Kenya Country Operational Plan

COP 2016

Strategic Direction Summary

May 25, 2016

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Acronyms – SDS COP 2016

ACT	The Accelerating Children's HIV/AIDS Treatment Initiative
AGYW	Adolescent Girls and Young Women
ANC	Antenatal Clinic
APOC	Adolescent Package of Care
APR	Annual Progress Report
ART	Antiretroviral Treatment
ARV	Antiretroviral
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CHW	Community Health Workers
CHEW	Community Health Extension Workers
CHMT	County Health Management Team
COP	Country Operational Plan
CrAg	Cryptococcal Antigen
CSO	Civil Society Organizations
CTX	Cotrimoxazole
DATIM	Data for Accountability Transparency Impact Monitoring
DBS	Dried Blood Spot
DCS	Department of Child Services
D4EC	Data for Epidemic Control
DHIS2	District Health Information System
DICE	Drop-In Center
DOD	Department of Defense
DOS	Department of State
DREAMS	Determined, Resilient, AIDS-free, Mentored, and Safe
DRM	Domestic Resource Mobilization
EA	Expenditure Analysis
EID	Early Infant Diagnosis
EIMC	Early Infant Male Circumcision
EMR	Electronic Medical Record System
eMTCT	Elimination of Mother to Child Transmission
FBO	Faith-Based Organization
FP	Family Planning
FSW	Female Sex Workers
FTE	Full Time Equivalent
FY	Fiscal Year
GBV	Gender Based Violence
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNI	Gross National Income
GOK	Government of Kenya
HCP	Health Care Professional
HHA	Healthy Heart Africa
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration

HCW	Health Care Workers
HEI	HIV Exposed Infant
HITS	HIV infected Infant Tracking (HIT) system
HMIS	Health Management Information System
HQ	Headquarters
HR	Human Resources
HRH	Human Resources for Health
HRIS	Human Resource Information System
HSS	Health Systems Strengthening
HTS	HIV Testing Services
ICF	Intensified Case Finding
INH	Isoniazid
IATT	Inter-Agency Task Team (IATT) for Prevention and Treatment of HIV Infection in Pregnant Women, Mother and Children
IBBS	Integrated Biological and Behavioral Surveillance Survey
IM	Implementing Mechanism
IP	Implementing Partner
IPC	Infection Prevention and Control
IPT	Isoniazid Preventive Therapy
ITT	Interagency Technical Team
KAIS	Kenya AIDS Indicator Survey
KASF	Kenya AIDS Strategic Framework
KEMSA	Kenya Medical Supplies Agency
KCM	Kenya Coordinating Mechanism
KNBS	Kenya National Bureau of Statistics
KP	Key Population
LMIS	Logistics Management and Information Systems
LNA	Limited Non-career Appointment
LOE	Level of Effort
LPV/r	Lopinavir/ritonavir
LTFU	Lost to Follow-Up
M&E	Monitoring and Evaluation
MAT	Medication-Assisted Therapy
MC	Male Circumcision
MCH	Maternal and Child Health
MOH	Ministry of Health
MSM	Men who have Sex with Men
MSP	Male Sexual Partners
MTB	Mycobacterium Tuberculosis
MTCT	Mother to Child Transmission
NACC	National AIDS Control Council
NACS	Nutrition Assessment Counseling and Support
NASCOP	National AIDS and STI Control Programme
NCD	Non-Communicable Diseases
NHIF	National Health Insurance Fund
NNRTIs	Non-Nucleoside Reverse Transcriptase Inhibitors
NSP	Needle and Syringe Program
OGAC	Office of the Global AIDS Coordinator

OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PBAC	PEPFAR Budget Allocation Calculator
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PHDP	Positive Health, Dignity, and Prevention
PITC	Provider-initiated Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
POART	PEPFAR Oversight and Accountability Response
PPP	Public-Private Partnership
PTA	Parent-Teacher Association
QA/QI	Quality Assurance/Quality Improvement
RRI	Rapid Response Initiative
RTK	Rapid Test Kit
SAM	Severe Acute Malnutrition
SAPR	Semi-Annual Program Results
SDS	Strategic Direction Summary
SFI	Sustainable Financing Initiative
SBOR	Systems and Budgets Optimization Review
SCMS	Supply Chain Management System
SI	Strategic Information
SID	Sustainability Index and Dashboard
SIMS	Site Improvement through Monitoring System
SNU	Sub National Unit
STI	Sexually Transmitted Infections
TAT	Turn Around Time
TB	Tuberculosis
TBD	To Be Determined
TOR	Terms of Reference
UE	Unit Expenditure
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USG	U.S. Government
VCT	Voluntary Counseling and Testing
VL	Viral Load
VMMC	Voluntary Medical Male circumcision
WHO	World Health Organization

Goal Statement

The PEPFAR interagency team has worked collaboratively with the GOK, civil society, and other stakeholders to develop a COP that builds on the roll out of Test and START to rapidly increase national ART coverage from 63% to 83% by 2017 and accelerate progress towards sustained epidemic control. Given achievements to date and leveraging opportunities with GOK, GFATM and central initiatives, PEPFAR has the opportunity to accelerate saturation in select counties and achieve greatest impact by deepening epidemic control at the sub-national level in the 27 counties which account for over 90% of HIV burden. Solidifying strategic shifts started in COP15 in partnership with GOK to align investments with the epidemic profile, PEPFAR will concentrate efforts in the five (5) highest burden counties and intensify support in an additional 11 counties to reach saturation in 16 counties by the end of Fiscal Year 2017, and continue aggressive scale-up in the other 11 high burden counties. While six of the 27 counties have already been saturated in the aggregate by APR15, PEPFAR will redouble efforts in COP16 to close gaps in reaching children, men, and key populations. In the remaining 20 counties, PEPFAR will target 13 counties for sustained facility-level support and seven (7) counties for central-level support. In addition to clinical and prevention activities (including KPs and VMMC), PEPFAR support for OVC, strategic information, and system strengthening will be prioritized to maximize the return on USG investments towards helping Kenya achieve sustained epidemic control and shared 90-90-90 goals.

PEPFAR will support GOK in achieving these ambitious goals by building on the unprecedented policy shifts during FY16 to implement Test and START, roll-out PrEP, and pilot differentiated service delivery models. The PEPFAR pivot combined with the GOK's RRI and new guidelines for Test and START to be launched by June 2016 will enable Kenya to reach saturation by 2017 and achieve the first and second "90" by 2019, as outlined in the KASF. As for the third "90," Kenya has a well-developed VL testing system projected to perform over a million tests in 2016. The VL system will be used to monitor the third "90" with targeted strategies to ensure optimal use of VL. In addition, PEPFAR continues to use quarterly POART and SIMS findings to assess performance and further sharpen strategies and approaches to most efficiently deliver expected results. Specifically, activities in COP16 are refined to improve testing strategies using index clients for family/partner testing while adopting population-level testing in two of the five highest burden counties, Homa Bay and Siaya, to intensify patient identification; accelerate eMTCT and improve pediatric treatment through tracking of mother-baby pairs and leveraging existing MCH platforms; better reach men through linkages with NCD services drawing from SEARCH study and PPP opportunities; address GBV and other gender disparities, especially for adolescent girls and young women; maximize efficiency of clinic visits through expansion of fast-tracking and multi-month scripting for stable patients; increase treatment retention through community-based adherence counselors, treatment literacy, and stigma reduction; strengthen OVC support by linking beneficiaries to HIV clinical services and concentrating on household economic strengthening. Based on results of the SBOR pilot and SID exercise, PEPFAR will also strengthen county-level governance and supply chain systems to reduce stock outs of commodities, improve

lab networks to increase use of VL, and institutionalize cost-effective approaches for HRH management. In addition, efforts to bridge DATIM and DHIS2 will be pursued as a real game changer. Through these strategic investments and tailored approaches, PEPFAR will firmly place Kenya on the glide path towards sustained epidemic control by providing ART for 1,155,970 Kenyans.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country profile

Kenya is a lower-middle income country with a population of 43 million and per capita gross national income (GNI) of $2,780 (KNBS 2009/2015 projection; World Bank 2013). Approximately 6.8% of gross domestic product (GDP) is spent on health, 18.7% of which is spent on HIV (2012/13 National Health Accounts). Kenya demonstrates bold leadership in supporting Sustainable Development Goals (SDGs) as a co-facilitator in drafting the SDGs, and as the host for the second High-Level Meeting on the Global Partnership for Effective Development Cooperation in late 2016. The Kenya AIDS Strategic Framework (KASF) is fully aligned with the 90-90-90 global targets set by UNAIDS towards ending AIDS as a public health threat by 2030, and the GOK has fast-tracked key policy shifts that will enable attainment of these ambitious targets.

The most recent UNAIDS report estimates a total of 1,366,771 adult and pediatric people living with HIV (PLHIV) in Kenya (NACC, unpublished). This new estimate, which is 18% lower than prior year estimates, is due to a change in computation methodology rather than a reduction in burden. Kenya has an estimated 56,355 new HIV infections and 32,986 HIV-related deaths per year (NACC, 2015). The national adult prevalence is estimated at 5.3 –5.6%, depending on the source (5.3%: NACC 2015, ages 15-49; 5.6%: KAIS 2012, ages 15-64), and varies widely by geographic region, ranging from 0.1% in Wajir to 25.4% in Homa Bay (NACC, 2015). Ninety percent of PLHIV are in 27 of the 47 counties, with the five highest burden counties (Homa Bay, Kisumu, Migori, Nairobi and Siaya) accounting for 49% of all PLHIV. Females, especially young women, are disproportionately affected with higher HIV prevalence compared to their male counterparts (6.6% vs. 4.9%, respectively among those aged 15-49 and 3% vs. 1% among those aged 15-24) (NACC, 2015; NASCOP, 2014). Among key populations (KP), high HIV prevalence rates persist, ranging from estimates of 18.2% among men who sex with men (MSM), 29.3% among female sex workers (FSW), and 18.7% among people who inject drugs (PWID) (NASCOP, 2015). Fisherfolk in the lake region of western Kenya constitute a priority population with an estimated ~26% HIV prevalence (KEMRI, 2015; NASCOP, 2014; FELTPAA, 2010). These demographic and epidemiological data are summarized in table 1.1.1 and 1.1.2 below.

Significant progress has been made in the number of PLHIV who know their status and are enrolled in care and antiretroviral treatment (ART). By the end of Fiscal Year 2015 (FY15), 977,771 (71%) and 857,472 (63%) of the estimated 1,366,771 were enrolled in HIV care and ART respectively. However, ART coverage for men is low at 58%, as compared to women at 68%. In addition, the five highest burden counties still account for 50% of the unmet need, with four of

them having ART coverage lower than the national average (Homa Bay 52%, Kisumu 60%, Migori 60%, and Siaya 50%). With PEPFAR support, Kenya is on course with review of the treatment guidelines, which includes Test and START, differentiated service delivery models, and pre-exposure prophylaxis (PrEP). The revised guidelines are scheduled for release in June 2016, while implementation will be initiated earlier within the four priority Determined, Resilient, AIDS-free, Mentored, and Safe (DREAMS) counties (Homa Bay, Kisumu, Nairobi, and Siaya). These important policy shifts will rapidly increase ART coverage and accelerate progress towards epidemic control.

Tremendous scale-up of prevention of mother to child transmission (PMTCT) services has occurred in the last eight years, which has tripled the number of women tested during pregnancy up to 1,233,462 by APR15. Overall, 82% of the estimated 74,470 HIV+ pregnant women were identified in FY15. However, of the 61,510 HIV+ pregnant women identified, only 55,400 (90%) were provided with ARV prophylaxis for PMTCT, representing a national coverage of 74%. In line with the current national PMTCT guidelines, the vast majority (98%) of the women received life-long ART (Option B+), up from 57% in FY14. In FY15, 48,310 infants were tested for HIV in PEPFAR supported sites, with 68% of them being tested within six to eight weeks in line with the national policy. Among those tested, 5.4% were HIV-infected – the positivity rates were 3.2% among those tested within six to eight weeks and 9.5% among those tested between two and 12 months.

The implementation of the Accelerating Children's HIV/AIDS Treatment (ACT) Initiative has been critical in scaling-up ART among pediatric patients. At the end of the first year of the ACT Initiative, Kenya increased the number of children on ART to 79,422, achieving 73% of the two-year target. Nonetheless, much remains to be done to further increase ART coverage of the estimated 159,731 HIV+ children. In addition, viral suppression among children has been sub-optimal. A recent national survey reported viral suppression rates (<1000 copies/mL) of 69% among children 0-14 years, compared to 89% in adults (NASCOP, 2013, unpublished).

Stigmatization and criminalization of KP behavior remains a major obstacle to successful HIV prevention, care and treatment. According to the most recent data from 2011, diagnosed infections ranged from estimations of 30% among MSM to 60% among FSW in Nairobi, while ART coverage was markedly lower, ranging from 6% among MSM to 34% among FSW.[1] Similarly, qualitative interviews among a priority population, the fisherfolk community, suggest that stigma, misperceptions, and logistic barriers contribute to high levels of HIV infection and low access to care and treatment (FELTPAA, unpublished).

During calendar years 2014 and 2015, 424,894 voluntary medical male circumcisions (VMMC) were performed in Kenya, representing 42.2% of the five-year target of the second national VMMC strategic plan (2014 – 2019). All VMMC priority counties are approaching or have achieved 80% coverage for males 15-29 years. Consequently, the country is transitioning from “catch up” to

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

"sustainable" phase of the VMMC strategy, whereby services for males older than 15 years will be limited to maintaining coverage above 80% while services for boys aged 10-14 years will be prioritized along with the initiation of Early Infant Male Circumcision (EIMC).

Achieving sustained epidemic control will be predicated on optimal coverage of clinical and prevention interventions as well as a number of systemic processes falling into place along the 90-90-90 cascade as indicated in table 1.1.2. PEPFAR will address three key programmatic gaps in the clinical cascade in the Country Operational Plan for FY 2016 (COP16) including weak commodity and logistics management, limited county health system human resource capacity, and sub-optimal use of viral load (VL). Gaps were identified in the context of achieving HIV epidemic control, the national sustainability profile, and health systems investments.

Table 1.1.1. Key National Demographic and Epidemiological Data															
	Total		**<15**						**15+**						
			Total		**Female**		**Male**		**Total**		**Female**		**Male**		**Source**
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Total Population	42,961,187		17,831,020		8,842,888		8,988,132		25,130,167		12,828,547		12,301,620		KNBS 2009 Census projection for 2014
HIV Prevalence (%)		3.18%		0.90%		0.90%		0.90%		5.3%		6.6%		4.9%	2014 projections in 2015 National HIV estimates
AIDS Deaths (per year)	32,986		8,106		4,020*		4,086*		24,880		12,701*		12,179*		2014 projections in 2015 National HIV estimates
# PLHIV	1,366,923		159,731		79,215*		80,516*		1,207,192		785,433		581,490		2014 projections in 2015 National HIV estimates
Incidence Rate (Yr)		0.13%		0.07%		NA		NA		0.18%		NA		NA	2014 projections in 2015 National HIV estimates
New Infections (Yr)	56,355		12,515		NA		NA		43,840		NA		NA		2014 projections in 2015 National HIV estimates
Annual births	1,533,248														Kenya Vital Stats Report Aug 2015, 2014 reference year
% >= 1 ANC visit		96.0%													KDHS 2014
Pregnant women needing ARVs	75,470	100%													2015 projections in 2014 National HIV estimates
OVC aged 0-17 years[1]	2,600,000		2,020,264		978,617		1,041,648		576,657		291,034		285,623		KAIS 2012
Notified TB cases (Yr)	83,539		7,495		3,591		3,904		76,047		28,155		47,892		National TB program
% TB cases that are HIV infected	27,267	33%	1,867	25%	904	25%	963	25%	25,400	33%	11,924	42%	13,476	28%	National TB program (TIBU)
% Males Circumcised	10,055,454						641,905	21.8%					9,403,549	91.2%	KAIS 2012
Key Populations															
Estimated Program Intervention Population Size of MSM*	20,998														(NASCOP Consensus Report)
MSM HIV Prevalence		18.2%													IBBS 2010-2011

Estimated Program Intervention Population Size of FSW	133,675														(NASCOP Consensus Report)
FSW HIV Prevalence		29.3%													IBBS 2010-2011
Estimated Population Size of PWID	18,327														(NASCOP Consensus Report)
PWID HIV Prevalence		18.7%													IBBS 2010-2011
Estimated Size of Priority Populations (Fisherfolk)	122,088														KEMRI RCTP 2013 Fisherfolk study
Fisherfolk HIV prevalence		26.2%													FELTP AA 2011
Estimated Size of adolescent girls/young women 15-24 years	4,351, 423														KNBS 2009 census, 2015 projection
Total young women 15-24 years that are PLHIV	130,543														Census*KAIS prevalence
Adolescent girls/Young women HIV prevalence		3.0%													KAIS 2012

1. Prevalence rate for 15+ is presented for persons aged 15-49
2. This category has been modified from "Orphans" to "OVC aged 0-17 years"
3. This indicator used the KAIS 2012 estimate of males who reported circumcision. NB: the population of males <15 years who reported circumcision does not include males aged <18 months.

