USAID Malaria	3,0500,000	7,876,968	7	121,201,846	Supporting malaria prevention and treatment, supply chains, strategic information, and

					other health system components
USAID Family Planning	26,000,000	4,941,996	5	126,735,080	Support FP services, supply chains, strategic information, and other health system components
Nutrition	4,000,000	2,375,536	3	13,229,204	Support nutrition interventions in the country
NIH					
CDC (Global Health Security)					
Peace Corps					
DOD Ebola					
Quarantine	303,000	-	2		Surveillance of migrant populations and refugee camps
CDC DTRA	369,725	-			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 and detecting threats , responding to international emergencies and reconstructing health systems
Global Health Security: Program Costs	3,908,588	1,149,508	1	-	Help develop health systems that prevent avoidable epidemics, early threat detection and rapid and effective response
Global Public Health Capacity Development	45,000	-	2	-	Global Health Protection research to KEMRI and Ministry of Health (MOH)
Improving Program Effectiveness	135,900	-	1	-	HIV AIDS clinical research
Malaria	335,374	-	1	-	Malaria research
Pandemic Influenza	857,884	-	2	-	Flu research
CDC OD	1,319,127	-	-	-	Management support
MCC					
Total	**92,368,012**	**42,001,971**	**48**	**185,921,563**	

PHOENIX FY 2017

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

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**
Other Public Private Partnership		300,000				
Total		**300,000**	-	-		

PHOENIX FY 2017

2.3 National Sustainability Profile Update

The 2018 Sustainability Index and Dashboard (SID) 3.0 results show some progress in Kenya towards sustained epidemic control. Three elements scored dark green suggesting that no further investment is required in these areas (Planning and Coordination, Policies and Governance, and Quality management); six (6) elements are light green suggesting that little to no investment is required (CSO engagement, Private Sector Engagement, Public Access to Information, Technical and Allocative Efficiencies, Financial/Expenditure Data, Performance Data); six (6) elements are yellow (described below) and will need some degree of support. No elements scored red.

Sustainability Strengths:

- **Policies and Governance:** National AIDS Control Council (NACC), National AIDS & STI Control Programme (NASCOP) and the GOK continue to lead the country in the development of key health and HIV policy and strategy documents that serve as the foundation to guide all key stakeholders on how and where to invest in the HIV response. Notably in the past two years, Test and Start, VMMC as well as eMTCT policies, guidelines for key population and self-testing were finalized and disseminated. In addition, all 47 counties finalized and disseminated costed County AIDS Strategic Plans with funding and leadership of NACC. Coordination and implementation of these and other key policies remain critical elements to propel the country towards epidemic control.

- **Quality Management:** Under SID 2.0, the country planned and witnessed an increase in the coordination and capacity of the

MOH, including NACC and NASCOP, to institutionalize management information systems, strategic plans, workforce development programs and other key inputs to ensure that modern quality improvement methodologies are applied to managing and providing HIV/AIDS services. While the country has a Kenya HIV Quality Improvement Framework (KHQIF) in place, it still relies on donors to implement these structures at the county and facility level.

- **Technical and Allocative Efficiencies:** Kenya's adoption of a Program Based Budgeting approach has helped counties to prioritize and improve resource allocation for health and HIV. Although the government (national and county level) has increased its allocations to HIV, poor budget execution remains an issue. Moreover, donors continue to finance the majority of ARV needs. The public health insurer (NHIF) has integrated HIV in the benefit package, however HIV is not reimbursed given the extent of donor subsidies. Studies will be undertaken to explore efficiency improvements through differentiated service delivery models, but also through the costing of an essential benefit package (inclusive of HIV services) to be financed through insurance.

- **Financial/Expenditure Data:** The MOH is supported by PEPFAR to routinely conduct national/county level budget analyses, and monitor trends in health and HIV expenditures through use of National Health Accounts (NHA), including the HIV sub-account, the Kenya National AIDS Spending Assessment (KNASA) and select County Health Accounts (CHA). These data are used to inform advocacy and planning for increased allocations to health and HIV, monitor shifts in domestic financing (including household spending), and influence budget execution.

Sustainability Vulnerabilities:

- **Planning and Coordination:** Despite improvements in this area, much remains to be done to ensure adequate planning and coordination, and to improve efficiency in resource use particularly given the roles of NACC, NASCOP and county governments under the devolved system of government.

- **Human Resources for Health (HRH):** Kenya has inadequate capacity to meet all local staffing needs at facility and community level. HRH management capacity at national and county government levels remains limited for achievement of PEPFAR service delivery targets. Support to engage professional unions and strengthen capacity for negotiations is needed to minimize ongoing labor disputes and avoid disruption of services**.**

- **Commodity Security and Supply Chain:** Despite marked progress in this area, devolved units will need to be targeted for strengthened commodity management and infrastructure at county, sub-county, facility and community levels. County leadership and oversight of supply chain functions remains weak and requires continued support even while domestic resources are being mobilized for commodity procurement and supply chain systems strengthening.

- **Laboratory**: Laboratory systems were prioritized given the critical role in testing, care and treatment continuum. There is a broad strategic plan in place that covers policy, quality assurance, technical guidance and HRH. A health economist will map out resource allocations and funding streams and monitor progress to help develop implementation frameworks and road maps for improving quality assurance and routine monitoring. The road maps will set targets with benchmarks. The technical capacity of the MOH to perform more complex laboratory tests will be expanded. Additionally, more complex testing such as viral load (VL), (EID) and HIV drug resistance will be transitioned from research settings to public health institutions. With new molecular diagnostic labs established, competent staff will be required to run them.

- **Domestic Resource Mobilization:** Although national and county governments are contributing more resources for health and HIV, financing of the HIV response remains heavily donor dependent (in particular, donors finance ~90% of ARV needs). To maintain and expand current HIV program gains, PEPFAR is supporting the GOK to mobilize adequate domestic financing including through health financing reforms that focus on pre-payment schemes that will reduce out of pocket spending, as well as potential private sector contributions.

- **Epidemiological and Health data:** Surveillance activities are largely driven by donors. MOH capacity should be strengthened to improve coordination for KP surveillance as well as coming up with a single national agenda for KP surveillance and surveys. Some counties carry out surveys but still depend on development partner funding. Expanded incidence surveillance is needed in additional counties. Incidence data are available, but fine age and sex disaggregation is not uniformly available.

Additional Observations:

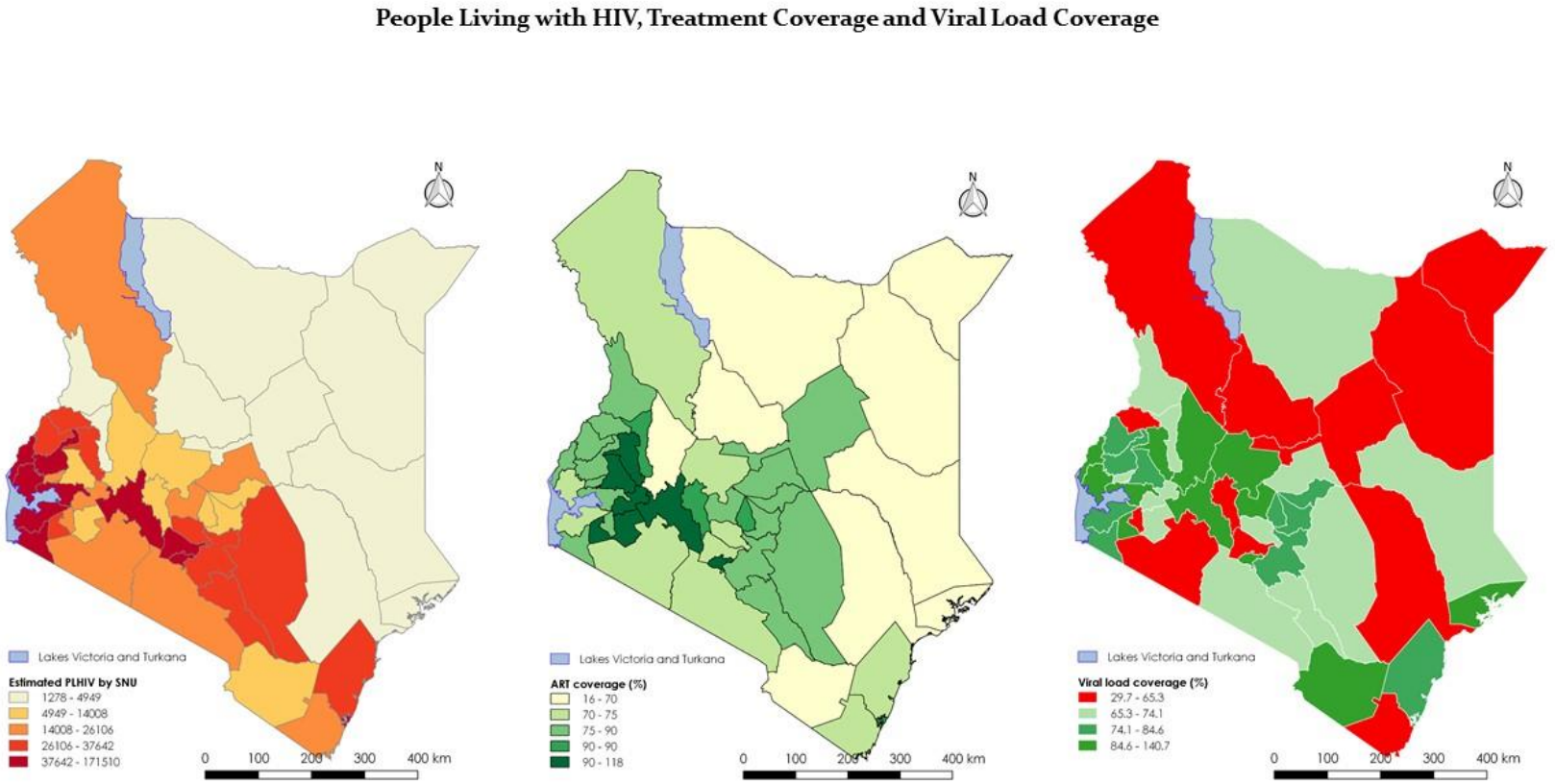
Civil Society: stakeholders could benefit from additional PEPFAR training to ensure effective advocacy, accountability audits and engagement in PEPFAR and other HIV-related processes. Further, NACC in partnership with NASCOP will continue to champion the engagement of county leadership in the SID process and has mobilized USG support to adapt the national tool for use at county level.

2.4 Alignment of PEPFAR investments geographically to disease burden

Consistent with COP16 and COP17, PEPFAR investments are aligned geographically to HIV burden. As expected with program-based budgeting, strategic objective costs varied across implementing mechanisms due to different service delivery models between government, non-government and private facilities; higher costs in hard-to-reach areas; and patient density in high burden counties that reduce overall strategic objective costs. The overall PEPFAR investment continued to reflect the geographic alignment started in COP15 and ensures concentration of investments in the five highest burden counties (Nairobi, Homabay, Kisumu, Siaya and Migori) to close the remaining ART gap as well as to accelerate progress towards attainment across all scale up (high burden) counties. The investment was lower in the six (6) sustained counties, and even lower in the seven (7) lowest burden counties which were categorized as sustained commodities for COP18. 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 the same as those used in COP17.

Funding projections for meeting the COP 2018 prevention targets were based on assessments of what partners actually spent in achieving similar targets in FY17 (Expenditure analysis of 2017). Reductions and increments where applicable were made based on proposed changes in approaches or projected efficiency savings.

Figure 2.4.1: People Living with HIV, Treatment Coverage and Viral Load Coverage



2.5 Stakeholder Engagement

The PEPFAR interagency team continues to engage all key external stakeholders—national and county government entities, the UNJT, GF, civil society, private sector and professional bodies—throughout the program cycle. For COP18 planning, the interagency team engaged stakeholders in various fora to ensure coordination on strategic, programmatic, technical and policy advocacy issues with national and shared priorities. This engagement included focused discussions with county health management teams and public administrators in high burden counties, including a series of high level discussions with the five high burden counties representatives as well as the Council of Governors (CoG) leadership. The PEPFAR interagency team continues to meet during the quarterly POART and ad hoc meetings with CSO, UNAIDS and UNJT, GF as well as the GOK, to disseminate program results and information as well as obtaining input on programs with specific considerations for human rights, gender, people with disabilities, KP and PLHIV perspectives. All written feedback from key stakeholders was incorporated into the COP18 plan. In addition to addressing the detailed program issues and priorities raised in the COP18 SDS as part of the sustained dialogue with all stakeholders, the USG interagency team will maintain stakeholder engagement throughout the COP17 implementation process as well as in a phased COP18 II approach, if required.

3.0 Geographic and Population Prioritization

The HIV epidemiologic profile used in COP18 was based on 2015 UNAIDS estimates of 1,517,707 PLHIV (1,419,537 adults ≥15 years and 98,170 children <15 years). However, additional considerations were made based on: a) preliminary SPECTRUM estimates from the accelerated UNAIDS 2018 data process which indicated the possibility of a lower HIV burden of 1,490,000; and b) data triangulation from various points indicating that the HIV burden in western Kenya may be lower than the spectrum model estimate. Despite the potential changes in actual burden, the five counties prioritized in COP16 and 17 as having the highest HIV burden remained unchanged, accounting for nearly 45% of the national HIV burden.

Based on the national data, ART coverage increased from to 969,433 (64%) in FY16 to 1,041,326 (69%) in FY17. However, analysis by finer age and sex disaggregates revealed significant disparities: ART coverage among children was 83% compared to 68% among adults; ART coverage among women was 59% for those aged 15-24 years old and 82% for those aged 25+ years, compared to 38% and 47% among men of similar age groups. Based on the COP18 revised definition of attained, no county met the new geographic criteria of having achieved ≥90% treatment coverage in both males and females within all age bands. As a result, the two (Embu and Kericho) counties classified as attained in COP17 were reverted to the sustained county category in COP18.

Among the five highest burden counties, Homabay and Siaya lagged behind with ART coverage at 62%; this compares to 68%, 77% and 83% 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 a prevalence of ~25% according to KAIS 2012).

ART uptake among KP (MSM, PWID and FSW) remains suboptimal nationally. FY17 program data show an average ART uptake of 43% across all key population groups.

In FY17, 227,000 males were reached with VMMC services translating to 90% achievement of annual targets. All focus counties except Nandi and Nairobi achieved ≥ 80% VMMC uptake. However, APR16 data indicated that even in the counties where the 15-29 age band had been saturated based on the available modeling data, more men in need of VMMC were identified, making a strong case for continued expansion and validation of the VMMC coverage estimates; this is scheduled for COP18.

Review of 2015 HIV estimates indicated that the original four (4) counties selected for DREAMS program in COP15 and 16 (Homabay, Nairobi, Kisumu and Siaya) continue to have disproportionately high number of new HIV infections among 15-24 year olds in Kenya, collectively accounting for 44% of the 268,586 incident HIV infections. The three additional counties included in COP17 DREAMS expansion (Migori, Mombasa and Kiambu) also have a high

HIV incidence with 7%, 4% and 3% of national estimates, respectively. Thus, the focus of COP18 will be geographic and population expansion within these counties, aiming to achieve saturation before expanding to other counties.

Based on program performance, the PEPFAR interagency team maintained the COP17 geographic prioritization strategy for most counties in COP18. These include 25 counties prioritized for scale up to saturation to achieve ≥ 81% ART coverage and to close the coverage gap among men, children, youth 15-24 years old and KP. In addition, nine (9) counties are prioritized for aggressive scale up, putting them on a trajectory to achieving ART saturation by FY20.

In COP18, therefore, 182,811 new patients will be initiated on ART, bringing the total current on ART to 1,273,604 including 417,442 adult men, 93,928 children and 214,869 youth (15-24 years). In line with the pivot, 95.7% of the ART patients will be within the 34 counties prioritized for scale up to saturation, with the five highest burden counties accounting for 45%.

Within prioritized counties, PEPFAR will target efforts to reach sub-populations at greater risk for HIV, with higher HIV prevalence and with reduced access to services such as populations within any geographic hot-spot (towns, transport corridors, beaches, informal settlements, etc.); men; adolescents and young people 15-24 years; KP including FSW, PWID, TG and MSM; uniformed personnel including the military; prison populations; and fisherfolk. To achieve these ambitious targets, targeted provider initiated testing, PNS and concentrated community testing for KP will be implemented. Additionally, special emphasis will be placed on creating synergies across prevention of mother-to-child transmission (PMTCT), orphans and vulnerable children (OVC) and DREAMS, VMMC, and KP to ensure these are optimized. ART optimization, including roll out of Dolutegravir (DTG)-containing regimens as the preferred first-line antiretroviral treatment will begin in FY18. This transition will be sustained in FY19 for all eligible populations including children ≥ 10 years and ≥ 30 kilograms.

Based on these aggressive targets, PEPFAR will support the country to achieve ART coverage of 84% in COP18. With gender and age-focused strategies, ART coverage will be increased to 62% for adolescents and young adults aged 15-24 years, 72% for men, 95% for women and 95% for children <15 years based on the 2015 PLHIV estimates. With this prioritization, PEPFAR will support Kenya to reach sustained epidemic control ensuring that no one is left behind. PEPFAR will continue to provide technical, programmatic and financial oversight to partners in prioritized SNU to assure quality and implementation fidelity.

Table 3.1: Current Status of ART Saturation

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP18**	**# Current on ART (FY17)**	**# of SNU COP17 (FY18)**	**# of SNU COP18 (FY19)**
Attained	0	23,532	2	0
Scale-up Saturation	1,214,876	876,017	25	25
Scale-up Aggressive	231,413	118,431	9	9

Sustained	52,654	12,647	4	6
Sustained Commodities	18,765	7,527	7	7
	1,517,707	**1,038,154***	**47**	**47**

*excludes military

4.0 Program Activities for Epidemic Control in Scale-Up Locations and Populations

4.1 – 4.3 COP18 Programmatic Priorities for Epidemic Control

4.1 Finding the missing, getting them on treatment and retaining them

COP18 targets are focused to achieve the 95-95-95 goals across all finer sex and age disaggregated bands. Targets are based on PLHIV 2015 estimates, preliminary PLHIV 2017 estimates (national; not yet disaggregated by county), APR17 achievements and expected coverage in FY18. A cascade approach considering gaps in identification, treatment and retention of HIV positive individuals among children <15 years, youth between 15-24 years and adults 25+ years by gender was employed to reach the 95-95-95 goals at the national level. APR17 and FY18 data analysis reveal identification and linkage gaps among children <15 years, young people aged 15-24 and men 25+ years; suboptimal testing and identification of PLHIV among KP and <80% VMMC coverage among men aged 25+ years in target counties also persist.

In COP18, PEPFAR will implement high yield facility and targeted community based testing approaches to identify 190,852 PLHIV and link at least 95% to treatment. Fidelity of HIV testing, screening and linkage tools rolled out in FY17 will be monitored at all sites in scale up counties to direct testing of individuals most likely living with HIV, reduce over testing and link all identified positive individuals. High yield strategies such as PNS to diagnosed HIV positive clients and patients with high VL and other similar approaches will be scaled up at all sites with a target to identify 31,760 of the HIV positive target in COP18. To increase identification and linkage of PLHIV among key and priority populations, targeted community outreach testing will be employed alongside PNS, scale up of comprehensive drop-in centers (DICE) and same day ART initiation. HIV self-testing will be offered on the platform of all test modalities in high burden counties to reach men and partners of HIV positive individuals unwilling to avail themselves at health facilities for a test with referral for facility testing information for all reactive cases. HIV diagnostic and index client testing approaches will be employed in sustained SNU. VMMC pivot-aligned client centered demand creation will be implemented to increase coverage among the 25+ "hard-to-reach" age band.

TB-HIV

Kenya is a high TB burden country with a prevalence of 558/100,000 and a 50% TB case detection rate[8]. In 2017, 85,188 of 169,000 WHO estimated incident TB cases were notified, 29% of which were

[8] National TB prevalence survey 2016

HIV positive[9]. The majority (87%) of co-infected TB/HIV cases were within the 34 counties that account for 95% of PLHIV. In Kenya, 97% of identified TB patients are tested for HIV and 98% of TB/HIV patients are on ART during TB treatment[10]. While TB and HIV services are integrated in nearly all PEPFAR supported sites with high (96%) uptake of TB symptom screening of PLHIV, the low yield (2%), high TB prevalence and low case detection, despite multiple contact of TB patients with health providers, suggest the need for a more aggressive approach to screening and diagnostic evaluation. This will entail further integrating screening for TB and HIV among patients attending OPD, which has been shown to have a case identification for both TB and HIV. This strategy will be employed in facilities that have not optimized OPD HIV testing. High TB-HIV case fatality among notified patients further calls for improved TB diagnostics and quality of care.

The GeneXpert® mycobacterium TB and rifampicin resistance (MTB/RIF) test is the initial diagnostic test for PLHIV presumed to have TB. A total of 157 GeneXpert® machines have been installed in laboratories spanning each county in Kenya and a specimen referral network has been established to cover all HIV treatment sites countrywide. Efforts are underway to optimize machine utilization from the current 50% to 80%. There has been marked improvement in the implementation of TB infection prevention and control at site level with over 90% of sites meeting expectation during site improvement through monitoring system (SIMS). Since 2015 Kenya has been scaling up isoniazid preventive therapy (IPT) among PLHIV. To date over 800,000 PLHIV (80% of those currently on treatment) have been initiated on IPT with support from the MOH, GF and PEPFAR. PEPFAR played a critical role in developing and operationalizing IPT policy documents, engaging implementing partners and monitoring the integration of IPT into the standard package of HIV care in various service delivery models.

In COP18, PEPFAR will support provision of IPT to patients not previously on preventive therapy and initiate 90% of newly enrolled patients. Concurrent efforts will build the capacity of site level staff on topics including the identification, management and reporting of adverse drug reactions and other events. In addition, PEPFAR will support the GF evaluation of IPT and TB screening cascades and outcomes in various TB-HIV integration models and use the results to improve the quality of services. PEPFAR will continue to support forecasting and quantification for IPT commodities, printing of tools and evaluation of the impact of IPT on the HIV-TB epidemic. GF will continue to procure the bulk of the required isoniazid and pyridoxine, as PEPFAR supports buffer stocks. To improve case detection, PEPFAR will support the integration of active TB case finding in HIV testing at all service delivery points, procurement of limited stocks of TB urine lateral flow lipoarabinomannan assay (TB-LAM) for hospitalized patients and support the development and operationalization of a revised TB diagnostic algorithm that includes HIV testing of all presumed TB patients. Investments will concentrate on strengthening and expansion of the specimen transport networks for GeneXpert® testing and drug resistant TB surveillance; expansion of continuous quality improvement to cover GeneXpert® assay, smear microscopy and TB culture through external quality assurance including proficiency testing will be bolstered. Resources will be set aside for the scale up

[9] WHO 2017 global TB report
[10] PEPFAR DHIS DATIM APR 2017

of previously supported activities including: universal HIV testing of patients with 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; maintain proper TB infection prevention in health care settings, conducting surveillance of TB among health care workers; support routine TB screening and contact tracing in HIV, MCH, prison clinics and other hospital settings, diagnostic work-up and appropriate management as per the national TB guidelines; and monitoring and evaluation, including integration of the TB electronic recording and reporting system (TIBU, which also means "to cure" in Swahili) with existing electronic medical record (EMR) systems and provision of tools.

Adult treatment

Kenya has made substantial progress with increasing the number of adults living with HIV on ART in the past 15 years. By the end of FY17, 1,041,326 (69%) out of the estimated 1,517,707 PLHIV (UNAIDS, 2015) were on ART, representing a 7% (71,893) increase from APR17 (969,433). The geographic prioritization of COP18 is similar to COP17, where 45% of total patients targeted for treatment were in five (5) high burden counties. At APR17, two (2) counties (Embu and Kericho) that had been prioritized as attained and contributed 2% of all on treatment. However, these counties are being reprioritized as sustained upon analysis of gender and age-band disaggregated data. The remaining 34 scale up counties—both saturation and aggressive—contributed to 95% of those on treatment. In FY19, PEPFAR aims to increase the total number of children and adults on ART to 1,273,604 in order to achieve an overall ART coverage of 84%; 75% in males, 89% in females and 95% in children <15 years. To attain epidemic control, PEPFAR aims to achieve ≥ 90% ART coverage in the five (5) high priority counties and ≥ 80% in all scale up to saturation counties by end of FY19. To accomplish these ambitious targets, Kenya will initiate 182,811 new patients on ART, 25% of whom will be from the five (5) high burden counties and achieve a net new ART of 113,241.

Following the successful launch and implementation of the 2016 ART guidelines, recommending that all PLHIV be enrolled onto treatment, Kenya's focus has been to retain all patients in HIV medical care and foster adherence to ART for optimal and durable viral suppression. One of the proven strategies to retain patients will be to expand differentiated care by frequency of service. As of APR17, about 50% of eligible patients had elected a form of differentiated service delivery. Kenya expects to increase this to 60% and 70% in FY18 and FY19, respectively. In addition, patient centered models will be expanded to other populations, such as children and adolescents, with a focus on 200 high volume sites in 20 high burden counties and 500 high volume sites in 27 high burden counties in FY18 and FY19, respectively. As part of retaining men in treatment, Kenya plans to enhance peer support through male support groups led by expert patients, especially for those newly enrolled as well as those who are experienced on treatment, and establishment of male friendly corners in health facilities, a model that has demonstrated good results in Lesotho. In addition, Kenya will strengthen the peer mentor model, building on the success demonstrated by flexible clinic hours for men and leverage clinical decision support technology to track defaulters and those lost to follow-up, especially in high burden counties. In

order to initiate and maintain optimal quality of care to ensure adherence and hence durable viral suppression, Kenya plans to roll out optimized ART regimens by the end of FY18. As previously mentioned, the roll out of DTG as a first and second line treatment for adults, pregnant women and for children ≥ 30 kilograms will begin in FY18 as evidence reveals it to be efficacious and safe with a high genetic barrier of resistance. Kenya will continue to monitor implementation of these strategies through monthly and quarterly reviews, SIMS assessments, performance tracking, and monitoring visits as well as data triangulation to improve overall performance and achievement of COP18 targets. Retention will be tracked by timing of ART initiation, age-band and gender at site, county and implementing mechanism level in order to identify areas for program improvement.

When scaling up VL monitoring, Kenya performed 1,011,308 VL tests in FY17 (among the 1,041,326 PLHIV on ART); after accounting for repeat testing, the VL uptake was 90%. In 2017, 85% of adults (25+ years), 64% of adolescents (10-19 years) and 65% of children (<15 years) accessing VL testing were virally suppressed (https://viralload.nascop.org). In FY17, Kenya strengthened its VL capacity by hiring additional staff, increasing the availability of testing equipment within laboratories, expanding and strengthening VL sample transport and return of results networks, and bolstering the NASCOP VL database to monitor uptake and suppression. To support achievement of 90% viral suppression in FY19, focus will continue towards: enhancing clinic-based quality assurance systems to increase patient access to VL testing; increasing the use of the national, web-based laboratory management information system to streamline sample–results management via remote sample log-in and printing of results at the peripheral site level; and expanding clinical mentorship.
Viremia clinic implementation is a proven, patient centered approach to improve viral suppression for patients with non-suppression. This approach will be scaled up in COP18 from 685 clinics to 1795 clinics in FY19. Through this approach, case managers and clients focus on treatment literacy in sessions during clinic days, intensified adherence counselling is provided, and regular communication is reinforced via phone calls/SMS reminders on adherence and appointment days.

Facility and community-based care and support

Kenya will continue to support: expansion of differentiated care models; adherence and retention strategies especially for men <30 years of age on treatment, young women and pregnant and breastfeeding women; pharmacovigilance; human resource strengthening especially to enhance linkage to treatment; and VL access and suppression through demand creation and optimized use of VL results 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 co-trimoxazole, cryptococcal meningitis screening, ART monitoring as per national 2016 guidelines and promote positive health, dignity and prevention (PHDP). In addition, Kenya will prioritize TB prevention and treatment through optimized TB screening, improved diagnosis using GeneXpert and TB-LAM and IPT among all eligible PLHIV.

PEPFAR Kenya has been implementing differentiated service delivery models since 2017, which has reduced the transaction costs for patient travel to facilities, increased peer support and community involvement, reduced workload from the health worker's perspective and has maintained and improved patient outcomes. As part of patient centered care, treatment literacy will continue to be offered to stable patients in differentiated models including multi-month prescriptions, fast tracked patient flows and the option of community ART pick up. PEPFAR will work to ensure there is adequate linkage between the facility and communities for both data capture and referrals. Linkage registers and facility referral tools will be used to track and facilitate follow-up as well as complementary support to develop monitoring and evaluation instruments including ART distribution forms, fast-track forms and registers.

In COP18, Kenya will intensify and scale up PHDP interventions and patient literacy to all PLHIV ≥15 and their caregivers at all HIV clinical settings and in the community to prevent onward transmission of HIV as well as to maintain the health of patients. PHDP interventions will be delivered by health care providers, counselors and peer educators. Services will include risk reduction, STI screening, FP counselling, adherence and retention interventions, knowledge of status, partner testing, disclosure counselling as well as psychosocial support groups for all PLHIV. Adherence and retention in care strategies will be strengthened. Meaningful involvement of PLHIV (MIPA) to enhance adherence and retention will be scaled up including peer models such as mentor mothers, adolescent and adult peer mentors, PHDP and evidence based medication adherence interventions such as Operational Triple Zero (OTZ) at both facility and community levels. Adolescents and young people (AYP) ≥15 years will receive both OTZ and PHDP interventions.

Pediatric Treatment

The HIV estimates for pediatric patients (<15 years) in Kenya decreased from 159,731 (UNAIDS, 2014) to 98,170 (UNAIDS, 2015); consequently, ART coverage in CLHIV was 82% as of APR17. Even though Kenya has reached ≥80% ART coverage in high burden counties, there remains a substantive number of new infections in HEI (<1 year) and treatment gaps remain among older children infected with HIV. Similarly, the estimated ART unmet need for adolescents aged 10-19 years remains high at 49%. There was a substantive improvement in the quality of pediatric care in FY17 as identified through SIMS visits, especially pediatric testing, ARV dosing and treatment monitoring and improved access to adolescent services; however, linkage to community services remains suboptimal.

