Kenya

Country Operational Plan

(COP/ROP) 2019

Strategic Direction Summary

Thursday, July 11, 2019

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1.0 Goal Statement

PEPFAR Kenya's overarching goal is to support Kenya's effort to achieve and sustain HIV epidemic control through epidemiologically-informed population and geographic targeting, focus on efficient identification modalities, partner and site monitoring and accelerated national and county government ownership and self-reliance for HIV programming. To support this goal, Kenya will prioritize resources with geographic and programmatic shifts and focus based on the current HIV needs. The geographic shifts will entail categorization of counties into a) Evolve b) Scale c) Reboot and d) Transition. In these county categorizations, PEPFAR will focus on implementation with fidelity, reorienting investments based on disease burden and unmet need, as well as transitioning HIV Services to Local Partners in order to sustain epidemic control.

Optimal case identification and durable viral suppression remain critical goals in these efforts toward HIV epidemic control. Case identification through recency testing will help detect recent HIV infections among all newly diagnosed individuals in real-time linking this activity to index testing and other case finding modalities to increase HIV-positive yield. Recency testing will be rolled out nationally, with an initial focus in evolve and reboot counties, to monitor trends in the proportion of new infections.

The envisioned shifts need the right national policies. The country has adopted and implemented differentiated service delivery models, including six-month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents. The 2018 ART guidelines also envisaged treatment optimization with not only with the scale up of TLD which has now been updated to include women of child bearing potential, but also transition of older treatment regimens for children and adolescents. On Viral load suppression, PEPFAR Kenya has continued to register favorable outcomes with overall suppression rate of 90%, however, gaps do remain with certain populations such as very young children (<1yr) and adolescents (10-19yrs) with overall rates at 76%.

Kenya will shift towards country and county led ART response and pilot county health departments towards a more sustainable HIV/AIDS program while increasing investments and responsibilities for the Government of Kenya (GOK). The program will ensure Human Resources for Health (HRH) efficiencies such as reductions in the number of program management staff by merging TA teams, rightsizing and redistribution of staff across facilities in line with efficient testing and differentiated care models. Each county will have one lead implementing partner together with a Faith Based Organization (FBO) partner with complete transition out of the seven central support counties with low burden.

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A sustainable HIV epidemic response needs both national and county governments to increase budgetary allocations towards HIV epidemic control interventions with a corresponding significant reduction in donor dependency. PEPFAR/Kenya will initiate deliberate actions geared towards reaching out and sensitizing key influencers and decision makers at all levels of government, in a bid to secure increased domestic resources allocation and use. The private sector will also be engaged as they form part of the broader domestic resources contributors.

The PEPFAR Kenya team continues to engage all stakeholders in Kenya who support efforts towards epidemic control. We recognize the invaluable input the stakeholders provided in the conceptualization and development of the COP 19 as well as the quarterly POART and key technical working group meetings. The PEPFAR Team will continue to ensure engagement of CSOs including FBOs, the private sector, UNAIDS and UN Joint Team (UNJT), Global Fund (GF) as well as the Government of Kenya (GOK) to address the program issues and priorities raised in the COP19 SDS as a means to achieving epidemic control in Kenya.

2.0 Epidemics, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Kenya is a lower-middle income country with a population of 47.8 million and per capita gross national income (GNI) of $1,340 (KNBS 2018 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 9.2% in 2018/19[3] 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) 2014/15-2018/19 is fully aligned with the global 90-90-90 targets by 2020 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.

UNAIDS estimates a total of 1,559,966 adults and children living with HIV in Kenya (Kenya HIV Estimates 2019). With this estimate, Kenya has approximately 48,308 new HIV infections and 25,033 HIV-related deaths per year, with an estimated 122,446 children living with HIV (Kenya HIV Estimates, 2019). The national adult (15-49 years) HIV prevalence is estimated at 4.8% and varies widely by geographic region, ranging from 0.1% in Wajir to

[1] National Health Accounts (NHA 2012/13)
[2] National Health Accounts (NHA 2015/16)
[3] MoH National and County Health Budget Analysis (2018/19)

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21.0% in Siaya (Kenya HIV Estimates, 2018). Females, especially young women, are disproportionately affected with higher HIV prevalence compared to their male counterparts (8.0% vs. 4.9% respectively among those aged ≥25 years and 2.7% vs. 1.5% among those aged 15-24 years) (Kenya HIV Estimates, 2019).

Overall, significant progress has been made in the number of People Living with HIV (PLHIV) who know their status and are enrolled in ART. By the end of FY18, 186,903 PLHIV had been identified positive for HIV and 1,084,100 were receiving life-saving antiretroviral therapy (PEPFAR Panorama 2018). This was largely facilitated by the strong collaboration between PEPFAR, GOK, 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. Overall, new infections and all-because mortality among PLHIV has been significantly reducing in Kenya from 2010 to 2018, while ART coverage has gone up (Figure 2.1.4, Kenya HIV Estimates, 2019).

Elimination of mother-to-child transmission of HIV remains a key goal of Kenya's HIV epidemic response. In FY 18, Kenya achieved 85% of PMTCT STAT and 89% of PMTCT ART targets compared to FY17 achievement of 69% and 66% for the same indicators respectively. PEPFAR FY18 performance was similar to national MoH performance. Of those attending first Ante Natal Care (ANC), 99% knew their HIV status while 98% of those identified HIV positive initiated ART. The early infant diagnosis (EID) coverage improved due to enhance post-natal HIV retesting and HIV-exposed infants (HEI) identification at immunization clinics. Of the 60,763 tests, 67% (41,015/60,763) were tested at age < 2 months while 33% (19,948/60,763) were tested between 2-12 months. Total of 1,715 (2.8%) were identified PCR positive and 87% linked to treatment. The program will continue to utilize the national eMTCT framework launched in 2017 which provides an opportunity to close these gaps in COP19. Improving EID coverage will remain a priority in COP19, with an increased focus on early testing of HIV exposed infants within 2 months through enhanced retention, post ANC 1 retesting and referral and HEI screening at immunization. (*The program began reporting on the correct denominator in FY19, based on MER Indicator Reference Guide Version 2.3 FY19)

To address HIV prevention needs for adolescent girls and young women (AGYW), Kenya scaled up implementation of interventions through DREAMS. The goal of the DREAMS Kenya Program is to reduce new HIV infections, reduce violence and response to violence among adolescent girls and young women (AGYW). At the end of Q2 FY 19, 300,042 AGYW

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(ages 9-24 years) were cumulatively enrolled in the seven DREAMS sub-national units (SNU) (Homabay, Siaya, Kisumu, Migori, Nairobi, Kiambu and Mombasa) against a target of 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. By end of FY18 a total of 277,193 girls had completed at least 1 service, 111,848 had completed an entire primary package and 53,126 girls more than 1 primary package (source: DREAMS database). COP19 provides an opportunity to build on this success to optimize coverage. In CoP 19 the program will prioritize strategic shifts that will include phasing out cash transfers and phasing in vocational training for young women as well as ensuring an optimal mentor mentee ratio of 1:6. The program will begin a data re-alignment process with the Ministry of Health systems.

Based on the overall voluntary medical male circumcision (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, and 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 18.3% among PWID (2011, IBBS). Fisherfolk in the lake region of western Kenya constitute a priority population (PP) with an estimated 23.4% HIV prevalence

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(KEMRI Asembo Fisherfolk IBBS, 2016). 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 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. In 2018, the first phase of a PEPFAR-funded size estimation activity, led by the National AIDS & STI Control Program (NASCOP), provided updated estimates of KP sizes based on programmatic mapping (32,580 MSM, 167,940 FSW and 16,063 PWID). ART coverage through KP-friendly services is estimated at well below 50% in all three populations. 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. Targets and resource allocation may be adjusted as we redesign the Kenya Key Populations Program with an intention of meeting the 95:95:95 goals in COP19.

Since COP 2017, the PEPFAR Kenya Key Population program embarked on institutional and organizational capacity building of key population led organization to improve their capacity to implement health programs and fundraise. There are 12 local KP-led 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) SAPTA in Nairobi, Nyarwek in Kisumu, Nyanza RHS in Kisumu, ISHTAR MSM in Nairobi, NOSET in Nairobi, KISWA in Kisumu and Tamba Pwani (Kilifi) with increased capacity to develop and implement HIV and AIDS, and violence prevention and response programs in addition to fundraising for their own developed programs. In COP19, PEPFAR will continue building strong partnerships with the KP Consortium, and Trans* organizations to ensure the KP program is owned and managed by Key Populations. 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 2020 (COP19) in the context of achieving HIV epidemic control, strengthening the national sustainability profile, and leveraging transformative health systems investments.

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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		
Total Population	47,848,953	100	9,707,750	20.3	9,911,166	20.7	4,732,996	9.9	4,764,503	10.0	9,657,378	20.2	9,075,159	19.0	KNBS population projections 2018
HIV Prevalence (%)	46,069,412	4.8		0.6		0.7		2.7		1.5		8.0		4.9	Spectrum 2019 estimates (total for 15-49 years)
AIDS Deaths (per year)	25,033		2,534		2,630		1,603		1,530		7,488		9,248		Spectrum 2019 estimates
# PLHIV	1,559,966		60,875		61,571		119,488		71,863		786,354		459,815		Spectrum 2019 estimates
Incidence Rate (Yr)								0.27		0.11		0.14		0.11	Spectrum 2019 estimates
New Infections (Yr)	48,308		4,959		5,088		11,202		4,981		12,648		9,430		Spectrum 2019 estimates
Annual births	1,414,212														Spectrum 2019 estimates
% of Pregnant Women with at least one ANC visit		95.5													KDHS 2014 (% recv ANC from skilled provider up to 5 years prior to survey)
Pregnant women needing ARVs	63,079														Spectrum 2019 estimates
Orphans (maternal, paternal, double)	2,274,005														Spectrum 2019 estimates
Notified TB cases (Yr)	95,774		4,716		5,263		6,877		9,642		23,228		46,048		National TB Program data, 2018
% of TB cases that are HIV infected	25,475	26	704	15	774	15	1,122	16	858	9	9,766	42	12,251	27	National TB Program data, 2018
% of Males Circumcised		92.6								91.4					2014 KDHS, overall is for 15-49, 25+ not reported in survey. MC Prevalence survey underway in VMMC –priority counties.
Estimated Population Size of MSM*	32,580														2018 KP size estimate

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MSM HIV Prevalence		18													KARPR-Report-2018
Estimated Population Size of FSW	167,940														2018 KP size estimate
FSW HIV Prevalence		29													KARPR-Report-2018
Estimated Population Size of PWID	16,063														2018 KP size estimate
PWID HIV Prevalence		18													KARPR-Report-2018
Estimated Size of Priority Populations															
Fisherfolk Prisoners Uniformed services military AGYW 15-19 AGYW 20-24	123,065 85,273-200,000 108,000 30,000 2,498,353 2,234,644														Data presented are for targeting purposes and may not reflect actual size. Sources various including: Fisherfolk: FELTP AA 2011, AGYW: KNBS population projections 2018 Others: NASCOP Consensus Report
Estimated Prevalence in Priority Populations (Fisherfolk)		23.4													Fisherfolk: IBBS 2016 among fisherfolk,
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.* *Cite sources*														

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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	47,848,953	N/A	1,559,966	N/A	1,082,927	69%	89%	13,194,592	183,906	145,087
Population <15 years	19,618,916	N/A	122,446	N/A	76,670	63%	76%	1,918,996	8,361	8,631
Men 15-24 years	4,764,503	1.46	71,863	N/A	26,747	37%	76%	1,387,061	6,312	4,132
Men 25+ years	9,075,159	4.88	459,815	N/A	289,631	63%	90%	2,564,211	51,958	40,321
Women 15-24 years	4,732,996	2.68	119,488	N/A	67,273	56%	85%	2,834,249	28,827	23,289
Women 25+ years	9,657,378	8.04	786,354	N/A	622,606	79%	91%	4,490,075	88,448	68,714
MSM	32,580*	18.2**	5,930***	N/A	2,324****		92%****	25,291****	849****	512****
FSW	167,940*	29.3**	49,207***	N/A	14,645****		91%****	131,589****	2148****	1926****
PWID	16,063*	18.3**	2,940***	N/A	463****		100%****	13,528****	285****	78****
Fisherfolk	123,065*****	23.4*****	N/A	N/A	N/A	52.5% *****	N/A	N/A	N/A	N/A

Notes: *2018 KPSE, **KARPR-Report-2018, ***Calculated, ****MER and other program data, *****2016 Fisherfolk IBBS, Asembo

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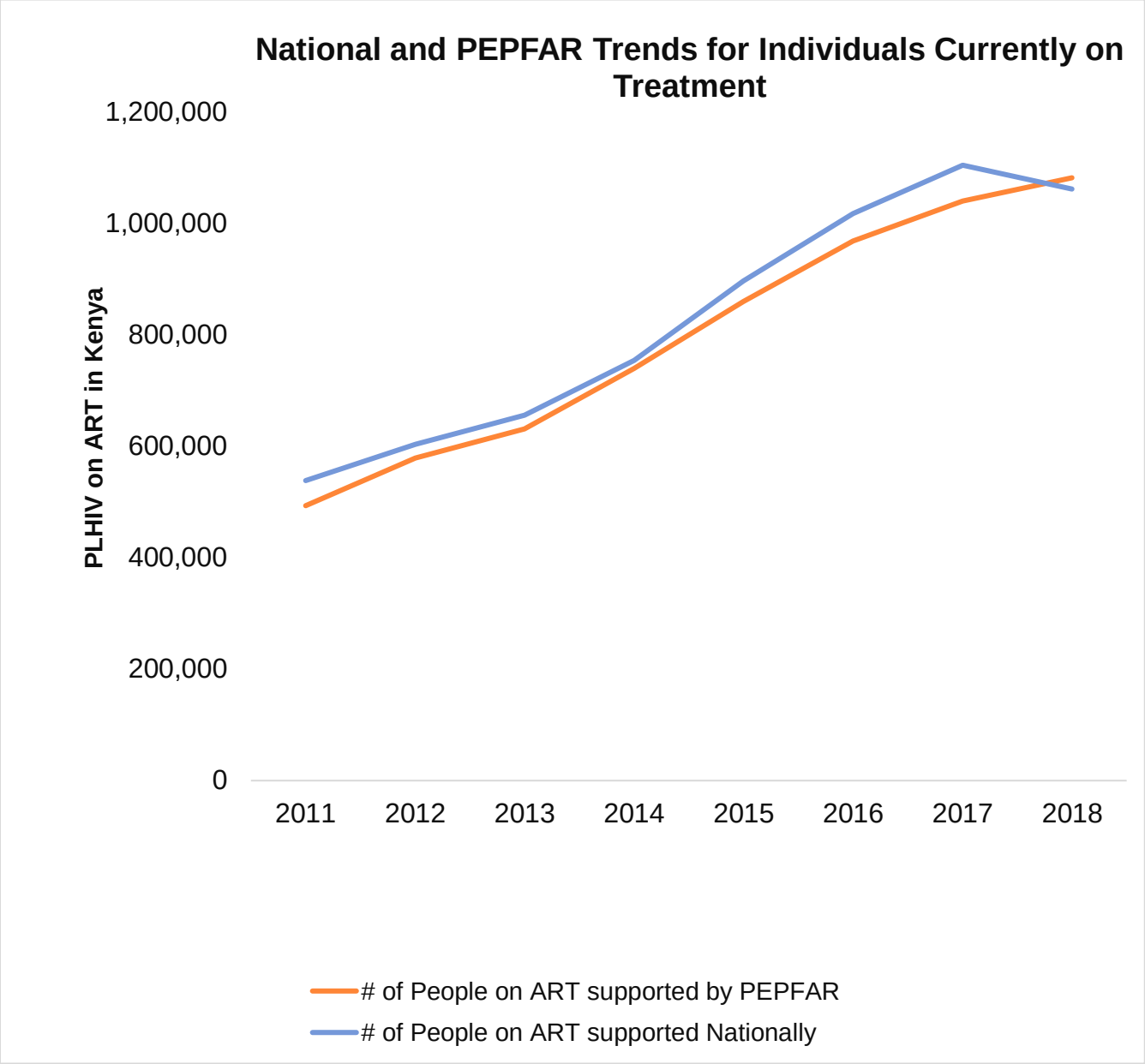
Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment



*For the same time period the reporting rate to MoH decreased due to the MoH rolling out new facility-level reporting tools. The transition and differing versions of reporting tools negatively impacted overall reporting.

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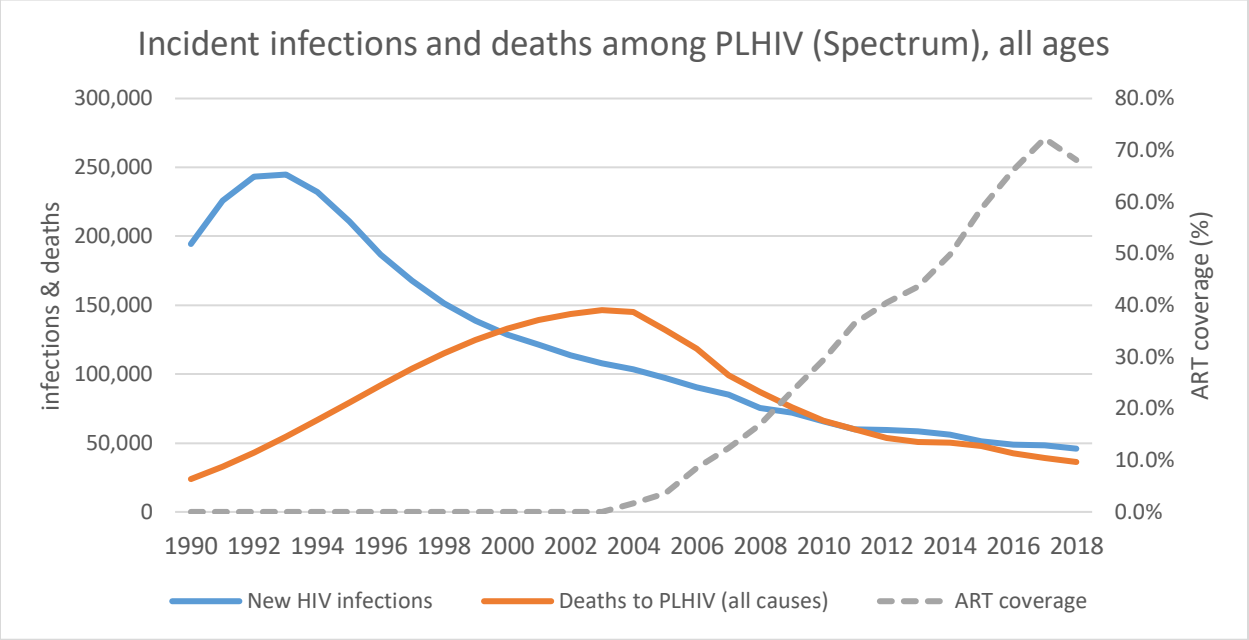
Figure 2.1.4 Trend of New Infections and All-Cause Mortality among PLHIV



2.2 Investment Profile

The GOK remains committed to ending AIDS by 2030, making for strategic health 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 under the universal health care (UHC) agenda will advance progress to ensure equitable and affordable access to essential health services, particularly for the disadvantaged, vulnerable and poor in Kenya, including people living with or affected by HIV

The current health financing landscape indicates an improvement in government financing to the health sector. The proportion of total government budget allocation to health for both national and county levels has started showing improvement at 9.2 percent in FY 2018/19 after decreasing significantly from 7.8 percent before devolution in FY 2012/13.

However, out-of-pocket spending still remains a large source of health financing (accounting for 32.8% of total health spending in 2015/16)[4], placing vulnerable households at greater risk of incurring catastrophic or impoverishing health expenditures (estimated at 6.2% in 2013). Funding to the health sector remains limited. 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 expansion of health resources. The

[4] Kenya National Health Accounts, 2015/16

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clamour 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 Kenya FY (KFY) 2017/18), leaving few resources to be used for health or other services.

While public sector contributions to HIV/AIDS have increased from 18.8% in Kenya Fiscal Year (KFY) 2012/13 to 22.1% in KFY 2015/16[5], donors remain the predominant source of HIV financing, contributing 62.3% of HIV expenditures in KFY 2015/16. The remainder of shares are borne by households through out of pocket spending and employers at 9% and 6.5% respectively. Kenya's contribution as part of its Global Fund (GF) counterpart-financing requirement was $22 million in 2017/18 and 28/19 for procurement of ARVs and test kits, and is expected to increase by $25.4 million in KFY 2019/20 as shown by the budget estimates presented to the National Assembly. This is further expected to increase to $31 million by KFY 2020/21. Nevertheless, 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 2013/14 to 27.2% in KFY 2018/19[7] reflecting the extent to which county governments prioritize health investments over other sectors. Anticipated increases in salary increments resulting from the ongoing labour disputes are expected to significantly impact county allocations to health. However, current efforts to rationalize staff and clean up payroll will help contain the wage bill (currently 75.8% of county allocations in KFY 2018/19) thereby freeing up resources to finance drugs, medical supplies or other critical service delivery inputs.

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.

[5] HIV Sub Account/NHA 2015/16
[6] Global Fund application 2017
[7] MoH National and County Health Budget Analysis (2018/19)

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Standard Table 2.2.1: Annual Investment Profile by Program Area

Table 2.2.1 Investment Profile by Program Area							
Program Area	**Total Expenditure US$***	**% PEPFAR**	**% GF**	**% GOK**	**% Other Bilateral**	**% UN Agencies**	**% All Other International**
Clinical care, treatment and support	480,362,531.00	51%	9%	40%	0%	0%	0%
Community-based care	14,446,767.00	91%	9%	0%	0%	0%	0%
PMTCT	47,460,045.92	34%	2%	62%	2%	0%	0%
HTC	83,742,905.15	53%	3%	44%	0%	0%	0%
VMMC	18,597,751.00	100%	0%	0%	0%	0%	0%
Priority population prevention	12,450,020.88	96%	4%	0%	0%	0%	0%
AGYW Prevention	2,998,784.00	76%	24%	0%	0%	0%	0%
Key population prevention	10,908,962.10	80%	19%	0%	0%	1%	0%
OVC	74,550,682.00	43%	0%	0%	21%	35%	0%
Laboratory	27,916,436.77	37%	19%	44%	0%	0%	0%
SI, Surveys and Surveillance	16,920,128.00	86%	14%	0%	0%	0%	0%
HSS	26,620,298.00	80%	19%	0%	0%	0%	1%
Total	**816,975,311.83**	54%	8%	33%	2%	3%	0%

*These are expenditure estimates based on the Kenya Global Fund application for 2017 and GOK estimates for 2018/19.