- * =Distributed proportional to population size in the absence of other guiding values

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months)									
				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	42,961,187	3.79%	1,366,771	857,472	87%	726,370	795,6018	215,123	*165,138*
Population less than 15 years	17,831,020	1.0%	159,703	78,238	85%	46,943	2,047,006	18,059	*11,171*
Pregnant Women	1,665,800	5%	74,470	55,400	No specific data	80%	1,233,462	61,510	*28,983*
MSM	26,715	18.2%	4,862						
FSW	208,711	29.3%	61,152						
PWID	18,171	18,7%	3,398						
Priority Pop (Fisher Folk)	122,088	26.2%	32,226						
Priority Pop (Young women)	4,351,423	3.0%	142,953						

1.2 Investment Profile

The GOK is fully committed to combating HIV/AIDS and has more than doubled budget allocations for HIV/AIDS since 2005. However, the national HIV/AIDS response in Kenya remains heavily donor dependent. The main sources of funding are: PEPFAR (64%); GOK (21%); GFATM (8%); and other sources account for 7% (including household spending) as indicated in table 1.2.1. More recently, PEPFAR analysis of county budget allocations in 12 counties demonstrate increasing financial commitment towards the HIV program with a total of $2 million committed in FY16/17 county budgets. Further, PEPFAR support contributed to the restoration of a commodities budget line under the National Treasury, with an initial allocation in 2015/16 of $26.5 million to meet GFATM Counterpart Financing requirements (of which $20 million is committed to procure antiretrovirals (ARV) and rapid test kits (RTK)) and a similar amount proposed for the 2016/17 budget. As the current GFATM grant ends December 31, 2017, PEPFAR will work with the Kenya Coordination Mechanism (KCM) to develop the concept note for a new grant that continues to maximize synergy between the U.S. Government (USG) and GFATM investment, especially for commodities as indicated in table 1.2.2, and strategically align with domestic and other available resources to achieve epidemic control.

Notwithstanding the above, significantly greater investment for health is needed from both national and county governments. Efforts to increase the fiscal space for health must be accompanied with measures to address inefficiencies in the use of limited resources and reduce direct out of pocket payments. Domestic resource mobilization (DRM) must maximize private sector contributions and health insurance platforms in line with Kenya Vision 2030 equitable financing plans. See also Section 6.0 where the domestic financing activities, both COP16 funded and those funded by the Sustainable Financing Initiative (SFI), are detailed.

Table 1.2.1 Investment Profile by Program Area[2]

Program Area	Total Expenditure	% PEPFAR	% GFATM	% GOK	% Other
Clinical care, treatment and support	$ 315,123,101	68%	9%	23%	0%
Community-based care	$ 13,082,313	100%	0%	0%	0%
PMTCT	$ 37,842,624	66%	0%	32%	2%
HTC	$ 46,680,655	43%	1%	56%	0%
VMMC	$ 7,198,663	100%	0%	0%	0%
Priority population prevention	$ 6,772,420	92%	8%	0%	0%
Key population prevention	$ 12,211,839	70%	29%	0%	1%
OVC	$ 85,153,093	40%	0%	15%	45%
Laboratory	$ 1,446,167	100%	0%	0%	0%
SI, Surveys and Surveillance	$ 37,584,606	69%	31%	0%	0%
HSS	$11,861,188	98%	0%	0%	2%
Total	$ 574,956,668	64%	8%	21%	7%

Source: GOK, National AIDS Spending Assessment , 2013. All amounts in USD

PEPFAR will continue to engage with GOK, GFATM and other non-governmental stakeholders to encourage an increased contribution to HIV-related commodities. PEPFAR contributions for COP16 factor latest program plans not yet captured in the current biannual Forecasting and Quantification report 2015 – NASCOP will lead annual review and update of the current biannual plan in June 2016, and development of a new a biannual report in 2017, which will align forecasts with commodity needs of the evolving Kenya HIV response program.

Table 1.2.2 Procurement Profile for Key Commodities[3]

Commodity Category	Commodity Requirements (USD)	Available Funds in USD (%)				Total Available Funds in USD
		GOK	PEPFAR	GFATM	Others	
ARV	173,098,224	14,503,036	92,000,000	69,075,956	0	175,578,992
Rapid test kits	9,227,890	2,357,264	9,395,477	6,164,390	0	17,917,131
Other drugs	N/A		10,326,367	1,983,508	0	12,309,875
Laboratory reagents	N/A	0	6,749,678	1,833,601	295,891 *(1%) CHAI UNITAID*	8,879,170
Condoms	N/A	0	0	4,401,711	8,442,000 *(33%) (UNFPA)*	12,843,711
Viral load commodities	17,688,179	0	21,633,057	0	0	21,633,057
VMMC	1,292,548	0	575,000	717,548	0	1,292,548
MAT	4,142,988 (based on size estimate of 18,170)	321,156	0	0	0	321,156
Other commodities	N/A	0	0	2,601,342(nutrition commodities)	0	2,601,342
Sub-Total	**224,223,922**	**17,181,456**	**140,679,579**	**86,778,056**	**8,737,891**	**253,376,982**
Handling	13,847,858	2,395,983	10% (included above)	6,700,027	0	22,943,868
TOTAL	**238,071,780**	**19,577,439**	**140,679,579**	**93478,891**	**8,737,891**	**276,320,850**

Within USG, PEPFAR leverages various non-COP resources. These are derived from agencies' specific non-PEPFAR interventions, centrally funded mechanisms, private sector contributions, and PEPFAR central initiatives as seen in Table 1.2.3 and 1.2.4.

[3]NASCOP Forecasting and Quantification report 2015; PEPFAR commodity budget COP 2016. All amounts in USD.

Table 1.2.3 Internal USG Program Integration and Leveraging

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	Non PEPFAR In Country-Program Operations	PEPFAR COP Co- Funding Contributions **	Non PEPFAR IMs	Objectives
USAID MCH	$13,000,000	$4,000,000	3	$75,507,430			Support quality services for Maternal and child health
USAID TB	$5,000,000	$5,000,000	1	$2,118,187			Improve TB diagnosis, care and treatment
USAID Malaria	$35,000,000	$1,000,000	1	$69,168,037			Support Malaria prevention and treatment in select high burden counties
USAID Family Planning	$26,000,000	$8,500,000	3				Support FP services in country
USAID Nutrition	$4,000,000	$2,500,000	3				Support nutrition interventions in country
Peace Corps	$30,000			$30,000			HIV/AIDS Prevention mainstreamed into Education, Economic Strengthening, and Infrastructure Development
DOD	$7,000,000		1				Multiple research and public health programs that includes infectious disease such as diarrhea, TB, malaria & national Ebola testing
CDC Ebola	$26,050			$26,050			Support MOH planning for disease

							outbreak
CDC DGMQ	$727,047	$190,000	2	$290,518	$246,529		Surveillance of migrant populations and refugee camps
CDC DTRA	$1,869,038			$1,869,038			Disease surveillance, diagnostic of priority syndromic illnesses. Incidence and economic impact of Brucella. Non HIV-FELTP activities
CDC FELTP	$26,725	$26,725	1	$26,725	$ 319, 650		Technical assistance for FELTP/HRH Capacity building
CDC TB	$2,117,237	$1,969,005		$148,232			Tuberculosis Clinical Research
CDC DGHP	$5,821,074	$4,449,627	2	$1,371,447			Global Health Protection research to KEMRI and MOH
CDC DHAP	$1,903,310	$1,659,441	1	$243,869			HIV/AIDS clinical research
CDC DPDM	$2,500,787	$2,412,299	1	$88,488			Malaria research
CDC HDSS	$200,004	$200,004	1	-			Health and Demographic Surveillance System
CDC NCIRD	$895,667	$815,000	2	$80,667			Flu research
CDC NCEZID	$50,000	$50,000	1	-			Zoonotic disease research
CDC NCD/NCPIC	$37,000	$37,000	1	-			Non CD Injury Prevention Survey
CDC GID	$242,422	$75,000	1	$167,422			Polio eradication
CDC OD	$481,376			$481,376			Management Support
MCC	N/A						Ongoing discussions between GOK and MCC

Private Sector	$1,183,410		1		$651,646		Expand Health Insurance Coverage: USAID/Kenya through Global Development Alliance (GDA), Equity Group Foundation, Equity Bank
	$600,000	$600,000	1		$300,000		USAID/Kenya, through the Office of Education and Youth, intends to work with the 5by20 project: 600K incentive fund
	$1,377,294		1		$705,882		GOK, FUNZO and private sector, led by the Higher Education Loans Board
	$12,927,108	$500,000	1		$2,521,036		OVC - Equity Bank and Foundation: Wings To Fly with 500K incentive fund
PEPFAR Central Initiatives	$7,500,000*	$750,000	1		$500,000		*BD Labs for Life non-monetary support for labs quantified at $1.5 million per year for 5 years: NOTE - 750,000 from PSE OGAC Central Funds
	$693, 516	$693, 516	4		$1,900,000		Injection Safety

	$1,550,000	$1,550,000	1		$15,000,000		Key Populations
	$836,646	$836,646	2		$8,800,000		VMMC
Total	$125,402,195	$37,120,747	37	$151,617,486	$30,625,093		

Source: Kenya USG agencies and PEPFAR Coordination Office

Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
DREAMS	$18,018,077	$0	2	13	$6,000,000	To reduce HIV infection in AGYW by 40% by 2017
DREAMS Innovation	TBD	TBD	TBD	TBD	TBD	OGAC reviewing applications for Kenya
DREAMS Test & Start*	$20,000,000	$0	0	20	$0	Improve treatment outcomes for PLHIV
VMMC	$1,792,000	$717,584	0	13	$13,535,000	To achieve and sustain 80% VMMC coverage in target counties and raise VMMC coverage to about 80% in Turkana
Viral Load catalytic funds	$3,000,000 (FY16)	$0	0	?	?	Resources are ensuring that Kenya meets the VL demands of the pivot and Test and START
Other PEPFAR Central Initiatives	$3,000,000	$0	0	1 (HPP)	$1,200,000	Increase domestic resource mobilization (DRM) to sustain program gains and epidemic control in the absence of donor financing

Other PPPs	$500,000 (Partnership Incentives)	$213,000,000 (Equity, MasterCard foundations, UK AID and KfW)	0	1 (OVC scholarship and leadership program (Wings to Fly)	$0	Provision of Scholarships to OVCs to access high school education and Leadership Training
Other PPP	$0	$2,493,396	1	1 (Equity Afia)	$200,000	To increase access to and utilization of quality healthcare and affordable, comprehensive private health insurance
Other PPP	$0	$1,500,000	0	1 (Funzo Kenya)	$800,000	Enabling health workers access pre-service tuition fees towards increasing numbers of new graduates for provision of HIV/AIDs services
Other PPP	$0	$1,500,000 (in kind by BD)	0	1 (Bd Labs 4 Life (MOH)	$250,000	COP16 will be the 4th year of the Non-COP, Non-PEPFAR funds ($1.5M per year) which are provided in kind by BD. This is to strengthen labs.
Other PPP	$0	TBD (in kind by Astra Zeneca)	TBD	TBD	TBD	Leveraging AstraZeneca's HHA success in screening and treating men for hypertension to offer more comprehensive, integrated care and treatment to men. The PPP will be piloted in the highest HIV burden regions of Kenya with USAID clinical implementing partners (Homa Bay and Kisumu).

Total	**$42,810,077**	**$4,710,980**	**3**	**26**	**$41,706,157**	

*OGAC approved exception for use of funds beyond focus on men and funds have been received by the respective agency headquarters with obligation to implementing partners initiated by some agencies. See section 4.8 for information on the status of Test and START implementation.

1.3 National Sustainability Profile

The 2016 sustainability index and dashboard (SID) process was completed under the leadership of National AIDS Control Council (NACC). Together with government, the UN Joint Team on HIV/AIDS, civil society, and other partners, the USG team represented by inter-agency technical teams (ITT) used the SID results to inform discussions at the ITT Retreat, Data for Epidemic Control (D4EC) and D.C. Management Meeting.

Noting the limitation that the SID tool lacks sufficient granularity to fully measure ground realities, the key elements identified as sustainability strengths include: planning and coordination; policies and governance; civil society engagement; public access to information in Domain 1; quality management in Domain 2; and performance data in Domain 4. Stakeholders confirmed the need for continued strategic investments to deepen sustainability strengths in key elements of civil society engagement, quality management, as well as policies and governance. Specifically, investments are needed to ensure implementation of national and county policies, strategies, and plans, to operationalize and institutionalize quality assurance systems at county level; and to build capacity of CSO in effective advocacy, accountability audits, and compliance with donor requirements and procedures.

The SID elements identified as sustainability vulnerabilities and the prioritized areas for continued investments include:

Lab: Review, finalization, and implementation of the Lab Strategy, focusing on workforce development, VL infrastructure and use of results, and routine quality assurance/quality improvement (QA/QI).

Service Delivery: Institutionalization of new differentiated service delivery models.

Health Financing: Evidence generation to inform resource allocation and better track domestic expenditures with improved analytics on technical and allocative efficiencies. Complementary private sector engagement and National health Insurance Fund (NHIF) reform to cover HIV care and treatment in benefit packages.

Human Resources for Health: County HRH management capacity building to improve recruitment, retention, and productivity of the workforce. Complementary strengthening of pre-service institutions and professional bodies for effective production and regulation of the appropriate health workforce for sustained epidemic control.

Commodities Security and Supply Chain: Strengthened county-level supply chain management and logistics of the commodities to the county level to reduce facility-level stock-outs due to inadequate reporting, requisitioning, and distribution.

Notably, NACC has championed the engagement of county leadership in the SID process and has mobilized USG support to adapt the tool for GOK-led county-level SIDs to inform county-specific strategic plans and investment priorities.

1.4 Alignment of PEPFAR investments geographically to disease burden

Figures 1.4.1 and 1.4.2 compare PEPFAR expenditures in 2015 to burden of disease by county. On average, PEPFAR spent $331 per PLHIV in Kenya ranging from $98 to $2,147 (Figure 1.4.1). The variation is due to different service delivery models between government-owned, non-government, and private facilities; higher cost in hard-to-reach areas; and patient density in high burden counties that reduces the total cost per PLHIV. Figure 1.4.2 illustrates that the total PEPFAR expenditure overlays well with total PLHIV (Fig 1 & 2 within Fig 1.4.2), while the cost per PLHIV (Fig 1 within Fig 1.4.2) is primarily higher in Kenya's remote counties with very low burden (Lamu, Marsabit, Tana River, and Wajir). While the total spending in those counties is low (light green shade in Fig 1 within Fig 1.4.2), PEPFAR has categorized these counties as central support for COP16. For COP16, PEPFAR analyzed its investments to continue the geographic alignment started in COP15 and ensured concentration of investments in the five highest burden counties to accelerate their progress towards saturation.