In FY19, PEPFAR in collaboration with the MOH will implement targeted, high impact interventions across pediatric and adolescent clinical cascades. Momentum gained in FY18 will be leveraged to reach 93,705 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; index testing; routine screening of HEI and EID; in-patient testing; universal HIV screening for all eligible OVC; and prioritized out-patient screening. Use of technology will be piloted and scaled up in an effort to minimize testing of ineligible children. Early identification and linkage to ART for HIV infected infants will be enhanced through

optimized HEI screening, enhanced uptake of EID within 2 months of birth and enhanced mother-infant pair follow-up through longitudinal cohort tracking. 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 and IPT; and strengthening defaulter tracking systems to improve retention. Differentiated service delivery models will be strengthened to enhance retention in care. 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. The OVC platform will be utilized for HIV testing, psychosocial support and adherence support at the community level. The majority of testing services targeting OVC are provided at outreach sites; separate outreach registers are used to document these services.

Currently, viral suppression among children and adolescents is at 66% but ranges between 61% for 10-19 year old males to 70% for 15-19 year old females. As 90% of children and adolescents are on NNRTI-based regimens (NVP or EFV), they are at greater risk of developing drug resistance with suboptimal virologic control. Specific strategies to address viral suppression in pediatric patients (<15 years) and youth (15-24 years) include OTZ scale up: current program data for OTZ reveal promising outcomes with an increase of viral suppression for members enrolled in OTZ for at least 6 months from 77% to 84%. OTZ will be scaled up from 21 implementing partners to all 31 PEPFAR implementing mechanisms in Kenya to reach 58,000 AYP's from a baseline of 11,000. Other strategies include adoption of more friendly and durable 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. In COP 18, the program will support universal uptake of LPV/r based first line for this population and caregiver ART literacy training.

PEPFAR will work in collaboration with the MOH to operationalize transition to TLD for eligible children and adolescents ≥ 10 years and ≥ 30 kilograms. Treatment monitoring will be strengthened through: routine VL testing; enhanced, age appropriate adherence assessments; counselling and disclosure for children and adolescents; prompt shifts in the ARV regimen 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, and

peer support through the highly successful OTZ[11] scaled up 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 FY19, GF will continue to support procurement of first and second line pediatric ARV; LPV/r pellets were availed in FY17 and roll out is currently ongoing. In addition, systems support for pediatric implementation at facility and community levels will be provided, in collaboration with GOK, GF and other key stakeholders.

4.2 Prevention, specifically detailing programs for priority programming:

a. HIV prevention and risk avoidance for AGYW and OVC

DREAMS: The DREAMS Kenya Program provides a comprehensive package of biomedical, behavioral and structural interventions that primarily target adolescent girls and young women ages 9-24 years in seven DREAMS SNUs (Homabay, Siaya, Kisumu, Migori, Nairobi, Kiambu and Mombasa). The core package of services includes HTS and linkage to ART; PrEP promotion and provision; Condom education and provision; contraceptive method mix and post-violence care); school and community-based HIV and violence prevention social asset building; educational subsidies; cash transfers; parenting/caregiver programs; combined socio-economic approaches), community mobilization and norms change and characterization of male sexual partners (MSP) of AGYW ages 15-24 and linkage to Condoms, HTS, VMMC and ART. The program will strengthen HIV risk avoidance and prevent violence in girls aged 10-14 through incorporation of modules on sexual consent and importance of delayed sexual debut.

By end of FY17, PEPFAR had cumulatively enrolled 144,821 AGYW (ages 10-24 years) in the four original DREAMS SNUs against a target of 180,000 with an age group ratio of 30:41:29 (10-14, 15-19 and 20-24, respectively). In FY18, we planned to increase coverage to 252,000 AGYW and expand to three new SNUs (Kiambu, Mombasa and Migori). In FY19, Kenya will maintain the FY18 targets of reaching 252,000 AGYW ages 9-24 years and increase coverage in all the seven DREAMS SNUs. Scale up of DREAMS will be achieved through criterion-based partial and full graduation of AGYW ages 18-24 years. Parents/caregivers of AGYW and beneficiaries of cash transfer will be sensitized on the short term availability of cash transfer to avoid building expectation that CTs will be available on long term. Transitioning plan based on case management will be done to allow for partial graduation, which will be applied to AGYW who have received cash transfer, economic strengthening and educational subsidies to free up opportunities for new beneficiaries to access social protection interventions. Full graduation will be based on criteria such as attaining maximum layering for required services, economic independence, completion of school

[11] Operation triple zero is an asset based approach, where HIV-infected adolescents support are empowered to take charge of their treatment and encourage peers to achieve zero missed appointments, zero missed pills and zero viral load.

or vocational training, and/or transition to national or county government social protection programs and empowerment to negotiate condom use, and independently access SRH services such as condoms, contraception, PrEP and HTS.

Of the 252,000 AGYW to be reached in FY19, the distribution of AGYW targets by SNU was informed by the 2015 adult HIV incidence and AGYW population in the priority SNUs (Homabay-49,025; Siaya-40,134; Kisumu-44,366; Nairobi-35,794; Kiambu-34,283; Mombasa-20,416; and Migori-27, 982). The table below shows the distribution of targets by age group.

FY19 Targets by Age Group

Age Group	9-14	15-17	18-19	20-24
# of AGYW	50,400	91,728	54,936	54,936
%	20%	36.4%	21.8%	21.8%

As PEPFAR recruits new beneficiaries, we will prioritize orphans and vulnerable children (OVC) currently enrolled in our OVC programs in DREAMS SNUs. In FY19, nine OVC partners will be supported to offer DREAMS interventions to eligible AGYW. PEPFAR is currently promoting innovative ways of enhancing participation among young women ages 20-24 years to accommodate their child-care and economic responsibilities. In FY18 and FY19, PEPFAR will work with clinical partners to develop and roll out a standard operating procedures (SOP) for referral of pregnant AGYW below age 24 from ANC clinics to DREAMS programs to enhance uptake of services among AGYW ages 20-24. In FY19, PEPFAR will reach 136,080 AGYW with school and community based HIV & violence prevention interventions; 201,600 AGYW with HTS services; initiate 7,510 AGYW ages 18-24 years on PrEP; provide condom education to 141,120 AGYW; offer post violence care services to 25,200; support 32,054 young women to gain vocational skills or start income generating activities; reach 39,413 parents and caregivers of AGYW ages 9-18 with parenting/caregiver program; support 108,360 AGYW to remain in school or progress to secondary schools. In 2018, the GOK implemented the free day secondary education policy. This policy and stakeholder efforts to monitor uptake of secondary education will contribute in delaying early marriages and reducing HIV risk among AGYW in DREAMS SNUs and nationally.

In FY18 and FY19, PEPFAR will continue to address areas with sub-optimal achievements:

VMMC among male sex partners*:* To reach male sex partners of AGYW ages 15-24 with VMMC services in Siaya, the DREAMS program will undertake VMMC information, education, communication (IEC) and mobilization among AGYW enrolled in DREAMS and scale up and track VMMC referrals for male partners. Girls and young women enrolled in DREAMS will be encouraged to discuss VMMC with partners and to facilitate VMMC referral for their partners.

PrEP_NEW: In FY17, 4,512 (30%) were newly initiated on PrEP. In FY18, PEPFAR will continue to engage communities to address misconceptions about PrEP and build the capacity of health care

workers to normalize PrEP and make it available to AGYW and other community members. PEPFAR clinical partners will support health facilities to roll out PrEP to all populations to expand access in DREAMs SNUs which in turn will reduce stigma and enhance uptake among AGYW. In FY19, PEPFAR aims to initiate 7,510 new AGYW on PrEP.

***Combined Socio-economic (CSE) Approaches*:** By end of FY17, achievement in CSE interventions was low (13%). The PEPFAR country team is currently reviewing the implementation approach that partners are using and guiding partners to support market driven vocational training, linkage with private, national and county government entities to secure employment and entrepreneurship opportunities for our beneficiaries.

Parenting/Caregiver Programs: By end of FY17, we reached 17,856 (77%) parents and caregivers of AGYW ages 10-12 with Families Matter Program (FMP I). The FMP I will be adopted for expanded reach of parents and caregivers of adolescents ages 10-14. The Program did not offer FMP II to parents/caregivers of AGYW ages 15-19 years. We are currently adapting FMP II for parents/caregivers of AGYW ages 15-19 years and expect to roll out FMP II by FY18 Q3.

Post Violence Care Services: DREAMS provides comprehensive post-violence care package to AGYW enrolled in the program and adolescents reached through school-based HIV and violence prevention interventions. Our FY17 Q4 overall achievement was low (35%) with Nairobi having the highest achievement (81%) and all other posting less than a third of the SNU targets. While ongoing efforts to expand support of post-violence care services in all our care and treatment sites are progressing well, more effort will be required to sensitize communities and AGYW enrolled in our programs on service availability and to address the stigma and silence around gender-based violence (GBV). Training of health care providers and active case-finding in service provision points such as HIV clinics, out-patient, HTS points and MNCH by all PEPFAR implementing partners will expand access to services and enhance community sensitization on the importance of seeking post violence care services. In FY 17, PEPFAR supported the printing of MOH post GBV care registers and Post-Rape Care Forms; these tools will enhance tracking of services offered and reporting in the health sector. Justice for survivors of sexual violence is plagued by poor evidence collection and preservation, negating violence prevention efforts. In FY18, PEPFAR will support and improve access to justice for survivors of sexual violence by training health care providers in DREAMS SNUs in forensic evidence collection, supporting specimen preservation, transportation and complex analysis in central laboratories.

Collaboration with Global Fund: With additional resources available through GF targeting adolescents and young people in Siaya County, there will be close alignment at planning and implementation in order to optimize resource utilization for the greatest benefit.

OVC: Kenya has an estimated 2.6 million OVC (KAIS, 2012), of whom71.1% are orphans (single or double) and 28.9% vulnerable. There were. approximately 6,613 new infections among children

<15 years in 2015. The majority of these children reside in high burden counties (Kenya HIV Estimates Report, 2015). The estimated 36,000 annual AIDS-related deaths will lead to a continued increase in the number of AIDS orphans in Kenya (UNAIDS, 2015).

The PEPFAR OVC program aligns geographically to the HIV burden and where OVC unmet needs are greatest. In FY19, PEPFAR will reach 792,342 children and adolescents, of which 763,983 (96%) will be in the 25 scale-up to saturation and in the nine scale-up aggressive counties. This compares to FY18, where 95% of PEPFAR OVC targets were concentrated in the 25 scale-up to saturation and nine 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. This will be implemented through systematic case plan management and outcomes monitoring for OVC and their households using guidance and tools that are aligned to benchmarks for OVC programming in Kenya.

The GOK views OVC as a priority population in the national response to the HIV epidemic with clearly outlined strategies for improving child welfare through education, economic and social support. Social safety nets and protection programs targeting OVC households have been used to promote improved nutrition, school attendance and health service utilization. PEPFAR recognizes the need for programs and services for OVC focused on the delivery of a comprehensive set of core interventions. These include: basic health care; referrals for nutrition; linkages to HIV testing, care and treatment, including integration of adherence to ART; routine household monitoring; promotion of positive parenting; provision of psychosocial support to affected households; economic strengthening activities for households, such as group savings and loans, cash transfers and food subsidies; and education support for children.

Children infected with HIV who are identified through the facility and adolescent girls identified through DREAMS who are not receiving OVC support will continue to be prioritized as new entrants to the OVC program. The program will provide OVC services, including household economic strengthening interventions to the most vulnerable OVC living with HIV and the most at-risk AGYW among those already enrolled. The program will support interventions that target the caregiver and adolescent girls and strengthen the social welfare workforce. Eligible adolescents and their households will be assured access to HIV testing, treatment and care services, inclusive of a sexual risk screening of the most-at-risk children with unknown HIV status and violence exposure screening.

At the health facility level, the program will work closely with pediatric and PMTCT programs for integrated efforts to reach CLHIV with health, nutrition, education and protection services. The program will leverage on already existing maternal and child health (MCH) interventions to reach children <5 years at PMTCT within the child health and early childhood development (ECD) sites. The OVC program continues with community mobilization, monitoring growth for young children and providing referrals from the community to the facility for sick and malnourished children. Interventions for this age category will address cognitive stimulation, nutrition and

mitigation of developmental delays in HIV-exposed and infected children. PEPFAR will intensify health education and psychosocial support to OVC households through training local implementing partners, community health workers and other social welfare personnel e.g. community mentor mothers to identify, monitor, and link eligible households to counseling on grief, disclosure and positive living for children and their families. In order to achieve viral suppression among children and adolescents enrolled in PMTCT, the program, in collaboration with clinical partners, will build caregiver skills in parenting and care of HIV-affected, infected and exposed children and adolescents. Among partners who implement OVC at the facility level, OTZ training and tailored training of mentor mothers, lay counselors and social workers to support OVC viral suppression through home visits will be conducted. The training modules will include reinforcing adherence for children, fast tracking children <2 years and sick children living with HIV infected caregivers, including adolescent girls who are pregnant or breastfeeding and those who are failing on treatment. Data on viral suppression will be used to improve and refine the program through routine dashboard monitoring and integrated data reviews.

FY 19 Implementation strategy for reaching Young Women

PEPFAR will continue to implement DREAMS and employ community mobilization and engagement strategies to identify vulnerable in- and out-of-school adolescent girls. Mobilization strategies will include active recruitment and referral of young pregnant women at Antenatal care clinics (ANC), working with young women to define flexible safe space schedules and tailor interventions to fit in their lifestyles, making safe space activities relevant to the needs of the young women beyond HIV and reproductive health, working with young mothers to provide child friendly baby care arrangements that allow participation in dreams and economic activities and engaging male partners to support young women to participate in safe space activities. Based on need, the girls will be linked to health, HIV and other social services such as education, GBV protection and economic strengthening. Adolescent girls will be referred to reproductive health and other social services, including economic strengthening interventions and GBV prevention and mitigation. PEPFAR will mentor and coach the girls to be confident in advocating for their own needs and rights. Educational support will be provided to OVC by addressing barriers to enrollment, attendance and progression particularly for adolescent girls. OVC caregivers and adolescents will be supported to be more resilient to financial shocks through group savings and loan programs, as well as referrals and enrollment in social protection programs. As part of rights-based and gender transformative programming, PEPFAR will improve prevention and responses to violence and exploitation by supporting child protection. Working closely with DREAMS, the program will integrate regular GBV prevention sensitization at the facility and community while actively screening for GBV and linking OVC to comprehensive services including linkage to police, health care and justice. The program will participate in the county GBV technical working groups while strengthening GBV structures and working closely with Department of Children's Services (DCS) and stakeholders to carry out and disseminate the findings of the ongoing violence against children survey (VACS) in Kenya.

System level support will include participation in the review, development, dissemination and institutionalization of policies, guidelines, strategies 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. Through the community link desk persons (CHVs, community mentor mothers and social workers), the program will also work towards improving bi-directional clinical referrals to OVC programs and prioritize children and adolescents with poor retention and continued advocacy for same clinical appointment dates for children and caregivers, particularly in the high volume health clinics. The program will support ongoing evidence based strategies that enhance adherence and retention; these will be scaled up in addition to PHDP and patient literacy, MIPA, including Adolescent and Adult Peer Educators/Mentors, psycho social clubs and OTZ.

PEPFAR will continue to support ongoing efforts to roll out, strengthen and ensure optimal use of the national and county level Child Protection Management Information System (CPMIS) in collaboration with the DCS and other stakeholders. This system helps to flag highly vulnerable cases for additional follow-up, empowers local leadership with timely data for decision making and enhances advocacy for data ownership, resource allocation and monitoring of OVC activities. In FY19, PEPFAR will support OVC implementing partners (IPs) and DCS in focal counties, through trainings on CPMIS use, increase demand for and use of data through regular data reviews, dissemination of reports during quarterly data review meetings, and institutionalize CPMIS mentorship programs on basic data analysis, presentation and interpretation skills. In addition, all OVC IPs will focus on use and strengthening of the CPMIS, which is the DCS reporting system. DCS continues to roll out this system countrywide with support from various stakeholders.

Aligned with S/GAC guidance, further transition will occur in sustained counties in FY19 to scale-up in priority counties. Lessons learned from the Coordinating Comprehensive Care for Children (4Children) mechanism technical support in FY18 will be applied to select counties and local IPs in preparation for future transition and graduation.

Scale-Up Locations and Populations

In COP18, PEPFAR OVC programs continue to align with the epidemic profile and where OVC unmet need is highest. This approach to service coverage aligns geographically and programmatically with treatment scale up and DREAMS.

- PEPFAR will reach children (762,983) in the 25 scale-up saturation counties and nine (9) scale-up aggressive counties, approximately 96% of the COP18 target of 792,342 children and adolescent girls. Of the COP18 target, 635,228 are OVC (both girls and boys) and 157,464 additional OVC (adolescent girls between 10-17 years) who will be supported under DREAMS.
- COP18 investments per PEPFAR age categorization will comprise of <10 years (21%), 10-14 years (34%) and ≥15 years (45%) respectively. In APR 2017 (FY17) of the total OVC served, 23% were <10 years, 33% were 10-14 years and 44% were ≥15 years. The target continues to reflect

deliberate shifts in programming to focus on service package quality and accelerated transition of beneficiaries in sustained counties.

Sustained Locations and Populations

To address the complexity of transitioning children and families who are still in need of mitigation services, PEPFAR will work with the GOK and other stakeholders based on experiences from sustained commodities counties. Approaches will include:

- Cease enrollment of new beneficiaries and graduate/transition children and families on a rolling basis starting in the lowest burden counties using case plan readiness achievement guidance and tools.
- Provide targeted support to OVC households based on case plans developed to shift them towards self-sustenance.
- Support OVC who are CLHIV and ALHIV to access treatment and care services.
- Targeted secondary education support for most at risk OVC, especially adolescent girls.
- Intensive scale-up of household economic strengthening (HES) activities and targeted psycho-social support for households.

Age Band Interventions

Package of services for OVC <10 years

- Immunization, growth monitoring for young children and linkages to NACS.
- Access to health care with emphasis on eligibility screening for HIV testing, ART adherence, retention in treatment and care and viral suppression for all CLHIV.
- Child protection, birth registration and household succession planning including wills and inheritance.
- Early childhood support with cognitive/play materials and nutrition.
- Education support, primary school enrollment, attendance and progression (scholastic materials, bursaries and ancillary fees).

Package of Services for OVC age 10-14 years

- Health care with emphasis on eligibility screening for HIV testing, ART adherence, retention in treatment and care and viral suppression for all CLHIV.
- In and out of school health programs using age-appropriate materials (Families Matter I and II).
- Mentorship and coaching programs.

- Education subsidies to at risk OVC to access primary and secondary (bursaries and ancillary fees) to facilitate enrollment, attendance and progression.
- Protection services, including psychosocial support for OVC and caregivers, succession planning and basic legal documentation including birth certificates, post-rape care and GBV and other forms of violence care services.
- Support linkages to DREAMS services for adolescent and young pregnant girls such as cash transfers and safe spaces.
- Eligibility screening for HIV testing, ART adherence, retention in treatment and care and viral suppression for all HIV+ children.

Package of Services for OVC age 15-17 years

- Health care with emphasis on eligibility screening for HIV testing, ART adherence, retention in treatment and care and viral suppression for all HIV+ children.
- Adolescent referrals for reproductive health services and commodities (e.g. condoms) and other services including VMMC and HTS.
- Education subsidies to at risk OVC to access primary and secondary (bursaries and ancillary fees) to facilitate enrollment, attendance and progression.
- Vocational and entrepreneurial skills training for highly vulnerable out of school adolescents
- Protection services, including psychosocial support for OVC and caregivers, succession planning and basic legal documentation including birth certificates, post-rape care and GBV and other forms of violence care services.

Caregivers

- Targeted community mobilization to sensitize caregivers on the importance of HTS services for most at risk OVC, viral suppression and nutrition for CLHIV and linkage to age appropriate services.
- Health care with emphasis on eligibility screening for HIV testing, ART adherence, retention in treatment and care and viral suppression.
- Referrals for reproductive health services and commodities (e.g. condoms) and other HTS services.
- Link to post violence care services.
- Psychosocial support, support groups and disclosure for caregivers with young children and mentoring.
- In and out of school health programs using age-appropriate materials (Families Matter 1 and 11).
- HES for caregivers and linking them to social protection programs and existing resources.
- Community mobilization and norms change.
- Case plan development/refinement and monitoring outcomes towards achievement, graduation and transition benchmarks

Communities, Local Implementing Partners and County and National Government

- Strengthen case management and outcomes monitoring of children, adolescents and families through use of the recently developed guidance for benchmarks/case plan achievement for OVC programming in Kenya and the case plan achievement readiness assessment tools to inform development and refinement of existing case plans.
- Capacity building of GOK and local implementing partner structures to improve routine data collection and management.
- Engaging county structures for OVC service delivery quality improvement teams, e.g. Area Advisory and Locational Advisory councils (AACs and LAAC).

b. Children

Preventing mother-to-child transmission (PMTCT): As a lead technical partner to the MOH at both national and county governments, PEPFAR continues to provide technical support and direct PMTCT service delivery through implementing partners in alignment with the geographic and population pivot.

In FY17, due to health workers strikes and extended presidential elections, Kenya recorded lower than expected achievements in PMTCT indicators at 69% for knowledge of HIV status and 66% for ART, compared to FY16 of 75% and 76%, respectively. PEPFAR FY17 performance was similar with national MOH performance. Despite this low performance, 98% of those attending first ANC visits knew their HIV status with a similar 98% initiating ART among those eligible. Regarding EID coverage, 85% (58,437/68,660) HEI had an initial PCR test, of whom 3.5% (2,027/58,437) were HIV infected. Of these tests, only 64% (37,273/58,437) were tested at age <2 months while 36% (21,164/58,437) were tested between 2-12 months. PCR positivity was 3% (955) and 5% (1,072) respectively.

In COP 2018 (FY19), PEPFAR will continue to provide technical support and direct PMTCT service delivery through implementing partners that cover 65% (3,728/5,769) of health facilities within the 47 counties. These health facilities provide antenatal care to 1,218,514 (74%) of the 1,656,858 expected pregnancies and 83% of the 79,477 HIV infected pregnant and breastfeeding women in Kenya. The majority (82%) of these women will be in the scale up counties. HIV testing and ART uptake will continue to be optimized, aiming to at least maintain 98% achieved in FY17. Increased EID coverage will continue to be a priority in COP18, with an increased focus on early testing of HEIs. Ninety-five percent (62,424) of expected HEI will receive an infant virologic test, with 85% (54,605) receiving the test at age <2 months. Assuming 3.5% positivity among HEI, an estimated 2,194 HIV positive infants will be linked to treatment within PEPFAR sites.

To realign and achieve COP18 (FY19) targets in scale up aggressive and saturation counties, Kenya aims to optimize early ANC enrolment by leveraging on MOH-led community strategies to enhance referrals, improve known HIV status in all SNUs by optimizing HIV testing at ANC and post-natal period for women with either unknown or previously negative HIV status. Retesting of previously HIV negative women is done at 6 weeks, 6 months and thereafter based on risk per

current guidelines. Kenya will continue to enhance routine HEI screening at immunization clinics, outpatient and pediatric wards with referrals for follow-up of infected mothers and exposed infant pairs; conduct and utilize routine PCR positive audits results to review current strategies targeting underserved populations; provide same day ART initiation; transition to TLD-based regimen for pregnant women; provide psychosocial support for disclosure and adherence; optimize retention and tracking of mother infant pairs lost during follow-up; provide comprehensive clinical care monitoring of HIV infected pregnant and breast feeding women; and ensure effective referral to community based services. The Kenya Mentor Mother program will be scaled up to enhance the uptake of and adherence to interventions. Finally, the PMTCT program will enhance operationalization of the revised eMTCT framework and guidelines as well as fast track the roll out of revised monitoring and evaluation (M&E) tools.

The package in scale-up, saturation and high volume sites in sustained commodities support counties will include: optimizing the implementation of the minimum service delivery package with a focus on improved retention through mother-baby pair case management; enhanced interventions such as adherence counseling, pre-appointment and defaulter follow-up; risk reduction counseling and support groups focused on pregnant AGYW; use of VL monitoring; enhanced Mentor Mother engagement; and health worker recruitment, capacity building and mentorship. Additionally, Kenya will review and improve interventions targeting male partners in MCH settings including: index testing and partner notification; provision of HIV self-testing kits for partners of ANC clients; referral of negative male partners and male infants for VMMC; couples counseling and risk reduction support for discordant couples; and peer support groups and empowerment meetings for pregnant AGYW including referrals to OVC and DREAMS programs. Furthermore in these counties, family planning (FP) services will be integrated at ART clinics to reduce the unmet need for FP among HIV infected women of reproductive age. This will be complemented with the use of pregnancy intention assessment tools/checklists and FP support tools collected routinely from all women of reproductive age enrolled in the HIV program to appropriately identify individual client needs. Express treatment for stable patients (predominantly HIV positive women already on treatment prior to pregnancy) as a form of differentiated care will be adopted in PMTCT settings for stable patients and structured to meet the unique needs of HIV positive pregnant and breastfeeding women.

In the sustained and sustained commodities counties, PEPFAR will support commodity supplies, lab networking for VL and infant PCR, access and utilization of these results from the NASCOP EID website, and technical support to county level MOH including mentorship and supportive supervision, especially in high volume facilities. Previously, EID was conducted through the conventional molecular diagnostic instruments at strategically located labs through a robust lab referral network. Drug purchasing facility Unitaid, through the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) piloted the use of POC EID instruments (Alere Q) in 6 sites. This has now been rolled out in 12 sites with a plan to reach 45 sites at end of 2018. Meanwhile the MOH has laid the policy foundation for large-scale deployment of POCT for EID testing. It has developed

the “National POC implementation roadmap in Kenya” and “Utilization of multi-disease testing platforms for optimizing EID in Kenya”. This will lead to a structured scale-up of EID POC implementation starting with the hard-to-reach areas and those with long turnaround times.

c. Key Populations

The focus in COP18 for HIV prevention and treatment services among KP is on optimizing coverage, improving program quality and responses to loss in both prevention and treatment cascades. Services will be expanded to reach young KP, enhance flexibility in improving access, timely linkage and improving viral suppression. These efforts will facilitate optimization of linkage to treatment, enhanced retention, adherence and achievement of viral suppression for all cohorts. Sexual network testing strategies will be employed to enhance hot-spot based outreach services, with a specific focus on reaching younger MSM, FSW and PWID. Strategies to improve service uptake includes recruitment of youth peer leaders, health worker sensitization, targeted outreach and use of social media. The program will also strengthen health care worker sensitivity in provision of friendly and dignified integrated KP services, assuring that sub-grantees are also supported by institutional and technical capacity building alongside engagement of sub-grantees through review meetings to specifically add a statement in all job adverts prioritizing Key Populations candidates for vacant positions in the organizations. Roll out of differentiated care models for KP will be supported per national guidelines. PEPFAR will work with the KP Consortium to identify and engage transgender populations. PEPFAR will also work with KP communities to reduce stigma and discrimination at PEPFAR supported facilities.

The core package of services will include: condom and lubricant promotion, demonstration, distribution and promotion; targeted HTS; linkage and timely initiation on ART for those testing positive; TB screening and treatment; provision of PrEP for all eligible KP; screening and treatment for sexually transmitted infections (STI); peer education and outreach; risk reduction behavioral 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.

Innovative strategies to improve reach and HTS yield among KP will include: social network services (SNS); PNS; expanded peer outreach approach; and HIV oral self-testing. Since KP and their sex partners are at ongoing risk for HIV acquisition, the program will intensify scale up of screening and enrollment on PrEP as per the national guidelines.

In collaboration with the KP technical working group (TWG) and the Consortium, a review of monthly partner reporting will be conducted to monitor performance and enhance tracking of both KP prevention and treatment cascades with a view to improving reach, HTS, ART and VL testing coverage. Regular reporting and cascade analysis will facilitate timely opportunities to improve on cascade leaks. Linkage, adherence, patient literacy and other PHDP interventions will

continue to be provided to KP, particularly through meaningful involvement of KP living with HIV.

PWID services will be scaled up by adopting a high-impact-low-threshold model to increase access to high-risk injecting users and their social networks. A human rights based approach will continue to be employed particularly ensuring that all strategies address stigma and discrimination. To enhance an enabling health provision environment and increase options for service delivery, health service providers will be trained on KP friendly services and indigenous organizations will be supported to increase the reach and retention of female injecting drug users.

Service scale up to KP and their sex partners through stand alone and integrated DICE augmented by meaningful involvement of the KP community will be supported, particularly to include provision of ART at all eligible DICE. Differentiated care that enhances adherence and retention will be strengthened alongside scaling up the geographical distribution of DICEs, from the current 60 to 75 with a goal to increase access to comprehensive services under one roof.

An important addition to the KP program will be inclusion of prisons to ensure that incarcerated persons receive optimal and comprehensive HIV prevention and care services.

Services for FSW and MSM in the 25 scale up to saturation counties are targeted to reach 100% of FSW and 54% of MSM. In the nine (9) aggressive scale up counties, 94% of FSW and 42% of MSM are targeted for services. In COP18, targets are 30,318 MSM while FSW and PWID targets were allocated based on APR17 achievement at 186,825 and 16,744, respectively. In COP18 a target of 281,725 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 23 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). MAT sites will continue to receive mentorship, quality assurance and human resources. PEPFAR will engage regulatory bodies to ensure outreach for MAT for PWID and will also continue to support community mobilization and referral for MAT uptake.

The KP program is generally peer led. KP program Outreach workers and PE are KPs who mobilize their peers to access services during integrated outreaches and quarterly clinic visits, condoms and lubricants promotion and distribution. Key Population representatives are involved in County and National technical working groups that provide both technical and programmatic including M&E of KP programs. The PEPFAR Kenya interagency will continue to engage with KP service delivery organizations during program review meetings to prioritize KP individuals for vacant positions, when the needs arise.

d. VMMC

Based on the overall VMMC rate in Kenya of 91% (KAIS 2012), the national program focuses on non-circumcising communities in the former Nyanza region, portions of Rift Valley and pockets of other counties. Kenya introduced a second national VMMC strategy in 2014 targeting 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 (Homabay 56%, Kisumu 59%, Migori 73%, Siaya 56%, Turkana 26%). Counties with VMMC coverage above 80% but which host pockets of non-circumcising populations were also prioritized (Busia, Kericho, Nairobi, Nandi and West Pokot). Nine (9) of the VMMC focus counties are also prioritized for ART scale up to saturation while two are in the sustained category (Nandi and Kericho). These counties have large pockets of non-circumcising communities requiring VMMC services for epidemic control.