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Standard Table 2.2.2: Annual Procurement Profile for Key Commodities 2017/2018

Table 2.2.2 Annual Procurement Profile for Key Commodities 2017/2018					
Commodity Category	**Total Expenditure (USD)**	**PEPFAR (a)**	**GF (b)**	**Host Country (c)**	**Other**
ARVs	97,589,940	23,159,126	62,844,575	11,435,266	150,972
Rapid Test Kits	17,626,020	4,641,878	4,108,944	8,875,197	-
Other Drugs (TB, MAL, OI)	38,828,621	15,106,424	18,991,079	683,384	4,049,825
Lab Reagents	13,018,862	8,779,122	2,923,353	826,750	489,637
Condoms	2,237,818	-	1,224,955	-	1,012,863
Viral Load Commodities	16,678,593	16,678,593	-	-	-
EID	1,352,698	1,352,698	-	-	-
Other (equipment)	2,356,620	153,887	2,029,521	21,917	151,295
Program Management	14,173,240	3,309,803	8,357,531	1,748,446	757,460
Total	**203,862,413**	**73,181,531**	**100,479,959**	**23,590,960**	**6,612,052**

*USAID KEMSA Medical Commodities Program, FY 2017/18

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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 FY 2019 (US$)					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH	16,000,000	5,400,000	8	32,418,821	Supporting quality services for maternal and child health
USAID TB	5,000,000	4,552,927	1	1,311,978	Improving TB diagnosis, care and treatment
USAID Malaria	35,000,000	6,770,610	7	104,034,275	Supporting malaria prevention and treatment is select high burden counties
USAID Family Planning	21,600,000	12,291,514	9	121,580,029	Support FP services in the country
Nutrition	4,000,000	2,536,000	2	7,263,000	Support nutrition interventions in the country
NIH	-				
CDC (Global Health Security)					
DOD HIV Research	1,107,167		2		Support AFRICOS HIV Cohort and Pediatric Viral Load Studies
DOD Lab Support	27,457		1		Support proficiency panels for CRC Lab
DOD Ebola					
Quarantine	321,300	-	1		Surveillance of migrant populations and refugee camps

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CDC DTRA	1,101,074	1,101,074	2		Disease surveillance, diagnostic of priority syndromic illnesses. Incidence and economic impact of Brucella. Non HIV-FELTP activities
Global Disease Detection and Emergency Response	847,986	847,986	2		Building capacity, monitoring & detecting threats, responding to international emergencies and reconstructing health systems _GHSA-CDC). Developing an emergency supply chain for sending and receiving medical counter measures for emergency disease response (GHSA-USAID
Global Health Security: Program Costs	2,388,957	2,388,957	1		Help develop health systems that prevent avoidable epidemics, early threat detection and rapid and effective response
Global Public Health Capacity Development		1,400,000	1		Global Health Protection research to KEMRI and MoH
Improving Program Effectiveness	124,382	1,280,000	1		HIV AIDS clinical research
Malaria	126,000	994,641	1		Malaria research
Pandemic Influenza	498,412	1,488,000	1		Flu research
CDC OD	2,026,901	148,286	1		Management Support
MCC					
Total	90,169,636	41,199,995			

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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 (US$), FY 2019						
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**
OVC		-	-	-		
Other Public Private Partnership		600,000		1		Kenya is a part of countries in PPP with Becton, Dickinson and Company, CDC and the MoH's in select countries. BD's contribution is in kind which includes mentorship for laboratories and HCWs on QMS, equipment calibration and maintenance and IPC (which looks at HIV prevention in relation to patients and HCWs safety)
Total		**600,000**				

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2.3 National Sustainability Profile Update

The 2018 Sustainability Index and Dashboard (SID) 3.0 results showed some progress in Kenya towards sustained epidemic control. Three (3) elements scored dark green suggesting no further investment are required in those areas (Planning and Coordination, Policies and Governance, and Quality management); six (6) elements were 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 were yellow (described below) and needed some degree of support. No elements scored red.

The COP 19 includes an intervention to strengthen the national sustainability profile taking into consideration the national efforts on the implementation of the Global Fund Sustainability, Transition and Co-financing (STC) policy and the integration agenda to avoid duplication. The intervention will focus on the development of a negotiated responsibility matrix to monitor shifts in PEPFAR support to partner county systems including financing. COP 19 will also transition out of health facilities at county level in consultation with the national government, as the government takes on some responsibilities and/or align partners' support, for continuity of service delivery. This process will include identification and management of the lead clinical partner to support coordination and effective transition to county governments.

Sustainability Strengths:

- **Policies and Governance:** The national bodies responsible for guiding the country's policies in the control of HIV /AIDs epidemic, the National AIDS Control Council (NACC) and the National AIDS & STI Control Programme (NASCOP) 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. In the recent past, Test and Start, VMMC and eMTCT policies; and guidelines for KP and self-testing were finalized and disseminated. In addition, all 47 counties finalized and disseminated costed County AIDS Strategic Plans (CASFs) with NACC funding and leadership. Coordination and implementation of these and other key policies remain critical elements to propel the country towards epidemic control. The GoK has approved a one-year grace period addendum the Kenya AIDS Strategic Framework (KASF) to allow development of a second National Framework and update 47 CASFs.

- **Quality Management:** Under SID 2.0, Kenya witnessed an increase in the coordination and capacity of the MoH, including NACC and NASCOP, to

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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. There is a Kenya HIV Quality Improvement Framework (KHQIF) in place, however the country relies on donors to implement it at the county and facility level. There is need for PEPFAR Kenya to enhance local ownership of the KHQIF implementation in view of transitioning the activities and funding to government.

- **Technical and Allocative Efficiencies:** Kenya's adoption of a program based budgeting and UHC approach helped the national and county governments 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 and absorption remains an issue of concern. Moreover, PEPFAR and a few other donors continue to finance the majority of ARV needs in the country. The National Health Insurance Fund (NHIF) and the current pilot UHC program, have integrated HIV in the benefit package, however, HIV costs are not reimbursed given the extent of donor subsidies. COP19 will ensure full integration of HIV service costs are added to the essential benefit package, and new strategies are developed and implemented for reimbursing providers through pre-payment schemes including NHIF.

- **Financial/Expenditure Data:** PEPFAR has supported the MoH to routinely conduct national and 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). Through GF support, the country has also developed 47 financial profiles for each of the 47 counties. 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 allocation and execution.

Sustainability Vulnerabilities:

- **Planning and Coordination:** Despite improvements, much remains to be done to ensure adequate planning and coordination, and to improve efficiency in resource management particularly given the roles of NACC, NASCOP and county governments under the devolved system of government. On supply chain coordination, the national government will begin to play a greater role through a strengthened Directorate of Pharmaceutical Services/Health Products and

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Technologies (HPT). The directorate will lead coordination efforts across health programs at the national level as well as vertically across the two levels of government – county and national. At county levels, county HPT/supply chain units will be responsible for coordination of commodity planning and management within and across counties.

- **Human Resources for Health (HRH):** Kenya has a health workforce that is not sufficiently rationalized, right sized or with appropriate skills-mix for effective and sustained epidemic control. As a result PEPFAR investments in contracting health workers at facility and community levels are still needed. However, the county governments HRH management systems, need to be supported to a level where they can adequately meet all HRH needs, or reduce HRH for HIV services dependency ratio significantly. PEPFAR in COP 19 will invest more on health workers' rationalization and right sizing activities towards ensuring the program sustainably attains 95,95,95 cascade. As recommended by the recent HRH data call report, there will be reduction in implementing partner (IP) program management staff with savings going to fund the service delivery health workforce. COP 19 will strengthen county level HRH management capacity, apply the county HRH maturity index tool to graduate and initiate transition of PEPFAR funded responsibilities to counties. Labor disputes have continued to disrupt PEPFAR supported services, hence the program will continue engaging relevant stakeholders such as national government, council of governors, county governments and workers' leadership in effective mitigation measures such as regularizing face-to-face engagement with stakeholders, and mentorship on labor laws and negotiation skills. The site level workforce will be monitored regularly through the HRIS to ensure appropriate rationalization of HCW based on HIV program needs. Community level cadres recognition and support initiatives will be supported to ensure adequate numbers and skills mix in response to HIV epidemic control. Approaches that are workforce efficient including DSDM and targeted testing will be applied.

- **Commodity Security and Supply Chain**: Despite marked progress, 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. Without appropriate support to the national system, strengthening devolved units alone will not yield sustainable results. Numerous improvements will be supported at the

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national HPT unit including how to leverage non-USG funding sources; development of supply chain policies and strategies, and standards and guidelines for use in devolved units; and accountability for every commodity procured trough the establishment of a "Track and Trace" system. Similar units will be replicated at county level to provide a country-wide accountability for USG funded commodities. To avoid duplication of efforts, coordination will take place through the national and county governance systems as well as GF support. Other efforts will include the integration of LMIS into DHIS for efficient management and decision-making.

- **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, annual work plans, budgets and systems for laboratory services reporting, monitoring and evaluation. Additionally, there is policy guidance on HRH. The national TWG is implementing frameworks and road maps to strengthen national laboratory referral networks and access to HIV/TB related laboratory services, optimizing laboratory equipment/services, and improving quality assurance and routine monitoring. PEPFAR support for laboratory programs will be transitioned to the national and county governments. These programs will need to be monitored to ensure the gains made in the past years are not lost. The laboratory will continue implementation of lab-specific continuous quality improvement and assurance activities in collaboration with county governments in PEPFAR priority counties. This will entail maintaining all testing sites with EQA schemes to ensure accuracy of HIV/TB related tests from diagnosis through ART monitoring. Efficiency will be attained by adopting modern molecular diagnostic equipment that will require maintaining a competent workforce to run them. In addition, complex testing such as viral load (VL), (EID) and HIV drug resistance will be transitioned from research settings to public health institutions leading to an increased demand on the technical capacity of the MoH to continue performing such tests alongside managing the laboratory networks.

- **Domestic Resource Mobilization:** Although national and county governments have continued to increase contributions to the health sector including for HIV, financing of the HIV response remains heavily donor dependent 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 instituting health financing reforms that focus on pre-payment schemes aimed at reducing out of pocket spending, as well as potential private sector contributions especially in financing and service provision. Investments will be directed towards

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strengthening both national and county capacities in health planning and budgeting, evidence generation and advocacy for increased budgetary allocations for health and HIV including strategies for enhancing efficiency in resource allocation and use. The launch of UHC in Kenya presents an excellent opportunity for the health sector to increase domestic resources for health and HIV services and to develop strategies/frameworks to guide investments in the health sector for sustainable financing.

- **Epidemiological and Health Data:** The country has robust information systems that have ensured data availability and concordance among the various data sources. The data from these systems has underscored the importance of strengthening routine data systems towards improving HIV surveillance at all levels and for majority of HIV clients. Most of these systems are largely PEPFAR dependent for the system evolution part; there is a deliberate attempt to create a community of support to ensure these systems can be supported via local capacity in a sustainable manner. Surveillance and survey activities are majorly donor driven with coordination from MoH.

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. Stating with COP 18, the move towards local indigenous organizations funding began building the capacity of local CSO. These efforts include both FBOs and KP Organizations. NACC in partnership with NASCOP will continue to champion the engagement of county leadership in the SID process and will continue to mobilize 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-COP18, PEPFAR investments are aligned geographically to HIV burden. For COP19, preliminary KENPHIA results were consulted when developing estimated burden and unmet need for treatment by SNU. Counties were then ranked by unmet need for treatment based on these KENPHIA-informed estimates. 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 with higher costs in hard-to-reach areas, and patient density in high burden counties that reduce overall strategic objective costs. The overall PEPFAR investment was grouped by county according to ART coverage and unmet need. Twelve (12) Evolve counties, sixteen (16) Scale Counties, twelve (12) Reboot counties

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and seven (7) transition counties were categorized as sustained commodities for COP19. The PEPFAR team considered new disease burden estimates where there were significant changes in order to appropriately invest (e.g., Nakuru) as well as the complexities of urban metropolitan areas (e.g. greater Nairobi metro area); 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 while targeting counties with high unmet need, low ART coverage – see section 3.0 for county prioritization such as, Nakuru, Narok, Turkana, etc. These counties were identified as "reboot" shifting direction and interventions to expand ART coverage.

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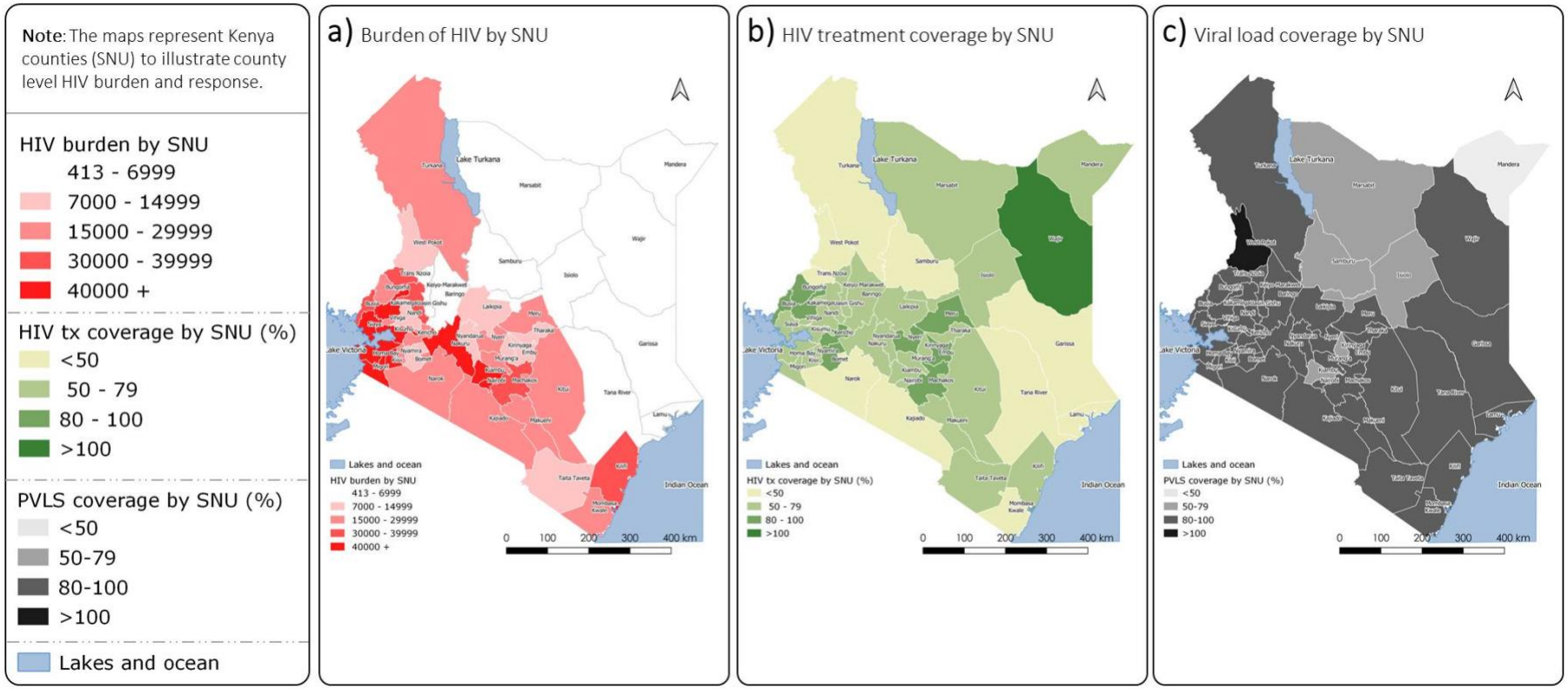
Figure 2.4.1 PLHIV, Treatment Coverage and Viral Load Monitoring Coverage



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2.5 Stakeholder Engagement

This year's COP process has been unique and evolved from the onset in January, noting that the COP 19 development process is still ongoing for Kenya. Following the release of the draft guidelines for stakeholder feedback in December 2018, the PEPFAR Kenya interagency team officially launched the COP 19 process mid-January. However, due to the security implications of the terror attacks that took place at the DUSIT hotel in Nairobi in addition to S/GAC strategic direction changes, the stakeholder engagements taken various forms and fora to ensure coordination on strategic, programmatic, technical and policy advocacy issues with national and shared priorities. Specifically, the team has met separately with the top leadership of the MoH including the Cabinet Secretary, Chief Administrative Secretary (CAS) and Principal Secretary as well as Director of Medical Services (DMS), NACC and NASCOP heads on key game changers and data points. The team also met with the Global Fund leadership, UN Joint Team and MoH (NACC and NASCOP) technical and program leaders as part of the COP 19 development process. These meetings were in addition to meeting with FBO, HIV & the Law, SI, KP and AGYW GoK-led technical working groups. The team also expanded GOK engagement to include focused discussions with the Council of Governors (CoG) leadership.

Alongside GOK meetings, the team continues to hold consultative meetings with CSOs as a consortium and key meetings with FBO and KP communities/networks/leadership. All stakeholders were part of the five (5) OGAC and KP TDYs hosted by the Kenya team between January and June 2019. The PEPFAR interagency team continues to meet during the quarterly POART and conduct ad hoc meetings with CSO, Private Sector, UNAIDS and UNJT, GF and GOK, to disseminate program results and information as well as obtain input on programs with specific considerations for human rights, gender, people with disabilities, KP and PLHIV perspectives. All written feedback and Power Point presentations from key stakeholders were reviewed and will be incorporated into the final COP19 plan. In addition to addressing the detailed program issues and priorities raised in the COP19 SDS as part of the sustained dialogue with all stakeholders, the USG interagency team will maintain stakeholder engagement throughout the COP19-implementation process. The Kenya 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.

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3.0 Geographic and Population Prioritization

In order to support both sustainability and targeted geographic focus towards HIV epidemic control; PEPFAR will prioritize resources based on current HIV needs and gaps as well as initiate a self-reliance process for Kenya. Counties were classified into the following categories: Evolve, Scale, Reboot and Transition (Figure 1 A B, C) Table A.1 and Table A.2).

Figure 1 (A)

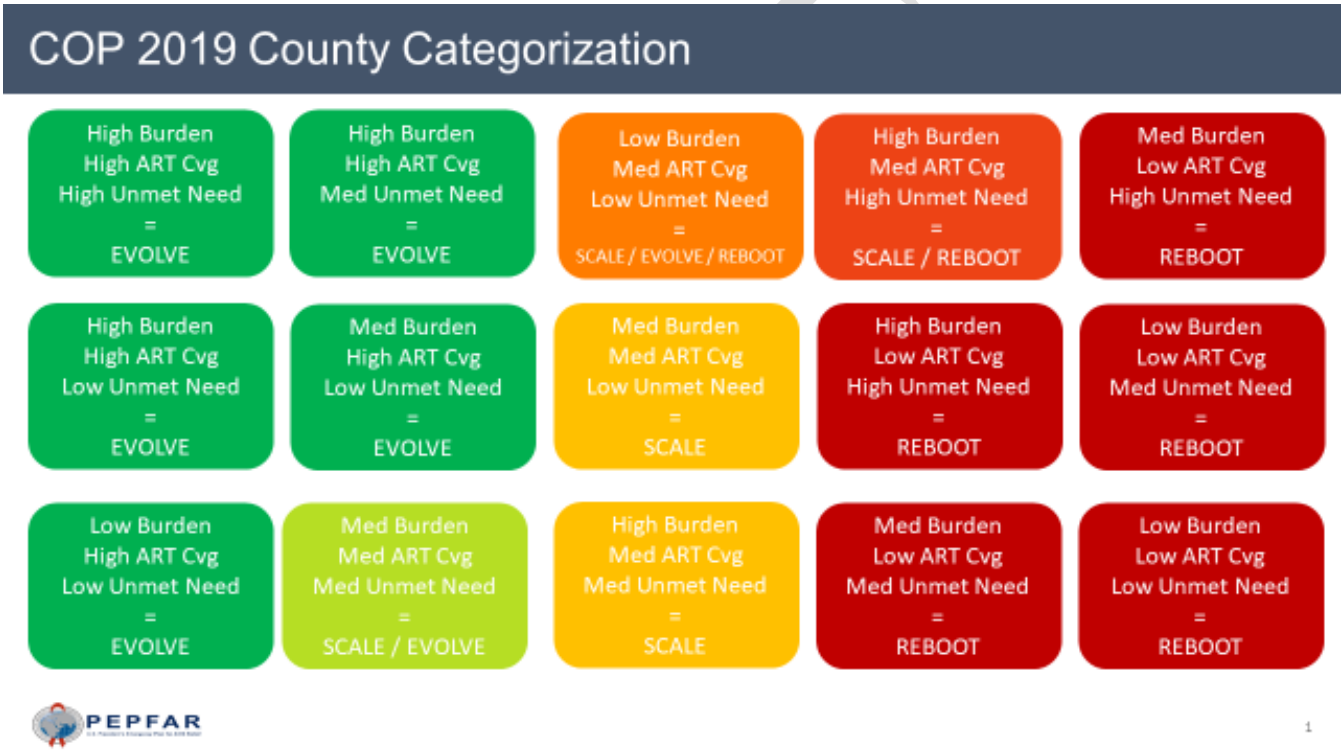

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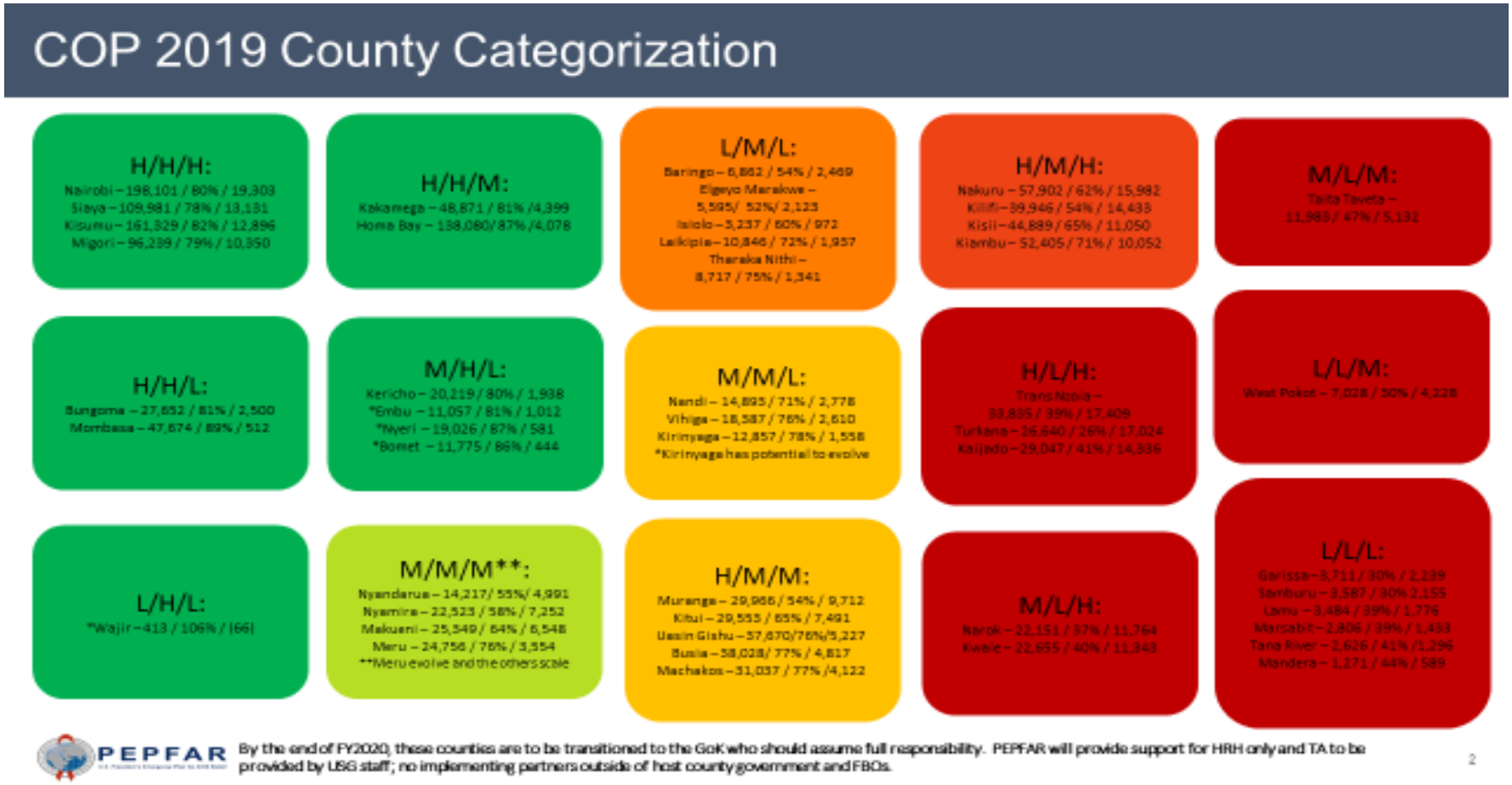
Figure 1 (B)



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Evolve counties: Include twelve counties accounting for 80% of PLHIV in Kenya, and with a high ART coverage of >78%. Nairobi, Kisumu, Siaya and Migori are in this category. These counties have a large number of PLHIV and high unmet need (≥10,000); Kakamega and Homabay have a large number of PLHIV and medium unmet need (<10,000 to >3,000); Bungoma and Mombasa have a large number of PLHIV and low unmet need (≤3,000), while Kericho, Embu, Nyeri and Bomet have a medium number of PLHIV and low unmet need (≤3,000).