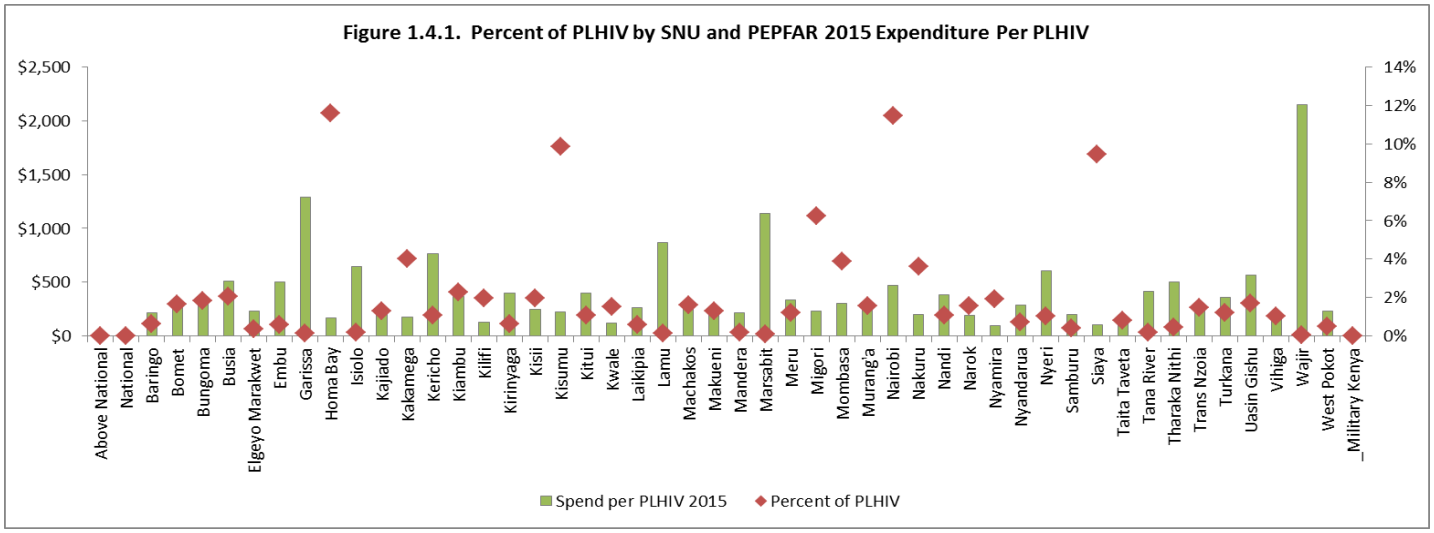
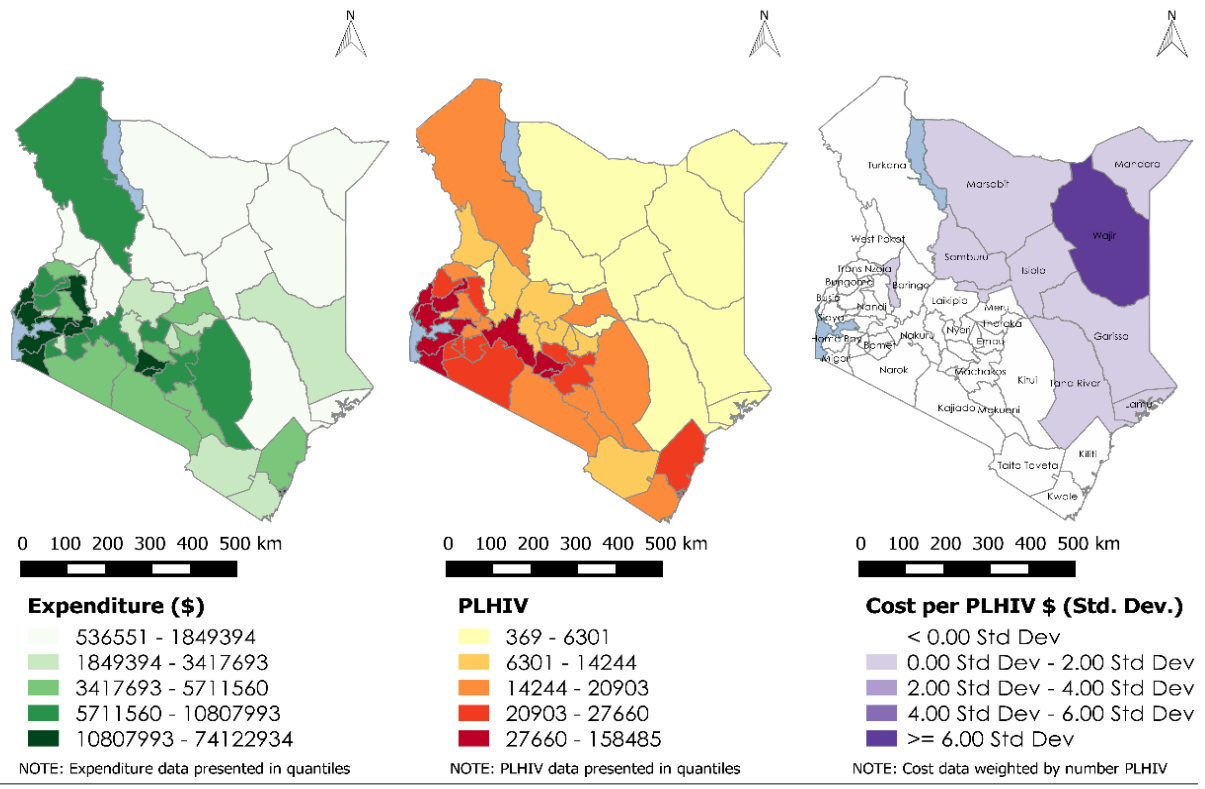


Figure 1.4.2 Total expenditure, PLHIV, and Expenditure per PLHIV by County

County	PLHIV
Homa Bay	158485
Nairobi	156772
Kisumu	134606
Siaya	129424
Migori	85607
Kakamega	55149
Mombasa	53040
Nakuru	49193
Kiambu	31174
Busia	27802
Kilifi	27092
Kisii	26921
Nyamira	26471
Bungoma	24965
Uasin Gishu	22972
Bomet	22392
Machakos	21932
Narok	21580
Murang'a	21122
Kwale	20576
Trans Nzoia	20188
Makueni	17901
Kajiado	17635
Meru	16478
Turkana	16475
Nandi	14735
Kitui	14582
Kericho	14503
Vihiga	14071
Nyeri	13893
Taita Taveta	10860
Nyandarua	9488
Kirinyaga	8471
Baringo	8470
Laikipia	8237
Embu	7824
West Pokot	6845
Tharaka Nithi	6165
Samburu	5453
Elgeyo Marakwet	4757
Mandera	2458
Tana River	2401
Isiolo	2252
Garissa	2089
Lamu	1715
Marsabit	1186
Wajir	369



DATA SOURCES: Number of PLHIV: Estimates and projections package modeling 2015
Expenditure data: Kenya PEPFAR expenditure analysis for FY 2015

Boundaries are not necessarily authoritative
Source of base shape files: http://www.ilri.org

1.5 Stakeholder Engagement

In coordination with NACC, the PEPFAR interagency team consistently engages key external stakeholders (national and county government entities, the UN Joint Team on HIV/AIDS, civil society, private sector, professional bodies) during COP development and throughout the implementation year to ensure coordination and alignment on strategic, programmatic, technical and policy issues. In addition to established coordination fora, PEPFAR convenes stakeholder meetings during COP development and the SID exercise; data meetings for PEPFAR oversight and accountability response (POART), Semi-Annual Program Results (SAPR), and APR; and planning for special initiatives such as SFI, DREAMS, ACT, and VL.

In addition, the PEPFAR interagency team meets quarterly with the CSO community to disseminate information and obtain input on programs with specific considerations for human rights, gender, people with disabilities, KPs, and PLHIV perspectives from their respective representatives and advocates. A detailed matrix on the engagement with CSOs during and beyond COP development is included in the CSO Engagement Strategy and Documentation under supplementary documents section of COP16. The annual PEPFAR Civil Society Engagement Strategy Plan, which is being finalized with CSO leadership, is an annex to the SDS. This plan will also be used to inform the PEPFAR CSO Terms of Reference (TOR) still pending review by CSO leadership and their respective constituents.

2.0 Core, Near-Core and Non-Core Activities

COP16 core, near-core, and non-core activities are aligned with the PEPFAR pivot and the approaches required to achieve sustained epidemic control. The team reviewed the country investment portfolio, as well as gaps and bottlenecks highlighted in the SID, site improvement through monitoring system (SIMS), and efficiencies gained through the SBOR process to bolster efforts for revised clinical guidelines (including Test and START and PrEP) and differentiated service delivery modalities being rolled out during FY16. As PEPFAR is the primary funder of the national response, combination prevention activities and components of community-based care, orphans and vulnerable children (OVC), and priority population prevention are identified as core activities, as is technical assistance for national scale-up of VL testing and for the national procurement and supply chain system. Core activities also reflect investment in Test and START, adult and pediatric ART, PMTCT, and VMMC. Near-core activities were closely reviewed and remained unchanged from COP15. The majority of non-core activities outlined in COP15 are ending in FY16; limited activities have been carried over to COP16 depending on county category and continuing needs to meet COP16 targets. Appendix A provides an outline of core, near-core, and non-core activities and transition plans.

3.0 Geographic and Population Prioritization

The PEPFAR interagency team reviewed the HIV epidemiologic profile based on the new UNAIDS estimates which were calculated using a range of program, surveillance, and survey data. With the availability of these estimates in February 2016, observed changes include a reduction in the total number of PLHIV in Kenya from 1,630,138 to 1,366,771. Specifically, there were reductions in the number of PLHIV in 42 of the 47 counties (highest reduction seen in Kisii, Nairobi, and Turkana counties having 42,981, 21,498, and 28,475 reduction respectively); and minimal increases in PLHIV estimates in 5 counties (highest in Vihiga county at 2,935 increase). These changes necessitated shifts in the county HIV burden prioritization listing, with some counties, notably Bungoma and Trans Nzoia moving up the scale, while Kisii and Turkana moved down the scale.

As a result of a concerted effort to scale up ART in FY15, and taking into consideration the new PLHIV estimates, the national ART coverage increased from 45% in FY14 to 63% in FY15. Furthermore, six scale-up counties (Busia, Kiambu, Kitui, Machakos, Meru, and Uasin Gishu) achieved >80% ART coverage overall by FY15. However, these counties require continued intensified investment to close coverage gaps for men, children, adolescents and key populations. For instance, pediatric ART coverage in these counties ranged from 59%-78%. Moreover, county coverage estimates are skewed by population movement as well as the type and location of facilities within certain counties, such as Uasin Gishu and Busia. While the ART coverage for Uasin Gishu is 100% by Fy15, coverage for residents of this county is below 80%. This county is home to Moi Teaching and Referral Hospital which is one of the two national referral hospitals and has the highest number of patients on treatment who come from across the country. Similarly, facilities in Busia serve a considerable number of non-resident patients including many truckers from across Kenya and the region, as well as patients from bordering high burden counties. Review of ART patient residence information from project records in the largest treatment programs in Usain Gishu and Busia indicated that only 71% and 68% of patients, respectively, were from the two counties; hence the need for continued scale up in these counties.

Based on progress to date, new epidemiologic estimates, and leveraging opportunities, the PEPFAR interagency team aligned the geographic prioritization for COP16. The prioritization allows PEPFAR to most efficiently increase the number of patients on ART by 20% above COP15 targets, while maximizing impact by deepening epidemic control at the sub-national level in the 27 counties which account for over 90% of HIV burden and 92% of ART unmet need. These include 16 counties prioritized for scale up to saturation to achieve >80% ART coverage, and 11 counties prioritized for aggressive scale up (to achieve a range of 50% to 80% ART saturation and close coverage gaps for men, children, and KPs). In COP16 therefore, 293,116 new patients will be initiated on ART, bringing the net new ART patients to 192,719, and the total current on ART at 1,155,970. In line with the pivot, 70% of the new ART patients will be within the 16 counties

prioritized for scale up to saturation, with the five highest burden counties accounting for 57% and two of which (Homa Bay and Nairobi) accounting for 20% of the total number of new ART patients. Within prioritized counties, PEPFAR will target efforts to reach those at higher risk for HIV, those with higher HIV prevalence, and those with poorer access to services such as populations within any geographic hot-spot (towns, transport corridors, beaches, informal settlements, etc.); young women; men; key populations including FSW, PWID, MSM; and fisher-folk. This will bring the national ART coverage to 83% for adults and 77% for children based on the estimated number of PLHIV by the end of FY17.

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

4.1 Targets for scale-up locations and populations

The COP16 targets were set based on the revised 2014 estimates of PLHIV, APR 15 achievements, and expected coverage in FY16. A cascade approach was employed in setting targets, which considered identification of new HIV+ individuals, efficient linkages to care and treatment, and expected loss to follow-up (estimated at 10% for new patients based on current program performance). Overall, COP16 aims to initiate a total of 293,116 on ART, bringing the total number of patients on ART to 1,155,970, 11% of whom are children below 15 years of age. This target represents a 20% increase from COP15. In support of the KASF, which is aligned with UNAIDS 90-90-90, PEPFAR will aim to achieve over 90% PLHIV diagnosed and 83% on ART by end FY17. PEPFAR expects to achieve this increased number of new patients on treatment through the Test and START strategy and cost efficiencies gained through differentiated service delivery models (Section 4.9).

Over 90% of the overall COP16 targets will be met in the 27 scale-up counties (described in Section 3.0) where 273,872 HIV+ individuals will be newly initiated on ART in FY17 (Table 4.1.1). The five highest burden counties will account for 166,664 (60%) of the 273,872 newly initiated on ART in the 27 counties and 57% of all newly initiated on ART nationwide. It is anticipated that in FY17, there will be 184,909 net new patients on ART and 1,049,847 current on ART in the 27 scale-up counties, with 16 additional counties achieving 80% coverage, while the other 11 counties are positioned to achieve saturation by end of FY18 and close coverage gaps. In order to reach the treatment coverage target in the 27 scale up counties, adult and pediatric patients will be identified and linked mainly through high yielding strategies such as provider-initiative testing and counseling (PITC), tuberculosis (TB) program, and PMTCT as summarized in table 4.1.2. A total of 204,411 adults and 33,406 children will be identified through PITC (Table 4.1.2), with 185,561 (91%) adults and 31,431 children (94%) linked to ART

Further, in response to the high TB/HIV co-infection and high TB-related mortality in PLHIV, PEPFAR will endeavor to increase the proportion of TB-HIV co-infected patients on ART from 86% in FY15 to 100% in FY17. This represents an estimated 24,284 on ART in FY17 and will be achieved by better integration of TB and HIV services, as well as strengthening adherence to testing protocols for all TB patients and those with presumptive TB (Section 4.7).

Equally important, PEPFAR prioritized diagnosis and ART initiation for HIV+ pregnant women. The COP16 goal in scale-up counties is to increase testing of pregnant mothers from 93% to at least 95% and increase enrollment into ART programs from 90% to at least 95% of those testing HIV+, with an expected yield of 29,083 patients newly initiated on ART.

VMMC target allocation by county and age group is discussed in Section 4.3, and summarized in table 4.1.3. Targets for community prevention interventions were set using the best size estimation data available and realistic coverage goals for priority populations and KPs in each of the geographic focus counties (Table 4.1.4).

In order to determine resource requirements to meet these ambitious HIV treatment and prevention targets, FY15 expenditure analysis (EA) data were reviewed, and unit expenditures (UE) were adjusted (Appendix B). The UE adjustments reflect improved program efficiencies, including prioritization of activities through core and near core categorization, and potential savings from implementation of differentiated service delivery models (resulting in 17% reduction in clinical visits as described in the "**differentiated service delivery models**" section on page 45), as well as considerations for fixed and variable costs at site level. The above site-level expenditure data were also reviewed through the SBOR process to minimize potential duplication and redundancies, and optimize synergy with other funding sources such as GOK and GFATM. The PEPFAR Budget Allocation Calculator (PBAC) was then used to generate resource needs by computing target based costs applying the adjusted UEs and lump sum costs at site and above-site levels. Additional considerations included contribution from central initiatives such as DREAMS, ACT, VL and VMMC. Finally, a determination was made to continue reducing PEPFAR investment in sustained and centrally supported counties (described in section 5.0) to allow further concentration of resources in the scale up counties.

Performance monitoring will include routine SIMS and other field visits, regular management meetings, and quarterly performance review (programmatic and financial) meetings. In addition, quarterly partner meetings will provide forum for cross-fertilization and sharing of local solutions to overcome barriers to achieving targets. During these meetings, results are disaggregated in order to provide greater granularity to effectively monitor performance alignment with the Kenya pivot. Lastly, implementing partners and USG will reinforce coordination and performance review meetings with national and county to facilitate resolution of policy or systems issues impeding program implementation.