In COP18, PEPFAR will continue to support the GOK VMMC strategy to increase and maintain VMMC coverage for men 10-29 years of age above 80% by supporting service provision through a mixed approach that prioritizes VMMC for 15-29 and 10-14 year age bands. Men aged 25-29 years whose uptake of VMMC has been suboptimal since program inception will be prioritized for demand creation. In DREAMS counties, older men age 30-34 years will be prioritized for VMMC when identified through male sex partner characterization, as sex partners of AGYW. In addition, there will be active referrals of eligible HIV negative adult men for VMMC services.

Modelling with the Decision Makers' Program Planning Tool, Version 2 (DMPPT 2) suggests that Kenya has achieved ≥ 80% coverage among 15-24 year old males while coverage among 25-29 year olds lags below 80% in most counties. Therefore, in COP18, VMMC services will continue to target boys aged 10-14 years while equally concentrating on 25-29 year old males. Geographically-aligned client centered demand creation will be applied to address barriers to VMMC uptake by this "hard-to-reach" age band. This innovative demand creation approach is projected to be more complex and require more resources than other strategies used in the past; thus, higher costs are projected to drive demand for VMMC among older men in FY19. Kenya will maintain implementing strategies for ensuring VMMC program safety including exclusive provision of surgical MC through dorsal slit technique to eliminate penile glans injuries associated with the forceps guided method.

Although DMPPT2 modelling results suggest near 100% VMMC coverage in certain age bands, demand remains high for the same ages. Therefore, in COP18, PEFPAR Kenya will maintain an ambitious target of 300,000 VMMC in 11 focus counties as in COP17. The country will provide VMMC services at the same level in all the priority counties based on demand until coverage estimates by age-bands are validated.

For sustainability, VMMC services will be integrated in routine public health services through a process involving inclusion of VMMC in pre-service training of health care providers for sustained

capacity building. Phased introduction of early infant male circumcision (EIMC) will also continue for long term sustainability. Components of the VMMC service package will be reviewed for alignment with the WHO/UNAIDS 2021 framework.

HIV Testing Services

In COP18, PEPFAR will continue to support Kenya's implementation of the National HTS guidelines, encompassing: a) self-testing; b) re-testing for certain sub-populations, including newly diagnosed PLHIV for verification before enrollment into treatment; and c) referrals and linkage from testing to treatment and to other post-test services, including PMTCT, VMMC, FP, TB and other prevention interventions. The national HTS guidelines lowered the age to consent from 18 years to 15 years, which provides an opportunity for testing adolescents. 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. In addition, COP18 will support implementation of PNS with on-going scale up in FY18. HIV testing services will be offered in facilities through strategies that include partner notification, targeted family testing, strengthening TB screening and HTS for all TB and TB presumptive clients, in-patient department (IPD) testing and self-testing. The following strategies will be continued in FY19 with modifications for facility testing: OPD/VCT optimized by testing less and yielding more; a more efficient provider-initiated testing and counseling (PITC) approach to increase positivity yield and reduce testing volumes; And testing of children of PLHIV to fill gaps in testing, identification and linkage.

For community testing, key and priority populations (AGYW, adolescent and young people, OVC, fisherfolk, military and uniform services) will continue to be tested as per testing guidelines while the following strategies will be continued with modifications:

- Testing in VMMC targeting high-risk screened clients;
- Multi-disease and weekend/extended hours testing targeting men; adolescent and young people; and KP. This strategy will be modified to selected facilities that are accessible to the targeted population, as well as already operating for extended hours for other services.

For key and priority populations, revised approaches will be implemented to optimize testing, including: identification and linkage to care and treatment social; sexual network analysis and partner notification; integrated HIV and non-communicable diseases (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 including safe spaces in high volume facilities in the 5 high burden counties for adolescents and young women. For sustained SNUs, HIV testing and counseling on request or as indicated by clinical symptomology or identified risk behaviors.

For HIV epidemic control, the program will implement a strategic mix of HIV testing modalities in high disease burden counties to improve testing coverage, yield and efficiency of HIV testing services. In COP18, the program will continue to scale up methods identified as high yield and

cost efficient (including PNS) to close the gap in the first 95. 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 through continuous quality improvement; improvement of the supply chain to eliminate testing interruptions in the scale up counties; scale up of innovative approaches known to improve HIV positive yield which include voluntary PNS/index testing (among newly diagnosed PLHIV and evaluating yield among existing patients on ART and focusing on those with high VL); and optimizing linkage (≥95%) to ART through innovative strategies; strengthen patient level counseling and documentation; and monitoring linkage rates by facility through data review meetings, offering mentorship and site support, counselor support and longitudinal follow for up to 12 months and strengthening other linkage strategies such as physical escorts of clients, patient level follow-up, MOH referral note, phone calls and physical tracing of clients. The following strategies will be applied to improve linkage to ART among adolescents and young people: peer to peer counseling/treatment buddies; SMS reminders, peer male PLHIV support groups that incorporate intensive adherence support and evening, weekend clinics as well as creating male friendly corners within existing facilities, and 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.

Specifically targeting in women 15-24 years, identification through PNS, facility testing, testing within the KP program as well as self-testing will be scaled up. Linkage to treatment services will also be enhanced through communication, sensitization and treatment literacy- to address low perception of risk and enhance the need to access HIV services.

The implementation of Test and Start Guidelines will aid in improving timely enrollment to treatment and also linkage optimization. The 2016 gender analysis identified low (and late) HIV testing coverage for men and KP as a main gap. The program will work on reducing access barriers to HIV services among KP and men through innovative strategies. HTS services will be optimized for early identification of HIV positive men through home and work place testing and multi-disease screenings for NCDs. Strategies for improving HTS coverage for KP will address access barriers through testing services in DICE and targeted outreach in hotspots.

HTS target

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. This calculation factored: county data on HTS strategies and positivity; linkage to enrollment for HIV treatment (95%); and estimates of attrition (10% for newly enrolled patients and 5% for those on ART for ≥ 12 months).

PEPFAR will be implementing effective strategies towards reaching total HTS_TST target (individuals- excluding PMTCT, TB and VMMC) of 6,811,837 (6,401,993 adults and 409,844 children). This represents a significant reduction of testing targets which is expected to be achieved through more efficient facility based testing, resulting in markedly reduced OPD testing from 8,096,428 in FY17, to 6,540,328 in FY18, to 4,805,521 in FY19 and scaling up of high yielding modalities like PNS, saturating testing in TB clinics, STI clinic, VCT, to account for 20% of the positives identified. Of the total testing target, 1,854,115 (27%) are in the aggressive scale up SNU; 4,849,366 (71%) in the scale-up saturation SNU; 103,578 (2%) in sustained SNU; and 4,778 in the sustained commodities SNU. Through this, Kenya will aim to identify a total of 160,080 PLHIV (4,647 children and 155,433 adults). Of these, 45,897 (29%) are in the aggressive scale up SNU; 110,286 (69%) in the scale up to saturation SNU; 3,039 (2%) in the sustained; and 428 in the sustained commodities SNU.

PEPFAR will continue engaging with GOK and GF to ensure sufficient funding and commodity security at national, county and facility levels. In COP18, quantification of commodities will be based on the targets set. The HIV commodity supply chain is well integrated and managed by KEMSA, providing the GOK better visibility on commodity usage and requirements.

4.3 Additional country-specific priorities listed in the planning level letter

High Burden County Performance

In line with the COP guidance, PEPFAR will continue investing in the 5 highest burden counties, which will contribute 47% of PLHIV on ART in Kenya. Given the indication of possible lower HIV burden in these counties than previously thought (RANC data and community serological surveys referenced in section 2.0), preliminary KENPHIA data will be utilized to update the targets. In the meantime, efficiency in PITC will be enhanced (stopped in low yield facilities, screening criteria implemented in high yield facilities), partner notification services will be scaled up, and intensive community-based testing will be stopped.

Case identification and linkage

Identifying the remaining undiagnosed PLHIV remains the greatest barrier to achieving 95-95-95. PEPFAR Kenya will continue scaling up methods identified as high yield and cost efficient strategies to close the gap in the first 90. Key case identification strategies will include: optimized PITC, PNS and targeted community testing for KP and PNS contacts.

PEPFAR Kenya supports Key population services through both standalone safe space (Drop in Centers) and Public health facilities with trained health providers to offer non-stigmatizing health services. Currently PEPFAR Kenya supports 74 Drop in Centers across the country with several referral public health facilities with trained health providers to offer non-stigmatizing and non-discriminatory services. A total of 52 Drop in centers offer ART on site. In COP 2018, in consultation with County health Services Department, PEPFAR Kenya will scale up ART drop in centers by 12 namely GSK (FSW) in Malindi, KNOTE (FSW&MSM) in Naivasha, NOPE (FSW and

MSM) Kikuyu; FAIR (FSW&MSM) Nakuru, KANCO (FSW&MSM) in Kakamega, Survivors (FSW&MSM) in Busia; KASH (FSW&MSM) in Nyamira, Tumaini DiCE (FSW, MSM and PWID) in Ugunja, Tumaini DiCE (FSW, MSM and PWID) in Siaya, Tumaini DiCE (FSW, MSM and PWID) in Asembo Bay, Tumaini DiCE (FSW, MSM and PWID) in Bondo, Burnt Forest Roadside Wellness Centre (FSW, MSM and PWID) in Uasin Gishu.

Index patient/partner testing has proven to be an effective method of identifying new positives and is a gateway to getting clients on treatment. Eligibility screening in outpatient departments (OPD) and PMTCT settings as well as other tailored testing strategies will be implemented. Equally important, PEPFAR prioritized diagnosis and ART initiation for HIV infected pregnant women.

Due to the continued low rates of case identification in high burden counties, PEPFAR will discontinue most community based testing activities and suspend support for testing in SNU and at sites where no or very few positives were identified in FY17 (Homabay, Kisumu, Migori and Siaya) until the updated HIV estimates are available through KENPHIA. PEPFAR will also establish an HIV incidence surveillance system among people newly diagnosed with HIV using the HIV rapid recency assay.

The program aims to link 90% of all newly identified HIV infected individuals up from 79% in FY17. There will be enhanced linkage strategies for all populations with emphasis on men and adolescents and young people age 15-24 years whose linkage was below the national average in FY17.

TLD Optimization

Roll out of DTG-containing regimens as the preferred first line ART will be introduced in FY18 and scaled up in FY19 for all eligible populations including children ≥ 10 years and ≥ 30 kilograms, DTG boosted TLD in HIV associated TB patients, pregnant and breastfeeding women. The first consignment of TLD is already in country in preparation for patient transition. It is expected that most patients on first line will have been transitioned to TLD within 8 months of the roll out. Discussions are ongoing with regards to the protocol for transition of patients on second line to TLD. There will be support for close monitoring of the supply chain to minimize wastage through expiries that may be occasioned by the transition into DTG and phase out of EFV, applying lessons from the stavudine phase out. With roll out of this efficacious regimen, the country envisions substantially improving viral suppression rates from 84% among adults ≥ 15 years to 69% among adolescents age 15-19 years and to 70% among children <15 years (APR17) to 90% among across all population groups.

Lab optimization

To ensure that countries have reliable, efficient and adequate laboratory instrument capacity to support program needs, PEPFAR collaborated with host governments and other donors to conduct a national mapping of both conventional and point of care (POC) instruments to inform their COP18 planning. Key data generated from this exercise, using a functional 80% of total instrument capacity, reveal there are 163 GeneXpert machines with a total capacity of 890,000 and total VL/EID capacity of 2,525,500 from 42 conventional platforms in 10 VL/EID testing labs with a combined capacity of 2,501,500 tests and 12 POCs Alere-Q (EID) with a combined capacity of 24,000and. There will be efficient utilization of existing equipment through the national laboratory network, and adoption of (near) point of care testing for EID using the GeneXpert machines in line with the national policy that is in development. COP 18 will support the ongoing discussion on the use of the GeneXpert platform for EID testing and capacity build PEPFAR supported sites on the testing and algorithm to ensure maximum utilization of the available testing capacity.

Through the lab instruments mapping and optimization exercise, Kenya recognized that the Gene Xpert is underutilized by at least 50%. Kenya is planning to optimize this by enhancing demand creation through intensified patient screening and offering Gene Xpert as the first test. Additionally Kenya has developed two key policy documents: one on POC roll-out and one on multi-disease testing integration where the Gene Xpert instruments will also be used for EID. These strategies are being developed collaboratively between HIV and TB programs. Kenya has been using and will continue using reagent rental approach in the critical lab testing. This has ensured several advantage including fairer pricing based on volumes, smooth supply of reagents and supplies, availability of back-up instrument and prompt repairs and servicing of equipment in case of breakdown as well as machine upgrade when there is technology evolution or need for higher throughput instrument. Based on this Kenya was able to conduct over 1 million VL tests with minimal interruptions.

Continued Engagement with Stakeholders

PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government. This will facilitate transparent planning processes as well as data and results sharing.

4.4 Commodities

Kenya has a robust and well integrated supply chain system for HIV commodities. The system is coordinated by NASCOP, and KEMSA manages logistics on behalf of all partners: the GOK, GF and PEPFAR. NASCOP as the chair of the Commodity Security Committee and the procurement planning 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, central and satellite facilities. Kenya will continue to manage the transition to TLD

while ensuring minimal wastage of the legacy medicines. The devolution of rapid test kit (RTK) allocation and reporting has addressed most of the challenges in distribution of RTKs faced in the past. The use of the NASCOP website to track RTK allocation and distribution has improved availability through increased visibility and accountability.

PEPFAR together with NASCOP and the county governments 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. This will be sustained through Centers of Learning in four counties (selected to represent PEPFAR pivot categories) to showcase supply chain standards in practice for other counties to benchmark. These standards will be implemented through two packages of support: supply chain leadership and supply chain service excellence. At the national level, PEPFAR will continue to support KEMSA and NASCOP to ensure optimal national forecasting, quantification, pipeline management and timely distribution. PEPFAR together with NASCOP will continue to strengthen the county-based distribution model to ensure rational use, reporting and accountability. Counties will continue to be allocated RTK quantities based on the geographic prioritization strategy and 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 bolster 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 "95". This will ensure that there are adequate stocks in the country and that there are no unforeseen funding gaps to address ARV requirements in FY19.

Adequate supply of VL testing commodities including VL and EID reagents is key to achieving the third "95". PEPFAR aims to support 100% of VL and 70% 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, reagents are accounted for electronically and PEPFAR will continue to support the website to provide 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 FY19. The PEPFAR Kenya team has carefully analyzed

the current commodity pipeline as well as expected GF and GOK resource allocations to formulate a PEPFAR budget request that supports scale up plans.

4.5 Collaboration, Integration and Monitoring

Facility and targeted community outreach strategies will be used to identify individuals living with HIV among KP and other targeted groups (children <15 years, youth, and men 25+ years) through high yield HTS modalities, scale up of partner notification services and index client testing populations. To increase linkage to treatment from 79% at (APR17) and FY18 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. Further, PEPFAR will actively engage key and priority populations (KP/PP), CSO, local communities and other stakeholders to address stigma and discrimination, harmful gender norms and other barriers to accessing HIV care and services, including PrEP for which GOK established guidelines targeting KP/PP. In addition, PEPFAR will routinely forecast site-specific commodity needs and work closely with KEMSA to ensure service delivery points (SDPs) receive uninterrupted supplies, e.g. RTK, condoms, lubricants and methadone.

In scale up counties, PEPFAR will support intensified demand creation, targeted HTS, linkage to treatment, provision of PrEP for all eligible most at risk individuals including discordant couples (clients whose partner have a VL >1000 cps or have refused ART), post-exposure prophylaxis (PEP) and VMMC. Innovative approaches will include: enhanced monitoring for better tracking and retention; implementation of PHDP; creation of PLHIV peer networks; setting convenient clinic working hours; and sensitizing public health personnel to KP friendly service provision.

4.6 Targets for scale-up locations and populations

Standard Table 4.6.1: Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	**Tested for HIV (APR FY19) *HTS_TST***	**Newly Identified Positive (APR FY19) *HTS_TST_POS***	**Newly Initiated on ART (APR FY 19) *TX_NEW***
Total Men	**3,329,269**	**78,727**	**75,650**
Total Women	**4,434,894**	**106,460**	**100,570**
Total Children (<15)	**465,270**	**7,446***	**6,539**
Adults			
TB Patients	***49,677***	**8,316**	**8,111**
Pregnant Women	***1,156,317***	**22,241**	**21,118*****
VMMC clients	***185,680***	**414**	**393**
Key populations	***280,142***	**7,231**	**6,869**
Priority Populations	***2,581,711***	**57,871****	**54,977****
Other Testing	***3,790,778***	**96,560**	**91,732**

Previously diagnosed and/or in care	**0**	**0**	**0**
Pediatrics (<15)			
HIV Exposed Infants	***62,503***	**2,309**	**2,186**
Other pediatric testing	***465,270***	**5,137**	**4,353**
Previously diagnosed and/or in care	**0**	**0**	**0**

*Includes HTS POS <15 and HEI POS

**AGYW – Adolescent Girls and young women aged 15-24

***95% of Newly Identified Positives in PMTCT program – Allocation by IM Tab

Standard Table 4.6.2: VMMC Coverage and Targets by Age Bracket in Scale-up Districts

Table 4.6.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts*					
SNU	**Target Populations**	**Population Size Estimate (SNU)**	**Current Coverage (date)**	***VMMC_CIRC* (in FY18)**	**Expected Coverage (in FY19)**
Homa Bay	10-29yrs	249,898	79%	53,122	100%
Kisumu	10-29yrs	267,197	87%	27,070	97%
Migori	10-29yrs	241,157	99%	49,217	**100%**
Siaya	10-29yrs	214,034	99%	49,274	**100%**
Turkana	10-29yrs	288,554	54%	29,129	64%
	Total/Average	**1,260,840**	**82%**	207,812	**99%**

*Only the top five VMMC priority counties with denominators for clearly defined SNU are included (collectively these 5 contribute to 70% of the country's COP 18 target).
Coverage estimates included in this table are modelled from DMPPT2.
The FY19 coverage in bold font are in excess of 100% hence the need for population based validation survey.
(The remaining 6 counties that are not included in this table are traditionally circumcising with high coverage but pockets of mainly migrant non-circumcising subgroups).

Standard Table 4.6.3: Target Populations for Prevention Interventions to Facilitate Epidemic Control

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate** (scale-up **SNU**)	**Coverage Goal (in FY18)**	**FY19 Target**
FSW*	**123,239**	**132,929**	**183,937**
MSM SW	**31,663**	**18,494**	**17,749**
MSM Not SW	**19,546**	**11,335**	**12,291**
PWID Male*	**11,057**	**13,828**	**14,913**
PWID Female*	**1,235**	**1,537**	**1,439**
Prisoners	**85,273**	**64,800**	**57,548**
AGYW	**1,426,545**	**252,000**	**252,000**
Fisherfolk	**Unknown**	**149,225**	**123,065**
Other	**Unknown**	**30,000**	**30,000**
TOTAL	**1,694,198****	**674,148**	**683,870**

*The target for these subpopulations is higher than the available population size estimate. This is because, targets were set based on FY17 Achievement figures.
**Excludes unknown figures.

Standard Table 4.6.4: Targets for OVC and Linkages to HIV Services

Table 4.6.4 Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY19Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY19 Target) OVC***
Homa Bay	170,587	103,450	**83,093**
Nairobi	98,954	107,980	**93,419**
Kisumu	160,050	89,077	**72,134**
Siaya	107,301	74,177	**54,768**
Migori	97,457	54,220	**44,387**
Kakamega	122,248	30,855	**25,289**
Mombasa	30,335	12,058	**11,181**
Nakuru	115,453	30,831	**25,686**
Kiambu	60,462	22,682	**15,949**
Busia	117,922	27,914	**22,317**
Kilifi	69,849	43,950	**38,696**
Kisii	104,561	16,949	**15,707**
Nyamira	72,867	3,269	**2,824**
Bungoma	58,898	21,003	**17,305**
Uasin Gishu	19,497	7,879	**6,484**
Bomet	62,853	7,852	**6,742**
Machakos	45,563	9,483	**7,264**
Narok	50,164	6,208	**5,192**
Murang'a	50,266	5,054	**3,632**
Kwale	87,921	4,639	**4,022**
Trans Nzoia	95,822	4,463	**3,427**
Makueni	89,372	5,258	**3,897**
Kajiado	38,165	8,146	**6,921**
Meru	53,110	12,558	**9,373**
Turkana	26,739	4,845	**4,322**
Kitui	39,430	5,932	**4,262**
Nandi	85,249	5,790	**4,556**
Kericho	50,257	11,810	**10,398**
Vihiga	55,118	6,291	**4,812**
Nyeri	27,911	9,712	**6,312**
Taita Taveta	17,813	4,292	**3,660**
Nyandarua	51,741	4,399	**3,170**
Kirinyaga	39,114	-	-
Baringo	19,767	3,377	**2,519**
Laikipia	16,773	4,085	**2,995**
Embu	16,500	4,595	**3,711**

West Pokot	67,967	1,965	**1,578**
Tharaka Nithi	24,339	11,738	**8,129**
Samburu	16,209	2,320	**2,250**
Elgeyo Marakwet	9,234	1,237	**862**
Mandera	75,157	-	-
Tana River	9,662	-	-
Isiolo	11,374	-	-
Garissa	19,200	-	-
Lamu	3,786	-	-
Marsabit	28,262	-	-
Wajir	15,000	-	-
Other		349	321
TOTAL	**2,706,279**	**792,691**	**643,563**

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

5.1 COP18 Programmatic Priorities

As part of COP18 planning, PEPFAR carefully considered program activities towards the 95-95-95 goals to achieve HIV epidemic control in 6 sustained counties (Kericho, Taita taveta, Baringo, Embu, West Pokot and Samburu) and populations acknowledging partnership with the GOK as well as other donors and public health actors. PEPFAR and thematic GOK-led TWGs considered the minimum package of services to be provided including quality assurance, as these areas and populations are to be primarily covered by non-PEPFAR entities. As presented in Table 5.22, targets are modest relative to PEPFAR's commitment in COP18 scale-up counties, but with clear impact on Kenya's HIV epidemic.

5.2 Targets for attained and sustained locations and populations

Standard Table 5.2.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Attained Support Districts

Table 5.2.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Attained Support Districts			
Attained Support Volume by Group		**Expected result APR 18**	**Expected result APR 19**
HIV testing (all	*HTS_TST*	***0***	**0**

populations)			
HIV positives (all populations)	*HTS_TST_POS*	**0**	**0**
Treatment new	*TX_NEW*	**0**	**0**
Current on ART	*TX_CURR*	**0**	**0**
OVC	*OVC_SERV*	**0**	**0**
Key populations	*KP_PREV*	**0**	**0**

There are no attained counties in Kenya

Standard Table 5.2.2: Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts

Sustained Support Volume by Group		**Expected result APR 18**	**Expected result APR 19**
HIV testing in PMTCT sites	*PMTCT_STAT*	**98,257**	**84,313**
HTS (only sustained ART sites in FY 17)	*HTS_TST/HTS_TST_POS*	**201,796/20,922**	**821,260/17,022**
Current on ART	*TX_CURR*	**40,525**	**42637**
OVC	*OVC_SERV*	**43,750**	**28,359**

5.3 Establishing service packages to meet targets in attained and sustained districts

Prioritized activities for Sustained SNU

HIV Testing Services

In sustained counties, HTS will be provided to symptomatic patients presenting in PEPFAR-supported high yield sites, presumptive TB cases as well as sexual 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 FY19.

PMTCT

In the sustained and sustained commodities counties, PEPFAR will support commodity supplies, lab networking for VL and infant PCRs, access and utilization of these results from NASCOP EID website. In addition, PEPFAR will provide technical support to county MOH including mentorship and supportive supervision, especially in high volume facilities.

OVC

Aligned with S/GAC guidance, further reductions will occur in sustained counties in FY19 to help scale-up the targets in the priority counties. Lessons learned from sustained commodities counties will be applied to selected counties and LIPs in preparation for future transition and graduation.

To address the complexity of transitioning children and families who are still in need of mitigation services in sustained counties, PEPFAR will work with the GOK and other stakeholders based on the experiences from the sustained commodities support counties. Approaches will include:

a) Cease enrollment of new beneficiaries and graduate/transition children and families on a rolling basis starting in the lowest burden counties using the case plan readiness achievement guidance and tools.
b) Provide targeted support to OVC Households based on the case plan developed to enable them to move towards self-sustenance.
c) Support HIV positive OVC and adolescents to access treatment and care services.
d) Provide targeted secondary education support for most at risk OVC especially adolescent girls.
e) Intensify scale-up of HES activities and targeted psychosocial for the HH.

OVC programs will continue to align with the epidemic profile and where OVC unmet need is highest. In COP18 the number of OVC served in sustained counties will be 28,359.

Treatment Services

a) Facility and community based care and support

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.

b) TB/HIV

In the sustained counties a package of quality services will be offered to ensure TB prevention, early diagnosis including drug susceptibility testing (DST), as well as appropriate treatment and monitoring. 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.

c) Adult treatment

In 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 VL (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 VL testing for patients with virologic failure (VL≥ 1000 copies). Quality of care for adult treatment will be assessed through scheduled SIMS visits.

d) Pediatric Treatment

In the 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 ≥ 12 months and community based ART where applicable. Sick, newly enrolled (≤12 months) children and adolescents as well as those with high VL (VL ≥1000 copies) will be closely followed up at the facility for psychosocial and adherence support, caregiver treatment literacy and management of OI. ART monitoring will be carried out as per guidelines: at six (6) months for newly enrolled patients; annually for existing patients; and targeted VL 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.

e) ARV Commodities

Kenya has a robust and well integrated national supply chain management system for ARV commodities. The supply of commodities to 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 sustained counties in order to assure a seamless supply chain system for HIV commodities.

Essential Laboratory Services for PLHIV

PEPFAR continues to support essential lab services for PLHIV in sustained SNUs through a nationally coordinated lab network that assures access to core HIV and TB diagnostic and monitoring tests. HIV testers in these counties are enrolled in the HIV panel test (PT) program while a few high volume testing sites enrolled into the HIV rapid testing continuous quality improvement (RT-CQI) initiative to ensure accurate HIV testing in achievement of the first 95. These SNUs are in the national network that ensures access to EID and VL testing with acceptable turnaround time. Additionally there is support to access GeneXpert testing for TB diagnosis. National lab systems support ensures that these counties benefit from lab commodity security, external quality assurance and equipment calibration and maintenance for accurate lab testing and reporting.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Addressing epidemic control

In COP18, Kenya prioritized system investments to ensure accelerated progress towards epidemic control and achievement of the program's goals and sustainability. This was aligned to efficiently remove systems barriers to epidemic control and influence technical gains in country and to foster greater accountability, transparency and utilization of evidence to accelerate progress towards epidemic control.

PEPFAR Kenya identified the key gaps and remedial activities and national policy shifts required to achieve 95:95:95 targets and complement site level approaches. The critical above-site investment approaches, all of which are critical in achieving epidemic control, include: i) domestic resource mobilization, ii) human resources management and development, iii) logistics management and supply chain strengthening, iv) information systems; v) host country institutional development; vi) assessments, evaluation, operation research; and vii) policy and governance.

Key strategic objectives under county systems strengthening include: increasing Sustainable Finance and Domestic Resource Mobilization for Kenya's health sector; improving the quality of training and increase the number of those graduating and entering the workforce; improving Management and Leadership of Health Workforce at the county level and; strengthening technical leadership and coordination for commodity management.

Human resources for health management approaches will include county level HRH units support to ensure efficient health workforce utilization at community and facility level, health workforce training to ensure quality of service providers, and HRH data system support for decision making and budgeting for adequate workforce. The recent workforce unrests have made it necessary to support health worker professional unions to minimize disruptions in service delivery and target achievement for epidemic control.

Strengthening technical leadership and coordination for commodity management will involve reinforcing commodity security TWGs, mainstreaming laboratory and nutrition commodities into one coordinated national supply chain system for all HIV commodities, in-service and pre-service curriculum development for supply chain management, and support for quantification and supply planning at national level.

Health financing approaches will include advocacy for increased allocations to health and HIV in national budget; technical assistance to 26 counties on program base budgeting; support for

evidence generation to inform domestic resource mobilization including monitoring DRM trends; TA to inform National Hospital Insurance Fund (NHIF) reforms and related sustainable financing for HIV as part of the GOK's Universal Health Coverage agenda.

The strategic objectives under the *information systems* approach include: enhancement of the health information systems (HIS) to address the entire spectrum of HIV service delivery; improvement of HIS solutions and capacity building of stakeholders to undertake HIS use; and strengthening of data quality and utilization and enhancement of the human resources information system (HRIS) utilization for workforce planning and allocation. Combined, these interventions will strengthen national information systems that support reporting, availability, analysis and use of high-quality data for effective decision making for PEPFAR, GOK, counties and other stakeholders. This will also lead to better measurement of the clinical cascade and Kenya's progress towards the 95-95-95 goals at national and sub-national levels. *Host country institutional development* will lead to strengthened institutional accountability for the management of community, facility and county HIV response, while increasing leadership and management capacity of county governments for effective outcome measurements, learning and accountability systems. *Assessments, evaluation, operations research* will establish national and county level surveillance systems and building capacity to analyze the epidemiological trends and disease burden and increase use and triangulation of assessments and operations research data to improve programmatic management and decision-making.

6.2 Identifying systems gaps

Kenya prioritized systems level investments based on gaps identified through various tools including SID 3.0, MER results and SIMS using a consultative process with the MOH, GF, and CSOs among other stakeholders. Kenya reviewed progress made based on COP16/17 Table 6 areas to identify those on or not on course to achieve the intended outcome and what activities were no longer relevant. Further, those Table 6 activities deemed to be at site level were dropped from Table 6 and included in the program areas. Equally important, SID domains scoring yellow (3.50-6.99)-emerging sustainability and requiring some investments were also prioritized in Table 6. This included the SID elements of domestic resource mobilization (5.71); epidemiological and health data (5.79); commodity security (6.39); service delivery (6.44) and HRH (6.55). However, there were two SID elements which appear to be sustained but require ongoing investment based on emerging/ongoing needs; these are: *policy and governance* (8.50) there is always a need for new/revised policies and technical area guidelines; *planning and coordination* (8.5) at county level, which is weak in a few counties even though the overall score is good.