Six of the Evolve counties (Nairobi, Kisumu, Siaya, Migori, Homabay and Kakamega) with a high and medium unmet need will be supported to rapidly increase the number of people on ART by scaling index testing, implementing efficient targeted facility testing, and self-testing for men and young people. In COP19, the counties will initiate a public health approach to index testing, which will be fully implemented in COP20 combining recency testing to hotspot mapping and mobilizing teams to identify the cases and engage them to treatment.

All twelve Evolve counties will initiate a self-reliance process to transition support of HIV services to the GOK and the counties. Embu, Nyeri and Bomet are expected to transition HIV services to GOK by end of FY20. In COP19, HIV services will be supported by one lead IP in the county, and in COP20, the lead IP will support mainly TA and right sized HRH, while transitioning other activities to the GOK. Additionally, in COP19, low volume sites identifying <10 HIV positive individuals and offering ART to <20 patients will be transitioned to GoK; and in COP20 PEPFAR will focus support to large volume high yielding sites through HRH right-sizing. PEPFAR-supported direct service delivery HRH levels will remain constant overall but may be reallocated based on where the need is greatest. PEPFAR expects to reduce its investments in PM and other above-site HRH across the country in COP19. HRH support will be rationalized and right sized to meet the site level workforce needs.

Scale counties: Include sixteen counties with medium ART coverage, ranging from ≥50% to <78%. These include Nyandarua, Nyamira, Makueni, Meru, Baringo, Elgeyo-Marakwet, Laikipia, Tharaka Nithi, Nandi, Vihiga, Kirinyaga, Muranga, Kitui, Uasin Gishu, Busia, and Machakos. These counties will be supported to scale up index testing, targeted testing and ART, in order to achieve >80% ART coverage. Case identification will be done mainly through index testing, efficient targeted facility testing and self-testing for men and young people.

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Similar to the Evolve counties HIV services in the Scale counties will be supported by one lead IP in the county, while low volume sites identifying <10 HIV positive individuals and offering ART to <20 patients will be transitioned to GOK. In order to achieve rapid ART scale up, partners working in these counties will be expected to meet their targets, and those not doing so, will be placed on a corrective action plan that will include HRH re-alignment. HRH rationalization and right sizing will be done to meet the workforce needs for these sites.

Reboot counties: include twelve counties with low ART coverage of <50%. These include Nakuru, Kilifi, Kisii, Kiambu, Trans-Nzoia, Turkana, Kajiado, Narok, Kwale, Taita Taveta, Samburu, and West Pokot. Five counties (Trans Nzoia, Turkana, Kajiado, Narok and Kwale) also have a high unmet need of >10,000, while two counties (Taita Taveta and West Pokot) have a medium unmet need (<10,000 to >3,000 unmet need). Rapid ART scale up will be supported in these counties to increase ART coverage, with case finding mainly done through index testing and efficient reduced facility testing.

Since these counties continue to have low ART coverage, non-performing partners will be replaced, to ensure the counties are supported by high performing partners, who will work with them to rapidly increase the ART coverage. Additionally, a self-reliance sustainability process will be initiated, with the aim of commencing transition of HIV services to GOK and the counties.

Transition counties: These are 7 counties, Wajir, Isiolo, Garissa, Lamu, Tana River, Mandera, Marsabit with low unmet need of <3,000. Except for Wajir is the only county in this group with a high ART coverage. The other six counties have a low ART coverage of <50%. These counties were transitioned to GOK in FY18. In FY19, they had one lead IP and other specialized technical assistance partners, mainly supporting large volume sites and providing support as part of a central support package. In COP19, these counties will be fully supported by GOK, and will not receive direct PEPFAR support, except for commodities that will be supported through the centralized national supply chain system for one last year.

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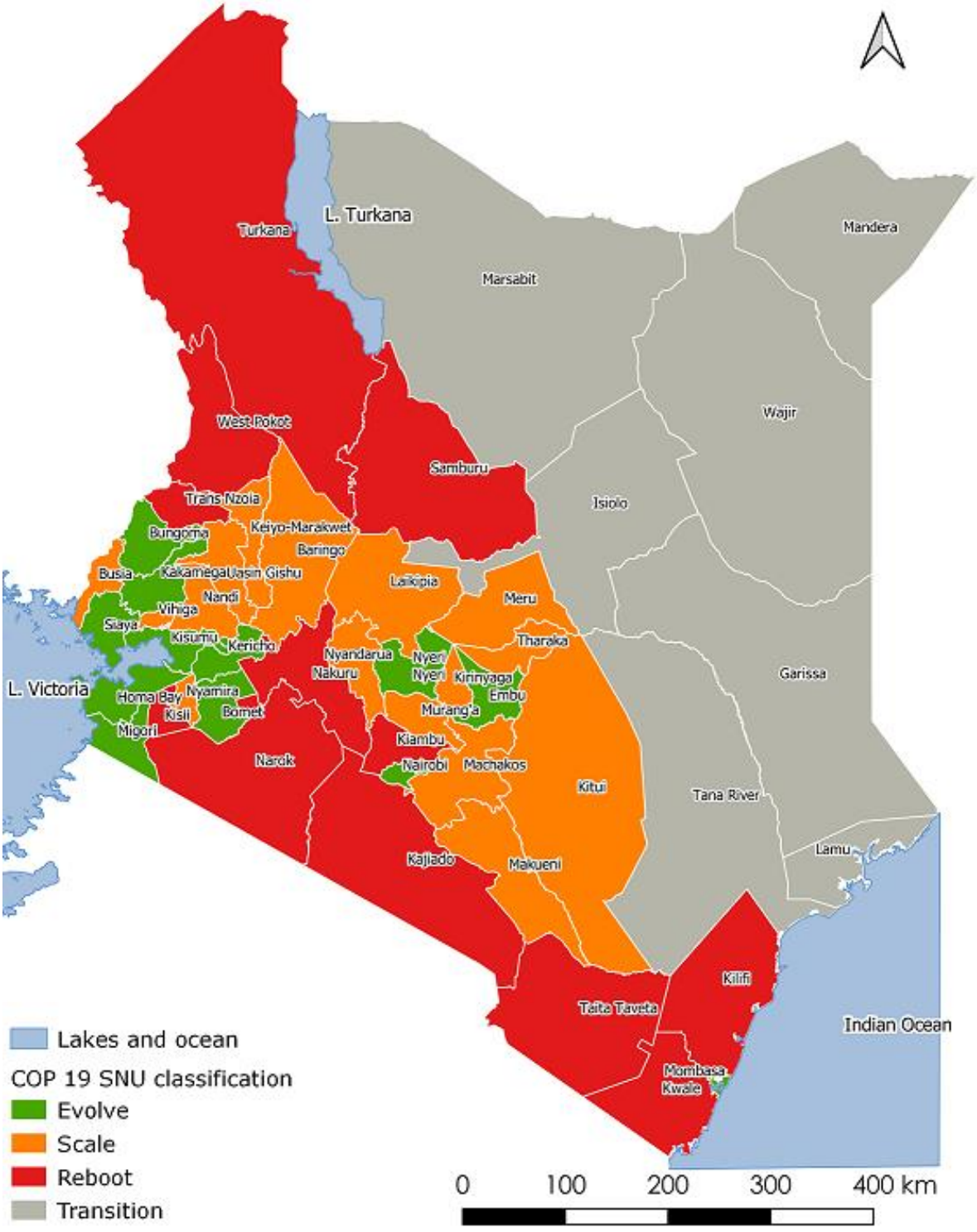
Figure 1 (c): Kenya County Prioritization of Evolve, Scale, Reboot and Transition Counties



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Population Prioritization: Both prevention interventions and rapid ART acceleration will be tailored to each county's epidemiologic profile, as well as age/sex disaggregated ART coverage and unmet need. Most counties will continue to focus on case identification strategies for men and young people, in addition to specific populations with low coverage and high unmet need.

Index testing, which has been shown to have good yield for all populations, including men, and efficient targeted facility testing will be employed, in addition to self-testing mainly for men and young people. Kenya is developing a guidance document for index testing expected in June 2019 that ensures consent procedures and confidentiality are protected and intimate partner violence (IPV) monitored through a screening process. We do not test people with risk of IPV. Linkage and retention will be enhanced for all populations, with heightened support for men and young women who have been shown to have lower retention. All populations, including children, adolescents and women will be supported to use optimal ARV regimens. Age/sex and other special population categories (e.g. nomadic groups, migrant workers, and cross-border populations) will receive tailored differentiated care models to enhance retention and achieve life-long friendly services.

VMMC Prioritization: The country's VMMC program has been implemented since 2008 mainly in five high HIV burden, culturally non-circumcising counties in the western region. VMMC has also been implemented in parts of some culturally circumcising counties in Rift Valley and Nairobi to meet the needs of migrant non-circumcising populations. All VMMC priority counties except Turkana have achieved 80% MC coverage in the 15-29 year age band. Uptake of VMMC by males above 25 years remains suboptimal across all counties while boys 10-14yrs continue to predominate among VMMC clients because of their high intrinsic demand for services.

In COP19, VMMC will continue to be supported in Homa Bay, Kisumu, Siaya, Migori, Nairobi, Nakuru, Busia, Turkana, Nandi and Kericho. VMMC service provision in West Pokot will be fully transferred to GOK as part of the broader transition plan.
In an attempt to ensure saturation of VMMC for older age bands by the end of FY20, COP19 VMMC targets are more ambitious for some age bands and counties than others. More granular target setting will be necessary to achieve the desired age pivots as overall saturation is attained across all counties. Therefore a population based MC coverage survey is underway in the top VMMC priority counties to generate granular MC prevalence data for finer target setting beyond COP19.

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DREAMS: In COP19, the DREAMS program will provide selected age appropriate primary interventions to all enrolled AGYW aged 9-24 years old. Based on need and vulnerability circumstances, some of the AGYW will receive secondary interventions, including education subsidy and combined socio-economic approaches to reduce on their risk of exposure to violence and HIV infection. The program will target 252,000 AGYW in seven DREAMS SNUs: six Evolve Counties (Homabay, Siaya, Kisumu, Migori, Nairobi and Mombasa) and one Scale up County (Kiambu). PEPFAR Kenya is already reaching a high proportion of the 9-14 year olds AGYW. The program will continue to strengthen HIV and violence prevention in girls aged 9-14 through age appropriate behavioral interventions that incorporate modules on sexual consent to prevent any form of coercive/forced/non-consensual sex and preventing early sexual debut. Layering, or the provision of multiple evidence-based services will continue to form the DREAMS core package for each DREAMS beneficiary. DREAMS will increase coverage by ensuring completion of primary package of services and graduating older AGYW that are fully layered while enrolling new AGYW for sustained epidemic control in the DREAMS SNU's.

OVC: Kenya views OVC as a priority population. In COP19, the program will target 629,819 children and adolescents 0-17 year-olds with an increased proportion a 50 percent increased proportion focus on primary prevention of HIV and sexual violence among boys and girls aged 9-14 years. Priority target population will be OVC infected and affected by HIV/AIDS aligned with the burden and unmet need. A target of 561,025 (89%), will be in 20 high burden counties classified as Evolve and Scale up Counties. Identifying, supporting and retaining HIV+ children and adolescents, HIV exposed infants, children living with HIV infected caregivers and most at risk adolescent girls will continue to be prioritized as new entrants to the OVC program in the prioritized counties as OVC transition from 13 low burden counties.

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Table 3.1: Current Status of ART Saturation

Table 3.1 Current Status of ART Saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP19**	**# Current on ART (FY18)**	**# of SNU COP18 (FY19)**	**# of SNU COP19 (FY20)**
Evolve	976,848 (62%)	716,995	-	16
Scale	241,412 (15%)	173,554	-	12
Reboot	352,065 (22%)	182,659	-	12
Central Support/Transition	17,548 (1%)	7,555	7	7

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

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

During COP19, PEPFAR will support HIV case finding across Evolved, Scale and Reboot SNUs. The strategies will be aligned to county HIV epidemic profiles and targeted to identify the missing populations towards closing gaps in the 1st 95. Focus will be efficient and effective case identification strategies including scaling up with fidelity Index case testing and targeted risk based testing at health facilities. Also, recency testing will be rolled out to inform targeted response for both case identification and HIV prevention services. In addition, real time monitoring through electronic data collection for HTS services (e-HTS) will be rolled out. To improve sustainability, a public health approach to disease surveillance and outbreak investigation will be integrated into HIV case findings. At its core will be increased engagement and collaboration with MoH, both at national and SNU levels to enhance government-led case finding, monitoring and response.

Specific activities for case finding within the 3 categories of SNUs are described below:

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Evolve- Counties	Scale Counties	Reboot Counties
Adult Men	**Adult Men**	**Adult Men**
• HIV active case surveillance using Public Health approach. • Scale up Index case testing as the primary testing modality. • Social Network Testing. • Symptom based testing (DTC) including testing of patients with symptoms of STI and TB aiming to reduce testing volumes. HIVST through utilization of community based distribution channels and FBO initiatives to reach young men in communities. • Recency testing and hot spot mapping to guide targeted case finding efforts. • Scale up e-HTS to improve data quality, reporting, utilization	• Appropriate messaging and demand creation for uptake of HTS among men. • Aggressively scale to fidelity Index Case testing with IPV integrated • Social Network Testing. • HIVST through utilization of community based distribution channels and FBO initiatives to reach young men in communities. • Implementation of Stringent integrated HTS eligibility/TB screening and age and risk driven testing for all eligible persons. • Immediate linkage of >95% of all New Positives though interventions like linkage officers, tracking registers, locator forms, call back systems and retrospective tracking of unlinked clients as well as peer escort systems. • Scale up e-HTS to improve data utilization and reporting systems.	• Recency testing and hot spot mapping to guide targeted case finding efforts. • Appropriate messaging for demand creation for uptake of HIV testing Services. • Implementation of stringent integrated HTS eligibility/TB screening and age and risk driven testing to reduce testing volumes. • Retraining of HCW and Aggressively scaling to fidelity Index Case Testing • Immediate linkage of >95% of all New Positives. • Testing of ALL women with unknown status at 1st ANC visit & subsequent visits for those opting out at 1st ANC visit. • HIVST through utilization of community based distribution channels and FBO initiatives to reach young men in communities. • Scale up e-HTS to improve data utilization and reporting systems.

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Adult Women	Adult Women	Adult Women
• HIV active case surveillance using Public Health approach. • Scale up Index case testing as the primary testing modality. • Social Network Testing. • Symptom based testing (DTC) including testing of patients with symptoms of STI and TB aiming to reduce testing volumes. • HIVST for women opting out on conventional HTS. • Recency testing and hot spot mapping to guide targeted case finding efforts • Scale up e-HTS to improve data quality, reporting, utilization • Testing of ALL women with unknown status at 1st ANC visit, subsequent visits for those opting out at 1st ANC visit • Maternal retesting in PMTCT context.	• Appropriate messaging and demand creation for uptake of HTS among men. • Aggressively scale to fidelity Index • Case testing with IPV integrated • Social Network Testing. • HIVST for women opting out on conventional HTS. • Implementation of Stringent integrated HTS eligibility/TB screening and age and risk driven testing for all eligible persons. • Immediate linkage of >95% of all New Positives though interventions like linkage officers, tracking registers, locator forms, call back systems and retrospective tracking of unlinked clients as well as peer escort systems. • Scale up e-HTS to improve data utilization and reporting systems. • Testing of ALL women with unknown status at 1st ANC visit & subsequent visits for those opting out at 1st ANC visit. • Maternal retesting in PMTCT context.	• Recency testing and hot spot mapping to guide targeted case finding efforts. • Implementation of stringent integrated HTS eligibility/TB screening and age and risk driven testing to reduce testing volumes • Retraining of HCW and aggressively scaling to fidelity Index Case Testing. • Immediate linkage of >95% of all New Positives. • Testing of ALL women with unknown status at 1st ANC visit & subsequent visits for those opting out at 1st ANC visit. • HIVST for women opting out on conventional HTS. • Maternal retesting in PMTCT context.

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Adolescents and children	Adolescents and children	Adolescents and children
• HIV active case surveillance using Public Health approach. • Scale up Index case testing as the primary testing modality. • Social Network Testing within social networks for adolescents. • Symptom based testing (DTC) including testing of patients with symptoms of STI and TB Assisted HIVST for adolescents opting out on conventional HTS. • Recency testing and hot spot mapping to guide targeted case finding efforts • Scale up e-HTS to improve data utilization and reporting systems. • Immediate linkage of >95% of all New Positives though interventions like linkage officers, tracking registers, locator forms, call back systems and retrospective tracking of unlinked clients as well as peer escort systems. • Early infant diagnosis.	• Appropriate messaging and demand creation for uptake of HTS among men. • Aggressively scale to fidelity Index Case testing with IPV integrated • Social Network Testing. • Assisted HIVST for adolescents opting out on conventional HTS. • Implementation of Stringent integrated HTS eligibility/TB screening and age and risk driven testing for all eligible persons. • Immediate linkage of >95% of all New Positives though interventions like linkage officers, tracking registers, locator forms, call back systems and retrospective tracking of unlinked clients as well as peer escort systems. • Scale up e-HTS to improve data utilization and reporting systems. • Early infant diagnosis.	• Recency testing and hot spot mapping to guide targeted case finding efforts. • Appropriate messaging for demand creation for uptake of HIV testing Services. • Implementation of stringent integrated HTS eligibility/TB screening and age and risk driven testing to reduce testing volumes. • Retraining of HCW and Aggressively scaling to fidelity Index Case Testing • Immediate linkage of >95% of all New Positives. • Assisted HIVST for adolescents opting out on conventional HTS. • Early infant diagnosis.

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Adult Treatment

Kenya has made substantial progress with increasing the number of adults living with HIV on ART in the past 16 years. By the end of FY18, 1,084,100 (69%) out of the estimated 1.6 million PLHIV (Kenya HIV estimates, 2019) were on ART, representing a 4% (42,774) increase from APR18 (1,041,326). The geographic prioritization of COP19 will be in 4 county categories determined by the current ART coverage thus 12 evolve counties (ART coverage is >78%), 16 scale up counties (ART coverage >50% but <78%), 12 reboot counties (low ART coverage <50%) and 7 transition counties (overall unmet need <3000). The evolve counties account for 80% of the PLHIV in the country. In FY20, PEPFAR aims to increase the total number of children and adults on ART to 1,329,340 while newly initiating 143,149 patients on ART. However the expected net new on treatment from projections of FY 19 to COP 19 will be > 140,000.

To attain epidemic control, PEPFAR-Kenya aims to achieve ≥ 90% ART coverage in the twelve (12) evolve counties and ≥ 80% in all scale up to saturation counties as well as the 7 reboot counties by end of FY20. PEPFAR Kenya treatment and HTS programs will work together to ensure all clients testing positive are linked to treatment with immediate initiation of life long ART (2016 ART guidelines). All clients testing positive should be supported through treatment literacy and psychosocial support, including linkage to existing PLHIV support groups and post-test clubs to make sound decision and to initiate life-long treatment with sessions that extend beyond the first Pre-treatment preparation sessions to include adherence counseling and follow up through first year of ART use. Partnerships will be fostered with PLHIV networks to rollout Treatment Literacy focusing on the health benefits of 'early' HIV treatment and life-long adherence. This is because majority of PLHIV who have disengaged from care or are LTFU have been clients new on ART. Case management will be done to all new clients to ensure all New on ART are retained. Physical escorts for all newly identified clients to ensure immediate linkage to care and treatment will continue to be emphasized. In addition lessons learn for the regular granular analysis of the reasons for Lost to Follow Up will help the program predict those who are likely to be disengaged from treatment. In addition lessons learn for the regular granular analysis of the reasons for Lost to Follow Up will help the program predict those who are likely to be disengaged from treatment.

Following the successful launch and implementation of the 2016 and the 2018 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. The 2018 ART guideline put more emphasis on the need for treatment preparation and adherence for those newly initiated on ART. One of the

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strategies to retain patients will be adequate treatment preparation for the new ART patients and to expand patient centered care and differentiated care models. The program will strengthen differentiated service delivery models that respond to the needs of the clients to address attrition by taking care of special subpopulations like older working men, school going children and young adults with flexible clinic operating hours. Community ART groups will take HIV services closer to the clients ensuring their life goes on as uninterrupted as possible. PEPFAR Kenya program is already doing multi month prescriptions and dispensing and will continue working with the ministry of Health to have a policy allowing up to six months dispensing of ART. As of APR18, about 60% of eligible patients had elected a form of differentiated service delivery. Kenya expects to increase this to 70% and 90% in FY19 and FY20, respectively. In addition, patient centered models will be expanded to other populations, such as children and adolescents, with a focus on 500 high volume sites in 27 high burden counties in FY19. 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.

As of end of FY 19, Kenya had already put more than 300,000 PLHIV on Dolutegravir (DTG) as per the 2018 ART guidelines. In both FY19 and FY20 the Kenyan program will scale up use of DTG as per the WHO guidelines in combination with other appropriate treatment options. While the guidelines previously limited the use of DTG on women of child bearing age, Kenya still has more than 43% of the total population of those already transited to DTG as women. Policy change on the use of DTG in children less than 14 years and below 30kgs has now began with the Ministry of Health. This will ensure that the Kenya leaps the current viral load suppression from 90% to 95% in COP19. Special focus will be given to children, adolescent, young people. Viremia clinics will be strengthened to focus care of those considered to have had virological failure. In COP19, Kenya will combine different strategies with a CQI approach to ensure all patients have durable viral suppression.

Evolve counties: The 12 counties in this category collectively have the highest burden of HIV in the country accounting for 80% of the PLHIV and have a high treatment coverage (>78%). The program will work with the national as well as specific county governments to identify and link to treatment the remaining HIV positive individuals while at the same time sustaining high viral suppression to prevent continuing transmission in the

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community. This will be achieved through use of high efficacious molecules (DTG) in all patient populations and case management for those who are struggling with viral suppression to identify and deal with their adherence barriers. Retention for both the new and older cohorts will be strengthened by ensuring robust treatment preparation, case management as appropriate, use of mobile technologies as well as physical defaulter tracking by the patient peers. PEPFAR 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 COP19 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 with a special focus of urban metropolitan areas

Scale up counties: The 16 counties in this category have low ART coverage (50 % to < 78%) and this will be a key focus of the program. The treatment team will work closely with the HTS team to ensure all identified are linked to treatment. Appropriate HRH will be provided at both sites to ensure improved treatment coverage to 80% in COP19. All strategies for viral suppression as well as retention will be utilized as outlined above in the evolve counties. Majority of sites in these counties are part of the SURGE strategy that PEPAFR Kenya is already implementing and will benefit from close monitoring and site level mentorship by PEPFAR technical staff.