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

Table 4.1.1 ART Targets in Scale-up Sub-national Units for Epidemic Control

SNU	Total PLHIV	Expected current on ART (APR 16)	Additional patients required for 80% ART coverage	Target current on ART (APR 17) *TX_CURR*	Newly initiated (APR 17) *TX_NEW*	ART Coverage (APR 17)
Nairobi	156,772	123,877	-	148,343	36,853	94%
Homa Bay	158,485	102,073	-	135,610	40,201	82%
Kisumu	134,606	89,398	-	121,875	41,417	81%
Siaya	129,424	82,020	-	105,806	30,569	80%
Migori	85,607	58,189	-	69,994	17,624	80%
Kisii	26,921	27,025	-	27,655	3,332	105%
Nakuru	49,193	29,703	-	37,706	10,974	80%
Kakamega	55,149	32,472	-	43,718	13,866	80%
Mombasa	53,040	39,670	-	39,933	4,230	80%
Kiambu	31,174	29,954	-	29,954	2,673	100%
Turkana	16,475	7,705	3,544	10,631	4,671	60%
Murang'a	21,122	14,516	-	16,846	3,781	80%
Machakos	21,932	19,168	-	19,963	2,712	95%
Uasin Gishu	22,972	27,955	-	27,955	5,591	125%
Bomet	22,392	12,619	2,351	16,456	4,898	70%
Busia	27,802	28,738	-	31,363	8,373	110%
Kilifi	27,092	15,273	1,454	20,243	6,487	75%
Nyamira	26,471	12,439	2,543	17,804	6,609	70%
Narok	21,580	9,314	3,492	15,130	7,621	65%
Makueni	17,901	15,048	-	16,989	3,446	90%
Trans Nzoia	20,188	14,518	-	15,097	2,031	85%
Bungoma	24,965	20,714	-	21,542	2,900	85%
Meru	16,478	13,570	-	13,760	1,547	100%
Kajiado	17,635	7,832	3,196	9,294	3,348	60%
Kitui	14,582	14,999	-	16,278	2,750	105%
Kwale	20,576	7,012	6,594	9,607	3,296	50%
Nandi	14,735	9,137	1,471	10,296	2,072	70%
Total	1,235,267	864,938	24,645	1,049,847	273,872	85%

*LTFU for new ART patients estimated at 10%.

Table 4.1.2 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Counties

Entry Streams for ART Enrollment	Tested for HIV (APR 17)	Identified Positive (APR 17)	Newly initiated (APR 17) *TX_NEW*
Adults			
Clinical care patients not on ART and PITC	**6,019,204**	**204,214**	**185,561**
HIV+ TB Patients not on ART	**62,302**	**24,284**	**24,284**
HIV-positive Pregnant Women	**995,417**	**29,083**	**29,083**
Pediatrics			
Clinical care pediatrics not	***1,280,774***	**33,406**	**31,431**

on ART and Provider Initiated Testing			
HIV Exposed Infants	**62,454**	**3,698**	**3,513**
Total	**8,420,151**	**294,685**	**273,872**

Table 4.1.3 VMMC Coverage and Targets by Age Bracket in Scale-up Counties

Target Populations	Population Size Estimate (SNUs)	Current Coverage (end of FY16)	*VMMC_CIRC* (in FY17)	Expected Coverage (in FY17)
0-60 days	**29,150**	**0%**	**4,000**	**13.7%**
10-14 years	**946,304**	**60%**	**139,544**	**74.7%**
15-19 years	**934,589**	**87.1%**	**25,826**	**89.9%**
20-24 years	**965,797**	**96.5%**	**21,699**	**98.7%**
25-29 years	**753,440**	**94.6%**	**19,212**	**97.1%**
30-34 years	**1,042,018**	**60%**	**29,719**	**62.9%**
Total/Average	**4,642,149**	***92.6%**	**240,000**	***95.1%**

Notes:
***Coverage for 15-29 yrs only**

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
KP-PREV			
FSW	**187554**	**69%**	**129,450**
MSM	**26,715**	**74.6%**	**19,930**
PWID	**17,816**	**81.9%**	**14,608**
PP-PREV			
AGYW	**542,893**	**29.4**	**159,864**
Fisher Folk	**122,088**	**84%**	**102,554**
Military	**135,000**	**34.7%**	**46,800**
Prisoners	**0**	**-**	**54,000**
Uniformed Services	**0**	**-**	**90,000**
Total	**1,032,066**	**49.5%**	**617,206**

Notes: AGYW population size estimate for only 4 DREAMS counties (Nairobi, Homa Bay, Siaya and Kisumu)

Table 4.1.5 Targets for OVC and Linkages to HIV Services

	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY17 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY17 Target) OVC_KNOWNSTAT*
Nairobi	**98,954**	**92,597**	**61,198**
Homa Bay	**170,587**	**90,755**	**38,209**
Kisumu	**160,050**	**52,082**	**29,475**
Siaya	**107,301**	**34,164**	**18,622**
Migori	**97,457**	**47,174**	**18,640**

Kisii	**104,561**	**16,949**	**15,008**
Nakuru	**115,453**	**32,394**	**11,242**
Kakamega	**122,248**	**32,742**	**6,197**
Mombasa	**30,335**	**13,510**	**3,196**
Kiambu	**60,462**	**22,682**	**10,359**
Turkana	**26,739**	**3,693**	**1,335**
Murang'a	**50,266**	**5,054**	**(252)**
Machakos	**45,563**	**11,100**	**3,105**
Uasin Gishu	**19,497**	**7,713**	**4,663**
Bomet	**62,853**	**4,305**	**4,023**
Busia	**117,922**	**18,800**	**2,491**
Kilifi	**69,849**	**43,966**	**15,724**
Nyamira	**72,867**	**3,506**	**804**
Narok	**50,164**	**7,388**	**(1,087)**
Makueni	**89,372**	**7,478**	**750**
Trans Nzoia	**95,822**	**1,931**	**1,502**
Bungoma	**58,898**	**21,061**	**4,002**
Meru	**53,110**	**17,459**	**5,856**
Kajiado	**38,165**	**10,393**	**(1,604)**
Kitui	**39,430**	**8,336**	**(1,623)**
Kwale	**87,921**	**5,313**	**1,940**
Nandi	**85,249**	**3,673**	**(1,292)**
Total	**2,131,095**	**616,218**	**252,483**

Program Area Summaries 4.2-4.10

4.2 Priority and key population prevention

Based on PEPFAR's geographic prioritization of HIV services for epidemic control and review of priority and KP program data, PEPFAR will invest in the provision of a comprehensive package of services tailored to each target population. Review of SIMS data for FY15 and FY16 quarter one (Q1) identified the need to focus on improving documentation and completion of service referrals for KP to: a) facilitate tracking of both treatment and prevention cascades; and b) improve ART and VL testing coverage. In addition, the gender analysis identified sexual and gender-based violence and stigma as barriers to KP accessing services.

A human rights-based approach will be adopted to provide services to KP and their sex partners through stand alone and integrated drop in centers (DICE). Services will include condom and lubricant promotion and distribution, HIV testing services (HTS) and linkage to ART, TB screening and treatment referral, sexually transmitted infections (STI) screening and treatment, peer education and outreach, risk reduction interventions, violence prevention and post violence care, alcohol and substance abuse counseling, positive health, dignity, and prevention (PHDP)

and structural interventions to foster an enabling environment for KP to access health services. Kenya will adapt World Health Organization (WHO) PrEP policy and develop guidelines that will support promotion and provision of PrEP to key and priority populations. Targeted coverage for this comprehensive package of services will be 56% of FSW and 76% of MSM in the 16 scale-up to saturation counties and 44% FSW and 24% of MSM in the 11 aggressive scale-up counties. In total, 54,044 KPs will be provided with HTS. Seventy percent of fisher folk will be reached in five of the scale-up to saturation counties (Busia, Homa Bay, Kisumu, Migori, and Siaya). Other priority populations include prisoners and uniformed personnel, including the military. For PWID, PEPFAR will support services offered primarily in safe spaces and integrated sites within public health facilities. PEPFAR will support Medication Assisted Therapy (MAT) and provision of methadone and linkage to the Needle and Syringe Program (NSP). PEPFAR aims to reach 81.9% of PWID with linkage to NSP and condoms, and 83% of PWID with MAT in three scale-up to saturation counties (Kisumu, Mombasa, and Nairobi).

In the 27 scale-up counties, PEPFAR will support intensified demand creation, targeted HTS and linkage to treatment. Innovative approaches include enhanced monitoring for better tracking and retention, implementation of PHDP, creation of PLHIV peer networks, setting convenient working hours, and training of public health personnel in KP friendly service provision. Community strategies will be used to reach KPs and other targeted groups like testing of index clients. The strategy will also be used to reach hard to reach populations like men in scale up to saturation counties. To increase linkage to care and treatment from 87% (APR15) to 95%, PEPFAR will support client escorts, use of telephone and short text message reminders, and community follow-up by peer educators. In low burden counties, PEPFAR will collaborate closely with the GOK to maintain support to KPs on care and treatment.

To reduce new HIV infections among adolescent girls and young women (AGYW), PEPFAR will implement the DREAMS Initiative in four scale-up to saturation counties: Homa Bay, Kisumu, Nairobi, and Siaya. The core package of services includes school-based HIV and violence prevention, post-violence care, condom promotion and provision, HTS and linkage to ART, PrEP promotion and provision, expanded contraceptive mix, social asset building, educational subsidies, cash transfer, community mobilization for normative change, parenting/caregiver skills building, characterization of male sexual partners (MSP) of AGYW ages 15-19 and 20-24 and linkage of MSP to HTS, VMMC and ART. The service package will be offered through adolescent friendly safe spaces and referral to health facilities and other community services. In addition, PEPFAR will fast track implementation of PrEP and Test and START in the four DREAMS counties prior to roll out in other counties. PEPFAR will support the NACC and the respective four county governments to strengthen coordination of AGYW programs and maximize synergies with other investments. DREAMS will leverage the PEPFAR commodity budget for HTS supply, USAID for contraceptive commodities, and PEPFAR supported OVC, VMMC and ART programs in the four scale-up to saturation counties. In addition to DREAMS central resources for the combined socio-economic approaches described above, the HQ guidance and forums for South-

South exchanges have helped the in-country team make multiple and complex decisions that allowed for fast implementation of the program and advanced shared learning.

Through active engagement of KP and priority populations, CSOs, and local communities and other stakeholders, PEPFAR will tailor investments to address stigma and discrimination, harmful cultural norms, and other barriers that impede the health and empowerment of priority and key populations. PEPFAR will utilize service uptake data to forecast site-specific commodity needs and work closely with the Kenya Medical Supplies Agency (KEMSA) to ensure KP service delivery points receive uninterrupted supplies of commodities such as RTKs, condoms, lubricants and methadone.

4.3 Voluntary medical male circumcision (VMMC)

Considering the overall male circumcision (MC) rate of 91% in Kenya, the national program focuses in non-circumcising communities in the former Nyanza region, parts of Rift Valley, and pockets in other counties. Since 2014, Kenya has implemented a second national VMMC strategy with a target of 1,001,757 circumcisions, while addressing cultural barriers to achieve 80% MC coverage in all priority counties by 2019.

Counties with MC coverage below 80% at the beginning of the second strategy (Homa Bay 56%, Kisumu 59%, Migori 73%, Siaya 56%, Turkana 26%) were prioritized for program roll-out to achieve 80% coverage by 2019. Counties with MC coverage above 80% but hosting pockets of non-circumcising populations were also prioritized for VMMC program implementation – namely Busia, Kericho, Nairobi, Nandi, and West Pokot. VMMC priority counties are among the 27 counties prioritized for ART saturation by end of FY17 to achieve epidemic control. While the VMMC program has performed well, review of SIMS data for FY15 and FY16 Q1 shows that there is room for improvement in clinical follow up for VMMC clients. In order to improve post- operative follow up, facilities will be encouraged to form continuous quality improvement (CQI) teams to identify the gaps in the follow up system and making the necessary changes. All VMMC providers will be reoriented on the importance of using the MOH ME and reporting tools and reminding them of the importance of the day 7 follow up. The service providers will also be reminded to continue providing consistent and correct information on follow up to all clients and provide follow up services according to the national VMMC package of care. Through the facility ME and CQI meetings the service providers will review the client data and all records to ensure that data is correct and up to date. The mobile and outreach services staff will also be looped in to help increase the follow up coverage This will be an important area of focus in COP16. Furthermore, to ensure efficient use of resources, the program will align with core/near-core/non-core framework outlined in section 2.0 and appendix A. Importantly, PEPFAR Kenya will leverage and ensure continuity of activities supported through the VMMC central initiative.

The COP16 VMMC target of 240,000 circumcisions represents a 14% increase in the five VMMC priority counties and an overall 20% increase. This target aims to accelerate saturation in VMMC priority counties by 2017 and close coverage gaps in other scale-up counties with pockets of non-

circumcising communities. A recent modelling exercise revealed that all VMMC priority counties are approaching or may have achieved 80% coverage for the 10-29 and 15-29 male age bands; only Turkana County has less than 50% coverage. When age bands are disaggregated, coverage varies even among counties. Most counties have saturated or will nearly saturate the 15-29 age band by APR16; however, certain counties will have less than 80% coverage in the 10-14 age cohort. In FY17, PEPFAR will continue to support the GOK VMMC strategy through county specific targeting to address unique age-groups with suboptimal MC coverage (e.g. greater emphasis on boys 10-14yrs in Homabay and Siaya, but to a lesser degree in Kisumu and Migori where this age band has already achieve 80% coverage) to reach and sustain 80% coverage for males 15-29 as a pre-condition to target other age bands.

In support of government led-sustainable models and policies in the National VMMC Strategy, PEPFAR will leverage central funding to validate the coverage of the 15-29 age band in the priority counties. To sustain 80% VMMC coverage beyond 2017, the program focus will shift towards circumcising annual cohorts of boys as they transition to the 10-14 year age band and newborn males aged 0-60 days in the priority VMMC counties where saturation among males 15-29 has been comfirmed. Concurrently, emphasis will be placed on transitioning VMMC services to government-led sustainable models of service delivery.

4.4 Preventing mother-to-child transmission (PMTCT)

PEPFAR continues to strive towards the virtual eMTCT as a lead technical partner to the MOH, and through implementing partners who serve approximately 95% (71,488) of the HIV infected pregnant population: 92% of whom are in the 27 (high burden) scale up counties.

In FY15, 1,233,462 (97%) of the approximately 1,273,731 pregnant women attending ANC in PEPFAR-supported health facilities were offered HTS, representing 74% national coverage. Overall, 61,510 (5%) were identified as HIV+, representing 82% of all identified HIV+ pregnant women in Kenya. Of these, 55,400 (90%) were provided with ARV prophylaxis for PMTCT, representing a national coverage of 74%. In line with the current national PMTCT guidelines, the vast majority (98%) of the women received life-long ART, up from 57% in FY14. In FY15, 48,310 infants were tested for HIV within 12 months in the PEPFAR supported sites, contributing to the national coverage of 65%. Among those tested, 66% were tested within 6-8 weeks in line with the national policy. Overall, 5.4% of the tested infants were HIV+; the positivity rates were 3.2% among those tested within 6-8 weeks and 9.5% among those tested between 2 and 12 months within PEPFAR supported sites. Consistent with this finding, review of SIMS data for FY15 and FY16 Q1 identified gaps in uptake of HIV testing for women during delivery and postnatal period, ART uptake for HIV+ pregnant and breast feeding women, early infant diagnosis and retention of mother-infant pairs.

To balance the elimination goals in Kenya with epidemic control in the 27 scale-up counties, COP16 PMTCT targets were set to reach 95% of pregnant women attending ANC with HTS and to

initiate 95% of identified HIV-infected women on ART in the 16 scale up to saturation counties. Based on existing data, all 27 scale-up counties have gaps in testing as well as ART uptake and adherence. Therefore, PEPFAR will support the 27 scale-up counties with health worker recruitment and capacity building in addition to support for implementation of the minimum service delivery package. PEPFAR will also support targeted community strategies and strategic engagement of private providers to improve identification and enrollment. Early (same day) ART initiation for HIV+ pregnant and breastfeeding women will be reinforced with support for adherence and retention, including use of mentor mothers (peer support) at the facility and community. Clinical monitoring of HIV+ pregnant women, including VL testing will be implemented, with targeted support for women with detectable viral load such as adherence support, repeat viral load testing and regimen adjustment per national guidelines.