SIMS scores were also reviewed to prioritize investment and complement site level approaches, e.g. low scores on commodity management and data quality assessment (DQA) as well as lab quality management systems. SIMS scores also informed where PEPFAR had made progress and thus no longer needed to invest such as Test and Start and differentiated models of care policies which scored green.

6.3 Leveraging host country and other donors

In COP18 planning, there was extensive stakeholder engagement and consultation with MOH, GF and other donors including the private sector. PEPFAR support will complement the already available support for critical areas such as policy and governance, institutional capacity building, and harmonization of different information systems.

6.4 Outcomes and benchmarks

COP18 Table 6 has clearly defined outcomes and annual benchmarks to monitor progress. The benchmarks are specific, measurable, achievable, relevant and time bound based on a 1-3 year period. Most of the benchmarks are incremental in nature and are easier to measure. Progress will be monitored biannually in Quarters 2 and 4 and will form part of the POART calls.

7.0 Staffing Plan

The COP18 staffing plan analysis reflects the geographic prioritization strategy and identifies of the right mix of skills required to achieve HIV epidemic control. Agencies agreed upon a common baseline for level of effort (LOE) by program area, 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. Interagency 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 herein. 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 COP18.

Long-term Vacant Positions: All agencies with vacant positions reviewed and updated position descriptions and job description help sheets to facilitate the re-advertisement of the positions through U.S. Embassy Human Resources (HR) or USAID HR offices. Nevertheless, given the volume of work at the U.S. Mission to Kenya—the largest U.S. presence in the region—processing HR actions typically takes more than six months 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. The Deputy PEPFAR Coordinator position became vacant in June 2016. We are liaising with agency leadership to recruit in COP18.

Proposed New Positions: DoD proposes to repurpose four local hire positions to improve

oversight of program and fiscal management of PEPFAR partners, fidelity and scale-up of interventions and achievement of results. The repurposed positions include a PEPFAR Deputy Director, a Director of Health Systems and Evaluation and two Senior Specialists: one in HIV prevention and the second in HIV Clinical/Treatment and Care. These positions will further sustain the DoD portfolio while strengthening the interagency PEPFAR Kenya team.

USAID proposes to repurpose a U.S. Personal Services Contract position into a number of local hire positions. These include an Adolescent Health Specialist and a Biomedical Prevention Specialist. In addition, USAID is repurposing an existing local hire Program Management Assistant FTE into a reclassified Social Protection/Legal Rights Specialist, who will focus on DREAMS and OVC programs given the expansion in this area. USAID is creating a new, 5-person SIMS/quality assurance team in lieu of using an institutional support contract and to ensure that implementing partner and site level targets are realized.

For COP18, the Cost of Doing Business (CODB) essentially remained the same from COP17 with the following key changes:

- HHS/CDC COP18 CODB allocation slightly increased from COP17 level by $500,000 to accommodate increased capital security cost sharing (new U.S. Embassy building) and standard salary increases.
- In COP17 and currently, Peace Corps Kenya has seven PEPFAR funded staff positions. As of May 26, 2018, however, the Peace Corps Kenya program will be further suspended and the entire staff will be terminated. Thus, in COP18 (FY19), there will be no PEPEFAR funded staff positions with Peace Corps Kenya and no CODB funding.
- State COP18 CODB allocation increased from COP17 level to accommodate LNA costs and standard salary increases.

APPENDIX A -- PRIORITIZATION

Table A.1 **SNU Prioritization**

County	COP	Prioritization	APR Results Reported	Treatment Coverage at APR by Age and Sex					
				<15Yrs Coverage	15-24 Male Coverage	15-24 Female Coverage	25+ Male Coverage	25+ Female Coverage	Overall Coverage
Nairobi County	COP 15	ScaleUp Sat	125,705	94%			68%	96%	73%
Nairobi County	COP16	ScaleUp Sat	141,541	92%	69%	52%	70%	98%	83%
Nairobi County	COP17	ScaleUp Sat	142,560	90%	60%	46%	71%	100%	83%
Nairobi County	COP18	ScaleUp Sat	158,678	100%	82%	82%	82%	102%	93%
Homa Bay	COP 15	ScaleUp Sat	92,465	91%			49%	97%	58%
Homa Bay	COP16	ScaleUp Sat	98,500	95%	22%	29%	47%	92%	62%
Homa Bay	COP17	ScaleUp Sat	99,734	93%	30%	38%	47%	89%	63%
Homa Bay	COP18	ScaleUp Sat	117,833	98%	51%	58%	64%	92%	75%
Kisumu	COP 15	ScaleUp Sat	92,212	86%			56%	105%	64%
Kisumu	COP16	ScaleUp Sat	97,973	87%	49%	38%	56%	92%	68%
Kisumu	COP17	ScaleUp Sat	98,770	85%	43%	37%	53%	98%	68%
Kisumu	COP18	ScaleUp Sat	108,227	92%	52%	60%	65%	92%	75%
Siaya	COP 15	ScaleUp Sat	73,440	87%			49%	97%	58%
Siaya	COP16	ScaleUp Sat	78,891	91%	37%	34%	47%	88%	62%
Siaya	COP17	ScaleUp Sat	79,399	90%	31%	29%	49%	91%	63%
Siaya	COP18	ScaleUp Sat	94,630	99%	60%	63%	64%	88%	75%
Migori	COP 15	ScaleUp Sat	59,912	107%			57%	122%	72%

County	COP	Prioritization	APR Results Reported	<15Yrs Coverage	15-24 Male Coverage	15-24 Female Coverage	25+ Male Coverage	25+ Female Coverage	Overall Coverage
Migori	COP16	ScaleUp Sat	64,577	113%	34%	47%	56%	111%	77%
Migori	COP17	ScaleUp Sat	65,673	113%	32%	46%	58%	114%	79%
Migori	COP18	ScaleUp Sat	72,317	108%	45%	62%	76%	110%	87%
Kiambu	COP 15	ScaleUp Agg	31,885	82%			60%	44%	45%
Kiambu	COP16	ScaleUp Sat	35,239	77%	61%	39%	59%	45%	50%
Kiambu	COP17	ScaleUp Agg	35,494	74%	51%	31%	60%	47%	50%
Kiambu	COP18	ScaleUp Agg	52,873	104%	63%	63%	63%	79%	75%
Mombasa	COP 15	ScaleUp Sat	40,885	71%			106%	90%	75%
Mombasa	COP16	ScaleUp Sat	43,018	63%	133%	81%	85%	74%	79%
Mombasa	COP17	ScaleUp Sat	42,678	54%	53%	31%	103%	86%	79%
Mombasa	COP18	ScaleUp Sat	48,879	90%	150%	88%	87%	86%	90%
Kakamega	COP 15	ScaleUp Agg	35,526	86%			60%	92%	70%
Kakamega	COP16	ScaleUp Agg	38,467	92%	75%	83%	61%	80%	76%
Kakamega	COP17	ScaleUp Sat	38,613	89%	74%	85%	61%	81%	76%
Kakamega	COP18	ScaleUp Sat	45,506	99%	100%	91%	72%	97%	89%
Nakuru	COP 15	ScaleUp Agg	32,336	71%			72%	110%	78%
Nakuru	COP16	ScaleUp Agg	35,530	69%	57%	48%	74%	109%	86%
Nakuru	COP17	ScaleUp Sat	35,757	68%	58%	49%	75%	110%	87%
Nakuru	COP18	ScaleUp Sat	41,217	90%	81%	81%	81%	121%	100%
Busia	COP 15	ScaleUp Sat	30,042	76%			75%	101%	78%
Busia	COP16	ScaleUp Sat	32,385	76%	63%	61%	76%	96%	84%
Busia	COP17	ScaleUp Sat	32,941	76%	53%	56%	78%	99%	85%
Busia	COP18	ScaleUp Sat	34,502	95%	72%	72%	77%	101%	90%
Kisii	COP 15	ScaleUp Agg	25,737	113%			54%	135%	76%
Kisii	COP16	ScaleUp Sat	27,901	114%	34%	40%	55%	128%	82%
Kisii	COP17	ScaleUp Sat	28,176	110%	35%	41%	56%	130%	83%

County	COP	Prioritization	APR Results Reported	<15Yrs Coverage	15-24 Male Coverage	15-24 Female Coverage	25+ Male Coverage	25+ Female Coverage	Overall Coverage
Kisii	COP18	ScaleUp Sat	31,633	113%	43%	55%	76%	130%	93%
Machakos	COP 15	ScaleUp Agg	21,477	101%			75%	83%	66%
Machakos	COP16	ScaleUp Sat	22,063	91%	40%	22%	72%	79%	68%
Machakos	COP17	ScaleUp Sat	22,435	93%	44%	25%	70%	80%	69%
Machakos	COP18	ScaleUp Sat	29,187	102%	74%	74%	74%	101%	90%
Kilifi	COP 15	ScaleUp Agg	20,566	84%			74%	82%	65%
Kilifi	COP16	ScaleUp Agg	20,663	80%	62%	43%	59%	72%	65%
Kilifi	COP17	ScaleUp Agg	21,030	83%	71%	56%	58%	70%	66%
Kilifi	COP18	ScaleUp Agg	23,564	99%	91%	57%	64%	79%	74%
Bungoma	COP 15	ScaleUp Agg	21,327	84%			60%	95%	71%
Bungoma	COP16	ScaleUp Sat	22,178	82%	66%	72%	59%	82%	74%
Bungoma	COP17	ScaleUp Sat	22,485	82%	69%	69%	60%	84%	75%
Bungoma	COP18	ScaleUp Sat	26,931	101%	71%	87%	71%	100%	89%
Makueni	COP 15	ScaleUp Agg	15,012	87%			53%	66%	51%
Makueni	COP16	ScaleUp Sat	15,234	84%	24%	16%	51%	61%	52%
Makueni	COP17	ScaleUp Sat	15,367	80%	26%	19%	50%	62%	52%
Makueni	COP18	ScaleUp Sat	26,286	98%	75%	75%	75%	101%	90%
Kitui	COP 15	ScaleUp Agg	17,303	109%			57%	78%	60%
Kitui	COP16	ScaleUp Sat	17,470	104%	30%	19%	59%	71%	60%
Kitui	COP17	ScaleUp Sat	17,591	101%	32%	21%	52%	74%	61%
Kitui	COP18	ScaleUp Sat	25,882	109%	73%	73%	73%	101%	90%
Murang'a	COP 15	ScaleUp Agg	11,648	89%			57%	42%	43%
Murang'a	COP16	ScaleUp Agg	12,970	91%	42%	27%	56%	45%	48%
Murang'a	COP17	ScaleUp Agg	13,096	85%	55%	28%	58%	45%	48%
Murang'a	COP18	ScaleUp Agg	20,297	85%	65%	65%	65%	79%	75%
Uasin Gishu	COP 15	ScaleUp Sat	27,444	81%			100%	142%	103%

County	COP	Prioritization	APR Results Reported	<15Yrs Coverage	15-24 Male Coverage	15-24 Female Coverage	25+ Male Coverage	25+ Female Coverage	Overall Coverage
Uasin Gishu	COP16	ScaleUp Sat	29,164	77%	78%	61%	99%	137%	109%
Uasin Gishu	COP17	ScaleUp Sat	29,244	79%	81%	44%	99%	141%	109%
Uasin Gishu	COP18	ScaleUp Sat	31,604	100%	97%	87%	101%	143%	118%
Trans Nzoia	COP 15	ScaleUp Agg	12,968	48%			41%	72%	50%
Trans Nzoia	COP16	ScaleUp Sat	13,665	45%	36%	30%	45%	65%	52%
Trans Nzoia	COP17	ScaleUp Sat	13,280	41%	46%	26%	42%	65%	51%
Trans Nzoia	COP18	ScaleUp Sat	23,417	90%	71%	71%	71%	108%	90%
Meru	COP 15	ScaleUp Agg	17,066	101%			81%	80%	66%
Meru	COP16	ScaleUp Sat	16,994	86%	40%	29%	77%	71%	65%
Meru	COP17	ScaleUp Sat	17,007	82%	39%	22%	75%	74%	65%
Meru	COP18	ScaleUp Sat	23,287	108%	73%	73%	90%	93%	89%
Nyamira	COP 15	ScaleUp Agg	12,257	81%			36%	89%	50%
Nyamira	COP16	ScaleUp Agg	13,055	83%	34%	41%	35%	75%	54%
Nyamira	COP17	ScaleUp Sat	13,207	82%	34%	42%	35%	76%	54%
Nyamira	COP18	ScaleUp Sat	21,799	97%	79%	79%	79%	104%	90%
Kwale	COP 15	ScaleUp Agg	7,501	44%			34%	40%	31%
Kwale	COP16	ScaleUp Agg	8,063	45%	52%	46%	25%	31%	34%
Kwale	COP17	ScaleUp Agg	8,255	42%	27%	27%	30%	38%	35%
Kwale	COP18	ScaleUp Agg	17,807	75%	61%	61%	61%	85%	75%
Turkana	COP 15	ScaleUp Agg	6,205	36%			28%	34%	28%
Turkana	COP16	ScaleUp Agg	7,253	42%	90%	36%	22%	31%	32%
Turkana	COP17	ScaleUp Agg	7,212	42%	95%	36%	22%	30%	32%
Turkana	COP18	ScaleUp Agg	16,780	75%	131%	59%	52%	89%	75%
Kajiado	COP 15	ScaleUp Agg	10,640	42%			46%	76%	52%
Kajiado	COP16	ScaleUp Agg	10,796	40%	31%	30%	44%	70%	53%
Kajiado	COP17	ScaleUp Agg	10,838	38%	38%	40%	43%	68%	53%

County	COP	Prioritization	APR Results Reported	<15Yrs Coverage	15-24 Male Coverage	15-24 Female Coverage	25+ Male Coverage	25+ Female Coverage	Overall Coverage
Kajiado	COP18	ScaleUp Agg	15,100	58%	62%	62%	62%	90%	75%
Vihiga	COP 15	Sustained	12,685	87%			60%	83%	65%
Vihiga	COP16	Sustained	13,035	90%	63%	70%	56%	70%	67%
Vihiga	COP17	ScaleUp Sat	13,054	82%	64%	71%	56%	71%	67%
Vihiga	COP18	ScaleUp Sat	17,346	100%	71%	71%	71%	103%	90%
Nyeri	COP 15	Sustained	15,085	147%			111%	79%	81%
Nyeri	COP16	Sustained	15,904	128%	94%	48%	102%	81%	85%
Nyeri	COP17	ScaleUp Sat	15,949	122%	112%	48%	108%	79%	85%
Nyeri	COP18	ScaleUp Sat	16,720	157%	98%	52%	103%	85%	90%
Kericho	COP 15	Sustained	13,768	75%			81%	110%	84%
Kericho	COP16	Sustained	15,584	87%	104%	80%	76%	112%	95%
Kericho	COP17	Attained	16,279	88%	115%	86%	80%	116%	99%
Kericho	COP18	Sustained	17,169	89%	184%	86%	86%	118%	105%
Narok	COP 15	ScaleUp Agg	6,985	50%			41%	59%	44%
Narok	COP16	ScaleUp Agg	7,804	49%	31%	26%	55%	61%	49%
Narok	COP17	ScaleUp Agg	7,870	53%	35%	29%	41%	61%	50%
Narok	COP18	ScaleUp Agg	11,838	86%	56%	56%	56%	90%	75%
Nyandarua	COP 15	Sustained	6,873	142%			70%	52%	54%
Nyandarua	COP16	Sustained	7,299	134%	67%	34%	67%	52%	57%
Nyandarua	COP17	ScaleUp Sat	7,330	126%	92%	45%	71%	49%	57%
Nyandarua	COP18	ScaleUp Sat	11,478	181%	69%	69%	69%	95%	90%
Kirinyaga	COP 15	Sustained	8,415	119%			87%	69%	68%
Kirinyaga	COP16	Sustained	9,068	114%	60%	34%	92%	70%	74%
Kirinyaga	COP17	ScaleUp Sat	9,378	113%	61%	37%	91%	74%	76%
Kirinyaga	COP18	ScaleUp Sat	11,090	123%	76%	76%	96%	88%	90%
Taita Taveta	COP 15	Sustained	4,955	42%			55%	52%	42%

County	COP	Prioritization	APR Results Reported	<15Yrs Coverage	15-24 Male Coverage	15-24 Female Coverage	25+ Male Coverage	25+ Female Coverage	Overall Coverage
Taita Taveta	COP16	Sustained	4,880	34%	23%	11%	49%	49%	41%
Taita Taveta	COP17	Sustained	4,983	39%	30%	12%	51%	48%	42%
Taita Taveta	COP18	Sustained	6,012	55%	41%	23%	52%	58%	51%
Nandi	COP 15	ScaleUp Agg	9,442	69%			80%	118%	84%
Nandi	COP16	ScaleUp Agg	10,296	77%	70%	39%	88%	113%	92%
Nandi	COP17	ScaleUp Agg	10,579	75%	56%	36%	86%	121%	94%
Nandi	COP18	ScaleUp Agg	11,266	86%	82%	59%	91%	121%	100%
Bomet	COP 15	ScaleUp Agg	9,586	79%			75%	122%	86%
Bomet	COP16	ScaleUp Agg	11,088	93%	74%	69%	83%	122%	99%
Bomet	COP17	ScaleUp Sat	10,732	84%	62%	55%	91%	115%	96%
Bomet	COP18	ScaleUp Sat	13,073	95%	97%	97%	97%	142%	117%
Embu	COP 15	Sustained	8,219	93%			90%	93%	74%
Embu	COP16	Sustained	7,948	91%	33%	21%	79%	84%	71%
Embu	COP17	Attained	8,040	90%	38%	19%	81%	85%	72%
Embu	COP18	Sustained	9,972	98%	75%	75%	87%	95%	90%
Tharaka Nithi	COP 15	Sustained	5,878	86%			85%	78%	65%
Tharaka Nithi	COP16	Sustained	5,950	77%	48%	24%	76%	73%	65%
Tharaka Nithi	COP17	ScaleUp Sat	6,013	76%	44%	23%	79%	74%	66%
Tharaka Nithi	COP18	ScaleUp Sat	8,138	98%	75%	75%	89%	94%	90%
Laikipia	COP 15	Sustained	6,895	87%			83%	122%	89%
Laikipia	COP16	Sustained	7,692	88%	76%	53%	78%	128%	99%
Laikipia	COP17	ScaleUp Agg	7,814	88%	108%	53%	89%	122%	101%
Laikipia	COP18	ScaleUp Agg	5,933	75%	78%	55%	62%	91%	76%
Baringo	COP 15	Sustained	3,001	57%			49%	74%	54%
Baringo	COP16	Sustained	3,167	57%	35%	32%	45%	72%	57%
Baringo	COP17	Sustained	3,222	58%	27%	19%	46%	77%	58%

County	COP	Prioritization	APR Results Reported	<15Yrs Coverage	15-24 Male Coverage	15-24 Female Coverage	25+ Male Coverage	25+ Female Coverage	Overall Coverage
Baringo	COP18	Sustained	3,855	75%	53%	53%	53%	83%	69%
West Pokot	COP 15	Sustained	2,173	42%			42%	63%	45%
West Pokot	COP16	Sustained	3,201	97%	166%	101%	41%	61%	67%
West Pokot	COP17	Sustained	3,523	89%	206%	113%	42%	71%	74%
West Pokot	COP18	Sustained	3,880	77%	173%	108%	67%	77%	81%
Elgeyo Marakwet	COP 15	Sustained	2,419	54%			48%	78%	55%
Elgeyo Marakwet	COP16	Sustained	2,722	54%	25%	48%	50%	79%	62%
Elgeyo Marakwet	COP17	ScaleUp Sat	2,645	53%	26%	27%	48%	81%	60%
Elgeyo Marakwet	COP18	ScaleUp Sat	3,944	90%	76%	76%	76%	104%	90%
Isiolo	COP 15	Sustained Com	2,095	107%			71%	69%	58%
Isiolo	COP16	Sustained Com	2,176	107%	21%	18%	72%	65%	60%
Isiolo	COP17	Sustained Com	2,066	102%	20%	15%	67%	63%	57%
Isiolo	COP18	Sustained Com	2,386	102%	51%	51%	56%	72%	66%
Mandera	COP 15	Sustained Com	481	5%			52%	14%	14%
Mandera	COP16	Sustained Com	513	7%	45%	22%	33%	9%	15%
Mandera	COP17	Sustained Com	525	8%	48%	22%	35%	9%	16%

County	COP	Prioritization	APR Results Reported	<15Yrs Coverage	15-24 Male Coverage	15-24 Female Coverage	25+ Male Coverage	25+ Female Coverage	Overall Coverage
Mandera	COP18	Sustained Com	542	50%	46%	12%	7%	7%	16%
Samburu	COP 15	Sustained	1,092	63%			30%	48%	37%
Samburu	COP16	Sustained	1,399	79%	74%	131%	27%	31%	47%
Samburu	COP17	Sustained	1,424	83%	96%	126%	30%	29%	48%
Samburu	COP18	Sustained	1,750	70%	96%	136%	48%	42%	59%
Marsabit	COP 15	Sustained Com	1,421	79%			54%	64%	50%
Marsabit	COP16	Sustained Com	1,205	47%	106%	78%	39%	27%	42%
Marsabit	COP17	Sustained Com	1,219	57%	106%	79%	29%	31%	43%
Marsabit	COP18	Sustained Com	1,352	85%	110%	79%	41%	31%	48%
Tana River	COP 15	Sustained Com	894	41%			35%	41%	32%
Tana River	COP16	Sustained Com	1,008	44%	62%	50%	28%	32%	36%
Tana River	COP17	Sustained Com	1,020	46%	58%	49%	30%	33%	37%
Tana River	COP18	Sustained Com	1,061	61%	47%	38%	29%	38%	38%
Garissa	COP 15	Sustained Com	1,087	17%			100%	53%	43%
Garissa	COP16	Sustained Com	1,158	13%	113%	94%	66%	31%	46%
County	COP	Prioritization	APR	<15Yrs	15-24 Male	15-24 Female	25+ Male	25+ Female	Overall

			Results Reported	Coverage	Coverage	Coverage	Coverage	Coverage	Coverage
Garissa	COP17	Sustained Com	1,223	16%	115%	100%	68%	33%	48%
Garissa	COP18	Sustained Com	1,333	50%	82%	68%	47%	48%	53%
Lamu	COP 15	Sustained Com	1,125	78%			61%	56%	49%
Lamu	COP16	Sustained Com	1,218	69%	59%	42%	54%	52%	53%
Lamu	COP17	Sustained Com	1,222	63%	24%	25%	62%	57%	53%
Lamu	COP18	Sustained Com	1,379	75%	46%	46%	46%	68%	59%
Wajir	COP 15	Sustained Com	214	8%			51%	18%	17%
Wajir	COP16	Sustained Com	249	11%	65%	41%	31%	10%	19%
Wajir	COP17	Sustained Com	258	11%	68%	43%	32%	10%	20%
Wajir	COP18	Sustained Com	252	50%	27%	17%	13%	13%	20%

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY18)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY19) *TX_CURR***	**Newly initiated (APR FY 19) *TX_NEW***	**ART Coverage (APR 19)**
Attained						
Scale-Up Saturation	1,214,876	970,857	1,044	1,042,933	127,827	86%
Scale-Up Aggressive	231,413	136,442	48,688	175,458	49,740	76%
Sustained	52,654	40,525	1,598	42,637	4,349	81%
Sustained Commodities	18,765	8,937	6,075	8,973	487	48%
Commodities (if not included in previous categories)						
Total	**1,517,707**	**1,156,760**	**57,405**	**1,270,001**	**182,403**	**84%**

APPENDIX B – Budget Profile and Resource Projections

B1. COP18 Planned Spending

Table B.1.1 COP18 Budget by Approach and Program Area

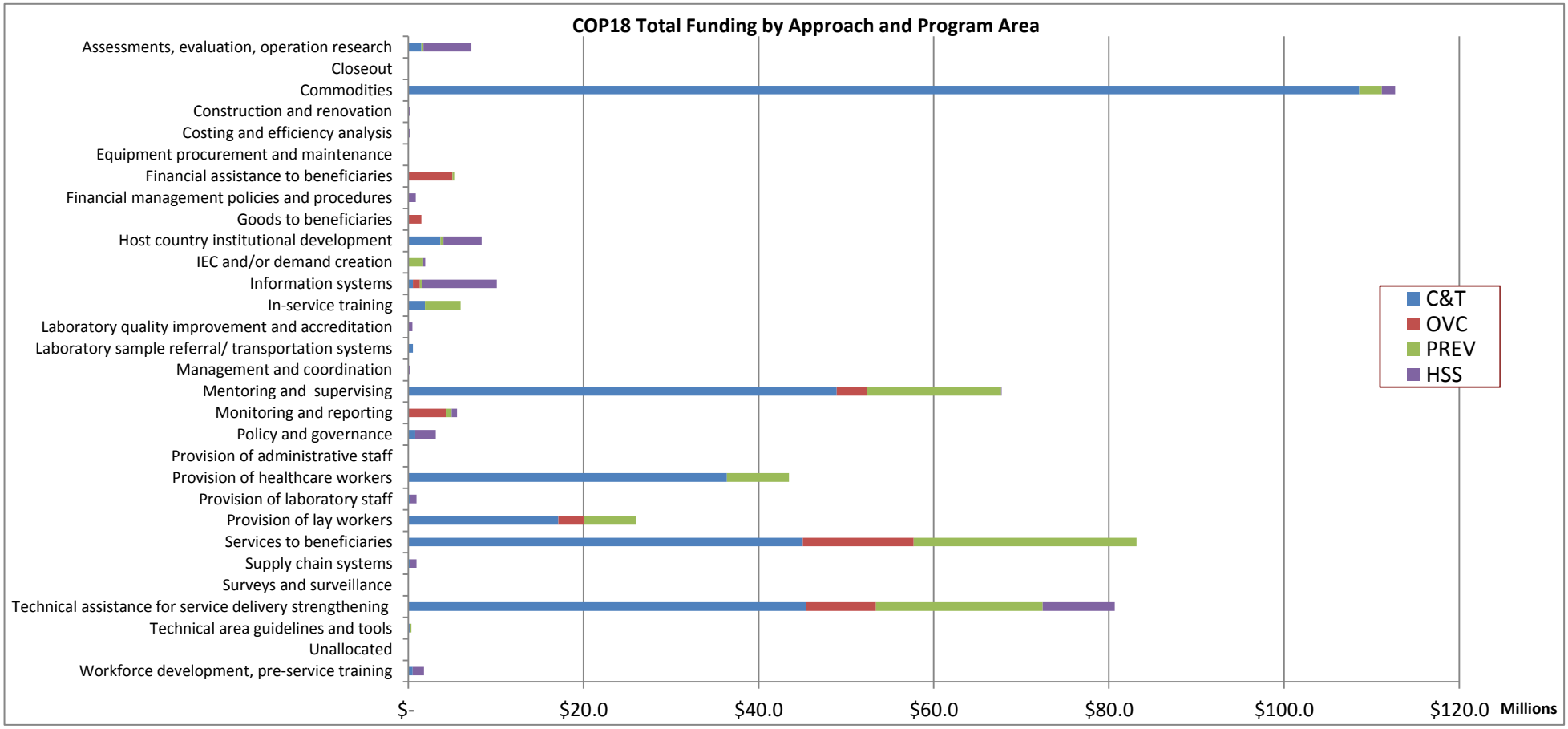


Table B.1.2 COP18 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$60,647,679	**$444,832,321**	**$505,480,000**

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	**$16,038,758**
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	**$2,998,784**
HVOP	Other Sexual Prevention	**$34,672,186**
IDUP	Injecting and Non-Injecting Drug Use	**$1,644,672**
HMBL	Blood Safety	**$1,459,721**
HMIN	Injection Safety	**$1,337,416**
CIRC	Male Circumcision	**$18,597,751**
HVCT	Counseling and Testing	**$44,108,014**
HBHC	Adult Care and Support	**$ 6,161,710**
PDCS	Pediatric Care and Support	**$1,417,631**
HKID	Orphans and Vulnerable Children	**$32,399,901**
HTXS	Adult Treatment	**$145,272,193**
HTXD	ARV Drugs	**$71,640,788**
PDTX	Pediatric Treatment	**$10,779,801**
HVTB	TB/HIV Care	**$10,046,453**
HLAB	Lab	**$10,272,206**
HVSI	Strategic Information	**$14,630,683**

OHSS	Health Systems Strengthening	**$4,539,523**
HVMS	Management and Operations	**$16,814,130**
TOTAL		**$444,832,321**

*Data included in Table B.2.2 should match FACTS Info records and can be double-checked by running the "Summary of Planned Funding by Budget Code" report

B.2 Resource Projections

COP18 IM funding was completed by identifying the strategic gaps that need to be closed in order to align to the strategic plan and the planning envelope. The Kenya COP18 Planned Country Allocation, Strategic Direction Information Memo and COP18 guidance was utilized as guidance.

The FAST tool, pre-populated with COP17 strategic objectives and approaches, formed the basis for the IM budgeting process. For each IM, activities were identified resulting in strategic objectives aimed at moving the program towards epidemic control. From there, incremental budgeting for each IM was applied by assessing activities to be scaled-up or down or completely dropped. This was informed by IM FY17 performance and COP18 priorities and strategic direction.

Expansion plans were based on performance gaps, geographic location, populations and shifts in funding were made to achieve targets for epidemic control. Other considerations taken into account for IM budgeting included project start up and close out costs, underperforming/overspending activities, new IMs and new programmatic strategies or approaches such as focus on treatment and retention of men and adolescents.

APPENDIX C – Tables and Systems Investments for Section 6.0

An excerpt of Table 6, including Funding Agency, Mechanism ID, Program Area, COP18 Strategic Objective and Approach are pasted below. The entire Table 6 Excel will also be submitted separately.