Reboot counties: These 12 counties have very low treatment coverage and efforts will be put to push their coverage to 80% within the COP19. HRH assessment and review of implementing partners will be done to ensure these counties are adequately supported to deliver on their target. Very close monitoring of these counties will be done with performance improvement plans given as appropriate. These counties will also benefit from the SURGE strategy. Viral suppression as well as retention will be addressed by the strategies outlines above.

Transition counties: The 7 counties have been transitioned to the government of Kenya but PEPFAR will continue supporting their commodity needs through the central supply chain. They will also benefit from technical support at national level.
When scaling up VL monitoring, Kenya performed 1,180,817 VL tests in FY18 (among the 1,084,100 PLHIV on ART); the viral suppression was at 86% same period. This has since improved to 90% as at SAPR FY19 In FY18, 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

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bolstering the NASCOP VL database to monitor uptake and suppression. To support achievement of 95% viral suppression in FY20, 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 strengthened in COP19 with emphasis on the quality of care in these clinics. Through this approach, case managers and clients focus on treatment literacy in sessions during clinic days, intensified adherence counseling is provided, and regular communication is reinforced via phone calls/SMS reminders on adherence and appointment days. The current use and planned scale up of DTG use is expected to increase viral suppression due to its better efficacy, higher genetic barrier to resistance, less side effects and easy administration

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) provision of co-trimoxazole, cryptococcal meningitis screening, ART monitoring as per national 2018 ART 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

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complementary support to develop monitoring and evaluation instruments including ART distribution forms, fast-track forms and registers.

In COP19, 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 counseling, adherence and retention interventions, knowledge of status, partner testing, disclosure counseling 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.

Children and Adolescents

Case Identification

In COP 19, PEPFAR in collaboration with the MoH will implement the heightened partner monitoring and support or SURGE strategy targeted at increasing the number of CLHIV identified and linked to care and treatment. Children will be tested as part of the ongoing PNS if they are contacts of an index adult if the adult is the biologic mother of the child or if the adult is the biologic father of the child and the biologic mother is deceased or of unknown status. Positive children will also be treated as index clients and their child-siblings and biologic parents will be offered a test. The program will institute a violence screening to unintended violence for these index clients. Conventional Case identification among children will use different strategies for sick and well children. For sick children, PEPFAR will continue to support testing of all children at high-yield entry points including pediatric inpatient wards, TB units, and malnutrition clinics. Within the outpatient department, children will be screened for eligibility for HIV testing using an age appropriate pediatric HIV testing screening tool. Those eligible will be offered an HIV test. 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. Children and adolescents who have been victims of sexual violence will also be offered HIV testing as per existing GBV protocol.

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PEPFAR Kenya will support identification of HIV infected adolescents through asset-based approaches. We will use operation triple zero (OTZ) model to scale up peer led index testing, including APNS for the sexually active adolescents. We will support the use of HIV Self testing to identify adolescents and use peers to distribute the HIV self-test kits and link the positives back to facilities for confirmation. We shall implement social network testing in select urban centers to locate adolescents at the highest risk of infection and offer them HTS. In order to accommodate in-school adolescents, we will support facilities to provide flexible hours for HTS, including Saturday and school holidays for in school youth. We will collaborate with the PMTCT Program to identify pregnant and breastfeeding adolescents and link them to OTZ plus that caters for the pregnant adolescent. We will utilize data on recency testing to map hot spots of transmission and to better target our HIV testing services. Adolescents on the OVC platform will be screened for risk for HIV using the girl roster tools and the HIV screening tool. Those eligible for testing will be linked to HTS, counseled on the importance of partner testing and supported to reach out to their partners for HTS.

PEPFAR will support demand creation for pediatric HIV testing services through the development and dissemination of messages targeting parents and caregivers of children. We will utilize social media platforms to reach out to the adolescents with messages on HTS and will use faith-based platforms to promote messages on pediatric and adolescent HTS.

Treatment Optimization

Currently, viral suppression among children and adolescents is at 80% compared to 89% for adults with children less than 2 having the lowest rates at 67%. The Kenyan 2018 and earlier care and treatment guidelines have included Nevirapine or an NNRTI as a preferred first line drug. Consequently, 60% of children and adolescents are on NNRTI-based regimens (NVP or EFV). These children have suboptimal virologic control and are at a higher risk of developing drug resistance. In order to address this, PEPFAR Kenya is working with the Ministry of Health to revise policy guidelines to ensure they are aligned to the 2018 WHO recommendations for optimal pediatric recommendations by September 2019. This optimization includes starting all newly enrolled children and adolescents on LPV/r or Dolutegravir (DTG)-based ARV regimens with optimized nucleoside reverse transcriptase inhibitors (NRTI) back bone (ABC/3TC or TDF/3TC).

We are also working with Ministry of Health and Global fund in the forecasting and quantification for the pediatric ARVs. As a country, we have opted to procure LPV/r pellets. We will also ensure that we procure more LPV/r 100mg/25mg tablets to ensure that

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children are on appropriate LPV/r formulations. By March 2019, we had adequate stocks of LPV/r pellets and are currently in the process of transitioning eligible children from LPV/r oral solution to the pellets. We have developed a transition plan aligned with school holiday months of December 19 and April 20 with complete phase out of Nevirapine by December 2019. County MoH teams and IPs will be mentoring sites to implement a systematic process to identify and transition all children as quickly as possible once sufficient commodities have been secured.

Improving Treatment Outcomes for Children

PEPFAR Kenya will support efforts to improve retention through adoption of appropriate family centered differentiated models of care for children. Both stable and unstable child-caregiver pairs will be enrolled in PAMA care. Stable pairs will benefit from multi-month refills, fast-track refills at the facility, as well as community refills together with their family members at community ART distribution points. Unstable pairs will received frequent follow up; family centered psychosocial support, home visits, linkage to OVC and directly observed therapy where applicable.

For adolescents and young people living with HIV (AYPLHIV), PEPFAR will scale up OTZ to reach 95% of all enrolled in care. Stable AYP's enrolled in OTZ model will receive multi-month scripting differentiated service delivery in OTZ stable clinics (OTZ-S) to improve retention in this population. On the other hand, OTZ with viraemia will be enrolled into OTZ- viraemic clinics (OTZ-V) to access intensified treatment support and promote re-suppression and prompt switch of regimen. Structured OTZ club meetings will be held during clinic visits and school holidays to provide treatment literacy, adolescent participation and adherence counseling in line with OTZ training modules. OTZ champions will also work with facility staff to promote appointment keeping, adherence and connectedness.

PEPFAR will support roll out of the treatment initiation and retention package through heightened partner monitoring and support strategy or SURGE. Through this initiative, there will be intensive monitoring of early retention for children and adolescents including the use of a custom second visit indicator. Activities to improve retention, including mentorship for supported disclosure; alignment of appointments to school holidays; peer support groups; a dedicated space or day for adolescent-focused care; an adolescent focal person at each facility; and linkages/referrals to community services and programs including social support will continue.

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For children, the program will work with OVC program and caregivers to empower households to provide basic needs for children on treatment including transport to the facility for drug refills. The program will work through community based organizations and community health volunteers using case management and home visits to identify challenges at household level and support them with addressing barriers to adherence.
At facility level, PEPFAR will support implementation of pediatric and adolescent service packages to enhance adherence and retention, mentorships for VL switch teams to promptly identify and switch failing children and adolescents, and quality improvement interventions to improve the VL cascade. We will support sites to use the OTZ model to provide peer-led psychosocial support, including adherence counseling and support, disclosure and stigma reduction for the adolescents. PEPFAR will continue to prioritize non-suppressed children and adolescents for enrollment into OVC programs. To close the treatment gap among children, PEPFAR will adopt a pediatric case management strategy that will improve bilateral referrals between facilities and PEPFAR OVC programs, increasing the percentage of CLHIV receiving these crucial wrap-around services, improving overall retention, and viral suppression for this age group.

Youth Friendly Services

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. Health care providers will be mentored on providing youth-friendly care, including ALHIV, SOPs, and procedures will be rolled out to ensure patient-centered care. Meaningful engagement of young people living with HIV will be realized through mentorship of 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. At community level the OVC platform will be utilized to access health care with emphasis on exposed children, eligibility screening for HIV testing, ART adherence, retention in treatment and care and viral suppression for all CLHIV.

TB-HIV

Tuberculosis is a leading cause of morbidity, Virologic failure and death among PLHIV. Kenya is a high TB, TBHIV and MDRTB burden country with a prevalence of 558/100,000 and a 50% TB and TB/HIV case detection rate[8]. Over the past 2 years Kenya has experienced a 10% annual increase in TB case notification and in 2018, 95,741 of 169,000 WHO estimated incident TB cases were notified including 25,000 (29%) HIV positive Cases[9]. In 2018, 98% of

[8] National TB prevalence survey 2016
[9] WHO 2018 global TB report

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identified TB cases had a known HIV status and 97% of TB/HIV patients were on ART during TB treatment[10]. TB and HIV services are integrated in nearly all PEPFAR supported sites and 96% of PLHIV currently in care are screened for TB symptoms. Nationally 180 geneXpert® machines have been installed in laboratories spanning each county and a specimen referral network established to cover all HIV treatment sites countrywide. Majority (85%) of presumptive TB cases are tested using the Xpert MTB RIF test for TB diagnosis. TB preventive therapy (TPT) has been scaled up with over 85% of PLHIV currently on ART having received a six-month course of isoniazid preventive therapy.

Despite the progress made, low TB case detection and high (10%) TBHIV case fatalities remain a major concern. In FY 2020, working with the ministry of health PEPFAR will strengthen integration of TB and HIV service delivery across the case identification, linkage to care and retention cascade to ensure maximum synergies.

PEPFAR will support integrated TB and HIV case finding including TB screening among individuals undergoing HIV testing eligibility assessment in outpatient and inpatient departments, maternal and child health clinics, prisons and other Key populations' clinics and ensure HIV testing of presumptive TB cases and TB contacts. In HIV clinics high quality TB symptom screening will be done for patients in facility service delivery model. At the community level, access to a mobile phone application for TB symptom self-screening and appointment scheduling among patients in differentiated service delivery models will be facilitated.

The GeneXpert test will be provided for all PLHIVs presumed to have TB. TB urine lateral flow lipoarabinomannan assay (TB-LAM) test will be availed for severely sick hospitalized patients and chest X-ray supported. Specimen transportation for GeneXpert® testing will be supported and Culture and Drug susceptibility testing (DST) services provided for PLHIV presumed to have drug resistant tuberculosis.

PLHIVs currently on ART and previously not had a 6 month course of IPT will be mopped up and 90% of those newly enrolling on ART initiated on IPT. Further, PEPFAR will support policy change to facilitate access to the more patient friendly TPT regimen (3HP) among PLHIVs in Kiambu County under the IMPACT4TB study. To improve TPT completion rates from the current 85%, active screening of adverse drug reactions (ADR) will be enhanced in clinical settings and support provided to rollout an ADR self-screening and reporting mobile application under development by the Ministry of health's pharmacy and poisons board. Systems used to enhance adherence to ART will be deployed to strengthen adherence to TPT.

[10] PEPFAR DHIS DATIM APR 2018

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Timely ART and TB treatment will be provided for all TBHIV patients and follow up of TB/HIV patients including case management will be enhanced to improve treatment success and cure rates. TB and HIV adherence assessment and defaulter management will be integrated to optimize retention and treatment success and mortality audits instituted to determine populations at risk of death.

4.2 Prevention, specifically detailing programs for priority programming

a) **HIV Prevention for AGYW and Children**
(with special emphasis on primary prevention of sexual violence and HIV for 9-14 year-old boys and girls, including through the Faith and Community Central Initiative.)

DREAMS

The goal of the DREAMS Kenya Program is to reduce new HIV infections, reduce violence and response to violence among adolescent girls and young women (AGYW) The program offers a comprehensive evidence-informed package of biomedical, behavioral and social protection interventions that address individual, familial, community and structural factors that increase girls' HIV risk. The package of interventions includes HTS and linkage to ART; PrEP promotion and provision; Condom education and provision; contraceptive method mix; post-violence care; school and community-based HIV and violence prevention; social asset building; educational subsidies; 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 provides selected age appropriate primary interventions to all enrolled girls and young women and based on need and circumstances, some of the beneficiaries receive secondary interventions. Enhancing layering of interventions is critical in meeting the multiple needs of vulnerable girls and young women, their families and communities.
In COP 19, the program will target 252,000 adolescent girls and young women ages 9-24 years [FY2019 COP Guidance, page 216, 244,308] in seven DREAMS SNUs (Homabay, Siaya, Kisumu, Migori, Nairobi, Kiambu and Mombasa). Through implementation of the DREAMS Kenya Graduation SOP, we will increase coverage in the same SNUs by age-based transitioning AGYW that are fully layered e.g. moving AGYW from one age category to the another (moving 9-14yrs to 15-17yrs for additional package of interventions) or full transition out of the program either to become a mentor or a DREAMS Ambassador. In

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COP 19, we will phase out cash transfers and phase in vocational training for out of school AGYW which is more sustainable and in line with GOK workforce development policy. Implementing partners will prioritize training in GOK supported vocational training institutions. The program will link AGYW graduates to economic strengthening, microfinance, and internship and employment opportunities.

Primary Prevention Among 9-14 year-olds

The Kenyan program is already reaching a high proportion of the 9-14 year olds AGYW based on the COP 18 guidance. At SAPR 2019, the program had reached over 40,000 AGYW ages 9-14. The DREAMS program will continue to strengthen HIV and violence prevention in girls aged 9-14 through age appropriate behavioral interventions that incorporate modules on sexual consent to prevent any form of coercive/forced/non-consensual sex and preventing early sexual debut. The primary prevention interventions have incorporated skills to support healthy decisions. Communities and families surrounding these adolescents will be supported through interventions aimed at strengthening their skills and knowledge to adequately support adolescents. The program will also leverage on OVC and FBO initiative to reach additional 9-14 year old AGYW within the DREAMS SNU's.

Additionally, the program will strengthen GOK prevention & response to violence (based on the Violence Against Children Study results). Currently, the program is in the process of adapting the WHO QA tool and this is expected to be fully rolled out in COP19. The program will support SGBV medical and forensic evidence collection, storage and transportation through training of health care workers in DREAMS SNUs to enhance access to justice for survivors.

DREAMS Layering: Layering, or the provision of multiple evidence-based services from the DREAMS core package to each DREAMS beneficiary, has been a core principle of DREAMS. Full layering means AGYW receiving a full package of primary interventions and additional secondary or contextual interventions based on AGYW's individual circumstances. DREAMS will continue with active linkage (linking to actual service at safe space as initiated by the provider) for bio-medical interventions as opposed to passive referrals to ensure that full layering takes place. Most of the services required will be offered at the safe spaces where applicable and tracking of completed referrals will be done to establish a cascade of prevention service referral. Some of the promising practices to be adopted in COP19 to increase layering will include: Implementing multiple interventions with small groups of AGYW at the safe space level; enhancing DREAMS program linkage to health facilities for strengthened facility-community linkage and cross referral; working with mentors to create demand for services among AGYW with poor layering and analyzing

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the AGYW_PREV indicator at site level on a regular basis to inform how to direct specific intervention implementation and reducing the risk of duplicative service provision.

Progress and Specific Plans for COP19

By SAPR 2019, PEPFAR program in Kenya had cumulatively enrolled a total of 300,042 adolescent girls and young women against a target of 252,000 (144%). At SAPR 2019, a total of 252,999 (84%) have remained active in DREAMS. Majority of the AGYW, 207,236 (82%) have completed at least one service in the DREAMS package of interventions at 50% of the time. There is however a significant drop off from one service completion to full layering. This is because, majority of AGYW who are fully layered with primary interventions have also received additional secondary intervention(s).

In COP 19, the program has maintained the annual targets at 252,000 AGYW with an age group ratio of 20:30:28:22 for 9-14, 15-17, 18-19 and 20-24 years old respectively. The program plans to fast track implementation in the four original SNU's to attain saturation and full layering among enrolled AGYW. As the program transitions AGYW based on age progression for additional age appropriate services, AGYW above age 18 who are fully layered and stable economically will be prioritized for graduation. Of the 252,000 AGYW to be reached in COP 1920, the distribution of AGYW targets by SNU was informed by the NACC 2018 HIV prevalence estimates. Percentage coverage by SNU was aligned to the HIV incidence (Table 1):

Table 1: Percentage DREAMS Coverage by SNU

Counties	New Infection (Adult)	Est. AGYW Population	DREAMS Targets	252000	% Coverage
Homa Bay	12279	185402	0.2	49025	26.4
Siaya	9869	157286	0.2	40134	25.5
Kisumu	10349	190751	0.2	44366	23.3
Nairobi	3098	311985	0.1	35794	11.5
Kiambu	4273	259512	0.1	34283	13.2
Mombasa	2426	158118	0.1	20416	12.9
Migori	5093	163491	0.1	27982	17.1

Table 2: FY20 DREAMS Targets by Age Group

Age Group	9-14	15-17	18-19	20-24

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# of AGYW	50,400	75,600	70,560	55,440
%	20%	30%	28%	22%

In FY19, nine OVC partners were supported to offer DREAMS interventions to eligible AGYW. This is expected to continue in FY20. As PEPFAR recruits new beneficiaries aged 9-17 years in DREAMS SNUs, priority will be given to orphans and vulnerable children (OVC) and the full package of DREAMS will be implemented. These will be in addition to the OVC targets in those SNU's to increase coverage for 9-17 years old. The program will review the Mentor: Mentee ratio to approx. 1:60 from the current disproportionally high ratio varying from 1:90 to 1:300.

Social Asset Building: PEPFAR is currently promoting innovative ways of enhancing safe space participation among young women out of school aged 18-24 years to accommodate their child-care and economic responsibilities. The program will reduce frequency of safe space meetings to improve participation and retention. The program will work closely with the PMTCT program to manage referral of pregnant AGYW below age 24 from ANC clinics to DREAMS programs and document referrals to inform linkage.

In FY20, PEPFAR will reach 240,408 adolescent girls and boys 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 ages 15-24 years; offer post violence care services to 25,200 AGYW; support 56,700 young women to gain vocational skills and access non-PEPFAR supported economic strengthening opportunities; reach 28,728 parents and caregivers of AGYW ages 9-17 with parenting/caregiver programs; support 49,442 AGYW to remain in school or progress to secondary schools.

Reaching Male Sexual Partners of AGYW:
The program will continue to safe space discussion as a platform to characterize male sexual partners of AGYW in small geographic areas and to work with other PEPFAR program to reach MSP with effective biomedical services such as HTS, Condoms, VMMC and ART and violence prevention. Girls and young women enrolled in DREAMS will be encouraged to discuss VMMC with sexual partners and to facilitate VMMC referrals for their partners.

PrEP: DREAMS will continue to scale up PrEP among eligible AGYW (18-24 years). A total of 201,600 AGYW ages 15-24 will be targeted with PrEP information, education and

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communication. An estimated 7,510 AGYW (18-24 years) will be newly initiated on PrEP. Key priorities will include community sensitization to reduce myths and misconceptions around PrEP and to increase demand among eligible AGYW.

Combined Socio-Economic (CSE) Approaches: Achievement in CSE interventions has been low. The PEPFAR country team has been reviewing the implementation approaches 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 DREAMS beneficiaries. Continuous reviews of the vocational training strategy will be done and most efficient and sustainable approaches will be prioritized in COP19.

Collaboration with Global Fund: PEPFAR, Global Fund recipient –the Kenya Red Cross, NACC and DREAMS implementing Partners in Siaya will soon hold discussions on opportunities for Global Fund to compliment PEPFAR DREAMS activities in Siaya County. Discussions will be critical to ensure geographic rationalization and minimal duplication in service delivery.

DREAMS Monitoring Strategy: In COP 2019, we will continue to work with UCSF Global Program to conduct routine interagency quarterly program review meetings with our implementing partners and to participate in NACC led AGYW program review forums and data sharing processes. At USG level, we will continue with monthly monitoring of achievements for underperforming partners and provide technical assistance to ensure attainment of country targets.

In summary:

1. Kenya will continue to implement DREAMS in 7 SNUS (Homabay, Siaya, Kisumu, Migori, Nairobi, Mombasa and Kiambu).
2. The program will reach 252,000 adolescent girls and young women ages 9-24 years (refer to FY2019 COP Guidance page 216, 244, 309) with a comprehensive biomedical, behavioral, social protection and structural interventions.
3. Key priorities include increasing coverage and layering of interventions among AGYW.
4. Keys shifts from COP 18 include phasing out cash transfers and phasing in vocational training with linkage to economic strengthening opportunities; transitioning of DREAMS.
5. To GOK; and implementing a mentor mentee ratio of 1:60; working closely with FBO initiative to scale up primary HIV and violence prevention among 9-14.

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6. PEPFAR will support GOK to strengthen violence prevention and response including sexual and gender based violence medical and forensic management.

b) Key Populations

The COP 19 key populations program focus is optimizing population coverage, account for full prevention and treatment cascades. In COP 19 PEPFAR together with Global fund targets to reach 90% of all Key Population sub-types in Kenya with HIV prevention interventions, identify and link to treatment 95% of the key population living with HIV and virally suppress 95% of all Key population on treatment.

PEPFAR with technical assistance from OGAC in consultation with Ministry of Health in Kenya, the Key Population community and implementing partners redesigned key population program focuses on optimizing coverage, improve program quality, close leakages in prevention and treatment cascades and improve viral suppression of Key Population on treatment. In COP 19, 90% of FSW, MSM and PWID based on the NASCOP 2018 Key Population Size Estimate will be targeted in 17 Counties which also double up as high HIV prevalence Counties. Transgender Population HIV prevention and treatment will be initiated in Nairobi, Mombasa and Kisumu Counties where significant TG population has been mapped. The Kenya Program will scale up the peer outreach model at KP hot spots and integrated public health facility approach to ensure program sustainability with phased retention of safe space services provision in major cities. Sexual network testing strategies will be employed to enhance hot-spot based outreach services, with a specific focus on reaching new and younger MSM, FSWs. PWID and TG. Strategies to improve service uptake includes recruitment of new peer leaders alongside promotion of long serving peer leaders into outreach workers and HIV prevention officers, health worker training to offer KP friendly services, increased targeted outreaches and use of social media. The program will coordinate with KP community and offer health care worker sensitization at KP select referral public health facility to provide friendly and dignified integrated KP services. Roll out of differentiated care models for KP will be supported per national guidelines.

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 and PEP for all eligible KP; screening and treatment for sexually transmitted infections (STI); peer education and outreach; risk reduction behavioral interventions; violence prevention and

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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), assisted partner notification, enhanced peer outreach approach and HIV oral self-testing targeting both KP and their sexual partners. Since KPs and their sex partners are at ongoing risk for HIV acquisition, the program will emphasize on scale up of screening and enrollment on PrEP as per the national guidelines. In collaboration with the KP TWG and the Consortium, a review of the monthly partner reporting will be done to monitor performance and enhance tracking of both KP prevention and treatment cascades with a view to improving reach, HTS, ART and viral load (VL) testing coverage. The 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 KPs, particularly through meaningful involvement of KPs living with HIV. PWID MAT services will be scaled up by adopting a mobile outreach model to increase access to high-risk injecting users unable to access the established static sites. A human rights-based approach will be adopted to ensure that all strategies address stigma and discrimination.