To improve monitoring of the mother-baby pair through the end of the breastfeeding period, PEPFAR will scale-up use of longitudinal HIV exposed infant (HEI) birth cohort reporting (HEI cohort registers) and HIV-infected Infant Tracking System (HITS). With PEPFAR supported pilots, HEI cohort registers have been shown to improve retention to 86% and HITS has been shown to improve linkage to 79%.

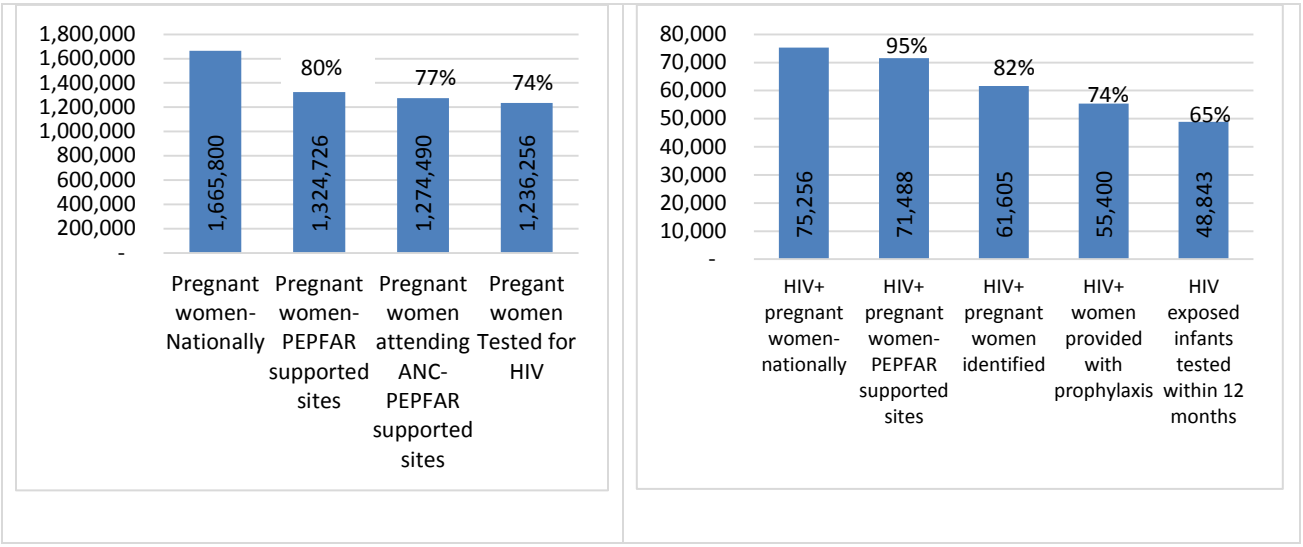
In the highest HIV burden and incidence counties, a comprehensive set of strategies will be implemented to prevent new HIV infection among women of reproductive age, including during pregnancy and breastfeeding. These will include HTS for women of reproductive age using the maternal and child health (MCH) platform, provision of HIV testing for sex partners, and repeat HIV testing during late pregnancy and postpartum period. Furthermore, in these counties, universal HIV testing will be conducted, VMMC services offered to male partners in non-circumcising communities, ART initiated for all HIV+ individuals (Test and START), and PrEP offered to HIV- women in sero-discordant relationships, including those who are pregnant and breastfeeding. Through the DREAMS Initiative, a package of prevention interventions will be implemented targeting AGYW at risk of acquiring HIV. To eliminate unmet need for family planning (FP) among HIV+ women of reproductive age, FP services will be integrated at MCH and in ART clinics, and linkages to other USG and non-USG support for contraceptive commodities will be strengthened to maximize FP/HIV integration.

Efficiency Analysis

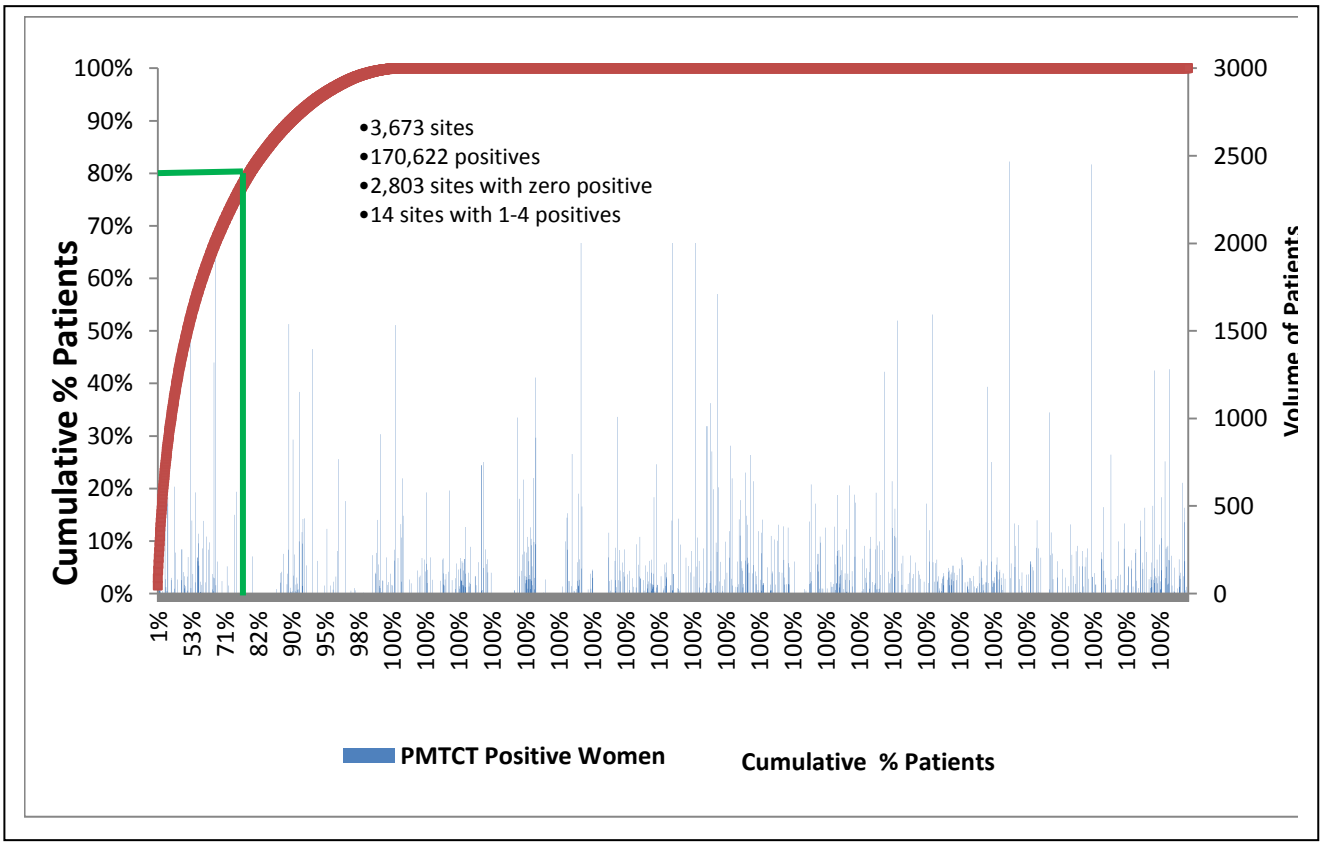
PEPFAR continues to support the GOK in the elimination of MTCT as a lead technical partner to the Ministry of Health and through implementing partners serving approximately 95% (71,488) of the HIV infected pregnant population, 92% of whom are in the 27 (high burden) scale up counties, 7% in the 13 sustained counties, and 1% in the seven central support counties. While support in the scale up counties includes community mobilization to boost ANC attendance, sustained counties only receive services for women who present in the facilities; central support counties access commodities and national level quality assurance activities.

Among the 27 scale-up counties, the five highest burden counties account for 53% of women in need of PMTCT while the other 22 counties account for 39% of national need. The COP16 target for pregnant women on ART in the 27 scale up counties represents a 30% increase compared to the FY15 results in these counties. The increased treatment targets are expected to be achieved through a combination of increased yield from testing, improved linkage and intensified services for initiation and maintenance on ART.

Figure 4.4.1: PMTCT Program Performance, FY15



PMTCT Yield by Site and Cumulative Number of Known HIV Positive Pregnant Women, FY15



The analysis of the graph above indicating 2,803 PMTCT sites with zero positive and 14 sites with 1-4 positive, is based on FY15 data to include the sites transitioned during COP14. PEPFAR Kenya PEPFAR Kenya supports the government's goal to eliminate MTCTC (eMTCT), while ensuring that efforts are aligned with OGAC guidance and the pivot. Direct service delivery and facility with low HIV+ yield (<5 positives) will continue to be transitioned to the GOK by the end of FY16, at which time none of these sites will receive PEPFAR support for PMTCT services. The team is working closely with national and county levels to ensure the continuity of high quality service delivery during this transition.

4.5 HIV testing services (HTS)

In accordance with the geographic and population prioritization outlined in Section 3.0, targets for HTS were calculated based on cascade analysis to meet the target number of new treatment slots in the 27 scale up counties (Section 4.1). The calculation of the number of new PLHIV that needs to be identified factored county data on HTS positivity, linkage to enrollment in HIV care (90%) and estimates of loss to follow-up (LTFU) (10% for newly enrolled patients). The approaches and scale of coverage are tailored to the distinct geographical prioritization categories. For the 16 scale-up to saturation counties, PEPFAR will support universal PITC in all supported sites, home-based HTS in high density and higher prevalence areas, testing of PLHIV family members, and HTS outreach to key and priority population hotspots. For the 11 aggressive scale-up counties, PEPFAR will support prioritized PITC in health facilities among high-yield populations, expanded high-yield index patient-partner and patient-family testing, and targeted HTS outreach to key/priority populations in hotspots. PEPFAR will support community testing and effective linkage in the five highest burden counties targeting priority populations such as fisherfolk as well as men and their families in hard to reach areas and informal settlements. Targeted HTS community testing within the 27 scale-up counties will reach 228,974 people in the 16 scale-up to saturation counties and 47,591 people in the 11 aggressive scale-up counties.

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

To ensure optimal HTS performance, strategies will be implemented in order to address areas needing improvement based on review of SIMS data for FY15 and FY16 Q1. These include capacity building for service providers on proficiency testing and quality assurance, improvement of the supply chain to eliminate testing interruptions in the scale up counties, scale up of approaches known to improve HIV+ yield, strengthening of linkage to ART and adoption of WHO/National Test and START Guidelines.

In addition, PEPFAR Kenya will aim to address a key gap identified through the gender analysis - the low (and late) HIV testing coverage for men and KPs. This will be achieved through innovative strategies for early identification of HIV positive men through home and work place testing and multi-disease screenings for non-communicable diseases (NCD) and strategies for improving HTS coverage for key populations.

Using the EA data by mechanism and by county, PEPFAR Kenya determined the 2015 average expenditure per test of $2.6 in facility based HTS and $14 for community-based HTS as being adequate (Appendix B). To address the potential challenge of shortage of RTKs, PEPFAR Kenya engaged with GOK and GFATM to develop strategies to ensure sufficient funding and commodity security at national, county and facility level.

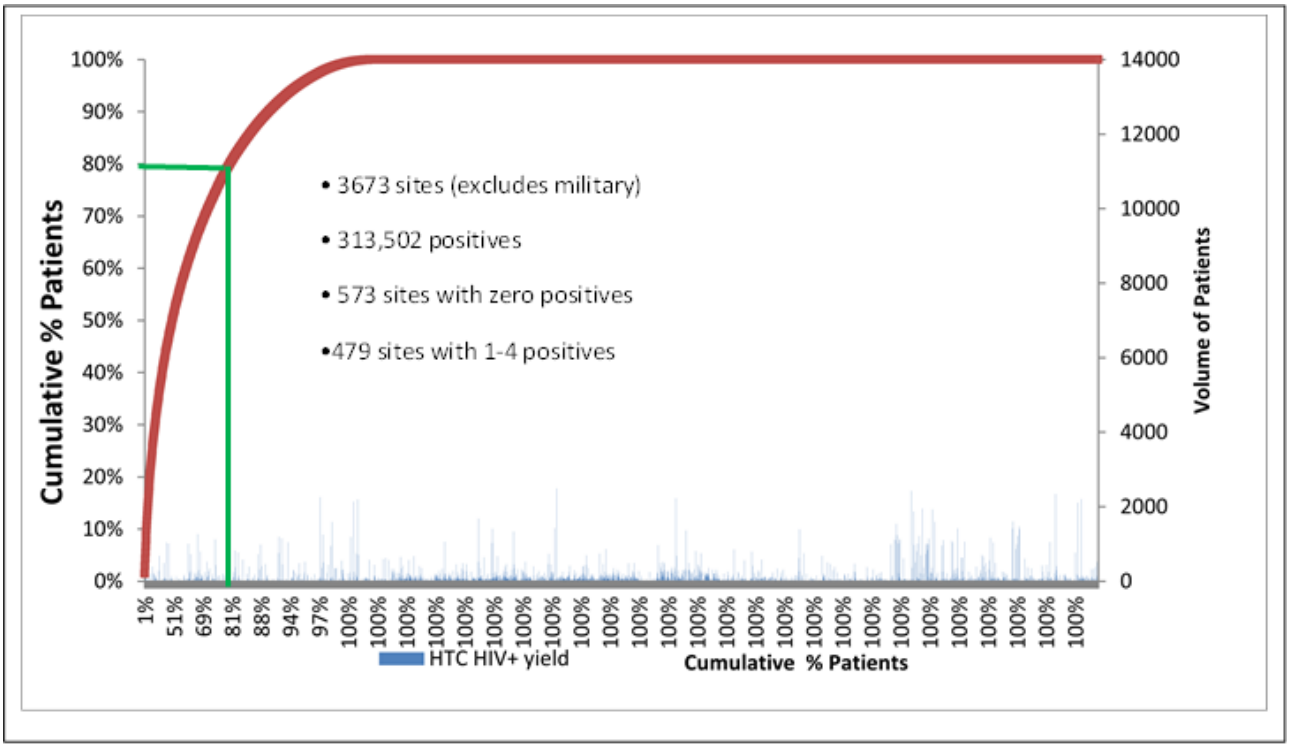
Currently, the GOK through NACC is spearheading a strategy to increase domestic resource mobilization. NACC has created a directorate of domestic resource mobilization and are engaging various stakeholders. Kenya will conduct a forecasting and quantification exercise in June 2016 to determine the HIV commodity needs beyond 2017. The HIV commodity supply chain is well integrated and managed by KEMSA, providing the GOK better visibility on the total commodity usage and requirements.

Efficiency Analysis

Following yield analysis, PEPFAR has in the last two fiscal years transitioned HTS services at 2,245 sites to the GOK, and will continue this analysis (including consideration for impact of RTK stock outs on facility yield) to ensure HTS is conducted in sites that yield at least five HIV+ individuals per year. By the end of FY15, 27 out of 47 counties accounted for 90% of the total HIV infected persons identified. Counties contributing the greatest number of tests and HIV+ identified are aligned with the scale up to saturation and aggressive scale up counties. As PEPFAR continues to pivot towards the prioritized counties and populations, more people will need to be tested in order to reach those HIV+ individuals who are yet to be identified. As per the APR15, the overall HTS yield stood at 3.3% down from 4.2% and 3.6% in 2013 and 2014, respectively. PITC in different settings of the health facilities continues to be the most cost-effective testing strategy - that produces high yield across all focus counties. Modalities to institutionalize PITC and ensure that HTS is offered as a routine service in all health facilities in the prioritized counties will be supported.

The analysis below of the 573 HTC sites with zero positives and 479 sites with 1-4 positives is based on FY15 data and include facilities that were transitioned during COP14. PEPFAR Kenya is committed to ensuring HTS is focused on high yield sites to maximize efficiencies of high quality services. The transition from low HIV+ yield (<5 positives) to GOK , which begun during FY15, will continue such that by end of FY16 all direct service delivery and facility monitoring will be provided by the GOK. The team is working closely with national and county level to ensure the continuity of high quality service delivery during this transition.

HTS Yield by Site and Cumulative Number of Positives identified, FY15



4.6 Facility and community-based care and support

During COP16, PEPFAR will continue to support a standard package of care and support services in the 16 scale-up to saturation and 11 aggressive scale-up counties. As part of the core, near-core, non-core exercise, care and support services currently provided were prioritized, and a core package was identified (Appendix A), which includes TB screening, isoniazid preventive therapy (IPT), nutrition assessment counseling and support (NACS) and therapeutic feeding for severe acute malnutrition (SAM), provision of cotrimoxazole, cryptococcal screening, ART monitoring as per national guidelines and promotion of PHDP.