Funding Agency	Mech ID	Program Area	COP18 Strategic Objective	Approach
USAID	7139	HSS	Increase Sustainable Finance and Domestic Resource Mobilization for Kenya's Health Sector	Costing and efficiency analysis
USAID	7139	HSS	Increase Sustainable Finance and Domestic Resource Mobilization for Kenya's Health Sector	Financial management policies and procedures
USAID	7139	C&T	Increase Sustainable Finance and Domestic Resource Mobilization for Kenya's Health Sector	Financial management policies and procedures
USAID	7139	HSS	Strengthen national and county linkages to enhance Kenya's health finance, policy and governance	Policy and governance
HHS/CDC	13346	C&T	Technical support for operationalization and implementation of Treat All guidelines, including improvement of clinic-lab interphase and resource mobilization.	Technical area guidelines and tools
HHS/CDC	13346	PREV	Provide technical support for HIV Self-testing; assisted partner notification services; Pre-exposure prophylaxis (PrEP) services; assessment of VMMC coverage by age bands; and implementation of the VMMC sustainability phase .	Technical area guidelines and tools
USAID	13868	HSS	Strengthened capacity of government to lead, manage and govern health communications and marketing	IEC and/or demand creation
HHS/CDC	13919	HSS	Strengthen laboratory capacity to ensure high-quality HIV diagnosis and monitoring tests, including HIV rapid tests, CD4, viral load, PCR-EID, TB microscopy and Gene Xpert. Also addresses systems barrier 2 (Laboratory in Table 6:3): weak lab quality improvement initiatives to ensure accurate and timely diagnostics.	Laboratory quality improvement and accreditation
USAID	14012	C&T	Strengthen the capacity of MOH facilities and County Health Systems	Host country institutional development
USAID	14022	C&T	Strengthen the capacity of MOH facilities and County Health Systems	Host country institutional

				development
HHS/CDC	16670	HSS	Fortify the HIV Health System by providing Organizational Capacity Building; Training and Mentorship on Human Resources for Health at middle-senior level management; addressing HRH technical gaps; and strengthening institutional capacity to offer and institutionalize e-learning courses	Workforce development, pre-service training
HHS/CDC	16687	HSS	Support Kenya Prisons capacity to plan, implement, evaluate, and manage a USG-funded grant for comprehensive HIV and TB prevention, care and treatment services	Host country institutional development
USAID	17709	C&T	Improve the quality of training and increase the number of those graduating and entering the workforce	Workforce development, pre-service training
USAID	17709	HSS	Improve the quality of training and increase the number of those graduating and entering the workforce	Workforce development, pre-service training
USAID	17709	HSS	Improve Management and Leadership of Health Workforce at the county level	Policy and governance
USAID	17709	HSS	Optimize Data use for effective Decision Making at National and County Level	Information systems
USAID	17709	C&T	Improve the quality of training and increase the number of those graduating and entering the workforce	Workforce development, pre-service training
HHS/CDC	17712	HSS	1a: SURVEILLANCE: HIV Case-Based Surveillance expansion (general & KP); Key Population Assessments [annual KPSE, IBBS]; Mortality Surveillance [establish sentinel surveillance sites]; Routine HIVDR surveillance; ANC Sentinel Surveillance. 2: MONITORING AND EVALUATION: M&E Tools Roll out; Print M&E tools; Cascade of Revised M&E Tools; Data Quality; Geo Spatial Analysis; Data Analysis, Use and Dissemination; Support Monitoring of 90-90-90 targets; Cohort Analysis; Data Review and Triangulation; Capacity Building for M&E; CoAg Evaluation	Assessments, evaluation, operation research

HHS/CDC	17712	PREV	1b: SURVEILLANCE: Establish HIV Recency Surveillance among PLHIV	Assessments, evaluation, operation research
USAID	17719	HSS	Strengthened and Functional County Health Systems	Host country institutional development
HHS/CDC	17945	HSS	Strengthen Health System by conducting and presenting evaluations and articles of key mHealth priority projects; scaling up the mLab System roll out and improve system functionality; increase the usability of C4C researching for innovative solutions to improve the application's usability and buy-in; and roll out the T4A system	Information Systems
HHS/CDC	17945	HSS	Strengthen Health System by conducting and presenting evaluations and articles of key mHealth priority projects; scaling up the mLab System roll out and improve system functionality; increase the usability of C4C researching for innovative solutions to improve the application's usability and buy-in; and roll out the T4A system	Information Systems
HHS/CDC	17945	HSS	Strengthen Health System by conducting and presenting evaluations and articles of key mHealth priority projects; scaling up the mLab System roll out and improve system functionality; increase the usability of C4C researching for innovative solutions to improve the application's usability and buy-in; and roll out the T4A system	Information Systems
HHS/CDC	17945	HSS	Strengthen Health System by conducting and presenting evaluations and articles of key mHealth priority projects; scaling up the mLab System roll out and improve system functionality; increase the usability of C4C researching for innovative solutions to improve the application's usability and buy-in; and roll out the T4A system	Information Systems
HHS/CDC	17948	HSS	Support regulation of quality laboratory practices and foster lab networks. The SO addresses systems barrier 2 (Laboratory in Table 6:3) called weak lab quality improvement initiatives to ensure accurate and timely diagnostics.	Laboratory quality improvement and accreditation
HHS/CDC	17950	HSS	Fortify Health System through the strengthening of laboratory capacity to ensure high-quality testing for HIV/TB diagnosis and monitoring tests; provision of support to site level infection control activities; promotion of appropriate utilization of blood product; and strengthening of haemovigilance. Also to support the functioning of the logistics office to enhance laboratory commodity management	Management and coordination
HHS/CDC	17956	PREV	Complete population-based survey of Male Circumcision coverage by county and age band to guide planning and resource investment for VMMC while supporting national and county governments in VMMC program leadership focusing on sustaining program quality and integration of VMMC into routine health services.	Host country institutional development

HHS/CDC	17956	PREV	Complete population-based survey of Male Circumcision coverage by county and age band to guide planning and resource investment for VMMC while supporting national and county governments in VMMC program leadership focusing on sustaining program quality and integration of VMMC into routine health services.	Host country institutional development
HHS/CDC	17956	PREV	Complete population-based survey of Male Circumcision coverage by county and age band to guide planning and resource investment for VMMC while supporting national and county governments in VMMC program leadership focusing on sustaining program quality and integration of VMMC into routine health services.	Host country institutional development
USAID	17958	HSS	Strengthened national governance of health informatics, monitoring, evaluations, learning and accountability systems	Policy and governance
USAID	17958	HSS	Strengthened national governance of health informatics, monitoring, evaluations, learning and accountability systems	Policy and governance
USAID	17958	HSS	Strengthened national governance of health informatics, monitoring, evaluations, learning and accountability systems	Policy and governance
USAID	17958	HSS	Strengthened national governance of health informatics, monitoring, evaluations, learning and accountability systems	Host country institutional development
USAID	17958	HSS	Strengthen capacity of national and county MOH on data analytics	Host country institutional development
USAID	17959	HSS	Strengthened National Information Systems that support reporting, provide data for decision making for GOK, counties and other stakeholders	Information systems
USAID	17959	HSS	Strengthened National Information Systems that support reporting, provide data for decision making for GOK, counties and other stakeholders	Information systems
USAID	17959	HSS	Strengthened National Information Systems that support reporting, provide data for decision making for GOK, counties and other stakeholders	Information systems
USAID	17959	HSS	Strengthened National Information Systems that support reporting, provide data for decision making for GOK, counties and other stakeholders	Information systems
USAID	17959	HSS	Improve institutional capacity of national and county MOH on use of health systems, quality data capture and reporting	Host country institutional development
USAID	17959	HSS	Strengthened National Information Systems that support reporting, provide data for decision making for GOK, counties and other stakeholders	Information systems

USAID	17959	OVC	Strengthened National Information Systems that support reporting, provide data for decision making for GOK, counties and other stakeholders	Information systems
USAID	17960	PREV	Develop and update VMMC data for decision making tools to support VMMC programming	Information systems
HHS/CDC	18214	HSS	Enhancement of the HIS systems to address the entire spectrum of HIV service delivery; Improvement of HIS solutions and capacity building stakeholders to undertake HIS use; Fortify the HIV Health system through the strengthening of data quality and utilization; and enhancement of the Human resources information system (rHRIS and iHRIS) utilization for workforce planning and allocation	Information Systems
HHS/CDC	18214	HSS	Enhancement of the HIS systems to address the entire spectrum of HIV service delivery; Improvement of HIS solutions and capacity building stakeholders to undertake HIS use; Fortify the HIV Health system through the strengthening of data quality and utilization; and enhancement of the Human resources information system (rHRIS and iHRIS) utilization for workforce planning and allocation	Information Systems
HHS/CDC	18214	HSS	Enhancement of the HIS systems to address the entire spectrum of HIV service delivery; Improvement of HIS solutions and capacity building stakeholders to undertake HIS use; Fortify the HIV Health system through the strengthening of data quality and utilization; and enhancement of the Human resources information system (rHRIS and iHRIS) utilization for workforce planning and allocation	Information Systems
HHS/CDC	18214	HSS	Enhancement of the HIS systems to address the entire spectrum of HIV service delivery; Improvement of HIS solutions and capacity building stakeholders to undertake HIS use; Fortify the HIV Health system through the strengthening of data quality and utilization; and enhancement of the Human resources information system (rHRIS and iHRIS) utilization for workforce planning and allocation	Information Systems
HHS/CDC	18223	HSS	Support accurate measurement of “90/90/90” and service delivery though improved linkage and tracking of loss to follow-up	Assessments, evaluation, operation research
HHS/CDC	18223	HSS	Support accurate measurement of “90/90/90” and service delivery though improved linkage and tracking of loss to follow-up	Assessments, evaluation, operation research
HHS/CDC	18223	HSS	Support accurate measurement of “90/90/90” and service delivery though improved linkage and tracking of loss to follow-up	Assessments, evaluation, operation research

HHS/CDC	18223	HSS	Support accurate measurement of “90/90/90” and service delivery though improved linkage and tracking of loss to follow-up	Assessments, evaluation, operation research
HHS/CDC	18223	C&T	Support for HIV and TB program implementation and evaluation including building capacity and infrastructure for program evaluations and surveillance projects for HIV/AIDS and TB, including using population based surveillance approaches	Surveys and surveillance
HHS/HRSA	18260	HSS	Integration of UPI in health services	Information Systems
HHS/HRSA	18260	HSS	To evaluate and monitor programs to build national HIS inventories	Information Systems
HHS/HRSA	18260	HSS	Defining Kenya HIS landscape and establish HIS governance structure	Information Systems
HHS/HRSA	18260	HSS	Develop standards and certification framework for HIS investments	Host country institutional development
HHS/HRSA	18260	HSS	Develop standards and certification framework for HIS investments	Host country institutional development
HHS/CDC	18262	HSS	Support countries to develop effective and sustainable Health Information Systems; strengthen their capacity to generate national and sub-national HIV incidence and prevalence estimates; and develop, implement and monitor Fast-Track strategies to reach key populations	Host country institutional development
USAID	18281	HSS	Strengthened Technical leadership and coordination for commodity management	Supply chain systems
USAID	18281	HSS	Strengthened county oversight and implementation of supply chain services	Supply chain systems
USAID	18281	HSS	Strengthened Technical leadership and coordination for commodity management	Supply chain systems
USAID	18318	HSS	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Policy and governance
USAID	18318	HSS	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Host country institutional development
USAID	18318	HSS	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Policy and governance
USAID	18318	HSS	Increased availability, analysis and use of quality data	Information systems

USAID	18318	HSS	Increased availability, analysis and use of quality data	Information systems
USAID	18318	OVC	Increase availability, analysis and use of high-quality data	Information systems
USAID	18318	OVC	Increase availability, analysis and use of high-quality data	Information systems
USAID	18318	HSS	Increased availability, analysis and use of quality data	Information systems
DOD	18493	HSS	To improve functionality of the DoD sponsored KEMRI lab in Kericho, Kenya - one of the national network labs for VL and EID services – the activity will increase efficiency to decrease turn-around-time (TAT) for testing results.	Construction and renovation
USAID	18494	C&T	Strengthened institutional accountability for the management of community, facility and county HIV response	Host country institutional development
USAID	18495	C&T	Strengthened institutional accountability for the management of community, facility and county HIV response	Host country institutional development
USAID	18496	C&T	Strengthened institutional accountability for the management of community, facility and county HIV response	Host country institutional development
USAID	18499	HSS	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Policy and governance
USAID	18499	HSS	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Policy and governance
USAID	18499	HSS	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Host country institutional development
USAID	18499	HSS	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Host country institutional development
USAID	18499	HSS	Increase availability, analysis and use of high-quality data	Information systems
USAID	18499	HSS	Increase availability, analysis and use of high-quality data	Information systems
USAID	18499	OVC	Increase availability, analysis and use of high-quality data (Child Protection Information Management System)	Information systems

USAID	18499	OVC	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Host country institutional development
USAID	18499	HSS	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Host country institutional development
USAID	18678	C&T	Enhance efficiency and sustainability of national TB program	Policy and governance
USAID	18678	C&T	Enhance efficiency and sustainability of national TB program	Information Systems
DOD	70108	HSS	Increase use and triangulation of study and operations research data to improve programmatic management and decision-making	Assessments, evaluation, operation research
DOD	70108	PREV	Increase use and triangulation of study and operations research data to improve programmatic management and decision-making	Assessments, evaluation, operation research
DOD	70111	HSS	Longitudinally assess the impact of clinical practices, biological factors and socio-behavioral issues on HIV infection and disease progression in a multi-country African context.	Assessments, evaluation, operation research
DOD	70111	C&T	Longitudinally assess the impact of clinical practices, biological factors and socio-behavioral issues on HIV infection and disease progression in a multi-country African context.	Assessments, evaluation, operation research
DOD	70111	HSS	Identify factors associated with virologic outcome and HIV drug resistance patterns in children & adolescents aged 1-19 years as part of an ongoing multi-country study in Kenya and Tanzania	Assessments, evaluation, operation research
DOD	70112	HSS	Increase use and triangulation of study and operations research data to improve programmatic management and decision-making	Assessments, evaluation, operation research
HHS/CDC	70114	HSS	Strengthening GOK's workforce capacity to respond to outbreaks, assess surveillance systems and carry out epidemiologic protocols.	Host country institutional development

Table 6 Attachment

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
1	USAID	HP Plus	HSS	Increase Sustainable Finance and Domestic Resource Mobilization for Kenya's Health Sector	Increase Sustainable Finance and Domestic Resource Mobilization for Kenya's Health Sector	Costing and efficiency analysis	Advocacy for increased allocations to health and HIV in national budget; Support evidence generation to inform domestic resource mobilization including monitorying DRM trends, improving budget execution TA to inform NHIF/UHC reforms and related sustainable financing for HIV	Inadequate domestic resource mobilization (DRM) to sustain program gains and epidemic control in the *absence of donor financing*
2	USAID	HP Plus	HSS	Increase Sustainable Finance and Domestic Resource Mobilization for Kenya's Health Sector	Increase Sustainable Finance and Domestic Resource Mobilization for Kenya's Health Sector	Financial management policies and procedures	Targetted TA/mentoring of of 26 counties on program based budgetiong for improved DRM at county level Evidence generation/budget analyses/expenditure reviews to inform County planning and advocacy, including HIV resource tracking, allocation and use	Inadequate domestic resource mobilization (DRM) to sustain program gains and epidemic control in the absence of donor financing
3	USAID	HP Plus	C&T	Increase Sustainable Finance and Domestic Resource Mobilization for Kenya's Health Sector	Increase Sustainable Finance and Domestic Resource Mobilization for Kenya's Health Sector	Financial management policies and procedures	Support to sub-county program based budgeting (deeper dive analysis)- linked to Cluster 4 counties	*Inadequate domestic resource mobilization (DRM) to sustain program gains and epidemic control in the absence of donor financing*

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
1	Domestic Resource Mobilisation	*5.71*	Budget line for HIV commodities retained and increased in national budget to reduce reliance on donor financing National HIV commodities budget fully executed	3 years	Total allocation for HIV commodities in national budget for current KFY Budget execution level for previous fiscal year	Budget line retained for HIV commodities at $26M in national budget allocation for Kenya fiscal year 2017/18 Budget execution for HIV commodities line item KFY 2016/17 = 62%
2	Technical and Allocative Efficiency	7.33	Demonstrated county capacity in 26 focus counties to undertake program based budgeting resulting in improved health and HIV resource allocation	3 years	Average county health budget allocation as a percent of total county budget across 26 counties Total allocated to HIV/AIDs (as a program line item for HIV/AIDS) across 26 focus county health budgets	Average county budget allocation to health as percent of total county budget is 26.5% across 26 focus counties in KFY2017/18 $4 M allocated to HIV/AIDS across 26 focus county health budgets KFY2017/18
3	Technical and Allocative Efficiency	7.33	Demonstrated county capacity in 26 focus counties to undertake program based budgeting resulting in improved health and HIV resource allocation	3 years	Average county health budget allocation as a percent of total county budget across 26 counties Total allocated to HIV/AIDs (as a program line item for HIV/AIDS) across 26 focus county health budgets	Average county budget allocation to health as percent of total county budget is 26.5% across 26 focus counties in KFY2017/18 $4 M allocated to HIV/AIDS across 26 focus county health budgets KFY2017/18

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
1	Budget line retained for HIV commodities at $28M or greater in national budget allocation for Kenya fiscal year 2018/19 Budget execution for HIV commodities line item KFY 2017/18 improved from KFY 2016/17		Budget line retained for HIV commodities at greater than KFY 2018/19 levels in national budget allocation for KFY 2019/20 Budget execution for HIV commodities line item KFY 2018/19 improved from KFY 2017/18		Budget line retained for HIV commodities at greater than KFY 2019/20 levels in national budget allocation for KFY 2020/21 Budget execution for HIV commodities line item KFY 2019/20 improved from KFY 2018/19	
2	Average county health budget allocation as percent of total county budget across 26 focus counties in KFY2018/19 is greater than or equal to KFY 2017/18 level Budget allocated to HIV/AIDS across 26 focus county health budgets increased from KFY 2017/18 level		Average county health budget allocation as percent of total county budget across 26 focus counties in KFY2019/20 is greater than or equal to KFY 2018/19 level Budget allocated to HIV/AIDS across 26 focus county health budgets increased from KFY 2017/18 level		Average county health budget allocation as percent of total county budget across 26 focus counties in KFY2020/21 is greater than or equal to KFY 2019/20 level Budget allocated to HIV/AIDS across 26 focus county health budgets increased from KFY 2018/19 level	
3	Average county health budget allocation as percent of total county budget across 26 focus counties in KFY2018/19 is greater than or equal to KFY 2017/18 level Budget allocated to HIV/AIDS across 26 focus county health budgets increased from KFY 2017/18 level		Average county health budget allocation as percent of total county budget across 26 focus counties in KFY2019/20 is greater than or equal to KFY 2018/19 level Budget allocated to HIV/AIDS across 26 focus county health budgets increased from KFY 2017/18 level		Average county health budget allocation as percent of total county budget across 26 focus counties in KFY2020/21 is greater than or equal to KFY 2019/20 level Budget allocated to HIV/AIDS across 26 focus county health budgets increased from KFY 2018/19 level	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
4	USAID	HP Plus	HSS	Strengthen national and county linkages to enhance Kenya's health finance, policy and governance	Strengthen national and county linkages to enhance Kenya's health finance, policy and governance	Policy and governance	Support the health sector IGF to facilitate policy dialogue between the two levels of government on health and HIV financing, and disseminate key analytics	Inadequate domestic resource mobilization (DRM) to sustain program gains and epidemic control in the absence of donor financing
5	HHS/CDC	Support Services for HIV Pandemic	C&T	Technical support for operationalization and implementation of Treat All guidelines, including improvement of clinic-lab interphase and resource mobilization.	Technical support for operationalization and implementation of Treat All guidelines, including improvement of clinic-lab interphase and resource mobilization.	Technical area guidelines and tools	Support implementing of new guidelines for ARV optimization and DTG roll-out	Incomplete roll-out of new guidelines and ARV optimization
6	HHS/CDC	Support Services for HIV Pandemic	PREV	Provide technical support for HIV Self-testing ; assisted partner notification services; Pre-exposure prophylaxis (PrEP) services; assessment of VMMC coverage by age bands; and implementation of the VMMC sustainability phase .	Provide technical support for HIV Self-testing ; assisted partner notification services; Pre-exposure prophylaxis (PrEP) services; assessment of VMMC coverage by age bands; and implementation of the VMMC sustainability phase .	Technical area guidelines and tools	Support implementing of new HTS guidelines	Low identification of PLHIV
7	USAID	Health Communication & Marketing	HSS	Strengthened capacity of government to lead, manage and govern health communications and marketing	Strengthened capacity of government to lead, manage and govern health communications and marketing	IEC and/or demand creation	Social marketing and distribution of condoms; Conduct SBCC activities for prevention, HIV testing, test and Start, PMTCT and VMMC	Low Knowledge of seroatatus, available treatment and prevention services. Poor attitudes and practices on HIV prevention.

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
4	Domestic Resource Mobilisation	5.71	Improved capacity of IGF/TWS to drive policy agenda and track implemenation of policy resolutions	3 years	Number of IGF TWG reports on key health financing polices and actions taken	Two IGFs per year
5	Service delivery	6.44	Complete roll-out of guidelines and ARV optimization	2 years	Complettion of guideline roll-out and ARV optimization for all eligible	5% guidelines and nd ARV optimization for all eligible
6	Service delivery	6.44	High yielding approaches in PLHIV identification	2 years	Status of HTS guidelines	HTS guidelines in development
7	Public access to Information	7.00	Increased knowledge, attitude and practice on HIV prevention and treatment	3 years	Proportion of people with known HIV status	53% knowledge of HIV status (KDHS 2014)

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
4	Two IGF TWGs supported per year with summary report/progress made		Two IGF TWGs supported per year with summary report/progress made		Two IGF TWGs supported per year with summary report/progress made	
5	50% guidelines and ARV optimization for all eligible		95% guidelines and ARV optimization for all eligible		N/A	
6	HTS guidelines developed and launched		Service quality assessment for HTS guidelines implementation		N/A	
7	80% knowledge of HIV status (KENPHIA)		90% knowledge of HIV status		95% knowledge of HIV status	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
8	HHS/CDC	Laboratory Regulatory Support	HSS	Strengthen laboratory capacity to ensure high-quality HIV diagnosis and monitoring tests, including HIV rapid tests, CD4, viral load, PCR-EID, TB microscopy and Gene Xpert. Also addresses systems barrier 2 (Laboratory in Table 6:3): weak lab quality improvement initiatives to ensure accurate and timely diagnostics.	Strengthen laboratory capacity to ensure high-quality HIV diagnosis and monitoring tests, including HIV rapid tests, CD4, viral load, PCR-EID, TB microscopy and Gene Xpert. Also addresses systems barrier 2 (Laboratory in Table 6:3): weak lab quality improvement initiatives to ensure accurate and timely diagnostics.	Laboratory quality improvement and accreditation	Support national coordination of lab QMS and accrediation activities	Weak lab quality management systems
9	USAID	AMPATHPlus	C&T	Strengthen the capacity of MOH facilities and County Health Systems	Strengthen the capacity of MOH facilities and County Health Systems	Host country institutional development	Support Counties in development of AWP and linking it with program based budgeting, Strategic planning	Weak capacity of the County Health Management Teams to plan and Budget for HIV and Health
10	USAID	APHIA PLUS IMARISHA	C&T	Strengthen the capacity of MOH facilities and County Health Systems	Strengthen the capacity of MOH facilities and County Health Systems	Host country institutional development	Support Central support Counties in development of AWP and linking it with program based budgeting, Strategic planning. Also support the CHMT to conduct supportive supervision and ccoodinate TWG meetings	Weak capacity of the County Health Management Teams to plan and Budget for HIV and Health

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
8	Laboratory	6.67	56 laboratories fully accredited to international standards	2 years	Number of fully accredited labs by a recognized body	18 laboratories fully accredited to international standards
9	Planning and coodination	8.5	Functional county Health Management teams with ability to plan and budget for health and HIV	3 years	Percentage of counties with AWP priorities reflected in the County program based budget for Health.	40% of supported counties with AWP priorities reflected in the County program based budget for Health.
10	Planning and coodination	8.5	Functional county Health Management teams with ability to plan and budget for health and HIV	2 years	Percentage of counties with AWP priorities reflected in the County program based budget for Health. Counties able to plan and coodinate supportive supervision activities and TWG meetings.	50%of supported counties with AWP priorities reflected in the County program based budget for Health.

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8	35 laboratories fully accredited to international standards		56 laboratories fully accredited to international standards		NA	
9	60 % of supported counties with AWP priorities reflected in the County program based budget for Health.		80 % of supported counties with AWP priorities reflected in the County program based budget for Health.		100% of supported counties with AWP priorities reflected in the County program based budget for Health.	
10	70 % of supported counties with AWP priorities reflected in the County program based budget for Health.		100% of supported counties with AWP priorities reflected in the County program based budget for Health.		N/A	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
11	HHS/CDC	University of Nairobi HIV Fellowship Program	HSS	Fortify the HIV Health System by providing Organizational Capacity Building; Training and Mentorship on Human Resources for Health at middle-senior level management; addressing HRH technical gaps; and monitoring and Evaluation of project performance	Fortify the HIV Health System by providing Organizational Capacity Building; Training and Mentorship on Human Resources for Health at middle-senior level management; addressing HRH technical gaps; and strengthening institutional capacity to offer and institutionalize e-learning courses	Workforce development, pre-service training	Build the capacity of Human Resources for Health and County Health Department systems to enable the country achieve epidemic control	Limited capacity at national and sub-national health authorities to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?
12	HHS/CDC	Kenya Prison Services	HSS	Support Kenya Prisons Service capacity to plan, implement, evaluate, and manage a USG-funded grant for comprehensive HIV and TB prevention, care and treatment services	Support Kenya Prisons capacity to plan, implement, evaluate, and manage a USG-funded grant for comprehensive HIV and TB prevention, care and treatment services	Host country institutional development	Train and mentor National and regional program and management staff in leadership, financial, human resource and program management, to build Kenya Prisons capacity to plan, staff, implement and report a sustainable HIV and TB control program in a timely and accountable manner by year 5 of the Project Operationalize eight regional Sub-ACU structures aligned to County and prisons governance structures, includingfilling of all technical program positions and establishment of strong, transparent financial management system	Lack of organizational capacity, and strategic program management to implement high quality, evidence-based HIV services within Kenya Prisons

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
11	Service delivery	6.44	Enhanced capacity of University of Nairobi to provide cost effective, relevant short online courses Enhanced capacity of local organizations to run successful HIV control and management programs	1 year	1. Number of new local participating organizations identified, assessed for capacity and supported to develop interventions to address identified capacity gaps 2. Number of new short courses developed and hosted on the learning platform 3. Number of learners drawn from local participating organizations/instituions recruited and assisted to complete online short courses	- Eight (8) online courses already developed - 375 leaners completed short courses -11 local participation organizations assessed and supported to address capacity gaps in the management of HIV control programs
12	Policies and governance)	8.5	100% of programme and management staff trained in leadership program and financial management	2 years	Proportion of leadership and program staff trained in strategic management of HIV &Tb services. Proportion r of ACUs established and staffed with technical program staff .	80 % of programme and management staff trained in leadership program and financial management

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11	-At least 20 new local participating organizations identified, assessed for capacity and supported to develop interventions to address identified capacity gaps - AT least 3 new short courses developed and hosted on the learning platform - At least 1000 learners drawn from local participating organizations/instituions recruited and assisted to complete online short courses		N/A		N/A	
12	90 % of programme and management staff trained in leadership program and financial management		100 % of programme and management staff trained in leadership program and financial management		N/A	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
13	USAID	HRH Kenya	C&T	Improve the quality of training and increase the number of those graduating and entering the workforce	Improve the quality of training and increase the number of those graduating and entering the workforce	Workforce development, pre-service training	Support preservice training for students form high disease burden hard to reach regions, for improved access to PEPFAR supported services	Insufficient numbers of skilled health workers to support treatment scale up
14	USAID	HRH Kenya	HSS	Improve the quality of training and increase the number of those graduating and entering the workforce	Improve the quality of training and increase the number of those graduating and entering the workforce	Workforce development, pre-service training	Institutionalization of PEPFAR supported in-service training to ; 1) enhance skills, 2) efficiencies in resources utilization (this approach saves up to 30% of resources) and 3) tracking of those trained through entry of training data into HRIS (minimized repeat trainees) and information is used for CPD by regulatory authorities.	Insufficient numbers of skilled health workers to support treatment scale up
15	USAID	HRH Kenya	HSS	Improve Management and Leadership of Health Workforce at the county level	Improve Management and Leadership of Health Workforce at the county level	Policy and governance	Support counties to ensure Human Resources for Health Units are functional, develop county long term HRH strategic plans to enhance hiring of more health workers and transition of existing ones in support of epidemic control.	Insufficient numbers of skilled health workers to support treatment scale up

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
13	Human Rresources for Health	6.55	Pre-service training institutions increase graduates of critical cadres required for epidemic control by graduating at least 900 PEPFAR supported students every year for next three years	3 years	Number of PEPFAR-supported graduates available for deployment in the high burden counties to meet the PEPFAR 90-90-90 strategy.	2500 PEPFAR supported students have graduated
14	Human Rresources for Health	6.55	Increase the number of training institutions offering in-service trainings by 4 institutions every year for the next three years	3 years	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	1. 16 training collages together with their satelite institutions supported with PEPFAR Resources to provide in-service trainning. 2. 50 faculty supported to provide PEPFAR supported in-service trainning
15	Human Rresources for Health	6.55	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	3 years	No. counties with functioning HRH units/HRH managers No. counties with improved budgetary allocations for HRH	1. 40 counites out of 47 have HRH units established, however only 10 of the 40 HRH Units are functional. 2. 5 PEPFAR supported counties have shown increase in HRH allocation by hiring additional 3200 health workers