To increase service uptake, more KP led organizations will be strengthened and funded to expand community led KP service provision. KP led stand alone and integrated drop in centers (DICE) augmented will be supported, particularly to include provision of ART at all eligible DICES to increase access to comprehensive services under one roof. Differentiated care particularly multi-month prescriptions that enhances adherence and retention will be strengthened

An important addition to the KP program will be inclusion of Prisons to ensure that persons under incarceration receive optimal, comprehensive HIV prevention and care services.

In COP 2019, PEPFAR targets to reach 147,597 FSWs, 7,072 MSMs, 550 PWIDs with MAT and 1,578 TG Population with HIV prevention and treatment services in a total of 26 HIV high and medium burden counties. The Kenya KP PEPFAR program will align KPIF investment to the COP19 geographic and strategic acceleration of case identification, treatment optimization and high impact prevention interventions.

c) **VMMC**

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Kenya has a high national prevalence of male circumcision (MC) of about 92% because most of its 47 counties are culturally circumcising. The country's VMMC program has been implemented since 2008 mainly in five high HIV burden, culturally non-circumcising counties in the western region (Homabay, Kisumu, Siaya, Migori and Turkana). Additionally, VMMC has also been implemented in parts of some culturally circumcising counties (Busia, Kericho, Nandi, Nakuru, and Nairobi) to meet the needs of migrant and other resident non-circumcising sub populations. The overarching strategy for Kenya's regional VMMC program is a phased approach which prioritized circumcision of older males (15+yrs) for immediate HIV prevention impact (phase I 2008-2014) followed by a transition in 2014 to expand the target age bands to include young adolescents (10-14yrs) after achieving high MC coverage among older males 15-29yrs. Currently, all top VMMC priority counties except Turkana have achieved 80% MC coverage in the 15-29 year age band although overall uptake of VMMC by males above 25 years remains suboptimal across all counties. Since 2014, boys 10-14yrs have constituted the bulk of VMMC clients served annually because of their high intrinsic demand for services. Consequently, Kenya has adopted a mixed approach which takes advantage of the inherent high demand among young adolescents 10-14yrs while intensifying demand creation among older males above 25+yr with suboptimal coverage (<80%) to achieve the desired age pivot for VMMC.

Concurrently, services for already saturated age bands (15-24yrs) will be deemphasized. Based on emerging evidence that the HIV prevention benefits of early infant male circumcision (EIMC) is delayed more than previously projected, further roll out of EIMC will be suspended until the desired age pivots for older males are achieved. Therefore, there are no EIMC targets in COP19 but limited service provision will continues at already established for sustained learning and to build on previous investments to avoid new startup costs when it becomes necessary to roll out EIMC in for ultimate long term sustainability.

Thus the overall COP19 VMMC is capped at 200,000 down from 300,000 in COP18 and prioritizes only two age bands (10-14 and 15-29yrs). Targets are more ambitious for some age bands and counties than others because of a deliberate attempt to ensure saturation of older age bands by the end of FY20. More granular target setting will be necessary to achieve the desired age pivots as overall saturation is attained across all counties. Therefore a population based MC coverage survey is underway in the top VMMC priority counties to generate granular MC prevalence data for finer target setting beyond COP19. Recent policy changes that will enhance implementation of COP19 VMMC activities include complete transition to dorsal slit as the preferred method of circumcision in the program, a shift from routine to targeting testing for boys 10-14 years, full implementation of tetanus mitigation

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policy through vaccination and clean wound care; plus implementation of safe surgery checklist in VMMC and policy for integration of VMMC into routine health services. Key areas of emphasis in COP19 include:

- Limiting HTS for 10- 14 yrs to those at elevated HIV risk and continued reliance on re-usable instruments for efficiency;
- Implementation client centred demand creation coupled with device-based circumcision to increase service uptake by older males (25+yrs);
- Suspending roll out of EIMC but maintain limited service provision to address demand for services at sites already established (No targets or investment in demand creation for EIMC);
- Deemphasizing Mobile VMMC in saturated counties –shifting to sustainable static models of service delivery;
- Phased integrating VMMC services within routine health care services; and
- Transfer full responsibility for VMMC service provision in West Pokot to GOK in COP 19 as part of the broader transition plan.

4.4 Commodities

Kenya continues to have a robust and well-integrated supply chain management system for HIV commodities. Over the years, Kenya has not experienced significant national stock outs of the major HIV commodities. However, with declining donor funding for HIV commodities and resultant funding gaps, commodity security is at risk both in the short and long term. Urgent and enhanced efforts are required to mobilize additional resources including increasing GoK funding commitments for procurement of these commodities. Projections of FY 20 commodity requirements against available funding show a funding gap of about 15% in the commodity budgets dependent on targets achievement. As initiatives for additional resources are intensified, there is also need to maximize utilization of GoK and Global Fund resources within planned timelines to improve predictability of their contribution to complement decreasing PEPFAR funds.

Some key commodities—RTKs, EID&VL reagents, PrEP drugs as well as adult co-trimoxazole will not be fully funded in FY 20 and with the apparent funding gaps, the country risks running down commodity buffer stocks (both at central and facility levels) therefore reducing resilience of the supply chain and increasing risks of stock-outs in case of disruptions in the supply side and/or changes in the demand and usage patterns. To mitigate associated risks, a health systems approach of establishing/strengthening national and county sustainability structures - supply chain units, will be supported to sustainably steward the supply chain system towards resiliency in a reduced funding landscape.

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Kenya has a well-functioning ARV distribution system made up of ordering, central and satellite facilities. To enhance efficiencies in the distribution system and reduce the overall turn-around times for orders, many of the satellite facilities are being upgraded to ordering or central sites ensuring that delays previously experienced over the last mile (between central sites and satellites) are reduced or eliminated The number of ordering sites has increased from 465 in October 2018 to 539 by June 2019. Moreover, KEMSA is piloting direct distribution to satellites in selected areas with planned scale-up to other regions in the course of the year.

In FY 19, the country successfully moved reporting of ARVs and related HIV commodities to the DHIS 2 platform with reporting rates of over 90% achieved by June 2019. This has enabled greater commodity data visibility and access enabling better tracking and utilization of this information for decision-making. As a spin-off, the country has developed an ART dashboard and website linked to the DHIS 2 where various analytics can be undertaken and visualized. The dashboard incorporates modules that allow for pipeline monitoring as well as order management and is linked to the KEMSA enterprise resource planning (ERP) system to enable seamless exchange of information. However, data quality is still a challenge and needs to be addressed to improve the overall quality of information derived from these platforms

Adult ART optimization process is on course, with patients being transitioned to optimized regimens as recommended in the revised ART guidelines released in August 2018. The transition process has been monitored closely ensuring that no stock-outs of the new regimens (mainly TLD and TLE 400) are experienced. The country is on course to meet the target of 400,000 patients on TLD by June 2018. This number is expected to rise further with the planned guideline revision to allow greater access to DTG-containing regimens for adolescent girls and young women. The country is on course in phasing out most of the legacy medicines- specifically LZN fixed dose combinations, nevirapine and efavirenz. However, some wastage of both adult and Paediatric LZN formulations is expected and will require consensus by PEPFAR, GF and GoK on how to handle any unused quantities. The country has fully transitioned from TLE 600 to TLE 400 with no wastage of the former regimen. Similarly, no wastage of TLD is anticipated despite initial delays and slow transition as well as the safety advisory in May 2018 which limited use of DTG in women. The country is also on course to introduce multi-month packs (90 count and 180 count) for the key first line adult regimens, TLE and TLD to support multi-month scripting for stable patients. KEMSA is working with manufacturers and the regulatory authority (The Pharmacy and Poisons Board) to ensure that the MMP are registered and retained on the

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list of registered medicines hence permitted for procurement and use in the country as well as leading stakeholder engagement for consensus-building and inclusion of these packs in the quantification processes.

Paediatric ARV treatment optimization is a key priority in FY 20. This will require a policy change that will align guidelines to WHO recommended ARV regimens and formulations for children. Key elements of the optimization are consolidation of paediatric regimens, greater use of PI-based regimens (Lopinavir/ritonavir) as well as Dolutegravir in first line regimens of eligible children and the phase-out of NNRTI-based (especially nevirapine-based) regimens. The initial procurement of appropriate formulations such Lopinavir/Ritonavir 40/10mg pellets have been done and commodities distributed to facilities with good uptake. The phase out of nevirapine-based formulations is underway with no new procurements planned. Optimized paediatric formulations will be prioritized in the country's FY 20 procurement plans.

Adequate supply of VL testing commodities including VL and EID reagents is key to achieving the third "95". PEPFAR aims to support VL and EID commodities while enhancing the MoH's capacity for national coordination of distribution and reporting within lab networks. Rational use of VL and EID supplies will be monitored continuously through DHIS2 and the online NASCOP EID/VL website, where each user facility directly inputs their data. Through the NASCOP EID/VL website, reagents are accounted for electronically and PEPFAR will continue to support the website to provide timely and accurate information for VL and EID reagents.

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. 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. In FY 19, the ARV order management function was transferred to counties who are now responsible for analysis of their commodity data and placing orders for commodities for their facilities as well as managing all in-county stocks. PEPFAR will continue to bolster the capacity of county

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commodity security teams to effectively oversee supply chain management systems and eliminate facility level stock-outs. At the site level, implementing partners with support from the national supply chain mechanism, Afya Ugavi will continue to coordinate closely with health facilities to bolster timely and accurate reporting, receipt and appropriate use of RTKs and other commodities.

4.5 Collaboration, Integration and Monitoring

HTS and Treatment

PEPFAR Kenya will work with MoH, UN- agencies and civil society to enhance efficiency and cost effective case finding interventions. Engagement will be through the national HTS technical working groups, to enable collaboration with all stakeholders to review HTS policy guidelines and revise to align with WHO 2018 guidelines. PEPFAR will collaborate with stakeholders to review the HTS eligibility criteria for all sub populations to reduce over-testing and improve yield for priority populations as well as scale up index case testing as the primary testing modality. PEPFAR will also, in collaboration with MoH work towards a public health approach in case finding. PEPFAR Kenya will involve the MoH in its activities and strengthen collaborative site visits and mentorship activities including performance reviews at county level.

The program will continue to work with and strengthen county teams and monitor the implementing partner performance closely through SIMs and quarterly reviews with performance improvement plans done for poorly performing partners to ensure that they achieve their COP19 targets. Technical working groups in each program area will be strengthened and the county MoH incorporated for synergy and efficiency. 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 to 95%, 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.

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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, 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. PEPFAR Kenya will work with MoH, UN family and civil society to enhance and improve outcomes of CALHIV. Through the pediatric and adolescent technical working groups, PEPFAR will work with all stakeholders to review pediatric ART policy guidelines and revise to align with WHO 2018 guidelines.

PEPFAR will support review of the HTS eligibility criteria for children and adolescent to reduce over-testing and improve yield for these priority populations. In collaboration with MoH and civil society, PEPFAR will support universal testing of all children of PLHIV newly diagnosed or existing in care. Further, we will work with MoH to implement family centered (PAMA care) for child-caregiver pairs in care to ensure, standard package to guide implementation, SOP has and tools to track performance.

TB

PEPFAR will continue to support forecasting and quantification for TB HIV commodities and printing of tools while Global Fund (GF) will to procure the bulk of the required isoniazid and pyridoxine. The ministry of health will procure (TB-LAM) and continue to support surveillance and culture and DST. Working with the USAID pure TB funded active TB case finding project, PEPFAR IPs will ensure HIV testing of all Presumptive TB cases identified. Collaborating with CHAI PEPFAR will support the pilot of 3HP among PLHIV in CDC sites in Kiambu County and support documentation of lessons learned to inform national scale up.

Further, PEPFAR will provide technical assistance in development of an application for TB symptom self-screening funded by Global fund and work with the PPB to develop an application for ADR self-screening and reporting. This is expected to facilitate intensified TB case finding and pharmacovigilance among patients in various service delivery models.
To improve the quality of reporting and longitudinal patient tracking and monitoring, a TBHIV module will be introduced in existing EMRS with linkage to the national TBHIV case based surveillance system (TIBU) to facilitate real-time data collection by frontline clinical staff. This will reduce the MoH sub county TBHIV coordinators burden of reporting and allow them to focus on supervision, monitoring and mentorship. In addition to routine IP quarterly meetings and site visits, PEPFAR will piggy back on MoH coordinated TBHIV

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quarterly meetings to review performance of IP supported sites and sub counties. 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. Deliberate efforts will be made to operationalize the use of the GeneXpert® platform for early infant HIV diagnosis. Leveraging available resources universal HIV testing of patients with diagnosed TB and timely access to ART for those with HIV infection will be ensured. Systems will be strengthened to 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

Use of unique identifiers across sites and programs in clinical settings

Working with and provide technical support to national and county governments to operationalize the use of GOK's "Huduma Namba" as Unique Patient Identifier in accessing services in the HIV patients' care and management clinics through the development, implementation, monitoring and evaluation of national policy framework, facility level guidelines and protocols. Provide facility level mentorship to health care workers during the implementation of Huduma Namba for effective and smooth transition in the health sector.

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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 Counties

Table 4.6.1: Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Counties			
Entry Streams for ART Enrollment	**Tested for HIV**	**Newly Identified Positive**	**Newly Initiated on ART (APR FY 20)**
	(APR FY20)	**(APR FY20)** ***HTS_TST_POS***	***TX_NEW***

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	HTS_TST		
Total Men	**209,365**	**8,319**	**7,973**
Total Women	**658,118**	**18,070**	**16,993**
Total Children (<15)	**74,870**	**1,895**	**1,920**
Total from Index Testing	**59461**	**7,866**	
Adults			
TB Patients	***12,264***	**1,370**	**1,370**
Pregnant Women	***224,643***	**1,830**	**1,830**
VMMC clients	-	-	-
Key populations	***39,946***	***4,440***	***42,18***
Priority Populations	-	-	-
Other Testing	***590,630***	***18,749***	***17,545***
Previously diagnosed and/or in care	-	-	-
Pediatrics (<15)			
HIV Exposed Infants	***8,230***		**183**
Other pediatric testing	***74,870***	**1,895**	**1,737**
Previously diagnosed and/or in care	-	-	-

*For scale up counties all VMMC is targeted towards children aged <15years who will not form part of targeted HIV testing.

*Index testing contributes 28% of all positives with a yield of 13.3%, this augments all the other approaches towards ensuring case identification is optimized in these counties.

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

Table 4.6.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts						
SNU	**Target Populations**	**Population Size Estimate (15-29) (SNUs)**	**Current Coverage % (date=2018)**	***VMMC_CIRC* (in FY20)**	***VMMC_CIRC* (in FY20)**	**Expected Coverage (in FY20)**
	15-29 years			10-14 Yrs	15-29 Yrs	
Nandi	15-29 years	156,505	>80%	4,189		>80%
Busia	15-29 years	117,425	>80%	9,441		>80%
	Total			13,631		

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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**	**FY20 Target**
FSWs	167,940	147,602
MSM	32,580	87,074
PWID	16,063	1,550
Fisher folk	123,065	123,065
Military	Unknown	56,160
Prisoners	Unknown	60,334
AGYW (9 -24 years)	7,591,561	252,000
TOTAL	**7,931,209**	**677,451**

OVC

PEPFAR Kenya Orphans and Vulnerable Children (OVC) activities will continue to emphasize comprehensive family-centered support targeting infected and affected children aged 0-17 years in line with current geographic epidemic trends. The program promotes integrated case management approaches to mitigate the impact of HIV/AIDS and ensure that children and adolescents remain AIDS free, healthy, safe, stable and schooled educated. The program will deliver most critical age appropriate services implemented through systematic case plan management and monitoring outcomes for OVC and their households using guidance and tools that are aligned to benchmarks for OVC programming in Kenya.

PEPFAR OVC program will deepen engagement with the public and private sector including community and faith-based organization and other children support structures at national, sub-national and community levels to enhance referrals and link to comprehensive services including to social safety net programs and other resources that ensure access to comprehensive services and sustain PEPFAR gains beyond program support. Kenya's OVC population is estimated at 2.3 million children (NACC 2018Kenya Estimates; 2019), of which, about 580,000 are orphans due to

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AIDS. There were approximately 8,000 new infections among children <15 years in 2018, majority of the infected and affected children reside in high burden counties.

In COP19, the program focus will be on primary prevention of HIV and sexual violence among boys and girls aged 9-14 years and combined prevention and risk reduction for 15-17 year-olds adolescents particularly the girls; risk assessment and improving access to HTS services, ART adherence support and retention; phased disclosure and psychosocial support; monitoring viral load suppression among HIV+ OVC and supporting access to basic healthcare, including nutrition particularly for children under-five and infected children that are failing treatment; educational subsidies and life skills, child protection; and socioeconomic support for parents/caregivers of OVC.

Progress and COP 19 OVC Priorities

As the OVC program continues to refine and evolve its approaches, focus and interventions, in COP19, it will continue to mitigate the impact of HIV/AIDS on children and adolescents as well as prevention. Emphasis will be laid on greater engagement of public, private and local partners, including faith-based organizations to facilitate graduation and transitions process, and to promote shared responsibility for sustainable services. In COP 19, PEPFAR is targeting 618,260 children and adolescents aged < 18 years, of which 561,025 (91%), are in the high burden counties - an increase from 87% in COP 18 PEPFAR OVC targets. (See Table 4.6.31). The OVC program will increase its graduation and transition rates from the current 5-7% to 11% in the high burden counties, and to about 18% in the medium counties using phased/gradual approaches. Additionally, the program will endeavor to fully transition beneficiaries out of PEPFAR support in the low burden counties. During this process, the program will ensure that approx. 5,533 HIV+ children and adolescents have individual response plans that ensure sustained access to HIV services, monitoring ART adherence and retention, as well as viral suppression beyond PEPFAR support.

The socioeconomic interventions will include data-driven combined household economic strengthening low-risk interventions and progress monitored through Case Plan Achievement Readiness Assessments (CPARA) and individual OVC household case plans. Currently, there are close to 70% enrolled households with case plans which will be used to facilitate graduation process that meets the Kenya/global benchmarks. Presently, the program supports approximately 270,600 households categorized into different levels of vulnerability (HHs ready to graduate – 4,264, on pathway – 40,087 and not ready -137,375) supporting 628,819 OVC. The program will work closely with the target households, local partners, county government and other stakeholders to facilitate responsible graduation for households that are ready and on pathway to graduation while supporting seamless transition of the highly vulnerable households in order to mitigate harm, uphold the best interest of the child and ethical principles.

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Kenya, 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. The program will continue to be guided by key guidelines and legislative frameworks that include the PEPFAR OVC guidance, National Plan of Action (NPA) for Children, the National Quality Minimum Standards for OVC programming and the Children's Act. The GOK has instituted various programs to assist children at risk, including OVC to access basic services mainly through the social safety nets and social protection program. Currently, the largest GOK social protection program is the Cash Transfer (CT) program covering all the 47 counties supporting over 947,692 poor and vulnerable households to access basic needs, and ultimately improve their wellbeing. Of this total, the OVC cash transfer program alone covers about 360,000 households which is 38 percent of the total households reached by the GOK Cash Transfer Program in the country which that the OVC PEPFAR program has continued to leverage. For example, by SAPR 2019, about 26,133 households enrolled in the PEPFAR OVC program supporting 78,000 OVC were benefiting from the GOK social protection programs that include the educational bursaries and the National Health Insurance Fund (NHIF).

In COP 19, the program will continue to strategically leverage the GOK support and other non-state investments utilizing the OVC vulnerability assessment data, available county sustainability and case investment plans to intensify work with the specific counties, systems and structures. Linkage with existing data systems will be strengthened, including the single registry that tracks beneficiaries served under the cash transfer program to address duplication. The program will ensure active participation in the next GOK budgeting process to facilitate responsible graduation and transition processes. Other opportunities being explored include dialogue with development partners, including with the new Kenya Social Inclusion Program (KSEIP) that is being implemented in 14 counties most which are in the Northern and Arid Lands region.

Table 4.6.3: COP 2019 OVC Targets by Age Band (OVC<18 years only)

0-9	**138,084**	**22%**
10-14	316,135	51%
15-17	164,041	27%
Total	**618,260**	**100%**

Priority Sub-Population

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The OVC program will continue to target 0-17 year-olds OVC infected and affected by HIV/AIDS aligned with the burden and unmet need. Identifying, supporting and retaining HIV+ children and adolescents, HIV exposed infants, children living with HIV infected caregivers and most at risk adolescent girls will continue to be prioritized as new entrants to the OVC program.

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 (FY20Target)** **OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target)** **OVC***
Nairobi	98,954	114,959	113,222
Homa Bay	170,587	77,104	75,478
Siaya	107,301	27,203	26,705
Kisumu	160,050	80,639	79,592
Migori	97,457	25,622	25,268
Kiambu	60,462	22681	22,272
Kakamega	122,248	22,118	21,664
Nakuru	115,453	28,886	28,399
Mombasa	30,335	12,457	12,288
Busia	117,922	24,122	23,672
Kisii	104,561	17,900	17,658
Kilifi	69,849	36,427	35,931
Uasin Gishu	19,497	12,391	12,136
Murang'a	50,266	5,032	4,938
Machakos	45,563	7,578	7,435
Bungoma	58,898	14,069	13,761
Trans Nzoia	95,822	8,757	8,534

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Kitui	39,430	5,048	4,944
Kajiado	38,165	7,549	7,438
Makueni	89,372	5,864	5,756
Meru	53,110	7,299	7,152
Turkana	26,739	10,264	10,139
Nyeri	27,911	4,999	4,887
Vihiga	55,118	4,147	4,040
Kwale	87,921	3,998	3,934
Nyamira	72,867	2,498	2,457
Narok	50,164	5,198	5,071
Kericho	50,257	12,577	12,403
Nyandarua	51,741	2,501	2,440
Kirinyaga	39,114	-	
Nandi	85,249	3,000	2,937
Embu	16,500	4,000	3,917
Bomet	62,853	6,765	6,661
Taita Taveta	17,813	4,003	3,948
Laikipia	16,773	233	229
Tharaka Nithi	24,339	139	136
West Pokot	67,967	135	133
Baringo	19,767	318	309
Elgeyo Marakwet	9,234	81	79
Isiolo	-	-	
Samburu	16,209	38	38

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Garissa	-	-	
Lamu	-	-	
Marsabit	-	-	
Tana River	-	-	
Mandera	-	-	
Wajir	-	-	
Military Kenya	-	214	209
Total	**2,543,838**	**628,819**	**618,210**

*KDHS 2014

Key Interventions and Focus

The program will focus on prevention among children and adolescents, including primary prevention of HIV and sexual violence among the 9-14 year-old boys and girls. Ensure implementation of case management approaches that are family-centered and closely coordinated with clinical facilities and monitoring OVC outcomes informed by individual case plan assessment results. Eligible children, adolescents and their households will be assured access to HIV testing through a systematic risk assessment, and link to treatment and care services. Routine, assessment will be inclusive of a sexual risk screening of the most-at-risk children with unknown HIV status and violence exposure screening. The program will continue to strengthen and create two-way referral pathways to clinical and other socioeconomic services. The program will support interventions that target the caregiver and adolescent girls and strengthen the community level social welfare workforce.

At community level, the program will engage OVC frontline providers'/community case workers to provide integrated case management services that support access to comprehensive age-appropriate services. These will incudes regular home follow up and monitoring, providing education and adherence support to mothers, including pregnant and adolescent mothers and identifying infants at high risk for lost to follow up as well as escorting children to the clinics where applicable. PEPFAR will intensify health education and psychosocial support to OVC households through training of local implementing partners, community health workers and other social welfare personnel e.g. community mentor mothers to identify, monitor, facilitate phased disclosure, identify and address barriers to service uptake, including stigma and discrimination.