Strategies will be implemented to improve and measure linkages to care from HTS, currently averaging 89% among those who know their status (KAIS 2012), and from facility to community-based services, a weak area identified in the initial SIMS visits. Efforts are underway with the MOH to develop national guidelines and tools for tracking linkages between services. Additionally, PEPFAR will invest in piloting innovative models for extending care and support services to priority populations who report difficulty in accessing traditional clinical platforms. These will include differentiated care models, extensive peer networks, mobile care and treatment services, and moonlight clinic hours for sex workers and men-only clinics on Saturday mornings. In order to accomplish this scale-up, PEPFAR and GOK (both national and county governments) are working on a HRH transition plan to absorb hired health care workers into civil service.

Improving retention in care remains a high priority for PEPFAR. Current data reveal a five times higher LTFU of patients who are not on ART compared to those on ART (NASCOP, 2014). With the 2016 adoption of WHO guidelines that recommend Test and START, it is anticipated that a proportion of the COP16 treatment targets will be reached by enrolling all newly eligible patients currently in care, thereby improving retention. Furthermore, PEPFAR Kenya will utilize evidence based strategies, such as community support groups, multi-disease prevention programs, differentiated service delivery models and other innovative strategies to retain patients in care.

4.7 TB/HIV

Kenya is a high TB burden country with an estimated prevalence of 120/100,000 and 80% case detection rate for all TB cases. In FY15, 83,359 of the WHO estimated 110,000 incident TB cases were notified and 33% of these were HIV infected, including 16,710 newly testing positive. The majority (88%) of TB/HIV cases are within the 27 scale-up counties, with 31% in the five highest burden counties. In Kenya, 97% of identified TB patients are tested for HIV and 94% of HIV/TB patients are on ART during TB treatment (Kenya TB program data FY15). While TB and HIV services are integrated in 90% of PEPFAR-supported ART sites and TB screening has been institutionalized in PEPFAR-supported ART sites, the low yield (2%) suggests the need to address the quality of screening.

Recently, the GeneXpert® mycobacterium TB and rifampicin resistance (MTB/RIF) test was made the initial diagnostic test for PLHIV presumed to have TB. A total of 126 GeneXpert® machines (including 42 PEPFAR-procured) were installed across Kenya and a specimen referral network was established to cover all HIV treatment sites countrywide. Efforts are underway to optimize machine utilization from the current 50% to 80%. TB infection prevention and control (IPC) remains a major challenge; 14 of 44 health facilities visited during the recent TB program review reported at least one health worker with TB in the preceding two years. These findings corroborate those of the recently concluded SIMS visits where 26% of the 377 facilities visited were found to require TB IPC remedial action.

Kenya recently launched IPT for PLHIV on a national scale, targeting to reach 80% national coverage by end of 2016. By the end of the first quarter FY16, 125,000 (13%) of the patients currently in care had been initiated on IPT. We aim to scale this up to 500,000 by end of FY16 and 800,000 by end of FY17.

With COP16, PEPFAR will focus on core TB/HIV activities to reach universal ART coverage among HIV-infected TB patients and address program areas identified as weak during review of SIMS data for FY15 and FY16 Q1. These include:

- Universal HIV testing for patients with presumed or diagnosed TB, and timely access to ART for those with HIV infection. Integration of ART in TB clinics in priority/scale-up counties to overcome persistent challenges with linkage to care and retention.
- Strengthen TB IPC in health care settings in anticipation for higher numbers of patients in care as well as conducting of surveillance of TB among health care workers.

- Support TB screening and active case finding in HIV, MCH and prison clinics and other hospital settings, diagnostic work-up and appropriate management as per the national TB guidelines.
- Strengthen and expand specimen referral network for GeneXpert testing to ensure early TB case detection and management among PLHIVs including drug resistant TB surveillance.
- Strengthen and expand continuous quality improvement for GeneXpert, smear microscopy and TB culture through external quality assurance including proficiency testing.
- Ensure that 80% of HIV patients screening negative for TB are initiated on IPT, followed-up, and reported. Monitoring and evaluation, including integration of the TB web-based surveillance system with the existing electronic medical record (EMR) systems in HIV clinics.

4.8 Adult treatment

By the end of FY15, 972,193 out of the total 1,366,771 PLHIV in Kenya had been diagnosed and linked to care, 857,472 were currently on ART and an estimated 726,370 virally suppressed. Review of SIMS data for FY15 and FY16 Q1 indicates the need to improve linkage, optimize ART initiation, viral load monitoring and strategies to improve adherence and retention. In line with KASF, PEPFAR aims to newly initiate 293,116 PLHIV (89% of these will be adults) on ART, bringing the total number of patients on ART to 1,155,970 in FY17, a 20% increase from FY16. To achieve these ambitious 90-90-90 targets, MOH with support from PEPFAR and other stakeholders are in the process of reviewing the Kenya ART guidelines to include Test and START (to ensure all identified patients are started on ART). The MOH/NASCOP has convened several meetings with the national treatment advisory committee consisting of university experts, technical staff from development partners (CDC, USAID, WHO, UNICEF, UNAIDS), implementing partners, CSOs and other stakeholders to initiate and support the guideline review and writing process, with a target to complete and start nationwide implementation by July 2016. The government has issued official communication allowing the implementation of Test and START in the four DREAMS dDiscussions are underway to address operational issues at the national and county level. Per the current plan, there will be immediate enrollment of the 46,391 pre-ART patients and all newly identified patients in the four DREAMS counties. Once the guidelines are launched, the country will roll out Test and START nationwide. However, PEPFAR support will focus on the scale up counties. With resource allocation for treatment based on unmet need in these counties, this approach will ensure strategic scale up while also making significant contribution to the national roll out of Test an START since these counties account for 90% of HIV burden. The majority of ARVs are procured through GFATM and PEPFAR, with GFATM procuring all pediatric drugs. Based on current funding, planned procurements, and national and PEPFAR treatment targets, there are no anticipated ARV shortages through December 2017, even with the implementation of Test and START.

In FY17, linkage to ART for patients identified HIV positive will be enhanced to achieve the 90% target. In the APR15 report, 84% of adults >20 years identified HIV+ were enrolled in HIV care, and 91% of those linked to care were initiated on ART. According to KAIS 2012, linkage to care

services in adolescents and adults who knew their HIV status was higher at 89%, suggesting a proportion of patients identified HIV+ eventually link to care over time. Strategies to enhance ART linkage will include same day ART initiation with continued adherence support (shown to be feasible in the SEARCH Study model), use of linkage officers and registers, and continued follow up of patient cohorts who do not link immediately to support their linkage within 6-12 months (also shown to be effective in the SEARCH Study model).

Men, young women, adolescents, key and priority populations have lower care/ART coverage. The PEPFAR Gender Analysis shows that 33% adult PLHIV on ARV are male compared to 67% female (APR15). PEPFAR will utilize community mobilization strategies targeting men (including lessons learnt from the SEARCH Study) and adolescents through establishing a Public-Private-Partnership (PPP) to use NCD platforms for comprehensive and integrated services to better reach men; and leverage DREAMS activities being implemented in four high burden counties to improve ART coverage for adolescents and young women. PEPFAR will also employ peer-based models and drop-in centers to reach more key populations as limited data show 34% and 6% ART coverage among FSW and MSM respectively.

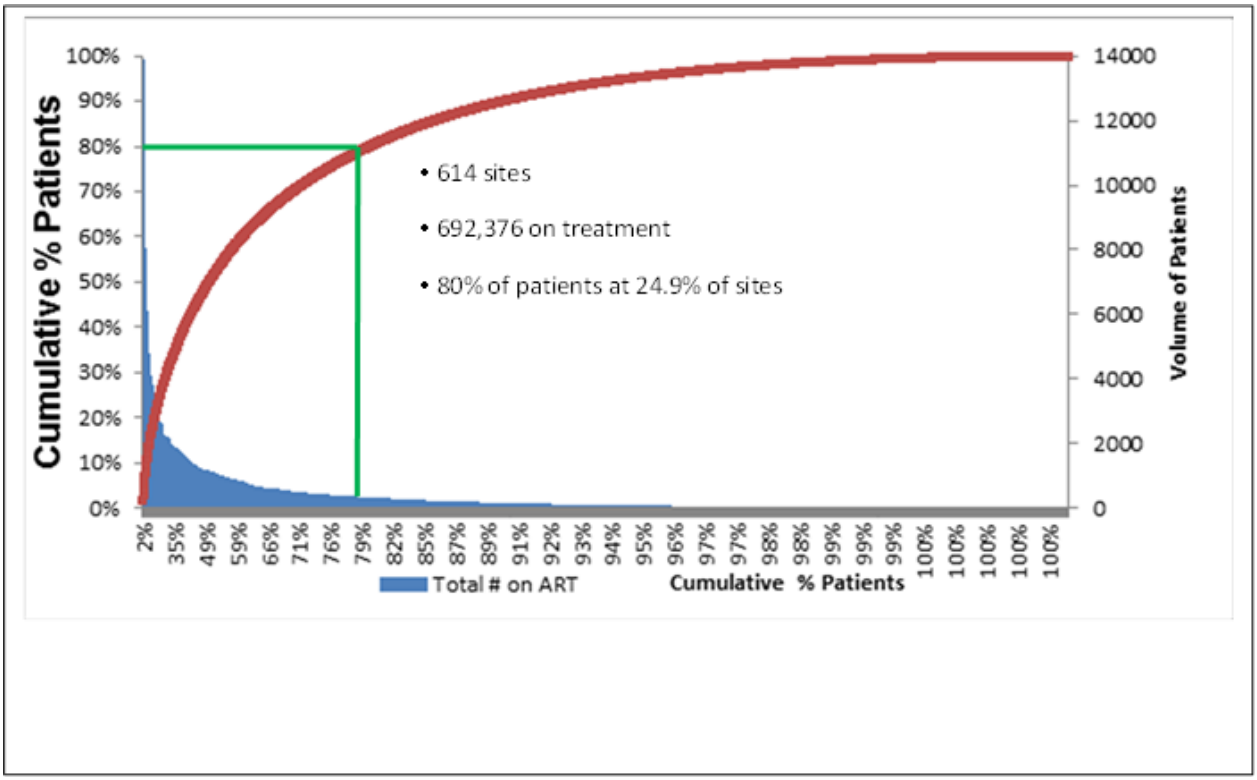
From a 2012 cohort analysis, retention in care at 12 months for adults was estimated at 75%, which improved to 84% in the past year. To further improve retention and adherence, facility and community initiatives will be implemented, including stigma reduction, patient literacy, implementation of PHDP interventions, age and gender appropriate support groups, targeted home visits, and timely defaulter tracing. Children and adolescents living with HIV who have socio-economic challenges will also be linked appropriately to OVC programs and other community support programs such as cash transfer programs under Department of Social Services and bursaries under 'Wings to Fly' program offered through Equity Bank.

Only about 65% of all PLHIV on ART is currently accessing the required routine viral testing - at six months of ART initiation and annually thereafter; only 85% of adults accessing VL testing were virally suppression. In FY16, Kenya received $3 Million catalytic funds to scale up access to VL by hiring more staff in the testing labs, improving VL networks (expanding and strengthening sample transport and return of results), and strengthening the already existing NASCOP data base used to monitor VL uptake and suppression rates. The country is working with Roche to validate the use of DBS on the Roche platform as well as with Abbott to ameliorate their support services by supplying new machines to replace very old machines. The MOH understands the critical role that the Abbott platform plays, and PEPFAR will continue to collaborate with Abbott to improve their services.

In FY17, clinic-based quality assurance systems will be enhanced to support full patient viral load access, and VL networks and use of the web-based data base will be optimized. Further, clinical mentorship (with more emphasis on pediatrics, pregnant women, and adolescents) will be supported to improve utilization of VL results for patient management in order to support achievement of 90% viral suppression.

ART volume by site and cumulative number of patients on ART, FY15

By end of FY15, 173 ART facilities had 1-9 patients while 604 sites had 10-49 patients on treatment. A total of 92 sites with 10-49 ART patients are in sustained counties while 32 facilities are in the central support counties. Therefore in FY16, sites with less than 10 ART patients are being consolidated, irrespective of location. PEPFAR support is being transitioned to GOK in facilities with less than 50 patients in the sustained counties; in the seven central support counties all direct service delivery activities will be transferred to GOK except for commodities, lab network support, and quality assurance activities. Geospatial analysis and stakeholder consultation at national and county levels have begun to ensure a smooth transition while monitoring low volume ART sites in priority counties. As the country prepares for Test and START, select low volume facilities in the high burden counties will be considered for fast-track ART delivery (i.e. prescription pickups for stable patients). A number of the low volume ART sites are private sector sites, receiving minimal PEPFAR support yet are critical for sustainability because the patients are able to contribute towards their care.



4.9 Pediatric treatment

Implementation of the ACT initiative coupled with mid-2014 revision of Kenya's guidelines (supporting ART for all children <10 years and adolescents with CD4 ≤ 500 cells/mm3) led to

rapid scale up of pediatric ART. At the close of the first year (FY15) of ACT implementation, 78,238 children were on ART, achieving 73% of the two-year ACT target of reaching 107,693 children with lifesaving antiretroviral. In FY16, the MOH is implementing a national rapid results initiative (RRI) to enrol an additional 28,251 children on ART in FY16 to close the gap. PEPFAR is closely working with the MOH to achieve this ambitious goal by adopting targeted, high impact interventions across the entire pediatric and adolescent HIV care and treatment cascade. Review of FY15 and FY16 Q1 SIMS data identified the need to improve facility-community linkage, routine HTS and VL load monitoring among children, and adolescent HIV services.

With COP16, PEPFAR will maintain the momentum gained during the ACT initiative to reach 126,515 (77% national coverage) children on treatment by end of FY17. To achieve this target, PEPFAR, in collaboration with the MOH, will further expand high yield pediatric testing efforts based on geographic and patient-clinical probability index (e.g. family and index testing, screening of infants for HIV exposure and early infant diagnosis (EID) support, in-patient testing, and prioritized out-patient screening). PEPFAR will also support efforts to improve follow-up of the mother-baby pair through longitudinal cohort tracking (HEI and HITS), optimize use of the immunization platform - which has over 90% coverage - for EID and linkage to ART for those HIV+, and use HTS linkage register and linkage officers.

Key implementation priorities of quality pediatric and adolescent care and support include opportunistic infection (OI) screening and prevention with universal provision of cotrimoxazole (CTX) and IPT, nutritional support, strengthening of psychosocial support systems, and defaulter tracking to improve retention. PEPFAR will support implementation of the MOH adolescent package of care (APOC) through roll out of age-disaggregated monitoring and evaluation (M&E) tools that are currently being piloted and training of health care workers (HCW) to implement adolescent friendly services, support adherence and address sexual reproductive health issues. Efforts will ultimately increase adolescent access to ART, improve treatment outcomes, and facilitate effective transition to adult care services.

The APR15 report showed 89% retention at 12 months for children newly initiating ART, but much lower for the very young (<2 years) and adolescents. Given the high risk of treatment failure, as evidenced by the national VL data that shows viral suppression rates (<1000 copies/mL) of 69% among children 0-14 years, while a recent survey showed drug resistance mutations (mainly to non-nucleoside reverse transcriptase inhibitors (NNRTIs)) in 89% of those who were not virally suppressed, treatment monitoring will be strengthened through routine VL testing and adherence assessment for children and adolescents on ART as per the national guidelines. Furthermore, GFATM will continue to make available lopinavir/ritonavir (LPV/r)-based regimens (including use of LPV/r pellets) for children < 3 years to enhance use of better regimen and adherence to assure viral suppression.

PEPFAR continues to support GOK to optimize the pediatric ARV formulary to be consistent with the inter-agency task team (IATT) Optimal Formulary List. There have been no reported ARV stock outs for the last two years. During FY17, GFATM will support procurement of 1st line and

2nd line pediatric ARVs, and provide 3rd line ARVs for children in conjunction with Janssen pharmaceuticals.