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13	A total of 1,000 new health workers graduating that are PEPFAR supported 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		A total of 1,000 new health workers graduating that are PEPFAR supported 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		A total of 1,000 new health workers graduating that are PEPFAR supported 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	
14	A 15 % increase in training institutions that are supported to provideaccredited PEPFAR supported in-service training. A 20% increase in faculty accredited to offer PEPFAR supported health worer in-service traning and mentorship in PEPFAR priority counties		A 15 % increase in training institutions that are supported to provideaccredited PEPFAR supported in-service training. A 20% increase in faculty accredited to offer PEPFAR supported health worer in-service traning and mentorship in PEPFAR priority counties		A 15 % increase in training institutions that are supported to provideaccredited PEPFAR supported in-service training. A 20% increase in faculty accredited to offer PEPFAR supported health worer in-service traning and mentorship in PEPFAR priority counties	
15	1. Increase by 10 the number of PEPFAr supported counties with Functional HRH units. 2. All functional HRH units to esnure budgetary increase to HRH for transitioning contracted health workers and hiring new staff		1. Increase by 10 the number of PEPFAr supported counties with Functional HRH units. 2. All functional HRH units to esnure budgetary increase to HRH for transitioning contracted health workers and hiring new staff		1. Increase by 10 the number of PEPFAr supported counties with Functional HRH units. 2. All functional HRH units to esnure budgetary increase to HRH for transitioning contracted health workers and hiring new staff	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
16	USAID	HRH Kenya	HSS	Optimize Data use for effective Decision Making at National and County Level	Optimize Data use for effective Decision Making at National and County Level	Information systems	Support county CHMTs to enter HRH information into the HRIS and use the information at county level for HRH decisions making, planning and budgeting. Use HRIS data for HRH analytics in support of epidemic control in PEPFAR priority counties i.e. staff distribution, skills mix and hiring.	Insufficient numbers of skilled health workers to support treatment scale up
17	USAID	HRH Kenya	C&T	Improve the quality of training and increase the number of those graduating and entering the workforce	Improve the quality of training and increase the number of those graduating and entering the workforce	Workforce development, pre-service training	Support preservice training for students form high disease burden hard to reach regions, for improved access to PEPFAR supported services	Insufficient numbers of skilled health workers to support treatment scale up

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
16	Human Rresources for Health	6.55	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.	3 years	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, development partners and regulatory bodies	1. Eight regulatory bodies supported towards transion from PEPFAR support based on implementation Matix. 2. 30 health worker labour unionists trained on negotaitions skills to minimise labour unrests
17	Human Rresources for Health	6.55	Pre-service training institutions increase graduates of critical cadres required for epidemic control by graduating at least 900 PEPFAR supported students every year for next three years	3 years	Number of PEPFAR-supported graduates available for deployment in the high burden counties to meet the PEPFAR 90-90-90 strategy.	2,500 PEPFAR supported students have graduated

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16	1.Increse by 30% PEPFAR supported regulatry bodies functions towards transition as stipulted in the regulatry bodies transition matrix. 2. Train 30 mebers of health workers unions on labour laws and negotoations skils to mitigate labour unrests.		1.Increse by 30% PEPFAR supported regulatry bodies functions towards transition as stipulted in the regulatry bodies transition matrix. 2. Train 30 mebers of health workers unions on labour laws and negotoations skils to mitigate labour unrests.		1.Increse by 30% PEPFAR supported regulatry bodies functions towards transition as stipulted in the regulatry bodies transition matrix. 2. Train 30 mebers of health workers unions on labour laws and negotoations skils to mitigate labour unrests.	
17	A total of 1,000 new health workers graduating that are PEPFAR supported 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		A total of 1,000 new health workers graduating that are PEPFAR supported 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		A total of 1,000 new health workers graduating that are PEPFAR supported 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	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
18	HHS/CDC	Strengthening Strategic Information in Kenya	HSS	Support CDC-Kenya in health system strengthening by providing technical assistance (TA) to NASCOP on establishing and enhancing national HIV/STI surveillance systems and national and county-level monitoring and evaluation systems; improving knowledge of epidemiologic trends; and tracking burden of disease in Kenya. Also provide support to MOH in RDQA and RDQI Implementation; and conduction of an evaluation of UCSF CoAg in accordance with ESOP. Additional scope includes conducting Lost to follow up study to help ascertain true ART outcomes and evaluate	1a: SURVEILLANCE: HIV Case-Based Surveillance expansion (general & KP); Key Population Assessments [annual KPSE, IBBS]; Mortality Surveillance [establish sentinel surveillance sites]; Routine HIVDR surveillance; ANC Sentinel Surveillance. 2: MONITORING AND EVALUATION: M&E Tools Roll out; Print M&E tools; Cascade of Revised M&E Tools; Data Quality; Geo Spatial Analysis; Data Analysis, Use and Dissemination; Support Monitoring of 90-90-90 targets; Cohort Analysis; Data Review and Triangulation; Capacity Building for M&E; CoAg Evaluation	Assessments, evaluation, operation research	SURVEILLANCE 'a. Expand HIV Case-Based surveillance among general and Key populations b. Perform annual estimates of key population sizes and conduct an IBBS c. Establish HIV-associated mortality surveillance in sentinell mortuaries d. Perform routine HIVDR surveillance e. Conduct enhanced ANC sentinell surveillance MONITORING AND EVALUATION a. M&E tools printing and distribution b. Conduct data quality audits (DQAs) c. Support data review, analysis, use and dissemination d. Support monitoring of 90-90-90 targets e. Support program evaluation including cohort analysis f. Capacity Building for M&E g. Support CoAg Evaluation	Inadequate accurate data along the clinical cascade, and new approaches that move beyond aggregate data.

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
18	Epidemiological and health data	5.79	Improved data quality and availability of multiple National data sources beyond aggregate data for triangulation and monitoring of the clinical cascade	2 years	Structures developed to faciliatate availability of accurate data to monitor clinical cascade	1. HIV CBS guidelines developed and launched 2. KP mapping done, IKPS protocol writen 3. Mortuary observation study to inform consenting procedures, protocol submitted MONITORING AND EVALUATION 1. Revised M&E tools developed 2. Capacity building for TOTs and master trainers done 3. Protocols for evaluations developed [Laboratory, LTFU, CoAg evaluation] 4. SOPs for national DQAs developed 5. The first data alignment meeting held

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18	At least one surveillance conducted annually. MONITORING AND EVALUATION Routine annual DQA. Annual data alignment meeting.		At least one surveillance conducted annually. MONITORING AND EVALUATION a. Routine annual DQAs. b. Routine annual data alignment meeting.		N/A	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
19	HHS/CDC	Strengthening Strategic Information in Kenya	PREV	Implement recency study among young pregnant women attending ANC (DREAMS)	1b: SURVEILLANCE: Establish HIV Recency Surveillance among PLHIV	Assessments, evaluation, operation research	a. Identify proportion of persons newly testing HIV positive who are recently infected (<~6mos) in high burden counties b. Identify proportion of persons newly testing HIV positive who are recently infected (<~6mos) in other epidemiologically significant settings (e.g. special populations, emergent areas) c. Collaborate with Partner Notification Systems to utilize information on recency to improve identification and follow-up of partners. d. Perform public health response for foci of new infections in order to contribute to epidemic control	Inadequate understanding of incidence among PLHIV for public health response and epidemic control.
20	USAID	APHIAplus Pwani (Mombasa and Kilifi counties)	HSS	Strengthened and Functional County Health Systems	Strengthened and Functional County Health Systems	Host country institutional development	Activity: 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**	Weak/non existence of county HIV Learning and Results Accountability Forums

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
19	Epidemiological and health data	5.79	Improved characterization of incident infections among AGYW, and availability of informed and appropriate prevention and identification strategies.	3 years	Structures developed to facilitate at health service delivery level, No. samples collected and successfully analyzed, Report developed and disseminated, Recommendations made	1. Concept sheet developed 2. Initial discussions with MOH and SI ITT held
20	epidemiological and health data	5.79	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.	3 years	Number of counties with functional learning and accountability forums.	Learning and accountability forums established and functional as measured by implemented actions from the forums

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19	System set up for incidence reporting.		Quarterly and progressively monthly incidence reports from at least one high burden county		Quarterly and progressively monthly incidence reports from all high burden counties	
20	County learning and accountability agenda institutionalized, owned and supported by at least 50% of key stakeholders as measured by before and after OCAT results.		Public participation index score in HIV program reviews and resources allocation using epidemiologic and program data improves by **3.0 out of 5.0 index score (IM to develop index score jointly with CHMT)**		Public participation index score in HIV program reviews and resources allocation using epidemiologic and program data improves by **4.0 out of 5.0 index score (IM to develop index score jointly with CHMT)**	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
21	HHS/CDC	mHealth	HSS	Strengthen Health System by conducting and presenting evaluations and articles of key mHealth priority projects; scaling up the mLab System roll out and improve system functionality; increase the usability of C4C researching for innovative solutions to improve the application's usability and buy-in; and roll out the T4A system	Strengthen Health System by conducting and presenting evaluations and articles of key mHealth priority projects; scaling up the mLab System roll out and improve system functionality; increase the usability of C4C researching for innovative solutions to improve the application's usability and buy-in; and roll out the T4A system	Information Systems	Design, develop, deploy and evaluate innovative mhealth solutions	Inefficiencies in the delivery of health care services that can be addressed by leveraging the use of mHealth tools
22	HHS/CDC	mHealth	HSS	Strengthen Health System by conducting and presenting evaluations and articles of key mHealth priority projects; scaling up the mLab System roll out and improve system functionality; increase the usability of C4C researching for innovative solutions to improve the application's usability and buy-in; and roll out the T4A system	Strengthen Health System by conducting and presenting evaluations and articles of key mHealth priority projects; scaling up the mLab System roll out and improve system functionality; increase the usability of C4C researching for innovative solutions to improve the application's usability and buy-in; and roll out the T4A system	Information Systems	Engage with appropriate stakeholders and service delivery partners, Train TOTs from SDP, provide technical assistance to SDPs and monitor the scale up efforts	Absence of buy-in of m-Health products by the SDPs thus lack of integration of m-Health solutio and use at the facility level

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
21	Epidemiological and health data	5.79	Efficiencies in health care delivery through the use of mobile technology	3 years	% of Program needs addressed by Mhealth solutions	Innovative Mhealth applications developed: T4A, MLAB, Revamped C4C
22	Epidemiological and health data	5.79	Improved and use of mHealth products at the facility	3 years	Percentage of target service delivery partners trained in the use of mHealth solutions.	Engaged with CHS and EGPAF

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21	Developed mhealth applications meet 100% of service delivery functional needs for HIV		Developed mhealth applications continually enhanced to meet the dynamic needs of the HIV program		Developed mhealth applications continually enhanced to meet the dynamic needs of the HIV program	
22	10% of SDPs sensitized on developed Mhealth applications translating in use of the systems within their supported facilities		50% of SDPs sensitized and using the developed Mhealth applications		90% of SDPs using the developed Mhealth applications	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
23	HHS/CDC	mHealth	HSS	Strengthen Health System by conducting and presenting evaluations and articles of key mHealth priority projects; scaling up the mLab System roll out and improve system functionality; increase the usability of C4C researching for innovative solutions to improve the application's usability and buy-in; and roll out the T4A system	Strengthen Health System by conducting and presenting evaluations and articles of key mHealth priority projects; scaling up the mLab System roll out and improve system functionality; increase the usability of C4C researching for innovative solutions to improve the application's usability and buy-in; and roll out the T4A system	Information Systems	Engage with HIS partners to identify collaborative areas of work, develop and implement the IL, perform monitoring and provide ongoing technical assistance.	Lack of data exchange results in duplication of efforts and compromises efficiency in the delivery of healthcare
24	HHS/CDC	mHealth	HSS	Strengthen Health System by conducting and presenting evaluations and articles of key mHealth priority projects; scaling up the mLab System roll out and improve system functionality; increase the usability of C4C researching for innovative solutions to improve the application's usability and buy-in; and roll out the T4A system	Strengthen Health System by conducting and presenting evaluations and articles of key mHealth priority projects; scaling up the mLab System roll out and improve system functionality; increase the usability of C4C researching for innovative solutions to improve the application's usability and buy-in; and roll out the T4A system	Information Systems	Ensure that there are approved protocols, develop scientific manuscripts and abstracts for conferences and journals and present at conferences	Lack of visibility of the important work being done results in duplication of efforts, lack of synergistic partnerships and stifling of the growth of the knowledge in the informatics field

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
23	Epidemiological and health data	5.79	Improvement in the efficiency of care through more timely patient communication, availability of data for clinical decision support etc.	3 years	Percentage of target systems that are interoperable with mHealth solutions	T4A included in the IL
24	Epidemiological and health data	5.79	Recognition of the important work of CDC Kenya in the mHealth space; enhanced bofy of knowledge in informatics.	3 years	Number of abstracts and manuscripts developed and submitted for consideration (4 abstracts and 1 manuscripts)	1 Umbrella protocol and 2 evaluation protocols under clearance; 1 abstract submitted for PHI conference consideration.

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
23	T4A and mLab included in the interoperability layer		All mhealth applications interoperable with all other key HIS in Kenya: EMR, PIS and LIS		All mhealth applications interoperable with all other key HIS in Kenya: EMR, PIS and LIS	
24	1 Umbrella protocol and 2 evaluation protocols have been cleared by ADS and 1 abstract accepted for PHI conference		Completed evaluation for mKemsa and SMS Printers; 4 abstracts submitted for conferences and 1 manuscript developed		Completed evaluation for mhealth applications in use in Kenya	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
25	HHS/CDC	Laboratory Networking	HSS	Support regulation of quality laboratory practices and foster lab networks. The SO addresses systems barrier 2(Laboratory in Table 6:3) called weak lab quality improvement initiatives to ensure accurate and timely diagnostics.	Support regulation of quality laboratory practices and foster lab networks. The SO addresses systems barrier 2(Laboratory in Table 6:3) called weak lab quality improvement initiatives to ensure accurate and timely diagnostics.	Laboratory quality improvement and accreditation	Training, mentorship and certification of national lab mentors to ensure suatainability of the lab QMS program in Kenya	Weak lab quality management systems
26	HHS/CDC	Implementation of Sustainable Laboratory Quality Systems	HSS	Fortify Health System through the strengthening of laboratory capacity to ensure high-quality testing for HIV/TB diagnosis and monitoring tests; provision of support to site level infection control activities; promotion of appropriate utilization of blood product; and strengthening of haemovigilance. Also to support the functioning of the logistics office to enhance laboratory commodity management	Fortify Health System through the strengthening of laboratory capacity to ensure high-quality testing for HIV/TB diagnosis and monitoring tests; provision of support to site level infection control activities; promotion of appropriate utilization of blood product; and strengthening of haemovigilance. Also to support the functioning of the logistics office to enhance laboratory commodity management	Management and coordination	Facilitate quarterly VL/EID interlab quarterly review meetings to review quality indicators and inter-lab coordination	Low access to Viral Load with long turn-around time

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
25	Laboratory	6.67	50 trained and certified laboratory auditors	2 years	Number of trained and certified laboratory auditors	16 trained and certified laboratory auditors
26	Laboratory	6.67	100% of VL labs have a TAT equal to or less than 10 days	3 years	Turnaround time from receipt of sample to dispatch	50% of VL labs have a TAT of equal to or less than 10 days

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25	32 trained and certified laboratory auditors		50 trained and certified laboratory auditors		NA	
26	70% of VL labs have a TAT of equal to or less than 10 days		85% of VL labs have a TAT of equal to or less than 10 days		100% of VL labs have a TAT of equal to or less than 10 days	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
27	HHS/CDC	VMMC QA Support	PREV	Impact VMMC services through the implementation of population-based survey to validate Male Circumcision coverage and strengthening of the government capacity to lead, sustain quality and integrate VMMC program in routine health services	Complete population-based survey of Male Circumcision coverage by county and age band to guide planning and resource investment for VMMC while supporting national and county governments in VMMC program leadership focusing on sustaining program quality and integration of VMMC into routine health services.	Host country institutional development	Finalize MC coverage survey, disseminate results and set new VMMC targets based on revised coverage estimatesby age bands and SNUs	Lack of VMMC coverage data to inform program planning
28	HHS/CDC	VMMC QA Support	PREV	Impact VMMC services through the implementation of population-based survey to validate Male Circumcision coverage and strengthening of the government capacity to lead, sustain quality and integrate VMMC program in routine health services	Complete population-based survey of Male Circumcision coverage by county and age band to guide planning and resource investment for VMMC while supporting national and county governments in VMMC program leadership focusing on sustaining program quality and integration of VMMC into routine health services.	Host country institutional development	Support quality assurance activities for sustaining provider compliance with VMMC guidelines on Dosal slit circumcision, MC devices	Inappropriate use of Forceps guided MC method and occasional lapses in compliance

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
27	Epidemiological and health data	5.79	MC coverage estimate by age group SNU available	1 year	Survey report	No validated MC coverage data by age band and SNU
28	Service Delivery	6.44	100% use of dorsal slit method for surgical MC in clients 10+yrs	1 year	% site reporting 100% use of DS method for surgical MC	<100%

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27	MC Coverage Survey report		N/A		N/A	
28	100% DS method use for surgical MC		N/A		N/A	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
29	HHS/CDC	VMMC QA Support	PREV	Impact VMMC services through the implementation of population-based survey to validate Male Circumcision coverage and strengthening of the government capacity to lead, sustain quality and integrate VMMC program in routine health services	Complete population-based survey of Male Circumcision coverage by county and age band to guide planning and resource investment for VMMC while supporting national and county governments in VMMC program leadership focusing on sustaining program quality and integration of VMMC into routine health services.	Host country institutional development	Support integration of VMMC in routine health services and its inclusion in preservice training curriculum for nurses and clinical officers	Weak systems for sustaining VMMC service delivery
30	USAID	Health Informatics Governance & Data Analytics	HSS	Strengthened national governance of health informatics, monitoring, evaluations, learning and accountability systems	Strengthened national governance of health informatics, monitoring, evaluations, learning and accountability systems	Policy and governance	Activity: Support Div. MEHRDI by building their capacity on Health Informatics Leadership & Governance: **Sustained Epi Control**	Weak leadership and governance capacity at MOH/MERDHI
31	USAID	Health Informatics Governance & Data Analytics	HSS	Strengthened national governance of health informatics, monitoring, evaluations, learning and accountability systems	Strengthened national governance of health informatics, monitoring, evaluations, learning and accountability systems	Policy and governance	Activity: Update and operationalize current HMIS policies, strategies, guidelines, standards & protocols and develop an implementation plan: **Sustained Epi Control**	Weak institutional capacity to implement and evaluate effectiveness of existing policies, guidelines and standards.

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
29	Human Rresources for Health	6.67	VMMC included in perservice training curriculum for nurses and clinical officers	3 years	VMMC modules in KMTC curriculum for Nurses and RCOs	No VMMC module in KMTC currila
30	epidemiological and health data	5.79	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 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.	1 year	% 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.	Leadership and Governance program received public service accreditation, becomes self sustaining
31	epidemiological and health data	5.79	Strengthened/improved capacity of MOH/DivMERDHI to implement the current policies, strategies, guidelines, standards & protocols. Policy implementation monitoring system fully functional. At least 75% of existing policies, guidelines and standards effectively implemented.	3 years	Number of existing HMIS/M&E policies, strategies, guidelines, and/or standards implemented. Policy implementation mentoring systems operational.	Assessments on barriers to policy, guidelines and standards implementation at national and targeted counties completed, action plans developed for phased implementation, policy implementation monitoring matrix developed and in use

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29	VMMC modules included in training curriculum for Nurses		KMTC tutors oriented on VMMC training currilum for nurses		VMMC included in preservice training curriculum for RCO's and tutors oriented	
30	Support ends in FY18, activity becomes self sustaining		N/A		N/A	
31	At least 30% of national HMIS/M&E policies, guidelines, protocols evaluated/reviewed for effectiveness. HIS ICC uses results from evaluation to support MOH in updating and/or imcrementaly enhance policy documents.		Overall index score improvement **(3.0 out of 5.0 Score)** in use of existing HMIS/M&E policeis, guidelines, protocols/standards in governance. **(IM to develop and present at HIS ICC policy implementtaion index score framework for validation)**		Overall index score improvement **(4.0 out of 5.0 Score)** in use of existing HMIS/M&E policeis, guidelines, protocols/standards in governance. **(IM to develop and present at HIS ICC policy implementtaion index score framework for validation)**	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
32	USAID	Health Informatics Governance & Data Analytics	HSS	Strengthened national governance of health informatics, monitoring, evaluations, learning and accountability systems	Strengthened national governance of health informatics, monitoring, evaluations, learning and accountability systems	Policy and governance	Activity: Support county governments to enforce full compliance to systems standards development and interoperability for all critical systems. **Sustained Epi Control**	Lack of full compliance to national health systems standards and interoperability framework for effective governance Health Informatics Investments
33	USAID	Health Informatics Governance & Data Analytics	HSS	Strengthened national governance of health informatics, monitoring, evaluations, learning and accountability systems	Strengthened national governance of health informatics, monitoring, evaluations, learning and accountability systems In FAST, there are two SOs with host country institutional development approaches, but only one SO is reflected here in table 6. Please reconcile.	Host country institutional development	Activity: Maximize efficient and effective use of PEPFAR resources in scaling up and adoption of best practices that promise greater impact in achieving and sustaining epidemic control in scale and aggresive saturation counties. **Sustained Epi Control**	Poor scale up and uptake of best practices in county HIV response among high burden counties
34	USAID	Health Informatics Governance & Data Analytics	HSS	Capacity of national and county MOH on data analytics strengthened	Strengthen capacity of national and county MOH on data analytics	Host country institutional development	Activity: Capacity building of national HIV programs (NASCOP&NACC) and Division of RMNCH/Nutrition programs in data analytics:**1st 90 & 2nd 90**	Weak data analytics capacity at national and county levels
35	USAID	Health IT	HSS	Strengthened National Information Systems that support reporting, provide data for decision making for GOK, counties and other stakeholders	Strengthened National Information Systems that support reporting, provide data for decision making for GOK, counties and other stakeholders	Information systems	Establish an Integrated National Health Information system (DHIS2, KMHFL2, KEMSA Health Commodity Information Management System, MCUL, EMR/EHRs, LMIS, DSL and DATIM4U, Viral Load Database). **All three 90s**	Lack of data exchange platform between DHIS2 and numerous critical subsystems

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
32	epidemiological and health data	5.79	Strengthened Council of Governors (COG) - led implementation and compliance to Kenya Health Enterprise Architecture (KHEA). Coordination framework for national and county systems interoperability governance committee established.	3 years	% of counties that use KHEA policy to enforce compliance among systems and data owners, coordination and collaboration on technical implementation in place	National MOH completes development and approval of Kenya Health Enterprise Architecture
33	epidemiological and health data	5.79	Increased inter and intra-county and sub-county learning and adaptive use of new knowledge in managing and leading county HIV response	3 years	A model for inter-county peer-to-peer learning is developed and adopted by the COG and the focus county. COG incorporates this model into their work plans and strategies. % of participating counties develop a HIS learning agenda endorsed by the county leadership incorporated into county annual work plans. % of the HIS learning agenda is effectively budgeted and implemented to improve practices in select counties.	Council of Governors' (COG) Intergovernmental Collaboration on M&E adopts and ratifies peer to peer learning agenda
34	epidemiological and health data	5.79	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 data analytics and visualization techniques.	3 years	Number of staff trained in data analytics and visualization. No. of information products developed and shared annually on HIV outcomes.	Priority data analytics framework for HIV/Nutrition and MNCH developed and approved by national and county programs
35	epidemiological and health data	5.79	100% of critical subsystems successfully exchanging data with DHIS2 Critical sub-systems: KMHFL2, KEMSA Health Commodity Information Management System, HRIS, MCUL, EMR/EHRs, LMIS, DSL and DATIM4U, Viral Load database)	3 years	Number of new HIS systems integrated to the NHIS, Number of health facilities accessing comprehensive data on DHIS2 platform	75% of critical subsystems successfully tested and exchange data with DHIS2

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32	At least 50% of focal counties achieve full compliance on systems interoperability by all systems and data owners		At least 75% of focal counties achieve full compliance on systems interoperability by all systems and data owners		At least 85% of focal counties achieve full compliance on systems interoperability by all systems and data owners	
33	75% of participating counties develop a HIS learning agenda endorsed by the county leadership incorporated into county annual work plans. At least 50% of the HIS learning agenda is effectively budgeted for and implemented to improve practices in select counties. At least 50% of targeted counties scale up best practices, institutionalizes knowledge based adaptive program planning and management of County HIV response initiatives		85% of participating counties develop a HIS learning agenda endorsed by the county leadership incorporated into county annual work plans. At least 75% of the HIS learning agenda is effectively budgeted for and implemented to improve practices in select counties. At least 75% of targeted counties scale up best practices, institutionalizes knowledge based adaptive program planning and management of County HIV response initiatives		100% of participating counties develop a HIS learning agenda endorsed by the county leadership incorporated into county annual work plans. At least 85% of the HIS learning agenda is effectively budgeted for and implemented to improve practices in select counties. At least 85% of targeted counties scale up best practices, institutionalizes knowledge based adaptive program planning and management of County HIV response initiatives	
34	Platform for monitoring progress towards 95:95:95 established at national and focal counties		50% counties semi-annually present score card on progress towards 95:95:95 to County Assembly Health Committee, CSOs, FBOs and Community leaders.		75% counties semi-annually present score card on progress towards 95:95:95 to County Assembly Health Committee, CSOs, FBOs and Community leaders.	
35	90% DHIS2-KMHFL2 facility metadata resolution application developed, tested and approved by HIS ICC. DHIS2 - KMHFL2 orgainzational and business processes alignment completed and management plan approved by MOH		98% DHIS2-KMHFL2 facility metadata resolution application developed and maintained. DHIS2 - KMHFL2 orgainzational and business processes alignment completed and management plan continuously updated		100% DHIS2-KMHFL2 facility metadata resolution application developed and maintained. DHIS2 - KMHFL2 orgainzational and business processes alignment completed and management plan continuously updated	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
36	USAID	Health IT	HSS	Strengthened National Information Systems that support reporting, provide data for decision making for GOK, counties and other stakeholders	Strengthened National Information Systems that support reporting, provide data for decision making for GOK, counties and other stakeholders	Information systems	Establish a data exchange platform between National reporting system DHIS2 and PEPFAR reporting system DATIM4U/DATIM. **All three 90s**	Lack of data exchange platform between DHIS2 and DATIM/DATIM4U
37	USAID	HealthIT	HSS	Strengthened National Information Systems that support reporting, provide data for decision making for GOK, counties and other stakeholders	Strengthened National Information Systems that support reporting, provide data for decision making for GOK, counties and other stakeholders	Information systems	Ensure data alignment between DHIS2 and DATIM both at national and in focal counties (Siaya, Homabay, Kisumu, Migori, Nairobi, Kakamega, Vihiga and Bungoma). **All three 90s**	Data Discordance between DHIS2 and DATIM at the focal counties (Siaya, Homa Bay, Kisumu, Migori, Nairobi, Kakamega, Vihiga and Bungoma)
38	USAID	Health IT	HSS	Strengthened National Information Systems that support reporting, provide data for decision making for GOK, counties and other stakeholders	Strengthened National Information Systems that support reporting, provide data for decision making for GOK, counties and other stakeholders	Information systems	Enhance and upgrade the Joint Partners Reporting portal (JPRP) for use by stakeholders and MOH for results and financial support. **All three 90s**	Lack of portal that supports PEPFAR partners attribution.
39	USAID	Health IT	HSS	Improved institutional capacity of national and county MOH on use of health systems, quality data capture and reporting	Improve institutional capacity of national and county MOH on use of health systems, quality data capture and reporting	Host country institutional development	Activity: 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) and health facilities in three (3) counties. **All three 90s**	Lack of in country capacity at national and county levels to manage the evolution of DHIS2-KMHFL2

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
36	epidemiological and health data	5.79	A fully functional Data Exchange Platform between DHIS2 and DATIM/DATIM4U established.	3 years	Number of complete and accurate reports (Quarterly) successfully submitted to OGAC from the data exchange module	A fully functional Data Exchange Platform between DHIS2 and DATIM/DATIM4U established.
37	epidemiological and health data	5.79	Increased data concordancy between DHIS2 abd DATIM	3 years	Number of complete and accurate reports (Quarterly) successfully submitted to OGAC from the data exchange module	Integrated and structured MOH - PEPFAR data Alignment and Use developed
38	epidemiological and health data	5.79	A fully functional Joint Partners Reporting Portal with partner attribution of results in KMHFL2-DHIS2 system	3 years	Number of PEPFAR partners with correct health facilities attribution in JPRP system	100% JPRP mapping of PEPFAR partners completed, regularly updated complete and accurate alignment of health facilities to all IMs available at all times.
39	epidemiological and health data	5.79	Capacity of regional-county based public and private universities strengthened to effectively manage evolution of DHIS2-KMHFL2	3 years	Number of local institutions with capacity to support HIS activities	At least all the 4 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.