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At the health facility level, the program will work closely with pediatric and PMTCT programs to reach children living with HIV 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 to monitor growth for young children and provide and track referrals from the community to the facility for sick and malnourished children. Ensure 100% of HIV+ children and adolescents enrolled in the OVC program is on ART, adherent, virally suppressed and in age-appropriate support groups. To achieve this, the program will utilize linkage coordinators as essential members of the multi-disciplinary care teams to track children that are failing treatment and establish barriers including the socioeconomic factors. In addition, the program will optimize use of the facility-community link desk persons particularly in the high volume health clinics to ensure adherence to clinical appointment.

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. The program will fast track children below 2 years and sick children living with HIV infected caregivers, including adolescent girls who are pregnant or breastfeeding and those who are failing treatment. Caregivers of OVC with high viral load or newly initiated on ART will be targeted for socioeconomic support. Data on viral suppression will be used to continually improve and refine the program through routine dashboard monitoring and integrated data reviews with the clinical.

Educational support will be provided to most at risk OVC particularly the adolescent girls. Data on school enrolment, out of school, attendance, and ability of the caregivers will continue to inform the beneficiaries to be supported. OVC caregivers and adolescents will be supported to be more resilient to financial shocks through group savings and loan programs, age-appropriate market-driven skills specifically for out-of-school at risk older OVC, as well as referrals and enrollment in social protection programs, including GOK school bursaries. The OVC program will continue to collaborate and optimize DREAMS and Faith-based platforms to maximize on efficiencies and ensure the unique and complex needs of children and AGYW and their families are met.

The program will work closely with DREAMS, and community based organization, including faith-based organizations maximizing their organizational structures and networks to address sexual violence and HIV prevention particularly for the young boys and girls aged 9-14 year-olds. The program will integrate regular gender-based violence (GBV) prevention sensitization at the community that will target community gatekeepers and leaders to understand the unique challenges and experiences, including stigmatizing and discriminatory contents, and needs of children and adolescents living with HIV. Support active screening for GBV, case conferencing

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and linking OVC to comprehensive services including linkage to police, health care and justice. The program will continue to participate and work closely with Department of Children's Services (DCS), child protection structures, and stakeholders in target counties and communities to disseminate the 2018 findings of the recently completed violence against children survey (VACS) in Kenya.

PEPFAR will continue to support ongoing efforts to strengthen and ensure optimal use of the national and county level Child Protection Information Management System (CPIMS) with a focus to gradually transition the system to DCS for sustainability. This system helps to flag highly vulnerable cases for additional follow-up, empowers local leadership with timely data for decision making, planning and enhances advocacy for data ownership, resource allocation and monitoring of OVC activities. In COP 19, PEPFAR will support OVC implementing partners (IPs) and DCS in focal counties, through trainings to increase demand for and use of data. This will be addressed through regular data reviews, dissemination of reports during quarterly data review meetings, mentorship programs on basic data interpretation, dashboards and data gaps. Through deepened stakeholder engagement, in COP19, the department of children services is receiving support from UNICEF expand CPIMS coverage in 9 additional counties. Aligned with S/GAC guidance, further transition will occur in medium and low burden counties in FY 19 and FY 20 to scale-up in high burden counties with high unmet need. Lessons learned from the FY17 transition from seven central support counties will continue to inform future graduation and transition processes.

High Burden Counties

In COP19, 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 (560,806) in the 20 high burden counties which is approximately 91% of the total COP19 OVC target of 628,813 of boys and girls below 18 years.
- COP19 investments per PEPFAR age categorization will comprise of <9 years (22%), 10-14 years (51%) and 15 - 17 years (27%) respectively. In APR 2018 of the total 797,126 OVC served, 24% were <10 years, 34% were 10-14 years, 22% were 15-17 years and 20% were above 18 years. The target continues to reflect deliberate shifts in COP 19 OVC programming to focus on service package quality and accelerated transition of beneficiaries in sustained counties.

Medium and Low Burden

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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 transition experience and lessons learned from the 7 central support counties in FY17. Approaches will include:

- Discontinuing any enrollment of new beneficiaries and fast track graduate/transition children and families on a rolling basis starting in the lowest burden counties using case plan readiness achievement guidance and tools. Targeted psychosocial support for affected households.
- Provide targeted support to OVC households based on case plans developed to shift them towards self-sustenance through low risk household economic activities, including savings and loans, financial literacy and one-off assets transfer. Work with the GOK and county stakeholders to subsume the highly vulnerable households in the cash transfer program.
- Develop and implement individual response plans to support OVC who are CLHIV and ALHIV to access treatment and care services. Coordinate with clinical facility through linkage coordinators as essential members of the multi-disciplinary care teams
- Targeted secondary education support for most at risk OVC, especially adolescent girls while linking them to available educational bursaries.

Summary of Age Band Interventions

Package of services for OVC <9 years

- Immunization and nutritional assessment/growth monitoring, counseling and linkage to food supplementation
- Access to health care with emphasis on exposed children, eligibility screening for HIV testing, ART adherence, retention in treatment and care and viral suppression for all CLHIV.
- Primary prevention to avoid HIV and violence before it occurs, 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, school levies).

Package of Services for OVC age 10-14 years

- Eligibility screening for HIV testing, ART adherence, retention in treatment and care and viral suppression for all HIV+ children.
- Primary prevention of sexual violence and HIV and link to post-rape care services.
- In and out of school health programs using age-appropriate materials (Families Matter I and II). Mentorship and coaching programs.

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- 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 safe spaces.

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.
- Market-driven livelihood activities e.g., 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-violence care services and GBV and other forms of violence care services.

Parents/Caregivers

- Targeted community mobilization to sensitize caregivers on the importance of HTS services for themselves and most at risk OVC, viral suppression and nutrition for CLHIV and linkage to age appropriate services.
- Parenting skills using age-appropriate EBI materials, knowledge on developmental stages, safeguarding children and adolescents, positive discipline, communication and understanding the service delivery points and utilization. Community mobilization and norms change.
- Psychosocial support, support groups and disclosure for caregivers with young children and mentoring.
- Targeted HES for caregivers and linking them to social protection programs and existing resources.
- Case plan development/refinement and monitoring outcomes towards achievement, graduation and transition benchmarks.

Communities, Local Implementing Partners and County and National Government

- Strengthening child protection information management systems, and child –focused committees

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- Coordinating and networking to facilitate graduation and transition processes.
- Support the local implementing partners to actively participate in the GOK budget planning cycle.
- Strengthen case management and outcomes monitoring of children, adolescents and families through use of the benchmarks/case plan achievement for OVC programming in Kenya
- Capacity building of GOK and local implementing partner partners to improve routine data collection, analysis, use and management.
- Engaging county structures for OVC service delivery including quality improvement teams, child protection reporting and response, case conferencing e.g. Area Advisory and Locational Advisory councils (AACs and LAAC).

4.8 Viral Load and Early Infant Diagnosis Optimization

- Strategies for TB/HIV integration and optimization of existing POC and conventional instrument capacities; this remains an MoH and non-PEPFAR partner activities. PEFAR will continue to provide TA to ensure appropriate placements and prevent duplication of efforts.
- Projected new sites or geographic areas in FY20 for EID and VL among PBFW only; Based on the current "maintenance mode" for the PEPFAR lab program, the lab program shall not venture into new sites or testing labs ,but instead strengthen and optimizes resource utilization for the already existing sites .
- Funds allocated in the FAST; (including commodity procurement, trainings or TA
- Transition arrangements for existing POC platforms owned by other stakeholders and located within PEPFAR supported sites

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

5.1 COP 19 Programmatic Priorities

Treatment-Pediatrics

In evolve counties, HIV active case surveillance using public health approach, targeted testing using a screening tools will be used at OPD, diagnostic testing and counseling will be done for symptomatic children and adolescent. Focused testing for children of PLHIV will be optimized. Assisted partner notification services will be done for adolescents. In scale up and reboot counties, PITC, index testing, PNS will be optimized to increase case identification and close the ART unmet gap in these counties.

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In evolve, scale up and reboot counties, a standard package for facilitated linkage, caregiver and adolescent treatment literacy, disclosure, psychosocial support, enhanced appointment and defaulter tracking systems will be implemented. There will be enhanced efforts to link and retain in care both new and existing patients on ART.

TB

Tuberculosis remains the leading cause of death among people living with HIV. The package of activities are similar in all counties. MoH systems will be strengthened to ensure that the gains made through PEPFAR investment in implementation of collaborative TBHIV activities are sustained in evolve counties.

5.2 Targets for attained and sustained locations and populations

Standard Table 5.2.1: Expected Beneficiary Volume Receiving Minimum Package of Services in Evolve Counties

Table 5.2.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Evolve Counties			
Attained Support Volume by Group		**Expected result APR 19**	**Expected result APR 20**
HIV testing (all populations)	*HTS_TST*	***4,600,138***	**2,941,801**
HIV positives (all populations)	*HTS_TST_POS*	***108,183***	**92,746**
Treatment new	*TX_NEW*	***105,315***	**87,450**
Current on ART	*TX_CURR*	***825,292***	**861,337**
OVC	*OVC_SERV*	***552,081***	**420,674**
Key populations	*KP_PREV*	***180,220***	**166,296**

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

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Standard Table 5.2.2: Expected Beneficiary Volume Receiving Minimum Package of Services in Reboot Counties

Table 5.2.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Reboot Counties			
Reboot Counties Volume by Group		**Expected result APR 19**	**Expected result APR 20**
HIV testing in PMTCT sites	*PMTCT_STAT*	**357,335**	**364,809**
HTS (only sustained ART sites in FY18)	*HTS_TST*	**1,810,804**	**1,231,972**
	HTS_TST_POS	**42,903**	**33,983**
Current on ART	*TX_CURR*	**234,519**	**255,540**
OVC	*OVC_SERV*	**153,159**	**145,836**

5.3 Establishing service packages to meet targets in evolve, scale, re-boot and transition counties

HIV Testing Services

Prioritized activities for Evolved SNUs

PEPFAR will continue to support HIV case finding activities in Evolved SNUs. These activities will include HIV active case surveillance using Public Health approach; Scale up Index case testing as the primary testing modality, Social Network Testing, Symptom based testing (DTC) in health facilities and VCT. Additionally, scale up of HIVST using both facility and community based distribution channels and enhanced FBO initiatives that include active community engagement. Recency testing, Scale up of e-HTS and Capacity Building to County Governments on sustainability and transition plans will also be prioritized. These activities will be supported to enable attaining the overall goal of Public health approach and Investments towards sustainability.

Prioritized activities for Scale SNUs

PEPFAR's support towards HIV case finding in scale SNUs will involve appropriate messaging that includes demand creation for uptake of HTS to close first 95 (identification) gaps, aggressively scale Index Case testing with fidelity, Social Network Testing. In addition, scale up of HIVST using both facility and community based distribution channels and enhanced FBO initiatives that includes active community engagement will be prioritized. Other activities include targeted HTS eligibility criteria such as testing of patients with presumptive TB, enhanced risk to HIV assessment. Immediate linkage of >95% of all New Positives through utilization of high impact linkage interventions like use of linkage officer, tracking register, locator forms, call back systems and retrospective tracking of unlinked clients as well as peer

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escort systems and case management strategy. PEPFAR in collaboration with stakeholders will also Scale up e-HTS in these SNUs. These activities will be supported to enable attaining the overall goal of targeted case finding to close 1st 95 gaps.

Prioritized activities for Reboot SNUs

PEPFAR's HIV case finding support in reboot SNUs will include mapping out epidemic hot spots to inform targeted case finding, appropriate messaging for demand creation for uptake of HIV testing Services by those at high risk of HIV acquisition, integrated HTS eligibility/TB screening and risk driven testing through an elaborate eligibility screening process using tools and VCT. Other activities will include continued and intense mentorship of HCW towards aggressively scaling to fidelity of Index Case Testing, immediate linkage of >95% of all New Positives as well as testing of ALL women with unknown status at 1st ANC visit and subsequent visits for those opting out at 1st ANC visit. Prioritize scaling up of HIVST using both facility and community based distribution channels and enhanced FBO initiatives that includes active community engagement as well as up e-HTS. These activities will be prioritized towards attaining the overall goal of aggressive case finding to close 1st 95 gaps.

N/B: There will be no PEPFAR support/presence in transition SNUs.

Treatment

Evolve counties are twelve, accounting for 80% of PLHIV in Kenya, and with a high ART coverage of >78%. There will be renewed focus of differentiating clinical care to these cohorts in these counties. This will be done by classifying PLHIV according to both frequency and type of service. Patients will be classified as having advanced disease or well (within the first year of ART) and stable and unstable (beyond the first year of ART). Those on ART beyond 1 year will be eligible for multi-month scripting with up to 6 month clinical appointments to provide better patient centered care, de-congest health facilities and improve retention. The goal is to ensure all stable patients are in a form of differentiated service delivery model. Retention will be a critical focus in these counties and will be strengthened by 1) Support documentation and patient literacy on facility transfer 2) Support Robust Treatment Preparation 3) Supporting Psychosocial Support through peer engagement 4) Supporting Defaulter Tracking using mobile technologies such as the Ushauri system 5) Continued Tracking of TX-CURR net growth 6) Full Scale Up of Differentiated Service Delivery for adults and adolescents and 7) Monthly Monitoring of Retention. Special focus will be on Bomet, Kericho and Bungoma counties which have had challenges with retention especially among young men. In these counties, Mentorship, technical Assistance and Supervision will be done differently by merging TA teams such that supporting teams may cover more geography as well as more program areas for efficiencies. In addition, clinical case management will be made efficient and effective by utilizing video conferencing platforms such as ECHO which have already proven to be successful (The 2018 ART guidelines were disseminated using this platform).

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In addition to these priority areas, there will be a minimum package of services that will initiate and maintain cohorts on treatment to ensure they have durable viral load suppression. The minimum package of services will include 9 clinical components in line with the 2018 ART guidelines. Namely; a) Antiretroviral Therapy: All PLHIV are eligible for ART irrespective of CD_4 cell count or percentage, WHO clinical stage, age, pregnancy status, or comorbidities and that ART should be initiated as soon as the patient is ready to start, preferably same day (except for patients with Cryptococcal meningitis or TB meningitis. The program will endeavor to optimize all their treatment regimens to have most adults on a backbone of Dolutegravir. It will also include regular viral load monitoring according to the guidelines) b)Positive Health, Dignity, and Prevention, GBV/IPV & Health Education and Counseling: All patients should be counseled and supported for disclosure of HIV status; partner/ family testing and engagement; condom use; family planning; sexually transmitted infections screening; and treatment adherence services. All females aged 15-49 years and emancipated minors accessing HIV care services should be screened for Intimate Partner Violence (IPV) as part of the standard package of care. Important is that all PLHIV should be provided with adequate treatment literacy. c) Screening for and Prevention of Specific Opportunistic Infections. d) All PLHIV should be screened for TB at every visit using the Intensified Case Finding (ICF) tool and assessed for Isoniazid Preventive Therapy (IPT) if screened negative for TB e) Reproductive Health Services: All PLHIV should be screened for STI at every clinic visit including ascertainment of pregnancy status should be determined for all women of reproductive age at every visit and their contraception need determined and met. F) Screening for and Management of Non-Communicable Diseases g) Mental Health Screening and Management. h) Nutrition Services: All PLHIV should receive nutritional assessment, counseling, and support tailored to the individual needs of the patients. All infants irrespective of HIV status should be exclusively breastfed for the first 6 months of life, with timely introduction of appropriate complementary foods after 6 months, and continued breastfeeding up to 24 months or beyond. i) Prevention of Other Infections: PLHIV (including children) should receive vaccinations as recommended by the National Vaccines and Immunization Programme.

Scale counties are twenty-one counties with medium ART coverage, ranging from ≥50% to <78. There will be focus in ensuring cohorts started and maintained on treatment are retained on treatment through similar strategies of retention as highlighted in the evolve counties: 1) Support documentation and patient literacy on facility transfer 2) Support Robust Treatment Preparation 3) Supporting Psychosocial Support through peer engagement 4) Supporting Defaulter Tracking using mobile technologies such as the Ushauri system 5) Continued Tracking of TX-CURR net growth 6) Full Scale Up of Differentiated Service Delivery for adults and adolescents and 7) Monthly Monitoring of Retention. These counties will still utilize efficient strategies to ensure optimal case management of patients such as the ECHO platform, which

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have already proven to be successful. This counties will still have the minimum requirements to initiate and maintain cohorts on treatment: a) Antiretroviral Therapy using optimized regimens that have a Dolutegravir backbone b) Positive Health, Dignity, and Prevention, GBV/IPV & Health Education and Counseling c) Screening for and Prevention of Specific Opportunistic Infections. d) All PLHIV should be screened for TB at every visit using the Intensified Case Finding (ICF) tool and assessed for Isoniazid Preventive Therapy (IPT) if screened negative for TB e) Reproductive Health Services F) Screening for and Management of Non-Communicable Diseases g) Mental Health Screening and Management. h) Nutrition Services i) Prevention of Other Infections.

Reboot counties are seven counties will low ART coverage of <50%. These counties will focus on ensuring that patients get the minimum package of services with utmost fidelity: a) Antiretroviral Therapy using optimized regimens that have a Dolutegravir backbone b) Positive Health, Dignity, and Prevention, GBV/IPV & Health Education and Counseling c) Screening for and Prevention of Specific Opportunistic Infections. d) All PLHIV should be screened for TB at every visit using the Intensified Case Finding (ICF) tool and assessed for Isoniazid Preventive Therapy (IPT) if screened negative for TB e) Reproductive Health Services F) Screening for and Management of Non-Communicable Diseases g) Mental Health Screening and Management. h) Nutrition Services i) Prevention of Other Infections. Retention through proven strategies as detailed in the Evolve and scale counties will be prioritized. Robust Viral Load monitoring to ensure all PLHIV have durable Viral Load suppression will be prioritized. This will include Improvements in patient and care giver literacy on medication adherence, treatment optimization with efficacious regimens: TLD Scale Up, Nevirapine transition in children, improvements in the Lab-Clinical Interface, Viral Load Utilization cascade through CQI, viremia Clinics: Dedicated Clinics for patients with VL>400copies/ml for psychosocial support and adherence and OTZ Scale up: Asset Based program dedicated to empower AYP to own their treatment

Transition counties are 7 counties, with low unmet need of <3,000. Except Wajir (with an ART coverage of 106%), the other six counties have a low ART coverage of <50%. These counties were transitioned to GoK in FY18. In COP19, these counties will not receive any direct PEPFAR support, except commodities that will be supported through the centralized national supply chain system.

Preventing Mother-to-Child Transmission (PMTCT)

As a lead technical partner to the Ministry of Health (MoH) at both national and county government, PEPFAR Kenya will continue to provide technical support and direct PMTCT service delivery through implementing partners (IPs). In FY 20, the direct service delivery support will be restructured to focus on high burdened locations and high-risk sub populations

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of PBFW using appropriate combination of interventions in the right scale to achieve MER targets and eMTCT.

To realign the program and achieve COP19 (FY20) targets, PEPFAR will provide differential support and package of services based on SNU needs. Counties have been categorized into four clusters as Reboot, Scale, Evolve and Transition, based on HIV Burden, ART coverage and unmet need. Further to county categorization, focus and support to health facilities will be guided by site volume, HIV burden and degree of unmet treatment need. In FY 18, Kenya achieved 85% of PMTCT STAT and 89% of PMTCT ART targets compared to FY17 achievement of 69% and 66% for the same indicators respectively. PEPFAR FY18 performance was similar with national MoH performance. Of those attending first ANC, 99% knew their HIV status while 98% of those identified HIV positive initiated ART. The EID coverage improved due to enhance post-natal HIV retesting and HEI identification at immunization clinics. Of the 60,763 tests, 67% (41,015/60,763*) were tested at age < 2 months while 33% (19,948/60,763) were tested between 2-12 months. Total of 1,715 (2.8%) were identified PCR positive and 87% linked to treatment.
**The program began reporting on the correct denominator in FY19, based on MER Indicator Reference Guide (Version 2.3 FY19.

For COP 19 (FY20) planning process, FY18 achievements, projected FY 19 performance and background of partner performance and local demographic context was used to generate PEPFAR targets by SNU and IP. The following data sources were used to determine PMTCT targets: MoH data alignment reports, DATIM results, first ANC, OPV1 immunization coverage. Using these sources, it was estimated that 90% (1,232,277) of pregnant women would seek services at PEPFAR-supported sites out of which 95% (1,170,669) would receive an HIV test or know their HIV status. Evolved counties account for 50% (578,692) of PMTCT stat (N) targets while the Reboot and Scale up counties account for 31% (364,809) and 19% (224,998) respectively. There are no targets for the transitioned counties. The PMTCT STAT POS targets are generated from national EPP Spectrum that estimates PMTCT need at 69,497. In FY 20, PEPFAR will target 87% (60,702) of the national PMTCT need in its supported sites and 95% (57,691) ART uptake of women in the supported counties.

EID coverage will be a priority in COP19, with an increased focus on early testing of HIV exposed infants within 2 months through enhanced retention, post ANC 1 retesting and referral and HEI screening at immunization. At least 95 % (57,666) of expected HEIs will targeted for infant virologic test, of whom 90% (51,598) receiving the test at age < 2months. An estimated 1,076 positive infants will be identified and linked to treatment. To align to expanding universal health care and Linda mama initiatives, Kenya hopes to improve on PMTCT indicators in all the 40 SNUs. HIV testing at ANC and post-natal period as per the MoH guidelines will be optimized

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including routine HEI screening at immunization clinics, outpatient and pediatric wards with referrals for both mother-infant pairs for same day ART initiation.

Other services provided will include psychosocial support for disclosure and adherence, optimized retention and tracking of mothers-infant pairs, comprehensive clinical care monitoring of HIV-infected pregnant and breast feeding women and finally referral to community-based services on a needs basis. In the high and medium volume sites, high-risk clients (High Viremia, treatment decliners/defaulters, newly diagnosed positives, AGYW) and stable post ANC clients, will be categorized and streamed through a differentiated care model. Peer support groups and empowerment meetings for pregnant adolescent girls and young women and referrals to OVC and DREAMS programs where possible will be carried out. In-depth review and impact of pregnant and breast feeding adolescent and young women to eMTCT will be evaluated and targeted interventions developed through national and county coordinated multisectoral and multidisciplinary approaches.

Pregnancy intention assessment and support including family planning (FP) services will be enhanced within ART clinics to reduce the unmet need for FP among HIV-infected women of reproductive age. Additional services will include male involvement strategies such as index case testing, provision of HIV self-testing kits, referral of negative male partners and infant males for VMMC, discordant couple counseling and risk reduction support, including PrEP for HIV-negative sex partner.

All HIV exposed infants will be longitudinally follow up as a cohort until status determined. Site level processes and outcomes that include client characterization and bottleneck analysis for sites recording high PCR positives will be fast tracked and additional mentorship support offered in collaboration with county government

The Kenya Mentor Mother roles will be supported to enhance uptake, retention and adherence to PMTCT interventions. Finally, the enhanced operationalization of eMTCT framework and guidelines including the roll out of revised M&E tools will remain a priority. In the evolved counties, (in addition to the basic package) LIPs in collaboration with the county governments will review and improve eMTCT and AIDS strategic frameworks, business plans, stakeholder matrix, and sustainability index monitoring. Activities will include transition of KMMP to county, reduced TA oversight and mentorship by LIP, strengthened county system to carry out supervision and data management including county led DQA. In these counties LIPs will initiate the transition of HRH staff from medium volume facilities to county.