Differentiated service delivery model for Adult and Pediatric Treatment: To optimize quality ART service delivery, Kenya will implement a differentiated service delivery model which will take into account the unique needs of stable patients and those who require more frequent monitoring. Stable patients defined as those who have been on ART >1 year, have completed TB treatment, have no active OIs, are adherent to ART, and have a VL<1000 copies/ml; will be supported through the fast track service delivery model. This will entail a facility-based clinical review every 6 months, during which eligibility criteria as a stable patient will be reviewed, an essential package of care provided including symptom review and physical examination, adherence assessment, TB screening with the intensified case finding (ICF) tool and VL monitoring as per the national algorithm; a 3-month supply of ARV will be provided along with a prescription for an additional 3-month ARV refill. The 3-month ARV refill will either be provided: a) in the health facility through a fast-tracked process (directly to pharmacy dispensing window, or to reception-triage-pharmacy, without queuing for a clinical review); or b) through a community-based refill either by qualified healthcare professional or trained lay health worker using pre-packaged supply for individual patients (such as community health workers (CHW) and community health extension workers (CHEW), peer educator, support group member) with appropriate documentation of the encounter.

Unstable patients are those who have been on ART for less than one year, who are ill, have TB (due to the current policy for monthly TB drug pickups, and require close monitoring to reduce the risk of death among TB-HIV co-infected patients on ART), are non-adherent to ART, have VL>1000 copies/ml, are under the age of 18 (for dose adjustment based on weight increases, as well as enhanced adherence support to improve viral suppression from the current 65% to 90%), or are pregnant or breastfeeding (require close monitoring to improve viral suppression from the current 80% to 90% and ensure viral suppression at delivery and during the breastfeeding period). These patients will continue with current bi-weekly visits for the first month, then monthly clinical appointments for the first 3 months, quarterly visits thereafter, and progress to 6-monthly appointments once considered stable. Additionally, these unstable patients will receive targeted adherence support in the community. This model is expected to reduce the number of visits from the current estimated of 4,998,041 to 4,129,338 (17% reduction).

The implementation of differentiated service delivery models will be monitored through site visits, routine (quarterly) partner progress reviews, semi-annual and annual partner progress reports. Retention and viral suppression are the key indicators of the impact for these interventions and will be monitored through the quarterly, semiannual and annual reports, as well as surveys. In addition, scheduled PEPFAR and GOK-led county and national stakeholders meetings will be held to share best practices and partner experiences for potential replication and scale-up; opportunities for partner learning visits will be explored.

Health Systems Strengthening for Adult and Pediatric Treatment: For 90-90-90 and sustained epidemic control to be realized, COP16 will prioritize strategic investments in key health systems. For **HRH** systems, PEPFAR will strengthen pre-service health worker training; build county capacity to improve recruitment, performance, deployment and retention of health workers, and to develop a staff transition plan from PEPFAR support to county government budgets; and institutionalize use of human resource information system (HRIS) data to inform workforce planning and budgeting.

PEPFAR will strengthen **supply chain management** by building capacity of county commodity security teams to effectively oversee commodity management systems for improved quantification, pipeline monitoring, tracking and reporting of commodities. As part of the quality improvement of **laboratory systems** to support epidemic control, PEPFAR will enhance the MOH's capacity for national coordination of lab services, including coordination of the integrated External Quality Assessment Scheme (EQAS). PEPFAR support in **health financing** will include evidence generation to inform advocacy, planning and resource allocation for HIV. Activities will include support to MOH to track expenditures and identify financial resource requirements for the national HIV response, program based budgeting to improve efficiency and ensure prioritization of HIV in county health budgets; and technical assistance to identify feasible options for domestic financing.

4.10 Orphans and Vulnerable Children

Kenya has an estimated 2.6 million OVC (KAIS, 2012) of whom up to 1.1 million are estimated to be orphaned due to AIDS related deaths (UNAIDS, 2014). The estimated 32,986 annual AIDS-related deaths will lead to continued increase in the number of AIDS orphans in Kenya (UNAIDS, 2014).

PEPFAR OVC programs continue to shift geographically, aligning with the epidemic profile and where OVC unmet need is greatest. In COP16, PEPFAR will reach 616,218 children in the 27 scale-up counties, approximately 84% of the COP15 target of 726,931 children. The target reflects a deliberate shift in programming to focus on the quality of the package of support and accelerated transition of beneficiaries in sustained counties and central support counties. This approach to service coverage aligns geographically and programmatically with treatment scale up and DREAMS.

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 to implement a phased transition plan of OVC support out of low burden counties throughout FY17. The plan will cease enrollment of new beneficiaries and graduate children and families on a rolling basis starting in the seven lowest burden counties. PEPFAR will provide technical support for the transition of beneficiaries in these counties, including household economic strengthening

interventions and strategies to transfer the most destitute children and families to other available programs. Household assessments will be carried out in these counties to identify those children whose families meet the economic threshold for graduation and identify those households that will need further support to be handed over to county services. Integrated and contextualized family resiliency models will better position target households for graduation and/or transitioning. For a detailed summary of the OVC transition plan, see appendix C.

To improve pediatric treatment, PEPFAR will build partnerships and connect local partners to a designated focal person in each clinic in order to ensure HIV exposed and infected infants access OVC services. To support DREAMS, the program will employ community mobilization strategies to identify, in- and out-of-school vulnerable adolescent girls and ensure their access to health, HIV and other social services such as education, GBV protection, and economic strengthening.

PEPFAR will continue to apply family-centered approaches to mitigate the impact of HIV/AIDS and ensure that children and adolescents remain AIDS free, healthy, safe, stable and schooled. This will include strengthened referrals to improve OVC access to health services, including HTS, HIV care and treatment, and NACS. ART adherence and promotion of HTS (including EID) will continue to feature in routine household interactions with caregivers. PEPFAR will continue to build skills in parenting of adolescents and caregiver capacity on care of HIV-affected, infected and exposed children. OVC caregivers (and older OVCs) will be supported to be more resilient to financial shocks through group savings and loans, as well as referrals and enrollment in social protection programs.

As part of rights-based and gender transformative programming, PEPFAR will improve responses to violence and exploitation by supporting child protection/GBV structures and contributing to activities outlined in the national "Violence Against Children Response Plan." Education support will be provided to OVC by addressing barriers to enrollment, attendance, and progression particularly for adolescent girls. For children under five, early childhood interventions will complement PMTCT and pediatric HIV activities with particular focus on addressing cognitive stimulation, nutrition, and potential of developmental delays in HIV-exposed and infected children.

System level support will include participation in the review, development, dissemination and institutionalization of policies, guidelines, strategies and quality standards. The capacity of county governments and community-based organizations (CBO)/faith-based organizations (FBO) partners will be strengthened to better plan, budget, implement, monitor responses, and advocate for OVC resources. Ongoing efforts to strengthen the national and county level child protection Management Information System (MIS) will continue in collaboration with the Department of Children's Services (DCS), UNICEF, and other stakeholders.

5.0 Program Activities in Sustained Support Locations and Populations

To ensure high quality services are provided in all counties while transitioning most of PEPFAR's investment to locations and populations with the highest HIV burden, the PEPFAR Kenya team has: a) conducted an analysis of program and epidemiologic data; b) defined a package of services to sustain support for locations and populations not identified as priority for epidemic control; c) engaged GOK and other stakeholders regarding transition of support; and d) outlined plans for sites and programs that will receive sustained and central support.

Based on the analysis of program and epidemiologic data, the 20 counties not identified as priority for epidemic control account for 22% of the population, but only 10% of the HIV burden. Of these counties, 13 counties accounting for 9% of the HIV burden will receive support to sustain services (sustained counties), while the remaining 7 counties accounting for 1% of the HIV burden will receive central support (central support counties).

5.1 Package of services in sustained support locations and populations

In sustained counties, HTS will only be provided to symptomatic patients presenting in PEPFAR-supported high yield sites, presumptive TB cases as well as partners and families of HIV infected individuals, and patients requesting a test.

The PMTCT package will include HIV testing of pregnant and breastfeeding women presenting in PEPFAR-supported high yield sites, ART for those identified as HIV+, adherence and retention support, including use of mentor mothers (peer counselors), and strategies to improve retention of mother baby pair, EID and linkage to ART for HIV+ infants.

Current patients on treatment and new patients through passive enrollment will be provided a PLHIV minimum package of care which includes ART, CTX prophylaxis, TB screening, PHDP package, and fluconazole and IPT prophylaxis per national guidelines. The expected volume of patients needing the minimum package of services in these areas has been calculated by county (Table 5.1.1). The estimated number to be tested through PMTCT sites was derived from assumptions noted above. Expected volumes for current on ART were derived using historical program data for retention and anticipated passive enrollment.

PEPFAR Kenya has invested modest resources in the sustained counties to support passive enrolment while engaging GOK to transition support for activities such as HRH (ongoing), trainings and supervision except for the high volume sites. Given that these counties are part of GOK's national acceleration plan and certain counties have large volume facilities and relatively high burden sub-counties, enrolment could exceed 5%. In such cases, PEPFAR Kenya will not

increase resources but encourage county governments to coordinate with other stakeholders for support.

Based on these calculations, HTS in PMTCT sites will decline by 18%, from 247,136 in FY16 to 203,136 in FY17, while other HTS will decline by 5%, from 467,941 to 442,505 over the same period. The decline in yield will be more modest due to improved targeting within facilities. Passive enrollment is expected in PEPFAR-supported ART sites, translating to a modest increase (5%) in current on ART (lower than 9% net increase in FY15) as a result of the above considerations. Overall, all PEPFAR supported sites in these regions will receive support for QA/QI to ensure national standards are maintained.

Existing condom distribution programs will be maintained, but local promotion programs will be discontinued. Regarding KP, HIV prevention services, STI screening and HIV care and treatment services will be transitioned to the national and county governments, with a focus on integration with the existing health system for efficiency and sustainability gains.

PEPFAR will discontinue active enrollment of new children and families in OVC programs. To support currently enrolled beneficiaries, key interventions include linkages for HIV positive children and adolescents to other HIV services and available resources at the county and community, targeted secondary education support, close monitoring of OVC outcomes and psychosocial support to families. In addition to the 8% of the enrolled OVCs expected to age out of the program during FY17, PEPFAR will accelerate graduation and handover of beneficiaries in order to redirect resources to scale up counties. To that end, PEPFAR will support capacity building of the local OVC partners, communities and county governments to identify and graduate children and families showing progress towards reduced economic vulnerability, intensify referrals and linkages to health services, and leverage available resources including social protection programs. Consequently, the number of OVCs served will decrease by 16%, from 107,648 in FY16 to 90,921 in FY17.

Resources required to support maintenance in these counties are projected at $34,807,453 using adjusted EA data in the PBAC.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts

Sustained Support Volume by Group	Expected result APR 16	Expected result APR 17	Percent increase (decrease)
HIV testing in PMTCT sites	**247,805**	**203,136**	**(18%)**
HTS (only maintenance ART sites in FY17)	**467,941**	**442,505**	**(5%)**
Current on ART	**90,421**	**95,119**	**5%**
OVC	**107,648**	**90,921**	**(16%)**

5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

As part of ongoing discussions with GOK, plans for transition of PEPFAR support from sustained counties is being implemented during FY16, and will continue in FY17. Transition from low yield (<5 HIV positives) PMTCT and HTC sites was initiated during FY15, and technical assistance and monitoring of these sites has been transitioned to GOK. In addition, there are plans to transition support from low volume ART sites (<50 ART patients) in all sustained counties to GOK by the end of FY16. Ensuring continued high quality HIV services are provided through successful transition to GOK and other partners is a primary concern for all parties. During FY16, PEPFAR Kenya, GOK and other stakeholders including GFATM will conduct detailed county specific ART volume analysis to examine geospatial factors and facility types, among other variables, to better understand the context and dynamics in developing plans for improved efficiencies. Consolidation of facilities with <10 ART patients will be carefully planned with county governments to improve efficiencies and ensure quality of services across all counties.

PEPFAR Kenya will transition support to all sites in the seven lowest burden counties – Garissa, Isiolo, Lamu, Mandera, Marsabit, Tana River, and Wajir - to GOK by the end of FY16. These counties account for 1% of the HIV burden and had 6,524 individuals on ART by end of FY15.

During FY16, all HIV service delivery support, (i.e. technical assistance by PEPFAR IPs and HRH support, and ongoing program monitoring) is in being transitioned and will be fully supported and managed by county governments through the county health management teams (CHMT) in FY17. Only national PEPFAR-support services will be provided to the seven counties which are commodities, access to the lab network, and quality assurance systems.

Similarly, PEPFAR will work with GOK and other stakeholders to implement a phased plan for gradually transition of OVC support in low burden counties throughout FY17. The plan will graduate children and families on a rolling basis starting in the seven lowest burden counties. In addition, PEPFAR will work to transition out of low burden sites in the 13 sustained counties and transfer the most vulnerable families to other providers to prevent interruption of services. A total of 3% (19,792) of FY17 targets will come from central support counties, a decrease from 4% (25,952) in FY16. In accordance with Office of the Global AIDS Coordinator (OGAC) guidance, OVC support will be transitioned to GOK in these counties at the end of FY17. PEPFAR will provide technical support for the transition of these beneficiaries including household economic strengthening interventions and strategies to transfer the most destitute children and families to other available support and programs. Based on an assessment of readiness to transition scheduled for May 2016, PEPFAR will assist sub-national unit (SNU) partners (GOK, CBO/FBO and private sector) to develop area specific transition plans and timelines including benchmarks (i.e., quarterly assessment of child and family economic stability) and indicators (i.e., % of families expected to graduate by end of FY16/FY17).

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

PEPFAR Kenya Systems and Budget Optimization Review (SBOR) Summary

Kenya served as a pilot country for the SBOR process. Following a desk review of information extracted from the COP15 SDS along with key funding data, an interagency headquarters assessment team undertook the SBOR with the Kenya team in December 2015. The process focused predominantly on three areas: Health Systems, Laboratory, and Strategic Information to identify potential overlap, duplications or activities which had habitually been funded but no longer required resources.

While no substantial overlap was identified in the three focus areas of the review, the team agreed that there were activities which had been funded in consecutive COPs, and no longer needed to be funded—predominantly in Health Systems. There were another set of activities which were more periodic and therefore may not require annual funding—predominantly in Strategic Information—and there were further areas of health systems which required greater clarification, including the range of management and supervisory support for clinical services under health systems and service delivery. This exercise identified and reprogrammed resources of $2.6 million for different activities within the same program area through the same implementing partner. For COP16, those activities were reviewed and funding was not allocated for similar services; resources were shifted to the five highest burden and scale-up counties to better align with the pivot for epidemic control. In addition, a number of USAID and CDC IMs are ending by September 2016, enabling PEPFAR Kenya to optimize and redirect resrouces high-impact interventions such as Test and START and differienated service delivery strategies in scale-up counties to bolster the clinical cascade for achieving 90-90-90 goals.

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

PEPFAR Kenya will concentrate its investment in systems that bolster the clinical cascade to achieve the 90-90-90 goals for sustained epidemic control. Three key programmatic gaps that impact the clinical cascade will be addressed in COP16: 1) weak commodity and logistics management; 2) limited county human resource management capacity; and 3) sub-optimal use of viral load. A fourth cross-cutting gap that will be addressed is the inadequate DRM at county and national levels to sustain program gains and epidemic control. Gaps were identified in the context of achieving HIV epidemic control, the national sustainability profile, and ongoing health systems investments. PEPFAR also considered potential inputs from other stakeholders, especially GFATM, to ensure complementarity in implementation. Indicators will be identified to track and monitor progress toward achieving the milestones and outcomes in outlined in the tables below.

Commodity and logistics management: Timely, complete, and correct facility stock reporting for RTKs, distribution to the facility, rational use, and forecasting remain challenges in Kenya. As all

commodities are procured at the national level, PEPFAR will continue to support NASCOP and KEMSA to ensure adequate and timely commodity procurement while placing greater focus on implementing partners at site level to bolster accurate reporting, receipt and appropriate use of RTKs. PEPFAR together with NASCOP is working to strengthen the RTK distribution system across the country through increased involvement of the counties. The counties will be empowered to monitor use, ensure reporting, and allocation of the RTK. Health is devolved to the county governments; therefore, the county government is in a better position to ensure rational use of the RTK and reporting. The counties will be allocated RTK quantities based on the pivot and they will be responsible for ensuring proper usage. Misusage of the RTK will mean the counties will need to use their resources to procure more kits. The country will also use the RTK electronic reporting tool to monitor usage and resupply. This will have a positive impact on the roll out of Test and START to achieve the first "90."