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36	National MOH - PEPFAR Data Alignment: Mapping of data elements and alignment completed, DATIM4U implementation plan developed and implementation approaches approved by all including MOH		PEPFAR Kenya fully transitions into DATIM4U, 100% alignment with DHIS2 achieved at targeted 20 counties		PEPFAR Kenya fully transitions into DATIM4U, 100% alignment with DHIS2 achieved at targeted 30 counties	
37	50% of focal counties operationalize MOH - PEPFAR data alignment through institutional capacity strengthening in data reviews, data quality assessments, and data quality improvement plan implementation		75% of focal counties operationalize MOH - PEPFAR data alignment initiatives. Joint MOH - PEPFAR data alignment initiatives including focussed data quality improvement planning & implementation institutionalized/co-funded by 50% of focal counties.		75% of focal counties fully own and support data alignment intitiatives (data alignment gets included in county annual work plans)	
38	JPRP Results and LOE Mapping of HIV partners completed, complete and accurate reports successfully generated.		National and at least 40% of County governments adopt JPRP framework as investments and results accountability tool		National and at least 60% of County governments adopt JPRP framework as investments and results accountability tool	
39	Number of students (16) and faculty (16) taking short courses and/or trainings on DHIS2-KMHFL2, EMRs/EHRs, LMIS, DSL, DATIM4U, MCUL and Viral Load database		Number of students (32) and faculty (32) taking short courses and/or trainings on DHIS2-KMHFL2, EMRs/EHRs, LMIS, DSL, DATIM4U, MCUL and Viral Load database. 50% of students and faculty attain level 2 DHIS2 Certification		Number of students (32) and faculty (32) taking short courses and/or trainings on DHIS2-KMHFL2, EMRs/EHRs, LMIS, DSL, DATIM4U, MCUL and Viral Load database. 50% of students and faculty attain level 2 DHIS2 Certification	

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40	USAID	Health IT	HSS	Strengthened National Information Systems that support reporting, provide data for decision making for GOK, counties and other stakeholders	Strengthened National Information Systems that support reporting, provide data for decision making for GOK, counties and other stakeholders	Information systems	Activity: Develop and Pilot an Online E-learning for CHRIOs, COs and Nurses as part of continuing professional development: **Sustained Epi Control**	Lack of an accredited e-learning platform for health care workers on health informatics in Kenya.
41	USAID	HealthIT	OVC	Strengthened National Information Systems that support reporting, provide data for decision making for GOK, counties and other stakeholders	Strengthened National Information Systems that support reporting, provide data for decision making for GOK, counties and other stakeholders	Information systems	Activity: Support Department of Children Services in managing system's (Child Protection Information Management System) evolution.	Weak institutional capacity at the Department of Children Services to effectively manage systems development, implementation and maintenance
42	USAID	Avenir Health	PREV	High-quality operational research studies and evaluations to advance HIV and AIDS program implementation are conducted	Develop and update VMMC data for decision making tools to support VMMC programming	Information systems	Finalization of VMMC modelling to estimate coverage by age and SNU	Inaccurate VMMC coverage information disagregated by Age and SNU

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
40	epidemiological and health data	5.79	MOH-Accredited e-learning platform for CHRIOs, COs and Nurses fully operational, reduced number of hotel-based trainings.	3 years	Number of Health workers completing accredited courses by cadre.	E-learning platform fully operational, University of Nairobi and MOH jointly set up accreditation mechanism for learners.
41	epidemiological and health data	5.79	Full time availability and use of Child Protection Information Management System (CPIMS) throughout the year.	3 years	Number of CPIMS users that report satisfaction with system's functionalities (data entry, reporting, decision support, and data visualizations - dashboards)	CPIMS hosting infrastructure set up at the University of Nairobi, School of Computing and Informatics. CPIMS successfully tested in Test Environment and piloted among sampled users.
42	Performance Data	7.67	Availabilityb of online tool to help in VMMC target setting and coverage by age and SNU	1 year	Availability of updated online DMPPT 2.0 (decision makers program planning tool)	Incomplete DMPPT 2.0 online tool

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40	E-leraning content development completed, accreditation by regulatory bodies achieved and 50% CHRIOs from 20 counties complete modules on DHIS2, KMHFL2 and EMRs/EHRs		60% of CHIROs and other targeted cadres complete modules on DHIS2, EMRs/EHRs, LMIS and receive level 2 proficiency certification		75% of CHIROs and other targeted cadres complete modules on DHIS2, EMRs/EHRs, LMIS and receive level 2 proficiency certification	
41	All targeted 20 counties successfully deploy and use CPIMS for data collection, reporting, analysis, and data visualization including use in managing children services.		100% fulltime system availability and use achieved in 8 counties (Siaya, Kisumu, Homabay, Migori, Kakamega, Bungoma, Busia and Vihiga)		100% fulltime system availability and use achieved in 12 additional counties (Nakuru, Narok, Trans Nzoia, Uasin Gishu, Turkana, Samburu, Baringo, Kiambu, Kitui, Mombasa, Kilifi & Kwale))	
42	Availability of online tool to help in VMMC target setting and and coverage by age and SNU		N/A		N/A	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
43	HHS/CDC	Health Information Systems Innovations	HSS	Fortify the HIV Health system through the strengthening of data quality and utilization; improvement of HIS solutions and capacity building stakeholders to undertake HIS use; and enhancement of rHRIS utilization	Enhancement of the HIS systems to address the entire spectrum of HIV service delivery; Improvement of HIS solutions and capacity building stakeholders to undertake HIS use; Fortify the HIV Health system through the strengthening of data quality and utilization; and enhancement of the Human resources information system (rHRIS and iHRIS) utilization for workforce planning and allocation	Information Systems	Design, develop, deploy and evaluate HIS Solutions to support service delivery	Inefficiencies in the delivery of health care services that can be addressed by leveraging the use of HIS solutions

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
43	Epidemiological and health data	5.79	Efficiencies in health care delivery through the use of HIS products	3 years	Status of HIS products been enhancement based on the latest systems requirements	EMR enhanced to meet the green card requirements; mobile HTS (Afya mobile and mUzima) have been developed

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43	EMRs (KenyaEMR and IQCARE) completely enhanced to meet the entire HIV continuum: HIV prevention, care and treatment		EMRs continually enhanced to meet the dynamic service delivery and reporting needs of the HIV program		EMRs continually enhanced to meet the dynamic service delivery and reporting needs of the HIV program	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
44	HHS/CDC	Health Information Systems Innovations	HSS	Fortify the HIV Health system through the strengthening of data quality and utilization; improvement of HIS solutions and capacity building stakeholders to undertake HIS use; and enhancement of rHRIS utilization	Enhancement of the HIS systems to address the entire spectrum of HIV service delivery; Improvement of HIS solutions and capacity building stakeholders to undertake HIS use; Fortify the HIV Health system through the strengthening of data quality and utilization; and enhancement of the Human resources information system (rHRIS and iHRIS) utilization for workforce planning and allocation	Information Systems	Develop curriculum, training materials and tools to cost effectively disseminate the training; Monitor and evaluate the impact of the trainings in the intergration of HIS into clinical service delivery	Lack of cost effective training modalities for HIS solutions and lack of M&E to evaluate effectiveness of the trainings

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
44	Epidemiological and health data	5.79	Well trained workforce and the use of HIS tools to improve service delivery	3 years	Percentage of target service delivery partners trained in the use of mHealth solutions.	Staff at over 640 facilities have been trained

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44	50% of USG service delivery partners have been trained in the use of the EMRs		100% of USG service delivery partners have been trained in the use of the EMRs		Service delivery partners are self sufficient in providing training to their staff on EMR use with little or no reliance on HIS partners	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
45	HHS/CDC	Health Information Systems Innovations	HSS	Fortify the HIV Health system through the strengthening of data quality and utilization; improvement of HIS solutions and capacity building stakeholders to undertake HIS use; and enhancement of rHRIS utilization	Enhancement of the HIS systems to address the entire spectrum of HIV service delivery; Improvement of HIS solutions and capacity building stakeholders to undertake HIS use; Fortify the HIV Health system through the strengthening of data quality and utilization; and enhancement of the Human resources information system (rHRIS and iHRIS) utilization for workforce planning and allocation	Information Systems	Develop datawarehouse governance and promote access and use of the warehouse, ensure data quality in all HIS products, provide reports and visuals for decision making	Lack of good quality data at the facility, county and national level for clinical and programmatic decision making.

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
45	Epidemiological and health data	5.79	Improved decisions at the clinical and programmatic levels resulting in better patient outcomes	3 years	DQA score from the data warehouse.	Data warehouse enhanced with analytics to inform the clinical care cascade.

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45	Data warehouse transmission tool to be enhanced to be multi-platform		100% identified systems are feeding data into the data warehouse with 90% DQA score		Datawarehouse being continually accessed by service delivery partners, MOH teams at the national and subnational levels and continually used to inform interventions and planning	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
46	HHS/CDC	Health Information Systems Innovations	HSS	Fortify the HIV Health system through the strengthening of data quality and utilization; improvement of HIS solutions and capacity building stakeholders to undertake HIS use; and enhancement of rHRIS utilization	Enhancement of the HIS systems to address the entire spectrum of HIV service delivery; Improvement of HIS solutions and capacity building stakeholders to undertake HIS use; Fortify the HIV Health system through the strengthening of data quality and utilization; and enhancement of the Human resources information system (rHRIS and iHRIS) utilization for workforce planning and allocation	Information Systems	Implement and scale up interoperability layer across the different HIS products; operationalize UPI into HIS products.	Lack of data exchange results in duplication of efforts and compromises efficiency in the delivery of healthcare
47	HHS/CDC	Kemri Non-Research	HSS	Support for HIV and TB program implementation and evaluation including building capacity and infrastructure for program evaluations and surveillance projects for HIV/AIDS and TB, including using population based surveillance approaches	Support accurate measurement of “90/90/90” and service delivery though improved linkage and tracking of loss to follow-up	Assessments, evaluation, operation research	Implement a surveillance system to monitor the 90-90-90 achievement in high burden counties	Nlack of accurate local estimates of HIV prevalence, incidence and mortality in high HIV-burden areas; need to monitor impact of progress towards 90-90-90 targets on population-level indicators of the HIV epidemic.

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
46	Epidemiological and health data	5.79	Improvement in the efficiency of care through more timely patient communication, availability of data for clinical decision support etc.	3 years	Percentage of target systems that are interoperable with HIS solutions; Percentage of target systems that have intergrated UPI.	ADT, Iqcare (EMR), T4A are currently part of the IL; UPI concept has been developed
47	Epidemiological and health data	5.79	Near-complete mapping of HIV diagnosis and treatment uptake in high-prevalence sub-county; Increased identification of PLHIV and improved linkage to care; Ability to distinguish geographic care-seeking patterns; More accurate assessment of LTFU vs mortality; Assessment of trends in HIV incidence, prevalence and mortality; Use of interoperability tools to share data elements between EMR, LIS and repository systems including dashboards shared with Siaya county government	3 years	No of sites included in surveillance system, no. of records captured in electronic HTS systems; No. of patients linked from service delivery pt to community census; no. of dashboard reports disseminated and No. of users	Zero

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46	100% of identified systems owners have been sensitized about the Interoprability layer and are working on system integration		100% of PEPFAR supported systems are interoperable with each other through the interoperability layer. 100% of PEPFAR supported systems supporting the UPI concept for HIV		Demonstrable benefits of using the interoperability layer and UPI directly contributing to efficiencies in HIV service delivery	
47	Linkage of demographic surveillance to facility records in five facilities, systems established, initiation of electronic HTS records and linkage to demographic surveillance		Routine surveillance reports; system functional & integrated for use by service delivery partners in Gem sub-county.		Routine surveillance reports available; system functional and integrated for use by service delivery partners in Gem and one or more of the neighboring sub-counties (Asembo, Karemo) within the HDSS.	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
48	HHS/CDC	Kemri Non-Research	HSS	Support for HIV and TB program implementation and evaluation including building capacity and infrastructure for program evaluations and surveillance projects for HIV/AIDS and TB, including using population based surveillance approaches	Support accurate measurement of "90/90/90" and service delivery though improved linkage and tracking of loss to follow-up	Assessments, evaluation, operation research	Finalize fisherfolk island surveillance effort (All 3 90s)	Limited information on HIV prevalence and clinical cascade on key and priority populations
49	HHS/CDC	Kemri Non-Research	HSS	Support for HIV and TB program implementation and evaluation including building capacity and infrastructure for program evaluations and surveillance projects for HIV/AIDS and TB, including using population based surveillance approaches	Support accurate measurement of "90/90/90" and service delivery though improved linkage and tracking of loss to follow-up	Assessments, evaluation, operation research	Integrate HIV POC recency testing into the LBBS to better understand the occurrence and risk factors for recent HIV infection, and to identify recent/incident HIV infection among persons for whom longitudinal HIV testing data are not available (i.e. in-migration; never tested, etc). Evaluate the acceptability and effectiveness of self-testing for HIV in the identification and linkage to care of PLHIV. area (All 3 90s, unique data toward #1)	Lack of field-validation of HIV incidence estimates to improve estimates process and address gaps in local-level HIV prevalence and incidence data; lack of local-level data on the incidence and risk factors for recent HIV infection; need to identify optimal strategies for operationalization of HIV self-testing in high HIV-burden counties.

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
48	Epidemiological and health data	5.79	Accurate assessment of HIV prevalence among fisherfolk on islands in Lake Victoria with action plan for addressing unmet needs for HIV services and prevention.	1 year	No of fisherfolk participating in serosurveillance; No. of participants newly identified HIV+; Dataset available for analysis; Report published /recommendations made	Zero
49	Epidemiological and health data	5.79	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 factors associated with HV infection and HIV service utilization; evidence base to inform implementation and scale up of HIV self-testing in a high burden county.	3 years	No. persons surveyed; No lab tests run; No. incident HIV+ identified; Dataset available for analysis; No of reports published;	Previous reports and publications

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48	Report and manuscript writing (Report and 1 manuscript published)		N/A		N/A	
49	Round 4 data collection complete in late FY18. Analysis and dissemination of data from FY16-Round 3 and previous 2 rounds		Round 4 data collection complete in late FY18. Analysis and dissemination of data from FY16-Round 3 and previous 2 rounds		Viral load and (if feasible) recency (ASANTE) testing of specimens collected during round 4 data collection; Round 4 data cleaned and available for analysis and dissemination.	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
50	HHS/CDC	Kemri Non-Research	HSS	Support for HIV and TB program implementation and evaluation including building capacity and infrastructure for program evaluations and surveillance projects for HIV/AIDS and TB, including using population based surveillance approaches	Support accurate measurement of "90/90/90" and service delivery though improved linkage and tracking of loss to follow-up	Assessments, evaluation, operation research	Provide western Kenya supportive staff for implementation of recency surveillance activities (in collaboration with UCSF Global Programmes)	Lack of data to describe proportionf of HIV infections which are recent
51	HHS/CDC	Kemri Non-Research	C&T	Support for HIV and TB program implementation and evaluation including building capacity and infrastructure for program evaluations and surveillance projects for HIV/AIDS and TB, including using population based surveillance approaches	Support for HIV and TB program implementation and evaluation including building capacity and infrastructure for program evaluations and surveillance projects for HIV/AIDS and TB, including using population based surveillance approaches	Surveys and surveillance	Implement a surveillance system to monitor the 90-90-90 achievement in high burden counties	Lack of accurate local estimates of HIV prevalence, incidence and mortality in high HIV-burden areas; need to monitor impact of progress towards 90-90-90 targets on population-level indicators of the HIV epidemic.

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
50	Epidemiological and health data	5.79	Availability of data on proportion of HIV infectious aquired in previous 6 mos, by location, age and sex	3 years	Number of recency samples evaluated	Zero
51	Epidemiological and health data	5.79	Near-complete mapping of HIV diagnosis and treatment uptake in high-prevalence sub-county; Increased identification of PLHIV and improved linkage to care; Ability to distinguish geographic care-seeking patterns; More accurate assessment of LTFU vs mortality; Assessment of trends in HIV incidence, prevalence and mortality; Use of interoperability tools to share data elements between EMR, LIS and repository systems including dashboards shared with Siaya county government	3 years	No of sites included in surveillance system, no. of records captured in electronic HTS systems; No. of patients linked from service delivery pt to community census; no. of dashboard reports disseminated and No. of users	Zero

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50	Report for year one (UCSF)		Report for year 2 (UCSF)		Report for year three (UCSF)	
51	Linkage of demographic surveillance to facility records in five facilities, systems established, initiation of electronic HTS records and linkage to demographic surveillance		Routine surveillance reports; system functional & integrated for use by service delivery partners in Gem sub-county.		Routine surveillance reports available; system functional and integrated for use by service delivery partners in Gem and one or more of the neighboring sub-counties (Asembo, Karemo) within the HDSS.	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
52	HHS/HRSA	International AIDS Education and Training Center (I-TECH)	HSS		Integration of UPI in health services	Information Systems	A. Support the development of a county wide policy for the implementation of Unique Patient Identifiers and provide high level TA to integrate Unique Identification with Universal Health Care initiatives. B. Ensure that Unique Identification technologies developed for HIV services are integrated in health services proposed by respective county governments. This will require coordination with respective county departments to sustain PEPFAR investments for long-term unique identification. Counties will in turn influence national health policies for adoption of National unique patient identifies.	Lack of policy on national unique patient identifier
53	HHS/HRSA	International AIDS Education and Training Center (I-TECH)	HSS		To evaluate and monitor programs to build national HIS inventories	Information Systems	Support HSE partners to design evaluations and disseminate findings.	Weak capacity of implementing partners to develop sound evaluation frameworks essential for partners to assess the impact of their SI innovations in improving patient care.
54	HHS/HRSA	International AIDS Education and Training Center (I-TECH)	HSS		Defining Kenya HIS landscape and establish HIS governance structure	Information Systems	Develop and institutionalize within MOH and county structures, an electronic inventory or Registry of all existing information systems and tools used at public health and mission health facilities in Kenya.	Fragmented implementation of HIS with associated duplication of efforts, hindering their optimized use in measuring progress towards attainment of the 95-95-95 targets.

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
52	Epidemiological and health data	5.79	Integration and use of unique patient identification into HIS to ensure patient's continuity of care , reduce duplication in treatment and provide more accurate patient count information for services rendered.	3 years	Proportion of counties with UPI policies	No UPI policies in place for any counties
53	Epidemiological and health data	5.79	Enhanced evaluation capacity will demonstrate the impact and outcome of SI efforts and also lead to process improvement	3 years	No of HSE partners supported to undertake evaluation activities.	No evaluation or written dissemination product from select HSE partner.
54	Epidemiological and health data	*5.79*	Availability of online inventory of HIS resources in Kenya can be used to make more informed decisions regarding SI investment, reduce duplication of effort and foster synergy.	3 years	Status of HIS Inventory institutionalization within the MOH	No HIS inventory in existence

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52	County wide UPI policies in at least 25% of the counties.		County wide UPI policies in at least 50% of the remaining 75% counties.		County wide UPI policies in 100% of the counties in Kenya.	
53	At least one evalaution and publication from each HSE partner		An established journal club, with at least 3 meetings in a year; At least 1 published manuscript from each HSE partner.		An established journal club, with at least 6 meetings in a year; At least 1 published manuscript from each HSE partner.	
54	HIS Inventory hosted within the MoH Kenya Master Health Facility List		Through MOH leadeship the inventory is continually populated with at least 80% of HIS solutions used in the public sector in Kenya		Through MOH leadeship the inventory is continually populated with at least 90% of HIS solutions used in the public sector in Kenya	

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55	HHS/HRSA	International AIDS Education and Training Center (I-TECH)	HSS		Develop standards and certification framework for HIS investments	Host country institutional development	Work with national and county health departments to operationalize HIS governance structures .	Weak governance of health information systems. Public sector oversight of HIS contributes to a lasting impact of PEPFAR informatics investments especially those used to manage and report service-delivery data.
56	HHS/HRSA	International AIDS Education and Training Center (I-TECH)	HSS		Develop standards and certification framework for HIS investments	Host country institutional development	Support the MOH to develop, consolidate and revise current standards and guidelines in Kenya and the integrate standards and certification guidelines into HIS policies	Lack of application of policies related to standards for health information systems for MOH
57	HHS/CDC	Strengthening Public Health Capacity and SI Systems	HSS	Support countries to develop effective and sustainable Health Information Systems; strengthen their capacity to generate national and sub-national HIV incidence and prevalence estimates; and develop, implement and monitor Fast-Track strategies to reach key populations	Support countries to develop effective and sustainable Health Information Systems; strengthen their capacity to generate national and sub-national HIV incidence and prevalence estimates; and develop, implement and monitor Fast-Track strategies to reach key populations	Host country institutional development	1. Strategic information generation at the sub-county level; 2. Health Information Systems (HIS) strengthening; 3. Fast-Track strategies for key populations	Lack of accurate and localized estimates of PLHIV by key disaggregates; Availability of data visualization tools to improve understanding and utilization of data

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
55	Epidemiological and health data	5.79	Establishment of a HIS governance structure in the MOH	3 years	Status of HIS governance structure within the MOH	No outlined governance structure in place at either national or county level
56	Epidemiological and health data	5.79	Institution of a policy for certifying HIS in Kenya to faciliate the standardized development of information systems in Kenya while promoting consistency and interoperability.	3 years	Status of HIS standards and certification policy	HIS standards and certification framework developed
57	Epidemiological and health data	5.79	Improved methodology, processes and dissemination products to generate sub-national HIV estimates; Improved dissemination products/apps/figures; better coordination for health information systems	3 years	Number of in-person and electronic meetings held to ensure that county and national partners are able to use denominator data from the HIV estimates; Number of graphs, maps and other images ("data visualizations") that show better and more intuitive understanding of sub-national HIV monitoring data, including PLHIV denominators	No HIV estimates at sub-county level

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55	Clear outline of a governance structure at the national level and in the high burden counties.		The governance structure that is made into policy is adopted by all county governments		At least 50% of county governments are investing in setting up and strengtheing structures for governance	
56	- HIS standards and certification framework developed into policy. - Policy implementation strategy developed and rolled out in at least 25% of the counties.		HIS standards and certification framework policy implementation strategy developd and rolled out in at least 50% of the remaining 75%		HIS standards and certification framework policy implementation strategy developd and rolled out in 100% and the national ministry of health staff are fully sensitized on the policy	
57	1. Development of HIV estimates for sub counties in all high burden counties using the most reliable methods and models; 2. Use of data in the HIV situation room (high burden counties with access and demonstrated use of HIVSR)		1. Development of HIV estimates for sub counties in all moderate burden counties using the most reliable methods and models; 2. Use of data in the HIV situation room (moderate burden counties with access and demonstrated use of HIVSR)		1.Sustained use of HIV estimates for sub counties in all high burden counties using the most reliable methods and models; 2. Use of data in the HIV situation room (All counties with access and demonstrated use of HIVSR)	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
58	USAID	Kenya Supply Chain Systems Strengthening (KSCSS) - Afya Ugavi new name	HSS	Strengthened Technical leadership and coordination for commodity management	Strengthened Technical leadership and coordination for commodity management	Supply chain systems	Implement full package of core leadership activities (*Strengthen Commodity Security TWGs; Commodity management continuous quality improvement [CQI] system and structures; Inclusion of commodity issues in county plans eg quantification, inventory management tools; Supportive Supervision and commodity audits/ end-use verification; Supply Chain capacity building; Commodity data reviews)* Other activities planned if funds are available are: *1.* Mainstream laboratory and nutrition commodities into one coordinated national supply chain system for all HIV commodities 2. In-service and pre-service curriculum development for supply chain management to increase human capacity for HIV management 3. Quantification and supply planning at national level	Weak commodities management capacity to ensure availability of quality HIV/AIDS commodities in response to the pivot
59	USAID	Kenya Supply Chain Systems Strengthening (KSCSS) - Afya Ugavi new name	HSS	Strengthened county oversight and implementation of supply chain services	Strengthened county oversight and implementation of supply chain services	Supply chain systems	Establish and support functionality of Centres of Learning *(Commodity management standards; Commodity management continuous quality improvement [CQI] practices; Sharing commodity management best practices including commodity storage)* Other activity to add to the package if funds are available is "Sentinel surveillance for adverse drug events for patient safety and ART guidelines review"	Weak commodities management capacity to ensure availability of quality HIV/AIDS commodities in response to the pivot

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
58	Commodity Security and Supply Chain	6.39	Core activities of supply chain leadership devolved from NASCOP to county governments	3 years	Number of counties implementing the core leadership package of supply chain services	Zero number of counties implementing the full package of core leadership activities at CHMT level
59	Commodity Security and Supply Chain	6.39	Implementation of priority interventions from COP2016 Supply Chain assessement	3 years	Number of functional demonstration sites for supply chain excellence as centres of learning (COLs)	Zero number of counties have established a centre of learning for supply chain excellence

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58	Full package of core leadership activities devolved for implementation in 4 focus counties		Full package of core leadership activities devolved and implemented in 6 additional counties of high HIV burden		Full package of core leadership activities devolved for implementation in 10 additional counties in line with the with HIV burden	
59	4 centres of learning established to implement and showcase standards for supply chain excellence		10 centres of learning implementing standards for supply chain excellence		20 centres of learning implementing standards for supply chain excellence	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
60	USAID	Kenya Supply Chain Systems Strengthening (KSCSS) - Afya Ugavi new name	HSS	Strengthened Technical leadership and coordination for commodity management	Strengthened Technical leadership and coordination for commodity management	Supply chain systems	Implement full package of core leadership activities (*Strengthen Commodity Security TWGs; Commodity management continuous quality improvement [CQI] system and structures; Inclusion of commodity issues in county plans eg quantification, inventory management tools; Supportive Supervision and commodity audits/ end-use verification; Supply Chain capacity building; Commodity data reviews)* Other activities planned if funds are available are: *1.* Mainstream laboratory and nutrition commodities into one coordinated national supply chain system for all HIV commodities 2. In-service and pre-service curriculum development for supply chain management to increase human capacity for HIV management 3. Quantification and supply planning at national level	Weak commodities management capacity to ensure availability of quality HIV/AIDS commodities in response to the pivot
61	USAID	County Measurement, Learning and Accountability Program - I (KIsumu, Migori, Homa Bay, Kakamega, Siaya, Kisii, Busia, Bungoma and Vihiga counties)	HSS	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Policy and governance	Activity: Support counties to develop and update HMIS/M&E Policies, guidelines and standard protocols: **Sustained Epi Control**	Weak institutional capacity to implement and evaluate effectiveness of existing policies, guidelines and standards.

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
60	Commodity Security and Supply Chain	6.39	Core activities of supply chain leadership devolved from NASCOP to county governments	3 years	Number of counties implementing the core leadership package of supply chain services	Zero number of counties implementing the full package of core leadership activities at CHMT level
61	epidemiological and health data	5.79	At least 75% of focal counties implementing existing policies, guidelines and standards. County Policy Implementation Monitoring system in place.	3 years	% of counties effectively implementing existing policies, guidelines and/or standards. % of implemented policies reviewed and adjusted.	Priority HMIS/M&E policies, guidelines and standard protocols being implemented

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60	Full package of core leadership activities devolved for implementation in 4 focus counties		Full package of core leadership activities devolved and implemented in 6 additional counties of high HIV burden		Full package of core leadership activities devolved for implementation in 10 additional counties in line with the with HIV burden	
61	At least 30% of focal counties have evaluated/reviewed effectiveness of implemented policies, guidelines and/or standards. Improved reporting and use of data from HMIS&M&E systems at county. Improved collection, reporting and use of quality data at focal counties		Overall index score improvement **(3.0 out of 5.0 Score)** in use of data in reviewing/ incrementally updating HMIS/M&E policeis, guidelines, protocols/standards in 30% of targeted counties		Overall index score improvement **(4.0 out of 5.0 Score)** in use of data in reviewing/ incrementally updating HMIS/M&E policeis, guidelines, protocols/standards in 50% of targeted counties	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
62	USAID	County Measurement, Learning and Accountability Program - I (KIsumu, Migori, Homa Bay, Kakamega, Siaya, Kisii, Busia, Bungoma and Vihiga counties)	HSS	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Host country institutional development	Activity: 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**	Weak/non existence of county HIV Learning and Results Accountability Forums
63	USAID	County Measurement, Learning and Accountability Program - I (KIsumu, Migori, Homa Bay, Kakamega, Siaya, Kisii, Busia, Bungoma and Vihiga counties)	HSS	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Policy and governance	Activity: Support stakeholder engagement on relevant issues: **Sustained Epi Control**	Weak stakeholders' coordination mechanisms
64	USAID	County Measurement, Learning and Accountability Program - I (KIsumu, Migori, Homa Bay, Kakamega, Siaya, Kisii, Busia, Bungoma and Vihiga counties)	HSS	Increased availability, analysis and use of quality data	Increased availability, analysis and use of quality data	Information systems	Activity: Development of data need and analysis framework, training and mentoring CHMTs on data analysis and visualization techniques: **Sustained Epi Control**	Lack of common county data analysis framework to guide regular and predictable data analysis.