In addition to the basic PMTCT package of services the scale counties will targeted to increase their coverage of PMTCT interventions to reach level of evolving counties. The frequency of TA

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by both MoH and LIP to sites accounting for 80% of numbers/targets will be increased and data of key indicators monitored on a monthly basis. The staff in high and medium volume facilities will be sustained.

Partner monitoring in the reboot counties will be enhanced through frequent visits by respective agencies. Surge like activities aimed at improving coverage will be carried out and bi- weekly monitoring of key PMTCT indicators done. HRH staff (both peer educators and clinical staff) will be reorganized to ensure HIV service points are optimally covered. There will be enhanced collaboration with other stakeholders for community identification and referral of PBFW. The basic package of services will be provided.

Transitioned counties will be directly under the county MoH as PEPFAR supports through central process including KEMSA for ART and RTK commodities, VL and EID samples through a national lab network. Technical support and monitoring through national DQAs and TWG review meetings will be carried out by the County.

Laboratory Services

PEPFAR continues to support essential lab services for PLHIV in evolved, scaled and reboot counties through a nationally coordinated lab network that assures access to core HIV and TB diagnostic and monitoring tests. The regional laboratory implementing partners will engage with the county lab leadership through the lead county clinical implementing partners to coordinate laboratory activities such as enrolling HIV testers in the National HV Proficiency Testing (PT) program, enrolling laboratories performing TB/HIV related tests to the nationally coordinated EQA program and following up on corrective interventions. High volume testing sites will continue implementing the HIV rapid testing continuous quality improvement (RT-CQI) initiative to ensure accurate HIV testing in achievement of the first 95. Support for continuous quality improvement activities in high performing sites will be transitioned to county MoH with the focus retained for high volume ART sites with weak quality systems. The established national sample referral network will ensure access to EID, VL and other TB/HIV related tests within acceptable turnaround time. 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.

Strategic Information

PEPFAR will continue to support strategic information initiatives in all priority counties towards generating and using high quality strategic information that will inform scaling with fidelity and refinement of working strategies towards achievement and sustaining epidemic control.

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All county typologies will be supported to conduct continuous data quality assessment and improvement initiatives towards timely, correct and consistent reporting to MoH (DHIS2) and PEPFAR (DATIM) systems that will help us move towards data alignment and hence sustainability of information systems.

Electronic health records including mhealth applications will also play a key role towards meeting the dynamic and evolving program and data needs of the HIV program as we move closer towards epidemic control, it shall be expected that all high volume facilities will adopt and consistently use electronic systems. We will continue working with counties to move towards better ownership and support of these systems for sustainability.

All priority counties will also be expected to implement key surveillance activities such as case based surveillance, recency testing for all newly diagnosed positives and mortality surveillance to aid in tracking the course of the epidemic and hence inform prompt program response.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Addressing epidemic control and achieving a steady state

In COP19, Kenya prioritized system investments to ensure accelerated progress towards epidemic control and achievement of the program's goals and sustainability move towards a steady state particularly at county level. The system investments focus both at national and county levels aligning to the new county-led model and prioritization as Kenya approaches epidemic control and the required tools to sustain it. Investment over the years has borne results and certain program areas have made progress, e.g. the laboratory program has led to universal viral load coverage. Subsequently, above-site investments have reduced over time from over 7% in COP17, 6.2% in COP18 and 5% in COP 19.

PEPFAR Kenya identified key gaps, 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) information systems; ii) assessments, evaluation, operation research; iii) laboratory systems; iv) policy and governance; v) human resources management; vi) supply chain management; and vii) domestic resource mobilization.

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

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strengthening of data quality and utilization and enhancement of the human resources information system (HRIS) utilization for workforce planning, rationalization and right sizing. Combined, these interventions will strengthen national information systems to 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. These efforts are geared towards eventual transition of interventions from PEPFAR to GoK and private sector support. *Assessments, evaluation, operations research* will establish national and particularly county level surveillance systems, building capacity to analyze epidemiological trends and disease burden, and increase use and triangulation of assessments and operations research data to improve programmatic management and decision-making.

The laboratory strengthening approaches include support the National Public Health Laboratory's integrated EQA program to ensure enrollment and participation into EQA program for PEPFAR supported tests including maintenance of database and provision of the EQA materials. PEPFAR support is on transition from three cycles annually in COP 18, two cycles in COP 19 and one cycle in COP 20. Lab support will be coordinated through the lead clinical partner to engage county lab leadership in enrolling HTS testers for PT/EQA and register Gene-Xpert labs into EQA, monitor performance and conduct corrective action for unsatisfactory results to ensure accurate HIV and TB tests in addition to implementing laboratory continuous quality improvement at high volume facilities. PEPFAR provided 100% support in COP18, but will reduce to 25% in COP19 and 15% in COP20 before full transition to MoH. Other programs to be supported on transition basis in COP19 are the equipment management program and the laboratory commodity management. One to three year transition plans have been laid out for this process and support will be integrated within the broader county health systems to increase sustainability.

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 concentrate on county level HRH units to ensure a rationalized and right sized workforce that is efficiently utilized for HIV at

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community and facility levels, health workforce mentorship and skills enhancement through innovative approaches that are cheaper and closer to the health worker service delivery point to ensure quality of service providers, and HRH data system support for decision making and budgeting for a rationalized and right sized workforce based on epidemic control needs. The workforce unrests and labor disputes have made it necessary to support regularized engagements between MoH, Council of Governors, County Health Management teams and health worker leadership for closer and continuous dialogues to minimize disruptions in service delivery and target achievement for epidemic control.

Strengthening technical leadership and coordination for commodity management at both the national and county levels 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 nine 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.

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 COP18 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. Activities related to systems support for transition and sustainability that were not in COP18 Table 6 were included. 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 and supply chain (6.39); laboratory service (6.67) and HRH (6.55). The SID elements of *policy and governance* (8.50) appear to be sustained but require ongoing investment based on emerging/ongoing needs: there is always a need for new/revised policies and technical area guidelines based on emerging evidence e.g. on HTS approaches, TB preventive therapy.

6.3 Leveraging Host Country and Other Donors

In COP19 planning, there was extensive stakeholder engagement and consultation with MoH, GF and other donors including the private sector. PEPFAR support will complement the already

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available support for critical areas such as policy and governance, institutional capacity building, and harmonization of different information systems. More responsibilities on systems support has been transitioned to MoH including blood safety and commodity support at national and county levels.

6.4 Outcomes and Benchmarks

COP19 Table 6 has clearly defined outcomes and annual benchmarks to monitor progress. Previous COP18 benchmarks and COP19 baselines have been described for each activity, and benchmarks are specific, measurable, achievable, relevant and time bound spanning anywhere from one to three years. Most benchmarks are incremental and thus easier to measure. Progress will be monitored biannually in Quarters 2 and 4 and will form part of the POART calls. Transition plans have been put in place for activities ending in COP 19-COP21, showing the roles of MoH at national and counties levels or other entities in assuming the support.

Table 6-E tab of the Excel workbook in Appendix C

SRE-Tool E worksheet in Appendix C

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7.0 Staffing Plan

DOD

PEPFAR-Kenya is committed to epidemic control, moving swiftly towards a county-led model and indigenous partners in assuming greater role of monitoring performance, technical assistance and mentorship and supportive supervision of facilities in maintaining high quality HIV service delivery. This is reflected in the COP19 interagency staffing patterns and level of effort (LOE) by program area and administration support.

The PEPFAR interagency discussed emerging and vacant positions to determine relevance for the each agency and entire country portfolio given the dramatic shifts in COP19. As such, USAID added 28 new positions. The number (full time equivalents) of PEPFAR Kenya staff and percent of time allocated remain aligned to the interventions described herein and maintain coverage for SIMS, business processes and intra-agency partner management.

Long-term Vacant Positions: All agencies reviewed vacant positions and updated those position descriptions to facilitate the re-advertisement of the positions to meet the needs in COP19. This includes agencies utilizing standardized job descriptions and other pre-classified position descriptions to expedite the placement and hiring of new staff. However, the biggest challenge in filling positions is the approval process timeline which often creates lengthy delays up to 12 to 15 months. For example, in COP17, DoD repurposed four local hire positions to improve oversight of program and fiscal management of PEPFAR partners. These positions were only classified in mid-COP18 and are awaiting final U.S. Embassy Human Resources (HR) approval to be advertised.

USAID

PEPFAR-Kenya is committed to epidemic control, moving swiftly towards a county-led model and indigenous partners assuming greater role in direct service delivery, monitoring performance, supportive supervision, and technical assistance and mentorship of facilities to maintain high quality HIV service delivery practice. This is reflected in the COP19 interagency staffing patterns and level of effort (LOE) by program area and administration support.

The PEPFAR interagency discussed emerging and vacant positions to determine relevance for the each agency and entire country portfolio given the dramatic shifts in COP19. As such, USAID 28 new positions. The number (full time equivalents) of PEPFAR Kenya staff and percent of time allocated remain aligned to the interventions described herein and maintain coverage for SIMS, business processes and intra-agency partner management.

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includes agencies utilizing standardized job descriptions and other pre-classified position descriptions to expedite the placement and hiring of new staff. However, the biggest challenge in filling positions is the approval process timeline which often creates lengthy delays up to 12 to 15 months. For example, in COP17, DoD repurposed four local hire positions to improve oversight of program and fiscal management of PEPFAR partners. These positions were only classified in mid-COP18 and are awaiting final U.S. Embassy Human Resources (HR) approval to be advertised.

Costs of Doing Business (CODB) is increasing for USAID in COP19 with the mandate to increase the amount of funding channeled through local implementing partners while reducing funding to international partners. USAID will beginning from COP 18 close some if it's international mechanisms and put out new solicitations seeking local and indigenous partners. By end of COP 19, USAID should have 70% of its funding flowing through local partners. With a significant increase in PEPFAR Kenya resources being provided directly to local entities in COP19, USAID/Kenya also must provide greater accountability for USG resources through fiduciary monitoring. Additional oversight is required to manage the significant challenges of the Kenya context regarding corruption and fraud both within and outside of the public sector. A more labor-intensive approach is also required for increased oversight and management of USAID/Kenya contractors and grantees to ensure that programs operate more efficiently and cost-effectively and that they meet PEPFAR targets. A critical component of this approach is more frequent monitoring, reporting and analyzing of results to make course adjustments and adapt program approaches. USAID/Kenya has also been unable to fulfill its Site Improvement through Monitoring System (SIMS) requirements, which significantly increase the demand for USG staff time dedicated to field visits. Hiring additional staff will provide support for a robust and intensive monitoring.

In COP 19, USAID will hire additional 28 new positions. An increase in USAID staff dedicated to PEPFAR will also bring USAID into balance with other PEPFAR implementing agencies at the U.S. Embassy to Kenya. USAID/Kenya business model also is changing to one of more direct staff engagement in managing development relationships with local governments and counties. In COP 19 USAID will work in 28 of the 47 counties and as lead agency in 22. This direct engagement with the GOU is aimed at strengthening and building the capacity of public institutions and building partnerships to leverage resources.

The twenty (28) positions above the COP 19 planning level include sixteen (16) Public Health Specialists positions that will serve in partner management roles and spend approximately 60% of their time outside of the U.S. Embassy on monitoring and supportive supervision visits to Local Partners and local governments, particularly county governments. The additional staffing will lead administration, finance, and operational support activities along with partner

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management and will spend approximately of their time monitoring activities in the field. USAID's vision is to increase in-house USAID staff capacity to reduce reliance on international partner staff as we transition to Local Partners. This will also enable USAID to make more effective use of U.S. taxpayer resources, as USAID will no longer have to pay international partners' overhead rates for "indirect costs."

With existing staff levels, both corruption and management capacity are significant potential risks as USAID expands its engagement with Local Partners as part of the Journey to Self-Reliance. Poor internal control is widespread in Kenya, and the hundreds of millions of U.S. taxpayer funds in commodities and other resources that are made available by USAID represent a ripe target for those who would seek to enrich themselves at the expense of Kenyans needing treatment and prevention services. Awarding a greater number of mechanisms to local organizations will increase the management and operational requirements of the mission. Current USAID staffing is inadequate to effectively and safely perform priority Mission goals and objectives.

USAID currently has 5 long-term vacant positions but these have been reviewed and job descriptions updated to meet the evolving needs of the office. Another 6 vacant positions are currently in recruitment process.

CDC

CDC Kenya has decreased its staffing by 8.1 FTEs or 10 positions from COP18 to COP19. The positions covered TB, epidemiologist, laboratory, public health specialists, and administrative functions. Over the course of the last year, the positions became vacant or were not possible to progress through the U.S. Embassy classification system. Thus, strategically, CDC decided to pause any new hires while we awaited COP19 strategic direction and budget, anticipating a downward trajectory in funding. Given the direction of the COP and a declining budget environment, CDC Kenya has decided not to rehire some of these positions and has terminated two NSDD-38 USDH positions. We intend to conduct a full human resources review and restructure existing positions to align to the COP19 priorities such as enhanced site level technical assistance, county engagement and establishment of county MOUs and transition plans – with a focus on human resources for health, and readiness toward direct G2G funding through CDC Cooperative Agreements. Existing vacancies (9) will be reviewed and all new hires will be aligned to the COP19 priorities.

PEPFAR STATE

No changes in State positions

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Proposed New Positions

DOD proposes no new positions in COP19, planning to have the LES positions filled.
CDC proposes no new positions.
USAID: done see above

In COP18, the Peace Corps Kenya program went to full suspension status, which will continue in COP19. Peace Corps will not receive funds in COP19. DoD CODB remains unchanged from COP18. CDC CODB remains the same as COP18. Despite a decrease in staff, CDC CODB remains the same as COP18 due to increases in salaries, rent, and PCS (incoming/outgoing staff).

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Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

County	COP	Prioritization	APR Results Projected	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	COP15	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%
Nairobi county	COP19	EVOLVE	193,173	65%	144%	106%	93%	106%	101%
Homa Bay	COP15	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%
Homa Bay	COP19	EVOLVE	122,268	89%	92%	100%	99%	73%	85%

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County	COP	Prioritization	APR Results Projected	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
Kisumu	COP15	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%
Kisumu	COP19	EVOLVE	121,375	77%	112%	92%	83%	66%	76%
Siaya	COP15	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%
Siaya	COP19	EVOLVE	96,787	81%	113%	112%	99%	72%	87%
Migori	COP15	ScaleUp Sat	59,912	107%			57%	122%	72%
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%
Migori	COP19	EVOLVE	81,693	78%	69%	92%	96%	73%	82%
Kiambu	COP15	ScaleUp Agg	31,885	82%			60%	44%	45%

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County	COP	Prioritization	APR Results Projected	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
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%
Kiambu	COP19	REBOOT	47,173	54%	68%	90%	64%	103%	85%
Mombasa	COP15	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%
Mombasa	COP19	EVOLVE	48,611	97%	243%	172%	97%	91%	105%
Kakamega	COP15	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%
Kakamega	COP19	EVOLVE	43,992	68%	80%	114%	87%	94%	90%
Nakuru	COP15	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%

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County	COP	Prioritization	APR Results Projected	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
Nakuru	COP18	ScaleUp Sat	41,217	90%	81%	81%	81%	121%	100%
Nakuru	COP19	REBOOT	46,328	72%	64%	91%	74%	75%	75%
Busia	COP15	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%
Busia	COP19	SCALE	36,154	79%	61%	94%	98%	101%	95%
Kisii	COP15	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%
Kisii	COP18	ScaleUp Sat	31,633	113%	43%	55%	76%	130%	93%
Kisii	COP19	REBOOT	36,018	65%	54%	64%	78%	71%	71%
Machakos	COP15	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%
Machakos	COP19	SCALE	27,981	98%	94%	141%	70%	89%	88%
Kilifi	COP15	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%

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County	COP	Prioritization	APR Results Projected	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
Kilifi	COP19	REBOOT	29,981	107%	128%	97%	61%	71%	75%
Bungoma	COP15	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%
Bungoma	COP19	EVOLVE	24,887	89%	63%	121%	96%	106%	100%
Makueni	COP15	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%
Makueni	COP19	SCALE	20,275	97%	80%	120%	59%	74%	75%
Kitui	COP15	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%
Kitui	COP19	SCALE	23,657	95%	77%	119%	59%	75%	75%
Murang'a	COP15	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%

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County	COP	Prioritization	APR Results Projected	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
Murang'a	COP19	SCALE	22,909	40%	64%	84%	56%	91%	75%
Uasin Gishu	COP15	ScaleUp Sat	27,444	81%			100%	142%	103%
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%
Uasin Gishu	COP19	SCALE	33,907	66%	73%	91%	87%	82%	82%
Trans Nzoia	COP15	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%
Trans Nzoia	COP19	REBOOT	20,330	80%	57%	82%	67%	70%	70%
Meru	COP15	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%
Meru	COP19	SCALE	22,296	81%	81%	125%	80%	77%	82%

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County	COP	Prioritization	APR Results Projected	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
Nyamira	COP15	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%
Nyamira	COP19	SCALE	16,897	80%	109%	98%	86%	59%	75%
Kwale	COP15	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%
Kwale	COP19	REBOOT	13,610	115%	84%	102%	57%	75%	75%
Turkana	COP15	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%
Turkana	COP19	REBOOT	15,984	84%	130%	83%	61%	70%	72%
Kajiado	COP15	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%
Kajiado	COP18	ScaleUp Agg	15,100	58%	62%	62%	62%	90%	75%
Kajiado	COP19	REBOOT	17,448	65%	65%	93%	76%	74%	75%
Vihiga	COP15	Sustained	12,685	87%			60%	83%	65%

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County	COP	Prioritization	APR Results Projected	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
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%
Vihiga	COP19	SCALE	16,562	69%	61%	84%	80%	92%	84%
Nyeri	COP15	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%
Nyeri	COP19	EVOLVE	17,507	89%	98%	63%	86%	95%	90%
Kericho	COP15	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%
Kericho	COP19	EVOLVE	18,207	89%	217%	134%	87%	85%	95%
Narok	COP15	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%
Narok	COP19	REBOOT	13,295	82%	57%	80%	65%	70%	70%
Nyandarua	COP15	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%

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County	COP	Prioritization	APR Results Projected	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
Nyandarua	COP18	ScaleUp Sat	11,478	181%	69%	69%	69%	95%	90%
Nyandarua	COP19	SCALE	12,807	67%	55%	72%	50%	93%	75%
Kirinyaga	COP15	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%
Kirinyaga	COP19	SCALE	11,571	59%	60%	80%	64%	100%	83%
Taita Taveta	COP15	Sustained	4,955	42%			55%	52%	42%
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%
Taita Taveta	COP19	REBOOT	9,000	88%	86%	58%	72%	77%	75%
Nandi	COP15	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%
Nandi	COP19	SCALE	13,418	77%	101%	76%	70%	87%	81%
Bomet	COP15	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%

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County	COP	Prioritization	APR Results Projected	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
Bomet	COP19	EVOLVE	10,597	91%	89%	126%	101%	98%	100%
Embu	COP15	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%
Embu	COP19	EVOLVE	9,965	84%	100%	153%	81%	86%	90%
Tharaka Nithi	COP15	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%
Tharaka Nithi	COP19	SCALE	7,853	64%	89%	134%	79%	77%	81%
Laikipia	COP15	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%
Laikipia	COP19	SCALE	9,764	124%	86%	83%	77%	75%	81%
Baringo	COP15	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%

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County	COP	Prioritization	APR Results Projected	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
Baringo	COP18	Sustained	3,855	75%	53%	53%	53%	83%	69%
Baringo	COP19	SCALE	5,156	107%	61%	85%	69%	74%	75%
West Pokot	COP15	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%
West Pokot	COP19	REBOOT	4,220	64%	165%	151%	73%	59%	75%
Elgeyo Marakwet	COP15	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%
Elgeyo Marakwet	COP19	SCALE	3,639	81%	66%	94%	76%	71%	75%
Isiolo	COP15	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%
Isiolo	COP19	GOK/TRANSITION	-	0%	0%	0%	0%	0%	0%
Mandera	COP15	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%

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County	COP	Prioritization	APR Results Projected	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
Mandera	COP18	Sustained Com	542	50%	46%	12%	7%	7%	16%
Mandera	COP19	GOK/TRANSITION	-	0%	0%	0%	0%	0%	0%
Samburu	COP15	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%
Samburu	COP19	REBOOT	2,153	78%	131%	263%	73%	45%	74%
Marsabit	COP15	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%
Marsabit	COP19	GOK/TRANSITION	-	0%	0%	0%	0%	0%	0%
Tana River	COP15	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%
Tana River	COP19	GOK/TRANSITION	-	0%	0%	0%	0%	0%	0%
Garissa	COP15	Sustained Com	1,087	17%			100%	53%	43%
Garissa	COP16	Sustained Com	1,158	13%	113%	94%	66%	31%	46%
Garissa	COP17	Sustained Com	1,223	16%	115%	100%	68%	33%	48%
Garissa	COP18	Sustained Com	1,333	50%	82%	68%	47%	48%	53%
Garissa	COP19	GOK/TRANSITION	-	0%	0%	0%	0%	0%	0%
Lamu	COP15	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%

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County	COP	Prioritization	APR Results Projected	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
Lamu	COP19	GOK/TRANSITION	-	0%	0%	0%	0%	0%	0%
Wajir	COP15	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%
Wajir	COP19	GOK/TRANSITION	-	0%	0%	0%	0%	0%	0%

A.2 ART Targets by prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected Current on ART (FY19 APR)	Additional Patients Required for 80% Coverage	Target Current on ART APRFY20 TX CURR	Newly Initiated APR FY20 TX New	ART Coverage APR20
Evolve	976,848	825,292	0	861,337	87,203	88%
Scale	241,412	199,561	0	212,571	26,941	88%
Reboot	352,065	234,519	47,133	255,540	32,789	73%
Central Support/Transition	17,548	9,196	4,843			
Grand Total	1,587,873	1,268,568	1,730	1,329,448	146,933	84%