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62	epidemiological and health data	5.79	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.	3 years	Number of counties with functional learning and accountability forums.	Learning and accountability forums established and functional as measured by implemented actions from the forums
63	epidemiological and health data	5.79	Functional County HIV Stakeholders' Coordination Framework in place.	3 years	Number of HIV stakeholders' coordination meetings held per year.	County stakeholders' coordination and collaboration forums established and fully functional measured by number of active participants
64	epidemiological and health data	5.79	Data analytical framework on priority HIV outcome indicators by focal county in place. County HIV data visualization dashboards in place.	3 years	% of focal counties regularly producing HIV county profiles. % focal counties regularly producing semi-annual scorecards on priority HIV outcomes.	County and sub-county priority HIV outcomes dashboards institutionalized

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
62	County learning and accountability agenda institutionalized, owned and supported by at least 50% of key stakeholders as measured by before and after OCAT results.		Public participation index score in HIV program reviews and resources allocation using epidemiologic and program data improves by **3.0 out of 5.0 index score (IM to develop index score jointly with CHMT)**		Public participation index score in HIV program reviews and resources allocation using epidemiologic and program data improves by **4.0 out of 5.0 index score (IM to develop index score jointly with CHMT)**	
63	Public participation in health planning, management, monitoring and evaluation improved. Ownership and leadership HIV response by civil society organizations and community increasingly evident.		50% of supported counties increasingly use ICD10 mortality data in data review forums and county HIV response program evaluations		75% of supported counties increasingly use ICD10 mortality data in data review forums and county HIV response program evaluations	
64	Quarterly production and dissemination of standard HIV county profiles on priority outcomes institutionalized.		50% of focal counties include production of HIV county HIV profiles on their costed work plans		75% of focal counties include production of HIV county HIV profiles on their costed work plans. 50% of supported counties use information from county profiles in prioritization of resources allocation at subcounty levels	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
65	USAID	County Measurement, Learning and Accountability Program - I (KIsumu, Migori, Homa Bay, Kakamega, Siaya, Kisii, Busia, Bungoma and Vihiga counties)	HSS	Increased availability, analysis and use of quality data	Increased availability, analysis and use of quality data	Information systems	Activity: 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**	Lack of common county data demand and use/framework to guide regular and predictable data quality and use.
66	USAID	County Measurement, Learning and Accountability Program - I (KIsumu, Migori, Homa Bay, Kakamega, Siaya, Kisii, Busia, Bungoma and Vihiga counties)	OVC	Increased availability, analysis, and use of high-quality data (Child Protection Information Management System)	Increase availability, analysis and use of high-quality data	Information systems	Activity: Conduct ICT infrastructure audits and assessments in Kisii, Busia, Bungoma and Vihiga. Deploy ICT infrastructure. **Sustained Epi Control**	Lack of a functional national child protection information management system (for all children including orphans and vulnerable children services) in the country.
67	USAID	County Measurement, Learning and Accountability Program - I (KIsumu, Migori, Homa Bay, Kakamega, Siaya, Kisii, Busia, Bungoma and Vihiga counties)	OVC	Increased availability, analysis, and use of high-quality data (Child Protection Information Management System)	Increase availability, analysis and use of high-quality data	Information systems	Activity: Conduct trainings on CPIMS use at Department of Children Services (DCS) and the focal counties. (Kisumu, Migori, Homabay, Kakamega, Siaya, Kisii , Busia, Bungoma and Vihiga) **Sustained Epi Control**	Weak institutional capacity to manage implementation and use of Child Protection Information Management System (CPIMS)

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
65	epidemiological and health data	5.79	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 estimates development. DQA/DQI activities conducted and corrective actions adopted in 8 counties by the CHMT and DCS using standard tools.	3 years	% of focal counties achieving increased county budget allocations by county assembly for HIV programming.	CASCOs jointly with partners regualrly plan and conduct DQA/DQI. CASCOs demand for and use HIV program, surveys and surveillance data performance reviews and program's interventions development
66	epidemiological and health data	5.79	100% functionality of CPIMS in Kisumu, Migori, Homa Bay, Kakamega, Siaya, Kisii, Busia, Bungoma and Vihiga counties)counties.	3 years	Number of additional counties effectively using CPIMS	CPIMS fully deployed and in use in Kisumu, Migori, Homabay, Kakamega, Siaya, Kisii , Busia, Bungoma and Vihiga counties
67	epidemiological and health data	5.79	Train 300 DCS, county, sub-county and PEPFAR implementing partner staff on CPIMS use	3 years	% of CPIMS users demonstrating system use competency skills.	CPIMS Modular training program accredited and cerified by Kenya School of Government

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
65	Standardized DQA/DQI activities instutionalized as part of targeted data reviews and data alignment by DCS, CASCOs and PEPFAR funded IMs in 8 counties. 100% counties plan and implement DQA/DQI with support from external partners.		50% of supported counties plan for and implement DQA/DQI activities with limited external support. 50% of supported counties demonstrate increased use of program, surveys/surveillance data in reviews, planning and high impact interventions development.		75% of supported counties plan for and implement DQA/DQI activities within their budget allocations. 75% of supported counties demonstrate increased use of program, surveys/surveillance data in reviews, planning and high impact interventions development	
66	100% fulltime CPIMS System Availability for targeted users		100% fulltime CPIMS System Availability for targeted users.		100% fulltime CPIMS System Availability for targeted users	
67	50% of CPIMS users demonstrating system use competency score of 3.0 out of 5.0		75% of CPIMS users demonstrating system use competency score of 4.0 out of 5.0 **(IM jointly with Department of Children Services to develop and operationalize Users' Competency Index Score)**		100% of CPIMS users demonstrating system use competency score of 4.0 out of 5.0 **(IM jointly with Department of Children Services to develop and operationalize Users' Competency Index Score)**	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
68	USAID	County Measurement, Learning and Accountability Program - I (KIsumu, Migori, Homa Bay, Kakamega, Siaya, Kisii, Busia, Bungoma and Vihiga counties)	HSS	Increased availability, analysis and use of quality data	Increased availability, analysis and use of quality data	Information systems	Activity: Support the DCS and 9 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, presentation, and interpretation skills. **Sustained Epi Control**	Weak capacity to demand and use data for policy making, program planning, and management.
69	DOD	TBD Viral Load Lab	HSS	To improve functionality of the DoD sponsored KEMRI lab in Kericho, Kenya - one of the national network labs for VL and EID services – the activity will increase efficiency to decrease turn-around-time (TAT) for testing results.	To improve functionality of the DoD sponsored KEMRI lab in Kericho, Kenya - one of the national network labs for VL and EID services – the activity will increase efficiency to decrease turn-around-time (TAT) for testing results.	Construction and renovation	Relocate viral load lab to its own space with the current structure	Insufficient space for efficient viral load smapling process
70	USAID	TBD - HIV AIDS Clinical Services Cluster 1	C&T	Strengthened institutional accountability for the management of community, facility and county HIV response	Strengthened institutional accountability for the management of community, facility and county HIV response	Host country institutional development	Support Counties in development of AWP and linking it with program based budgeting, Strategic planning	Weak capacity of the County Health Management Teams to plan and Budget for HIV and Health as a whole
71	USAID	TBD - HIV/AIDS Clinical Services Cluster 2	C&T	Strengthened institutional accountability for the management of community, facility and county HIV response	Strengthened institutional accountability for the management of community, facility and county HIV response	Host country institutional development	Support Counties in development of AWP and linking it with program based budgeting, Strategic planning	Weak capacity of the County Health Management Teams to plan and Budget for HIV and Health as a whole

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
68	epidemiological and health data	5.79	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.	3 years	% of focal staff who have successfully completed DDU modular training and received certification.	100% (300) of all targeted staff (DCS and county) complete DDU modular currilum and receive DDU competency certification.
69	Laboratory	6.67	Improved efficiency of viral load sample processing	1 year	Viral load lab relocated	Lack of sufficient space for viral load sample processing
70	Planning and Coordination	8.5	Functional county Health Management teams with ability to plan and budget for health and HIV		Percentage of counties with AWP priorities reflected in the County program based budget for Health.	40% of supported counties with AWP priorities reflected in the County program based budget for Health.
71	Planning and Coordination	8.5	Functional county Health Management teams with ability to plan and budget for health and HIV		Percentage of counties with AWP priorities reflected in the County program based budget for Health.	40% of supported counties with AWP priorities reflected in the County program based budget for Health.

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
68	100% (300) of all targeted counties demonstrate increased use of program and survey data in reporting, planning and portfolio management.		100% (352 targeted staff) of all targeted counties demonstrate increased use of program and survey data in reporting, planning and portfolio management.		100% (352 targeted staff) of all targeted counties demonstrate increased use of program and survey data in reporting, planning and portfolio management. 50% of focal counties plan and implement targteted surveys/surveillance activities for answering sub-county level HIV program data needs	
69	Viral load lab relocation completed		NA		NA	
70	60 % of supported counties with AWP priorities reflected in the County program based budget for Health.		80 % of supported counties with AWP priorities reflected in the County program based budget for Health.		100% of supported counties with AWP priorities reflected in the County program based budget for Health.	
71	60 % of supported counties with AWP priorities reflected in the County program based budget for Health.		80 % of supported counties with AWP priorities reflected in the County program based budget for Health.		100% of supported counties with AWP priorities reflected in the County program based budget for Health.	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
72	USAID	TBD - HIV/AIDS Clinical Services Cluster 3	C&T	Strengthened institutional accountability for the management of community, facility and county HIV response	Strengthened institutional accountability for the management of community, facility and county HIV response	Host country institutional development	Support Counties in development of AWP and linking it with program based budgeting, Strategic planning	Weak capacity of the County Health Management Teams to plan and Budget for HIV and Health as a whole
73	USAID	County Measurement, Learning and Accountability Program - II (Nakuru, Narok, Trans Nzoia, Uasin Gishu, Turkana, Samburu, Baringo, Kiambu and Kitui Counties)	HSS	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Policy and governance	Activity: Support counties to develop and update HMIS/M&E Policies, guidelines and standard protocols: **Sustained Epi Control**	Weak institutional capacity to implement and evaluate effectiveness of existing policies, guidelines and standards.
74	USAID	County Measurement, Learning and Accountability Program - II (Nakuru, Narok, Trans Nzoia, Uasin Gishu, Turkana, Samburu, Baringo, Kiambu and Kitui Counties)	HSS	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Policy and governance	Activity: Support stakeholder engagement on relevant issues: **Sustained Epi Control**	Weak stakeholders' coordination mechanisms

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
72	Planning and Coordination	8.5	Functional county Health Management teams with ability to plan and budget for health and HIV	3 years	Percentage of counties with AWP priorities reflected in the County program based budget for Health.	40% of supported counties with AWP priorities reflected in the County program based budget for Health.
73	epidemiological and health data	5.79	At least 75% of focal counties implementing existing policies, guidelines and standards. County Policy Implementation Monitoring system in place.	3 years	% of counties effectively implementing existing policies, guidelines and/or standards. % of implemented policies reviewed and adjusted.	At least 75% of focal counties implementing 75% of existing policies, guidelines and standards.
74	epidemiological and health data	5.79	Functional County HIV Stakeholders' Coordination Framework in place.	3 years	Number of HIV stakeholders' coordination meetings held per year.	50% of focal counties complete assessment of existing coordination structures. 50% of focal counties complete HIV stakeholders mapping exercise. 50% of focal counties conduct at least one HIV stakeholders coordination meeting.

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72	60 % of supported counties with AWP priorities reflected in the County program based budget for Health.		80 % of supported counties with AWP priorities reflected in the County program based budget for Health.		100% of supported counties with AWP priorities reflected in the County program based budget for Health.	
73	At least 60% of focal counties have evaluated/reviewed effectiveness of implemented policies, guidelines and/or standards. Improved reporting and use of data from HMIS&M&E systems at county. Improved collection, reporting and use of quality data at focal counties		Overall index score improvement **(3.0 out of 5.0 Score)** in use of data in reviewing/ incrementally updating HMIS/M&E policeis, guidelines, protocols/standards in 30% of targeted counties		Overall index score improvement **(4.0 out of 5.0 Score)** in use of data in reviewing/ incrementally updating HMIS/M&E policeis, guidelines, protocols/standards in 50% of targeted counties	
74	Public participation in health planning, management, monitoring and evaluation improves by **2.0 out of 5.0 index score** Ownership and leadership HIV response by civil society organizations and community increasingly evident **(Measured through qualitative assessments).**		Public participation index score in HIV program reviews and resources allocation using epidemiologic and program data improves by **3.0 out of 5.0 index score (IM to develop index score jointly with CHMT)**		Public participation index score in HIV program reviews and resources allocation using epidemiologic and program data improves by **4.0 out of 5.0 index score (IM to develop index score jointly with CHMT)**	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
75	USAID	County Measurement, Learning and Accountability Program - II (Nakuru, Narok, Trans Nzoia, Uasin Gishu, Turkana, Samburu, Baringo, Kiambu and Kitui Counties)	HSS	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Host country institutional development	Activity: 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**	Weak/non existence of county HIV Learning and Results Accountability Forums
76	USAID	County Measurement, Learning and Accountability Program - II (Nakuru, Narok, Trans Nzoia, Uasin Gishu, Turkana, Samburu, Baringo, Kiambu and Kitui Counties)	HSS	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Host country institutional development	Activity: 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**	Limited use of ICD10 at focal counties and facilities
77	USAID	County Measurement, Learning and Accountability Program - II (Nakuru, Narok, Trans Nzoia, Uasin Gishu, Turkana, Samburu, Baringo, Kiambu and Kitui Counties)	HSS	Increased availability, analysis, and use of high-quality data	Increase availability, analysis and use of high-quality data	Information systems	Activity: Development of data need and analysis framework, training and mentoring CHMTs on data analysis and visualization techniques: **Sustained Epi Control**	Lack of common county data analysis framework to guide regular and predictable data analysis

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
75	epidemiological and health data	5.79	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.	3 years	Number of counties with functional learning and accountability forums.	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.
76	epidemiological and health data	5.79	75% of focal counties adopt ICD10 training and implementation at health facilities.	3 years	% of health facilities by focal county reporting complete and accurate ICD10 reports in DHIS2.	50% of focal counties complete ICD10 training, start reporting in DHIS2
77	epidemiological and health data	5.79	Data analytical framework on priority HIV outcome indicators by focal county in place. County HIV data visualization dashboards in place.	3 years	% of focal counties regularly producing HIV county profiles. % focal counties regularly producing semi-annual scorecards on priority HIV outcomes.	HIV priority outcomes data needs analysis framework developed. 50% focal counties produce quarterly HIV county profiles regularly.

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75	County learning and accountability agenda institutionalized, owned and supported by at least 50% of key stakeholders as measured by before and after OCAT results.		M&E Intergovernmental collaboration forum within Council of Governors institutionalizes and uses learning and accountability agenda platform for scaling up inter-county adoption of best practices in managing at least county HIV response with support from PEPFAR investments.		Council of Governors' M&E Intergovernmental collaboration forum institutionalizes and fully funds inter-county learning and accountability agenda platform for scaling up inter-county adoption of best practices	
76	ICD10 mortality data increasingly used in data review forums and county HIV response program evaluations		50% of supported counties increasingly use ICD10 mortality data in data review forums and county HIV response program evaluations		75% of supported counties increasingly use ICD10 mortality data in data review forums and county HIV response program evaluations	
77	Quarterly production and dissemination of standard HIV county profiles on priority outcomes institutionalized.		50% of focal counties include production of HIV county HIV profiles on their costed work plans		75% of focal counties include production of HIV county HIV profiles on their costed work plans. 50% of supported counties use information from county profiles in prioritization of resources allocation at subcounty levels	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
78	USAID	County Measurement, Learning and Accountability Program - II (Nakuru, Narok, Trans Nzoia, Uasin Gishu, Turkana, Samburu, Baringo, Kiambu and Kitui Counties)	HSS	Increased availability, analysis, and use of high-quality data	Increase availability, analysis and use of high-quality data	Information systems	Activity: 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**	Lack of common county data demand and data use/framework guidelines to guide regular and predictable data use
79	USAID	County Measurement, Learning and Accountability Program - II (Nakuru, Narok, Trans Nzoia, Uasin Gishu, Turkana, Samburu, Baringo, Kiambu and Kitui Counties)	OVC	0	Increase availability, analysis and use of high-quality data (Child Protection Information Management System)	Information systems	Activity: Conduct ICT infrastructure audits and assessments in Nakuru, Narok, Trans Nzoia, Uasin Gishu, Turkana, Samburu, Baringo, Kiambu & Kitui. Deploy ICT infrastructure. **Sustained Epi Control**	Lack of a functional national child protection information management system (for all children including orphans and vulnerable children services) in the country.
80	USAID	County Measurement, Learning and Accountability Program - II (Nakuru, Narok, Trans Nzoia, Uasin Gishu, Turkana, Samburu, Baringo, Kiambu and Kitui Counties)	OVC	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Host country institutional development	Activity: Conduct trainings on CPIMS use at Department of Children Services (DCS) and the focal counties. (Nakuru, Narok, Trans Nzoia, Uasin Gishu, Turkana, Samburu, Baringo, Kiambu & Kitui). **Sustained Epi Control**	Weak institutional capacity to manage implementation and use of Child Protection Information Management System (CPIMS)

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
78	epidemiological and health data	5.79	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 estimates development.	3 years	% of focal counties achieving increased county budget allocations by county assembly for HIV programming.	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.
79	epidemiological and health data	5.79	100% functionality of CPIMS in Nakuru, Narok, Trans Nzoia, Uasin Gishu, Turkana, Samburu, Baringo, Kiambu and Kitui counties.	3 years	Number of additional counties effectively using CPIMS	CPIMS fully deployed and in use in Nakuru, Narok, TRans Nzoia, Uasin Gishu, Turkana, Samburur, Baringo, Kiambu and Kitui counties
80	epidemiological and health data	5.79	Train 352 DCS, county, sub-county and PEPFAR implementing partner staff on CPIMS use	3 years	% of CPIMS users demonstrating system use competency skills.	CPIMS Modular training program accredited and cerified by Kenya School of Government

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78	Standardized DQA/DQI activities instutionalized as part of targeted data reviews and data alignment by DCS, CASCOs and PEPFAR funded IMs in 8 counties. 100% counties plan and implement DQA/DQI with support from external partners.		50% of supported counties plan for and implement DQA/DQI activities with limited external support. 50% of supported counties demonstrate increased use of program, surveys/surveillance data in reviews, planning and high impact interventions development.		75% of supported counties plan for and implement DQA/DQI activities within their budget allocations. 75% of supported counties demonstrate increased use of program, surveys/surveillance data in reviews, planning and high impact interventions development	
79	100% fulltime CPIMS System Availability for targeted users		100% fulltime CPIMS System Availability for targeted users.		100% fulltime CPIMS System Availability for targeted users	
80	50% of CPIMS users demonstrating system use competency score of 3.0 out of 5.0 **(IM jointly with Department of Children Services to develop and operationalize Users' Competency Index Score)**		75% of CPIMS users demonstrating system use competency score of 4.0 out of 5.0 **(IM jointly with Department of Children Services to develop and operationalize Users' Competency Index Score)**		100% of CPIMS users demonstrating system use competency score of 4.0 out of 5.0 **(IM jointly with Department of Children Services to develop and operationalize Users' Competency Index Score)**	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
81	USAID	County Measurement, Learning and Accountability Program - II (Nakuru, Narok, Trans Nzoia, Uasin Gishu, Turkana, Samburu, Baringo, Kiambu and Kitui Counties)	HSS	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Increased leadership and management capacity of county governments for effective outcome measurements, learning, and accountability systems	Host country institutional development	Activity: Support the DCS and 9 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, presentation, and interpretation skills. **Sustained Epi Control**	Weak capacity to demand and use data for policy making, program planning, and management.
82	USAID	Bilateral TBD	C&T	New TB program	Enhance efficiency and sustainability of national TB program	Policy and governance	Support National TB and Leprosy Program to provide and disseminate policy guidelines on TB HIV and Roll out collaborative TB/HIV activities like IPT, IPC, increase Gene expert utilization	Weak coodination of TB/HIV activities at National and County level
83	USAID	Bilateral TBD	C&T	New TB Program	Enhance efficiency and sustainability of national TB program	Information Systems	Support National TB and Leprosy Program to provide ensure complete and timely reporting of TB/HIV activities	Inaccurate and late reporting
84	DOD	<Placeholder - 70108 Kenya DOD>	HSS		Increase use and triangulation of study and operations research data to improve programmatic management and decision-making	Assessments, evaluation, operation research	Evaluate impacts on key adherence and retention outcomes of the Enhanced Mentor Mother prograAm (EMMA) strategy to improve implementation of the standard of care (SOC). Estimate the additional cost to the PMTCT program of implementing the EMMA strategy. Adherence and retention outcomes are defined as: (1) proportion of women receiving an uninterrupted supply of their recommended ARV regimen from treatment initation through delivery, (2) the proportion who receive an uninterrupted supply from delivery through 24 weeks post-partum, (3) the proportion of HIV-exposed infants completing HIV testing at 72 weeks. (2nd & 3rd 90s)	Inadequate understanding of treatment and retention barriers of pregnant women and determine impact of peer mentor mothers on treatment outcomes

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
81	epidemiological and health data	5.79	Children Services Data Demand and Use (DDU) framework in place and institutionalized at all levels. 100% (352) of staff at DCS, CASCOs and PEPFAR IMs at focal counties demonstrate increased use of data for policy making, planning and program management.	3 years	% of focal staff who have successfully completed DDU modular training and received certification.	100% (352) of all targeted staff (DCS, CASCO, CHMT and PEPFAR funded IMs) completed DDU modular curriculum and receive DDU competency certification.
82	Planning and Coodination	8.5	Improved ability of the National Leprosy and TB Program (NLTP) to provide coodination of TB HIV activities	3 years	Number of new policies and guidelines developed and implemented	Current national TB startegic plan ends in 2018. National TB prevalence survey results published in 2017.
83	Performance Data	7.67	Improved, timely and accurate reporting on TB/HIV activities	3 years	Percentage of facilities and counties submitting timely and accurate reports on TB/HIV	80% of supported facilities with timely and accurate TB reports
84	Epidemiological and Health Data	5.79	TheThe Enhanced Mentor Mother ProgrAm (EMMA) strategy aims to provide a structured guide and checklist which will generate information for monitoring the interaction and close follow-up of the PMTCT patients. The EMMA strategy also employs mobile technology and other telephonic follow-up strategies to see if the use of mobile technology will improve retention and over PMTCT outcomes.	2 Years	Appropriate regulatory study paperwork; progress reports	Country-wide, Positivity rate of HIV exposed infants still stands at 8%; Lack specific population data

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81	100% (352 targeted staff) of all targeted counties demonstrate increased use of program and survey data in reporting, planning and portfolio management.		100% (352 targeted staff) of all targeted counties demonstrate increased use of program and survey data in reporting, planning and portfolio management.		100% (352 targeted staff) of all targeted counties demonstrate increased use of program and survey data in reporting, planning and portfolio management. 50% of focal counties plan and implement targteted surveys/surveillance activities for answering sub-county level HIV program data needs	
82	5 year national TB strategic plan developed that includes a detailed 5 year TB implementation plan		50% of the counties have a detailed TB HIV implementation plan		75%of the counties have a detailed TB HIV implementation plan	
83	90% of supported facilities with timely and accurate TB reports		95%of supported facilities with timely and accurate TB reports		100% of supported facilities with timely and accurate TB reports	
84	Data Collection Completion		Data Analysis complete to design HIV interventions targeting pregnant women; publish results		NA	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
85	DOD	<Placeholder - 70108 Kenya DOD>	PREV		Increase use and triangulation of study and operations research data to improve programmatic management and decision-making	Assessments, evaluation, operation research	Evaluate impacts on key adherence and retention outcomes of the Enhanced Mentor Mother prograAm (EMMA) strategy to improve implementation of the standard of care (SOC). Estimate the additional cost to the PMTCT program of implementing the EMMA strategy. Adherence and retention outcomes are defined as: (1) proportion of women receiving an uninterrupted supply of their recommended ARV regimen from treatment initation through delivery, (2) the proportion who receive an uninterrupted supply from delivery through 24 weeks post-partum, (3) the proportion of HIV-exposed infants completing HIV testing at 72 weeks. (2nd & 3rd 90s)	Inadequate understanding of treatment and retention barriers of pregnant women and determine impact of peer mentor mothers on treatment outcomes
86	DOD	<Placeholder - 70111 Kenya DOD>	HSS		Longitudinally assess the impact of clinical practices, biological factors and socio-behavioral issues on HIV infection and disease progression in a multi-country African context.	Assessments, evaluation, operation research	Understand factors associated with virologic suppression and drug resistance in HIV positive children and adolsecents (1-19 years) - (Sustained Epi Control).	Need to identify treatment strategies, evaluate the impact of social and biologic factors on HIV and its treatement and to investigate the pathogenesis of HIV

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
85	Epidemiological and Health Data	5.79	TheThe Enhanced Mentor Mother ProgrAm (EMMA) strategy aims to provide a structured guide and checklist which will generate information for monitoring the interaction and close follow-up of the PMTCT patients. The EMMA strategy also employs mobile technology and other telephonic follow-up strategies to see if the use of mobile technology will improve retention and over PMTCT outcomes.	2 Years	Appropriate regulatory study paperwork; progress reports	Country-wide, Positivity rate of HIV exposed infants still stands at 8%; Lack specific population data
86	Epidemiological and Health Data	5.79	Long-term cohort results of key outcomes in the areas of: • Demographic, social factors • HIV Outcomes • Non-HIV Health Outcomes • Health and Risk Behaviors • Mental Health and Cognition Additional detail available in quarterly HOP reports.	1 year	o % of target enrolled (n=1200 SRV; 600 KW) o Viral load <50 copies/ml; <1000 copies/ml o Clinical Staging, Opportunistic infections o HIV diagnosis date, time to engagement in care, time to ART initiation o ART Uptake, duration, regimen o Genotype resistance testing (baseline and virologic failure) o Longitudinal HIV test results (HIV uninfected group) o HIV status of partners and children born to female volunteers o Adherence to medications and visits	Selected data (not exhaustive) from FY17 HOP report: Q4FY17 enrollment: SRV, KY 1001 (82.9%) 207 (17.1%) 1208; KISUMU, KY 502 (81.9%) 111 (18.1%) 613 VL <1000, On ART (6+ Months) - n(%) SRV: 801(91.0%) KW: 426(94.6%). VL <50, On ART (6+ Months) - n(%) SRV: 757(86.0%); KW: 393(87.3%).

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
85	Data Collection Completion		Data Analysis complete to design HIV interventions targeting pregnant women; publish results		NA	
86	100% of target (n=1650) enrolled; Ongoing reporting on relevant indicators for PEPFAR		N/A		N/A	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
87	DOD	<Placeholder - 70111 Kenya DOD>	C&T		Longitudinally assess the impact of clinical practices, biological factors and socio-behavioral issues on HIV infection and disease progression in a multi-country African context.	Assessments, evaluation, operation research	Understand factors associated with virologic suppression and drug resistance in HIV positive children and adolsecents (1-19 years) - (Sustained Epi Control).	Need to identify treatment strategies, evaluate the impact of social and biologic factors on HIV and its treatement and to investigate the pathogenesis of HIV
88	DOD	<Placeholder - 70111 Kenya DOD>	HSS		Identify factors associated with virologic outcome and HIV drug resistance patterns in children & adolescents aged 1-19 years as part of an ongoing multi-country study in Kenya and Tanzania	Assessments, evaluation, operation research	Evidence of prevalence of and factors associated with virlogic failure in adolescents 1-19 years, disaggregated by age group and gender, used to optimize differentiated care models for increasing engagement in care, retention, adherence and viral load suppression.	Lack of understanding of factors associated with virologic suppression and drug resistance in HIV positive children and adolsecents (1-19 years) - (Sustained Epi Control).

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
87	Epidemiological and Health Data	5.79	Long-term cohort results of key outcomes in the areas of: • Demographic, social factors • HIV Outcomes • Non-HIV Health Outcomes • Health and Risk Behaviors • Mental Health and Cognition Additional detail available in quarterly HOP reports.	1 year	o % of target enrolled (n=1200 SRV; 600 KW) o Viral load <50 copies/ml; <1000 copies/ml o Clinical Staging, Opportunistic infections o HIV diagnosis date, time to engagement in care, time to ART initiation o ART Uptake, duration, regimen o Genotype resistance testing (baseline and virologic failure) o Longitudinal HIV test results (HIV uninfected group) o HIV status of partners and children born to female volunteers o Adherence to medications and visits	Selected data (not exhaustive) from FY17 HOP report: Q4FY17 enrollment: SRV, KY 1001 (82.9%) 207 (17.1%) 1208; KISUMU, KY 502 (81.9%) 111 (18.1%) 613 VL <1000, On ART (6+ Months) - n(%) SRV: 801(91.0%) KW: 426(94.6%). VL <50, On ART (6+ Months) - n(%) SRV: 757(86.0%); KW: 393(87.3%).
88	Epidemiological and Health Data	5.79	Evidence of prevalence of and factors associated with virologic failure in children and adolescents 1-19 years and HIV drug resistance patterns, disaggregated by age group and gender, used to optimize differentiated care models for increasing engagement in care, retention, adherence and viral load suppression.	2 years	• % enrolled toward enrollment targets (n=1000); • prevalence of viral failure measured as detectable plasma viral load >1000c/ml; • prevalence/patterns of HIV drug resistance	• Data anticipated as of COP18/FY19 start: o Enrollment numbers; o Initial prevalence data from those enrolled. • Recent data on which study rationale is partially based: o FY17 APR data -- KDF < 15 suppression rate 74% overall, 69% in 1-9, 79% in 10-14; -- KW < 15y suppression 70%, 1-9 years 69%, 10-14 y 72%; -- SRV: all < 15y 76% suppression, 1-9 years 73%, 10-14 79%.

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
87	100% of target (n=1650) enrolled; Ongoing reporting on relevant indicators for PEPFAR		N/A		N/A	
88	• 100% of target numbers (n=1000) enrolled; • viral failure prevalence estimated based on completed enrollment in those on first and second line treatment • prevalence/patterns of HIV drug resistance		• 100% of expanded target numbers enrolled for youth on second line therapy; • viral failure prevalence estimated based on completed enrollment in those on second line treatment; • prevalence/patterns of HIV drug resistance		N/A	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
89	DOD	<Placeholder - 70110 Kenya DOD>	HSS		Increase use and triangulation of study and operations research data to improve programmatic management and decision-making	Assessments, evaluation, operation research	Analysis of Networks for HIV Transmission among Active Military and Other Key Populations in Kenya (Sustained Epi Control).	Lack of a clear understanding of HIV transmission dynamics in the Kenya military to inform HIV prevention activities and to identify programmatic areas that need modification. Current and accurate data on disease transmission and associated risk behaviors are needed to make effective, evidence-based decisions
90	HHS/CDC	<Placeholder - 70114 Kenya HHS/CDC>	HSS	0	Strengthening GOK's workforce capacity to respond to outbreaks, assess surveillance systems and carry out epidemiologic protocols.	Host country institutional development	1. Enrol, train and graduate(in 3 years) 15 residents: a) Place 5 residents in HIV and TB site at national levels and PEPFAR priority counties to contribute to the 95-95-95strategy; b)Conduct 5 HIV TB related surveillance data analysis. 2. Facilitate five trainees to conduct planned research protocol in HIV and TB priority areas and develop manuscript on the same. 3. Provided support to national and county levels during outbreak and other public health investigations (five investigations). 4. Disseminate findings of investigations and studies both locally, regionally and internationally by supporting five residents to present HIV and TB related findings to local, and international conferences.	Lack of county health system capacity to meet the needs for scale up, transition and a sustained response; Insufficient numbers of skilled health workers to support treatment scale up

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
89	Epidemiological and Health Data	$ 5.79	Complete the analysis of sex networks among active duty military and other KPs in Kenya and generate data to develop specific HIV prevention interventions targeting soldiers	1 Year	Appropriate regulatory study paperwork; progress reports	Lack specific population data
90	Human Rresources for Health	6.55	1. Increased pool of graduates of critical cadres required for epidemic control 2. Disseminate HIV/TB studies or surveillance projects 3.Deployment of graduates at Counties and National programs	3 years	Number of students enrolled, graduating and placed at national and county	20 Graduates and 13 publications

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
89	Study conducted and results disseminated. Data derived from these analyses used to provide critical information for prevention programs aimed at interfering with HIV transmission among high-risk populations.		N/A		NA	
90	At least 15 of 20 students enrolled in FY 2017, will graduate in Dec 2019(COP 18) upon timely completion of their thesis. Due to funding cut 15 students will be enrolled in COP18 (FY 2019)		15 students enrolled in FY 2019 (COP 18) will be placed in county and national programs to conduct required projects . *Another new cohort of 15 students will be enrolled in COP 19.		15 students enrolled in FY 2019 (COP 18) will graduate upon timely completion of thesis defense. Another new cohort of 15 students will be enrolled in COP 20.	