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B1. COP 19 Planned Spending

Table B.1.1 COP19 Budget by Program Area

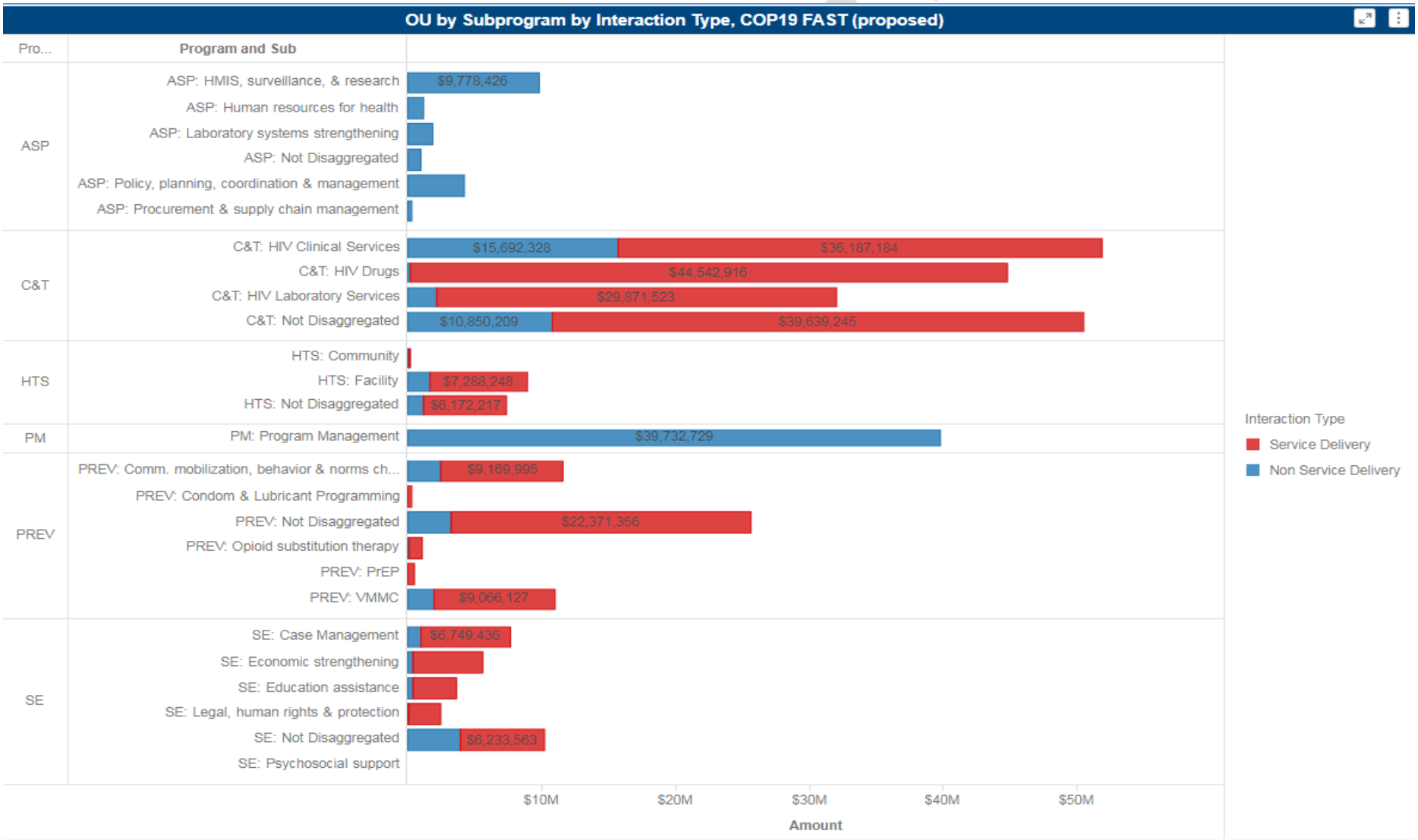

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Table B.1.2 COP19 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$US 131,138,762	**$US 243,792,239**	**$US 374,931,001**

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	$7,869,413
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	$7,489,812
HVOP	Other Sexual Prevention	$26,117,057
IDUP	Injecting and Non-Injecting Drug Use	$884,800
HMBL	Blood Safety	$0
HMIN	Injection Safety	$300,000
CIRC	Male Circumcision	$2,091,271
HVCT	Counseling and Testing	$9,750,779
HBHC	Adult Care and Support	$1,010,161
PDCS	Pediatric Care and Support	$0
HKID	Orphans and Vulnerable Children	$27,545,059
HTXS	Adult Treatment	$94,497,420
HTXD	ARV Drugs	$25,233,366
PDTX	Pediatric Treatment	$8,368,559
HVTB	TB/HIV Care	$7,547,205
HLAB	Lab	$310,311
HVSI	Strategic Information	$5,945,741
OHSS	Health Systems Strengthening	$2,326,218
HVMS	Management and Operations	$10,791,526
TOTAL		**$238,078,698**

Initiative Type	**Fiscal Year**	**2020**
	Funding Agency	**Amount**
Planning Level	DOD	$12,417,215
	HHS/CDC	$133,575,055
	State/AF	$1,027,424
	USAID	$186,237,229

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B.2 Resource Projections

COP19 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 COP19 Planned Country Allocation, Strategic Direction Information Memo and COP19 guidance was utilized as guidance.

The FAST tool, pre-populated with COP18 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 FY18 performance and COP19 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

APPENDIX D– Minimum Program Requirements

The minimum requirements for continued PEPFAR support include:

1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups (required in COP16).
2. Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents (required in COP16).
3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens (required in COP18).
4. Scale up of index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established (required in COP18).
5. TB preventive treatment (TPT) for all PLHIV must be scaled-up as an integral and routine part of the HIV clinical care package (required in COP18).
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.

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7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC, TB, and routine clinical services, affecting access to HIV testing and treatment and prevention (required in COP17 and COP18).
8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including >80% access to annual viral load testing and reporting.
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity (required in COP18).
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management (required in COP17 and COP18).
11. Evidence of resource commitments by host governments with year after year increases (required in COP14).
12. Clear evidence of agency progress toward local, indigenous partner prime funding (required in COP18).
13. Scale up of unique identifiers for patients across all sites.

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Key Area/Issue	Is it Met or Not	Policy Status	Implementation Status COP18 - # of sites, districts by population, partner	Implementation Status COP19 - # sites, districts by population, partner
TB preventive treatment (TPT) for all PLHIVs must be scaled-up as an integral and routine part of the HIV clinical care package.	Implementation in progress	Current work is focused on ensuring capacity within the GoK to mop up the remaining cohort of PLHIV eligible for TPT, ensuring improved documentation, reporting, and strengthening of pharmacovigilance.	Current program data from DHIS is at 70%. By the end of September 2019, we expect to be at 80%.	We will target the remaining 20% to benefit from TBT by end of September 2020. MoH has been leading both nationally and globally and has provided TA to other countries and HIV service providers. MoH and PEPFAR will continue to ensure that GOK health workers have adequate capacity to mop up the remaining cohort of PLHIV eligible for TPT, ensuring improved documentation, reporting, and strengthening of pharmacovigilance.

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Key Area/Issue	Is it Met or Not	Policy Status	Implementation Status COP18 - # of sites, districts by population, partner	Implementation Status COP19 - # sites, districts by population, partner
Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Policy Done. Implementation in progress	All COP 2019 treatment IP work plans need to reflect fidelity to achieve >95% linkage rate of identified positive clients. Treatment IP work plans should include a plan for same day initiation for newly identified clients or a return to care plan for identified known positives.	Current Kenya guidelines (2018 ART) include same day initiation of ART; a PLHIV is identified and he or she is linked to care to begin treatment. This guideline is foundational to our HIV public health approach. However, we wish to commit to identifying solutions to the gaps which actually impact the ability to have 100% linkage including unique identification of individuals, testing positive versus tests, and those linking to treatment across all sites and populations.	

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Key Area/Issue	Is it Met or Not	Policy Status	Implementation Status COP18 - # of sites, districts by population, partner	Implementation Status COP19 - # sites, districts by population, partner
Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC and TB services, affecting access to HIV testing and treatment and prevention.	Policy Done and Roll out in progress	Kenya is currently implementing a Universal Health Coverage tiered phased approach with a presidential target of full rollout to reach every Kenyan by 2022. One of the key principles of UHC is elimination of user fees.	USG is engaged in both the UHC design and pilot program and working with the GoK to ensure policy guidelines for UHC as well as NHIF reform ensure all user fee elimination.	
Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups.	Policy Done. Implementation in progress	Government has in place a policy since July 2016.		
Adoption and implementation of differentiated service delivery models, including six month multi-month scripting (MMS) and delivery models to improve identification and ARV	Policy Done and Implementation in progress	Guidelines are clear about definitions, including stable patients. Guidelines recommend differentiated services. Policies and capacity building initiatives have been rolled out.	At the end of December 2018, out of 1,069,000 on ART, there were 684,000 eligible for DSD. Of those, 467,000 (68%) were classified as stable. Of those,	PEPFAR – by the end of September 2019, 410,000 (60%) will be on DSD By the end of September 2020, 100% of those eligible will be on DSD.

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Key Area/Issue	Is it Met or Not	Policy Status	Implementation Status COP18 - # of sites, districts by population, partner	Implementation Status COP19 - # sites, districts by population, partner
coverage of men and adolescents.			297,000 (43%) were on a form of DSD.	MoH - We want to as a country profile our patients in order to inform our national targets. GOK targets for end of September 2019 TBD.
Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of nevirapine-based regimens.	Policy in Place. Adaptation in progress	Working in collaboration with GoK to ensure the TLD policy includes an option for informed consent for HIV positive women of child-bearing age.	By September 2019, PEPFAR and MoH have agreed that all of our eligible patients will have transitioned to TLD.	Continue roll out of TLD across all sites. Comment: DTG is not recommended to women and adolescents of child-bearing potential. However, women and adolescent girls who are on effective contraception should be offered DTG and may accept based on their discretion.

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Key Area/Issue	Is it Met or Not	Policy Status	Implementation Status COP18 - # of sites, districts by population, partner	Implementation Status COP19 - # sites, districts by population, partner
Scale up of Index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established.	Policy Done. Implementation in progress	Ongoing collaboration with GoK to ensure Index testing is the primary testing modality (at least 30% of overall number of positives should be ICT). Reduce stigma and intimate partner violence to ensure more HIV positive women are able to disclose their sexual partners	Kenya HTS guidelines (reprint 2016) include index testing as a promising modality. Kenya is developing a guidance document for index testing expected in June 2019 that includes consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is ensured. We do not test people with a risk of IPV.	
Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality	Policy Done. Implementation in progress	Ensure follow through on the lab optimization tool completed during COP 2018. Build capacity within the GoK to take on the ongoing monitoring	MoH has successfully completed VL/EID optimization activities (e.g., testing, receipt of results, networks) and ongoing monitoring to ensure reductions in	As part of capacity building and support to National and County governments, prioritize move to optimized the

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Key Area/Issue	Is it Met or Not	Policy Status	Implementation Status COP18 - # of sites, districts by population, partner	Implementation Status COP19 - # sites, districts by population, partner
across age, sex, and risk groups.			morbidity and mortality across age, sex, and risk groups.	services within MoH facilities.
Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Policy and Reporting Update In Progress	Currently consulting with GoK's Division Disease Surveillance (DDSR) and NASCOP SI	Initiate consultations and work with GoK to establish an active public health surveillance system capable of identifying new outbreaks as they develop and accurately track quality of care and subpopulation morbidity and mortality indicators.	Ensure the morbidity and mortality indicators are included in the national reporting database
Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high	Done and Implementation in progress	GoK has a policy that covers OVC. PEPFAR working with relevant government officials to identify what is current GOK programming for OVC outside of PEPFAR.	Improve DREAMS programs and services provided to 10 – 17 year old age bands, with an emphasis in the high burden areas. Ensure prevention services are offered to	Updated under OVC section of the presentation

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Key Area/Issue	Is it Met or Not	Policy Status	Implementation Status COP18 - # of sites, districts by population, partner	Implementation Status COP19 - # sites, districts by population, partner
HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management.			adolescent girls and boys identified as negative in the high burden counties.	
Evidence of resource commitments by host governments with year after year increases.	Done and implementation in progress	Kenya has a Health Financing Policy as well as HIV Investment and Domestic Resource Strategic Directive under KASF.	As part of the transition planning with GoK, begin developing a responsibility matrix with the GoK (including both National and Counties) for the HIV/AIDS program and encourage accountability.	Evidence of resource commitments by host governments with year after year increases.

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Key Area/Issue	Is it Met or Not	Policy Status	Implementation Status COP18 - # of sites, districts by population, partner	Implementation Status COP19 - # sites, districts by population, partner
Clear evidence of agency progress toward local, indigenous partner prime funding.	Policy adapted. Implementation by agency ongoing	Identify opportunities to move towards local, indigenous prime partners.	Agency Updates Available	Clear evidence of agency progress toward local, indigenous partner prime funding.
Scale up of unique identifier for patients across all sites.	In progress	Kenya has rolled out the Huduma Number which will cover all public services including access to health	PEPFAR team will collaboratively work with and provide technical support to national and county governments to develop and operationalize policy framework on unique patient identifier which is not HIV specific but for use in accessing all health care services in the health sector. Policy framework will ensure that patients confidentiality and other human rights including minor protection issues are duly adhered to.	Scale up of unique identifier for patients across all sites.

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Key Area/Issue	Is it Met or Not	Policy Status	Implementation Status COP18 - # of sites, districts by population, partner	Implementation Status COP19 - # sites, districts by population, partner
			Further, PEPFAR team will provide technical assistance to the two levels of government in the implementation of UPI guidelines, protocols and M&E tools for health care workers and managers at facility level.	
Viral load management: Country policy updated.	In progress	GoK to ensure the national viral load policy is compliant with the global standard (WHO guidance)	Viral load management: Country policy updated.	In progress
Screen better and test smarter: Stop over-testing.	In progress	Policy adoption of optimized testing that targets patients who are at risk of HIV, including focus on index testing. - MoH and PEPFAR remain committed to the same	Screen better and test smarter: Stop over-testing.	In progress

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Key Area/Issue	Is it Met or Not	Policy Status	Implementation Status COP18 - # of sites, districts by population, partner	Implementation Status COP19 - # sites, districts by population, partner
		interest: targeted testing and case-finding approaches as the entry to HIV epidemic control. - MoH is currently going to revise our guidelines to integrate focused and optimized testing approaches including both aPNS and HIVST. Indeed, 60% of our HIV self-testers are men. We are constantly reviewing our HTS data, especially where we may be testing many and our testing yield is going down. Our guidelines are nuanced based on the Kenyan context and considers donor requirements, including for Index testing, but cannot base them solely on the same.		

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SDS: COP 19 FBO Funding Initiative

Overview and Program Context:
Faith Based Organizations (FBOs) in Kenya are a key stakeholder to both Kenya MoH in healthcare providing nearly 40 percent of health services countrywide. Through its wide networks of health facilities and in partnerships with PEPFAR Kenya as local mechanisms, FBOs have and continue to offer comprehensive HIV/TB services nationally for the last decade. Unlike partners working in government owned public health facilities who benefit from human resource and other core investments, FBOs often have to make substantial investment in HRH, systems and capacity building to sustain HIV service delivery, with very good results. All facilities supported by FBOs have EMR for ART monitoring resulting better real time data utilization.

Beyond COP budgeting, the FBO funds will restore support to FBO clinical and prevention mechanisms contributing to COP targets and attain epidemic control, establish community- facility interface through utilization of their community infrastructures to reach men and youth in optimizing HIV services, advancing protection and justice systems for children through sexual and gender violence prevention. Kenyan FBOs have un tapped networks of religious and lay leaders, volunteers, congregations, youth ministries, health facilities, schools, colleges, universities, small communities and community based networks that can accelerate Kenya's epidemic control efforts. The FBO funds will be aligned to the broader PEPFAR Kenya geographic prioritization and FBO program footprint to leverage existing infrastructure and staffing especially in reboot and scale up SNUs. Additionally, PEPFAR will support FBOs to build their systems, structures and messaging to support sustainable HIV care and treatment and primary prevention of HIV and violence prevention among children and young people beyond this funding cycle through Faith based health services consortium (FBHSC). The proposed implementation plan is based on extensive consultations between FBO representatives, PEPFAR Kenya Team and guidance from SGAC.

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Table 1: FBO Intervention Matrix- Primary Prevention

Interventions	Intervention Description	Target Audience	Relevant MER Indicators
1. HIV Prevention among Adolescent and young persons (AYP) and Parenting	-Primary prevention of HIV and sexual violence -Capacity building for FBO structures to implement evidence based interventions e.g. Making Life's Responsible Choices (MLRC), Healthy Choices for a Better Future (HCBF); Families Matter! Program (FMP I); SASA! Faith; Faith Matters! Program; ROPES.	Integrate to church, school and community based programs that target AYP, e.g. Youth Brigade, Madrasa, Pathfinder, Sunday School, Youth, Parents and Adult Ministries.	PP_PREV
2. Sustainable education subsidies and economic strengthening	Strengthen faith community groups through structured economic strengthening trainings and sustainable revolving fund/Village Savings and Loaning. This will provide a sustainable approach for supporting education subsidies for OVC and adolescent girls and young women	Vulnerable members of Faith community groups -AYP beneficiaries	OVC-SERV
3. Community engagement and norms change	-Develop and implement a faith-based communication strategy to address gaps in HIV programming -Build capacity of FBO fraternity, media and institutions to deliver HIV and violence related messages -Implement evidence informed interventions (SASA! Faith; Men as Partners; Coaching Boys into Men; Real Fathers) to address harmful norms	Faith leaders and faith community groups e.g. Jumuia, Women's Guild, Men's and Women's Associations and Faith Leaders' networks e.g. Inter-Religious Council of Kenya; FBO Radio & TV; congregations, schools, colleges, health facilities	Custom Indicator: No. of people reached with structured messages to support 95-95-95; HIV and violence prevention and response; stigma reduction and justice for

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			survivors of violence
4. Violence prevention and response	-Roll out child safe guarding policy in FBO and PEPFAR supported programs to protect children -Implement evidence informed violence prevention interventions among adolescent and parents (e.g., SASA! Faith, Families Matter Program; Men as Partners). -Sensitize HCW, FBO resource persons and law enforcement to support access to comprehensive post-violence care and justice -Support training of HCW in medical and forensic SGBV evidence management. - Engage FBO and other communities on harmful norms that promote violence against children -Integrate violence prevention and response in faith-based teacher training and HCW colleges, schools, PEPFAR programs and other institutions.	-Adolescents and young people; boys and men in FBO settings; Faith leaders and Women's Guild, Men's and Women's Associations and Faith Leaders' networks –FBO Mass media audiences (Radio & TV); FBO Forums; Clients in FBO health facilities; FBO schools, colleges and institutions	GEND_GBV PP_PREV
5. Social asset building and safe spaces for AYP	-Strengthen existing youth structures to provide safe spaces for adolescent boys and girls and young people living with HIV -Through the interfaith religious council, support policy development	-Children, Adolescents and young people -Adolescent living with HIV	OVC_SERV (Other)-Kenya custom indicator

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	and dissemination for child safeguarding policy		
6. Expanded case finding, linkage, retention for men, youth and children	Utilize faith-based platforms to -Build capacity for targeted case finding among men, linkage to treatment, retention and adherence -Promote and mobilize men for HIV Self-testing and Test and Start. -Distribute self-testing kits; establish support and linkage structures for men who test positive -Promote VMMC among older men -Expand faith-based male PHDP groups for men, children and youth (OTZ clubs)	Faith leaders; Men's and women's associations, Youth Ministry, Mothers' Union, congregations; men, children and youth living with HIV; male champions and peer educators.	HTS_TST HTS_POS
7. Orphaned and Vulnerable Children (OVC) Programming	-Design sustainable OVC support systems* in faith-based platforms -Use faith-based platforms to identify orphans and vulnerable children; provide OVC package of services to children and their caregivers -work with faith communities and other stakeholders to enhance support for OVC and address violence against children	OVC; vulnerable young people, young mothers, parents and caregivers; child protection officers; faith-based schools.	OVC_SERV
*The Mulleys Children's Home (Kenya) is a model sustainable faith-based residential and community based OVC program that also supports child mothers through formal education, vocational training and self-reliance. The program is not dependent on donor funding but has ventured into economic activities that have benefitted thousands of vulnerable children and young people.			

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Table 3: FBO Intervention Matrix- Clinical Services aligned to COP targets

The FBO initiative funds executed through facility and community interventions are aimed at achieving COP targets while addressing exiting program gaps. These includes low uptake of HIV services among men and young persons; low uptake of VMMC among older men; late ANC attendance; Retention in care, limited community ART groups, HIV related stigma, and violence against children, girls and young women.

Technical Strategy:	**Interventions**	**Implementation area**	**Outputs**	**Outcomes**
All FBOs: KCCB, CHAK, COPTIC, EASTERN DEANERY				
HTS (HVCT)	Establish demand creation and referral for high risk clients including men for HIV services	Community level	Increased access of HIV testing services among men including roll out HVST	Increased population of men with known HIV status (individual, couple or HVST)
	Roll and distribute HIV self-Testing kits among men	Site & Community level	Increased uptake HVST among men	Increased population of men with known HIV status (individual, couple or HVST)
	Mop up and optimize coverage for PNS at site level (new positive, high viremia and eligible widows)	Site level	Improved PNS coverage of all index clients	Increased HIV positive yield
	Implement eHTS data tool for real-time data use and program improvement.	Site level	Increased coverage of eHTS platform	Increased data use from eHTS Platform by age, gender and population characteristics
HIV Care & Treatment:	Optimize linkage while tracking ART decliners	Site level	Improved ART uptake at diagnosis	Increased TX new

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(HTXS and PDTX)	Enhance retention and viral suppression among adults and pediatric clients enrolled in FBO sites	Site level	Increased retention of clients on treatment (Adults& pediatrics)	Increased TX net new and VL suppression by sub populations esp. men and youth.
	Adopt and/or implement community ART service delivery models, including six month multi-month scripting (MMS)	Site & Community level	Increased proportion of stable clients in DSD & MMS	Reduced site congestion and daily client- provider-ratio
PMTCT	Establish FBO community networks to increase early ANC enrolments and access to services	Community level	Increased early (1st trimester) ANC enrolment of pregnant women.	Increased coverage of pregnant women attending ANC and know their HIV status
	Implement GBV screening among PBF AGYW < 19 yrs. in ANC at first contact	Site level	Increase GBV screening in ANC	Improved GBV case identification and reporting
	Utilize MCH to increase male access to HTS and VMMC	Site level	Increase uptake of couple testing and referral for VMMC services	Increased coverage for couple testing
	Prioritize and optimize retention and VL suppression of PMTCT clients at risk of HIV transmission	Site & Community level	Increased retention and VL suppression by all sub populations	Reduced MTCT and mortality

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	Implement cohort monitoring of mother-infant pairs for optimal outcomes	Site level	Increased site implementing cohort monitoring for PMTCT	Increased MIP cohort data use for program monitoring
VMMC- in selected FBO sites in Siaya, Migori, Homabay and Kisumu. **(CIRC.)**	Conduct pre VMMC site assessment and activation	Site level	Site VMMC capacity assessment and improvements conducted	Optimized health systems for VMMC service delivery
	Review VMMC supplies and equipment needs	Site level	Established site level VMMC supplies and equipment needs including surgical rooms	Optimized health systems for VMMC service delivery
	Establish demand creation and referral for VMMC services	Site/community	VMMC rolled out and implemented to scale	Target achievements for VMMC services
Cross cutting (National and regional coordination)	Institutionalize Faith based health services consortium (FBHSC))	National	Established National FBO health sector coordinating organ	Functional National FBO health sector coordinating organ (mainstreamed HIV interventions, platform for engaging with MoH and county governors)
	Support Faith based health services consortium (FBHSC) through sub committees (Education, Health, Community, Policy	National	Established sub committees relevant to mainstreaming HIV services	Developed HIV prevention messages for church, schools and religious groups (men, youth women, couples etc.)

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	and compliance, etc.)			
	Conduct regular FBO progress review of HIV response and support in Kenya	National	National HIV stakeholders conference held annually	Increased HIV response in FBO settings

Coordination with GOK and County Governments:
PEPFAR funded FBOs in this initiative have engaged key National FBO networks and organizations in identifying priorities for this initiative in consultation with PEPFAR Kenya team and SGAC FBO focal points. During implementation, the Kenya FBOs will work closely with National and County governments to ensure their work is aligned and compliments existing initiatives. Key areas of collaboration include supporting the Kenya National Action Plan for preventing and responding to violence against children that is currently under development by the Kenya Department of Children's Services, UNICEF, PEPFAR and other stakeholders. The FBO initiative will be pivotal in engaging GOK and other stakeholders to fast track integration of a comprehensive sexuality curriculum in Kenyan schools.

Implementing Partner Support and Management: PEPFAR Kenya team will provide technical assistance to FBO partners to initiate new activities and to strengthen existing activities. To track progress, each agency will review partner performance monthly/quarterly and provide support to achieve set targets. The PEPFAR Coordination Office will chair a joint progress review especially in national and cross cutting activities.

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