Human resource capacity: This programmatic gap, which impedes the first and the second "90", will be addressed through pre-service activities with workforce cadres required for HIV service delivery at the facility and community levels; strengthening county capacity to improve health work appeal, performance, deployment and retention; and using HRH data systems to inform workforce planning and budgeting. PEPFAR will also coordinate with GOK to rationalize PEPFAR-contracted health staff and plan for transition to county government payroll, while monitoring the impact of such transitions on HRH performance and retention. The planned outcome of Capacity work is to ensure that 22 PEPFAR priority counties are supported to improve on HRH management and development systems to attract better quality staff, hire and deploy, and retain them for effective HIV /AIDS interventions. Further support will be provided to make evidence-based HRH decisions through the use of the HRIS system.

Viral Load: Activities to overcome the third programmatic gap address the third "90" through improved VL access to results and higher suppression rates. While Kenya has scaled-up the use of VL since 2015, not all patients are receiving annual tests per national guidelines. In COP16, Kenya will better optimize testing networks, maximize efficient use of Dried Blood Spot (DBS) for VL, and improve health care workers' understanding, interpretation, and use of VL results for monitoring patients' health. To improve turn-around time of VL results, additional support will be provided to strengthen sample referral networks through mapping, using high through-put platforms, and evaluating point of care devices.

Domestic Resource Mobilization: Inadequate domestic financing adversely impacts all levels of health and in COP16 PEPFAR will focus efforts to improve domestic resource mobilization through collecting evidence to inform advocacy, planning and resource allocation at national and county levels. For example, Program Based Budgeting (PBB) is a new requirement of Kenya's Public Financial Management (PFM Act) for counties to align budgeting to program targets and outputs, enhance transparency in resource allocations, and increase domestic resource mobilization for strategic programs. Thus far, 12 out of 22 counties have already undergone training and been provided with additional technical support (including HIV) which have

resulted in estimated $2 million mobilized for HIV in 2016/17 budgets. Additional counties will be supported in FY17 under the DRM, including the five highest burden along with a representative group of sustained counties; PEPFAR transition counties are not covered.

In addition, several other donors (Wordl Bank, DFID, UNICEF, WHO etc.) are supporting PBB across the country though not specifically for DRM or for HIV. Efforts are ongoing to harmonize the materials and approaches and leverage resources as needed, but USAID is seen as a lead partner to MoH for this. Moreover, work is ongoing with NACC to effectively link county HIV program plans to the PBB/budgeting processes.

Table 6.1.1 Key Programmatic Gap #1: Weak Supply Chain Commodity and Logistic Management						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP16 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
HIV Rapid Test Kits (RTKs) distribution not aligned with Kenya "pivot"	1. Allocation committee using expected allocation and data by site by the end of YR 1 2. County-level distribution systems established to support quarterly distribution of RTKs – designed with national and county stakeholders, with county responsibility for oversight and implementation: Benchmarks: • YR 1: 25% of counties • YR 2: 60% of counties • YR 3 100% of counties	1. RTK allocation committee utilizing expected test/site data as per COP15 and results of national supply chain assessment	-	0	None	Commodity Security and Supply Chain Score: 4.86
		2. PEPFAR interagency working group to collaborate work with MOH on expected RTK/site requirements	-	0	None	
		3. Improve timely distribution of RTKs through improved support and monitoring at all levels 4. Strengthen commodity security for lab commodities from national to county level	HLAB HTXS PDTX	$1,000,000	17950 (UMB) 17954 (GIS) 17947 (AMREF) 17951 (FHI 360) PEPFAR IMs in Care & Treatment	
Lack of timely and/or complete reporting by facilities	1. Quarterly (minimum) coordination with county to ensure timely data receipt and usage the end of YR 1 2. IP support for facility management embedded in all new USG solicitations by the end of YR 2	1. Increase MOH ownership of RTKs at facility level	-	0	None	Commodity Security and Supply Chain Score: 4.86
		2. Develop county level follow-up system to increase facility level usage and data reporting	HVCT		Service Delivery Mechanisms	
Weak commodities management	1. A national comprehensive supply chain plan in place to enhance	1. Enhance accuracy of quantification forecasts for	HVCT	$400,000	13701 (KEMSA)	Commodity Security

capacity to ensure availability of quality HIV/AIDS commodities in response to the pivot	coordinated county support, minimize duplication, maximize efficiencies and clarify transition plan away from donor support for HIV commodities supply chai by the end of YR 2 2. Evidence-based strategic and operational plan that responds to HIV program supply chain system strengthening assessment by the end of YR 3 3. A functional M&E plan institutionalized for tracking, distribution and reporting with improved accuracy, timeliness and reporting rates for all HIV program commodities to achieve outcomes aligned with PEPFAR's 90:90:90 pivot by the end of YR 3	required HIV commodities aligned to pivot; provide evidence/data to inform county planning and budgeting				and Supply Chain Score: 4.86
		Train key cadres in inventory management, data use, analysis and reporting, pharmacovigilance, and other commodities management areas	-	0	PEPFAR IMs in Care & Treatment	
		Conduct national supply chain assessment and propose improvement options (incl. procurement, distribution, reporting of HIV commodities (ARVs, OI drugs, RTKs, laboratory reagents, tests and supplies, nutrition supplements and HIV prevention commodities); monitoring supply chain system performance incl. in transition sites Develop a national comprehensive supply chain plan in line with PEPFAR SID 2.0 Develop and institutionalize a national supply chain monitoring and evaluation framework Support NPHLS through HIV laboratory commodities advisor to strengthen counties/facilities	OHSS	$575,000 $320,000	GHSC-PSM 17950 (UMB)	

		ability in tracking of lab commodities, required reporting, resource mobilization and mapping.				
TOTAL				**$2,295,000**		

Table 6.1.2. Key Programmatic Gap #2: Low county health system capacity to meet the needs for scale up, transition and a sustained response						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP16 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Insufficient numbers of skilled health workers to support treatment scale up	1. Pre-service training institutions increase graduates of critical cadres required for epidemic control by 5% every year for next three years 2. Increase the proportion of training institutions offering in-service trainings by 5 % every year for the next three years 3. Support at least 20 county health management teams using evidence-based approaches and HRIS for HRH workforce planning & budgeting, attraction and	5. Support health worker training systems to ensure increased key cadres numbers and updated workforce towards epidemic control	OHSS, MTCT HBHC HTXS OHSS	$1,662,500 $320,000 $850,000	14015 (Funzo) 13061 & 18213 (MOH) 16670 (HIV Fellowship)	Human Resources for Health: 6.50
		6. Support County Health Teams to ensure clinical staff numbers are rationalized, deployed according to planned targets, and retained in appropriate sites. Ensure structures are available for transition to county payroll of	OHSS MTCT HBHC HTXS	$3,157,500	17709 (Capacity)	

	retention by the end of YR 3 4. Engage up to eight regulatory boards to strengthen their regulatory systems to ensure quality training and performance of health professionals over the next three years.	PEPFAR supported health workers. Ensure HRIS data use for decision making.	PDCS PDTX			
		7. Strengthen MOH oversight and implementation of the HRH strategy and professional regulatory boards in support of county level workforce infrastructure toward achieving epidemic control.	OHSS	$200,000 $595,000	17709 (Capacity) 13179 (Emory)	
Inadequate domestic resource mobilization (DRM) at the county to sustain program gains and epidemic control in the absence of donor financing	1. Allocations to health and HIV increased or retained at current level of 21.5% in at least 22 county budgets by the end of YR 3 2. Demonstrated county capacity in at least 22 counties to undertake program based budgeting resulting in improved HIV resource allocation by the end of YR 3	1. Promote sustainable financing & DRM for HIV at County level: a. Program based budgeting support to 22 counties b. Generate evidence to inform health and HIV resource allocation for in county health budget; includes county budget analysis, county health accounts, expenditure tracking and identify marginal effects, opportunity costs, and priority settings	OHSS	$1,200,000	7139 (Palladium)	Financial/Expenditure Data Score: 4.17 DRM: 5.28

		c. Assist MOH to identify resource requirements for scale up and maintenance (i.e. HRH & key commodities), and sustainable financing options to fill gaps as PEPFAR support transitions				
Inadequate domestic resource mobilization (DRM) at the national level to sustain program gains and epidemic control in the absence of donor financing	1. Increased participation of private sector i.e. increased commercial sector participation in provision of ARVs, above current baseline by the end of YR 3 2. Budget line retained for HIV at current level of $20M or greater in national budget allocation for each year 3. 10 percent of ARVs for members paid by National Health Insurance Fund by the end of YR 3	1. Through Sustainable Financing Initiative (SFI), promote sustainable financing & DRM for health and HIV at national level: a. High level advocacy for increased allocations to health and HIV in national budget b. Analyses for inclusion of HIV in benefit package to be paid by insurance c. Private sector engagement in health financing and provision of ARVs d. Monitoring transition of donor support to domestic financing, & household spending		$3,000,000	SFI central funding (USAID) 7139 (Palladium)	
TOTAL				**$7,985,000**		

Table 6.1.3 Key Programmatic Gap #3: Low access to viral load results and low suppression rates						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP16 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Low access to VL with long turn-around time	1. 100% access to Viral Load (VL) for all eligible patients documented in the file Benchmarks: • YR 1: 70% • YR 2: 90% • YR 3: 100% 2. Decreased viral load testing backlogs with a TAT of 14 days Benchmarks: • YR 1: 40% • YR 2: 70% • YR 3: 100% 3. Increase the number of ART sites networked to VL testing facilities to 100% Benchmarks: • YR 1: 80% • YR 2: 90% • YR 3 100%	1. Hire laboratory supply chain advisor at national level	OHSS	$320,000	17950 (UMB)	Laboratory Score: 2.08
		1. Strengthen and improve coordination of sample referral networks through mapping of facilities and labs	HLAB HTXS PDTX	$1,000,000	17950 (UMB) 17954 (GIS) 17947	
		2. Support functioning of high through-put platforms and evaluate point-of-care devices	HLAB	$100,000	17950 (UMB) 12555 (UON)	

Low HRH capacity in VL use and interpretation	1. 90% of patients virally suppressed Benchmarks: • YR 1: 85% • YR 2: 90% • YR 3: 100% 2. Timely switch of failing regimen within 14 days of 2nd VL for reduced drug resistance among PLHIV on ART Benchmarks: • YR 1: 30 days • YR 2: 21 days • YR 3: 14 days 3. Increased cost savings for national HIV response by the end of YR 3	1. Develop job aids and provide ongoing clinical mentorship in utilization of VL results	HTXS PDTX	$100,000	PEPFAR IMs in Care & Treatment	Human Resources for Health Score: 6.50
		2. Register all patients with high VL for more intensive follow-up particularly for key populations, infants, and pregnant women	HTXS PDTX	$100,000	PEPFAR IMs in Care & Treatment	Service Delivery Score: 4.21
Sub-optimal utilization of information technology	1. Increased implementation of LIS for relay of results and commodity tracking in 100% of VL testing labs Benchmarks: • YR 1: 25% • YR 2: 50% • YR 3: 100% 2. Improved clinical decision making through utilization of VL within 2 week of receipt by clinician by the end of YR 3	1. Support utilization of Laboratory Information System for relay of results and commodity tracking	HTXS PDTX HLAB	$115,000	17950 (UMB) PEPFAR IMs in Care & Treatment	Epidemiological and Health Data Score: 5.36
		1. Improve utilization of electronic medical records for timely VL results and outcomes to patients	HTXS PDTX	$ 200,000	PEPFAR IMs in Care & Treatment	Epidemiological and Health Data Score: 5.36
TOTAL				**$1,935,000**		

Table 6.2.1 Test and Start						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP16 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Lack of policy, strategy and national guidelines on "Test and START"	1. Test and START national strategy and guidelines adopted and fully implemented by end of YR 1	1. Support MOH to develop Test and START policy and guidelines to include a	HTXS	$50,000	13061 & 18213 (MOH)	Policies and Governance Score: 7.02
		2. Collaborate with MOH to roll-out the implementation of Test and START guideline focusing on five highest burden and scale up counties initiated by July 2016	HTXS	$200,000	13061 & 18213 (MOH) PEPFAR IMs in Care & Treatment	
Inadequate commodity supply and/or weak supply chain at the county, sub-county and remote lower sites	1. 100% availability of ARVs to support Test and Start across all levels 2. Increase ARV storage capacity in sub-county and lower level ART sites to 6 months stock <u>Benchmarks:</u> • YR 1: 1 month • YR 2: 3 months • YR 2: 6 months	1. Expand drug availability through mentorship with national, county and sub-counties in ARV and other drug inventory reporting,	HTXD HTXS PDTX	$1,000,000	13061 & 18213 (MOH) 13701 (KEMSA)	Commodity Security and Supply Chain Score: 4.86
		2. Identify alternative storage models from the county to community to support three month scripting/ARV refill	HTXD HTXS PDTX	$2,000,000	13061 & 18213 (MOH) 13701 (KEMSA) PEPFAR IMs in Care &	

Gaps in HRH numbers and capacity, patient literacy, and adherence counselling	1. >95% retention and 90% viral suppression achieved by the end of YR 3 2. National guidelines for community-based models developed and implemented by the end of YR 3	1. Implement community-based models for Test and START to promote adherence and retention. This includes task-shifting and broader utilization of community health workers cadre.	HTXD HTXS PDTX	$ 1,000,000	PEPFAR IMs in Care & Treatment	Service Delivery Score: 4.21
TOTAL				**$4,250,000**		

6.2 Critical Systems Investments for Achieving Priority Policies

To ensure successful implementation of Test and START as well as new and efficient service delivery models, systems barriers will be addressed to promote: (i) the rapid development of policy and guidelines for Test and START; (ii) a reliable supply chain to support differentiated delivery of care models for stable patients; and (iii) a developed capacity among lay healthcare workers to enact the decentralization of services to the community, in order to improve health outcomes. The MOH is undertaking a local evidence review with its national treatment advisory committee, comprised of university experts, technical staff from the UN Joint Team on HIV/AIDS, development partners and other stakeholders. The aim is to complete revision of guidelines and initiate Test and START nationwide by June 2016. Differentiated service delivery models have taken into account the unique needs of ART patients to optimize delivery of care. The models will include fast-track management for stable patients and standard service delivery for patients requiring close monitoring, e.g., children, pregnant and lactating women, TB patients, and patients with VL>1000 copies/ml. The fast-track management approach offers a three-month ARV supply for stable patients, thus requiring improved drug storage options and timely delivery and accurate quantity of drugs at site level.

Improved coordination with GFATM is also critical to streamline support for the national quantification and procurement of commodities to accommodate higher number of ART patients with implementation of Test and Start, and increased buffer stocks at all levels of the supply chain system required by the new service delivery models. These differentiated service delivery models must also rely upon the capacity of community health workers (CHW), community health extension workers (CHEW) and peer educators to distribute drugs for adherent patients and to refer in case of failure.

Transition discussion of support from general policy development has been initiated; however, given the importance and capacity needs to develop Test and START and differentiated models of service delivery guidelines, PEPFAR support will be discrete through the launch and roll out to likely continue up to Q2 of FY17.

Table 6.2.1 Test and Start						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP16 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Lack of policy, strategy and national guidelines on "Test and START"	1. Test and START national strategy and guidelines adopted and fully implemented by end of YR 1	1. Support MOH to develop Test and START policy and guidelines to include a	HTXS	$50,000	13061 & 18213 (MOH)	Policies and Governance Score: 7.02
		2. Collaborate with MOH to roll-out and implement Test and START guidelines, beginning with the five highest burden (DREAMS plus one) and scale up counties initiated in July 2016 but continued through COP 2016. This will include Differeniated service delivery models.	HTXS	$200,000	13061 & 18213 (MOH) PEPFAR IMs in Care & Treatment	
Inadequate commodity supply and/or weak supply chain at the county, sub-county and remote lower sites	1. 100% availability of ARVs to support Test and Start across all levels 2. Increase ARV storage capacity in sub-county and lower level ART sites to 6 months stock	1. Expand drug availability through mentorship with national, county and sub-counties in ARV and other drug inventory reporting, forecasting, and timely distribution	HTXD HTXS PDTX	$1,000,000	13061 & 18213 (MOH) 13701 (KEMSA) PEPFAR IMs in Care &	Commodity Security and Supply Chain Score: 4.86

	<u>Benchmarks:</u> • YR 1: 1 month • YR 2: 3 months • YR 2: 6 months	2. Identify alternative storage models from the county to community to support three month scripting/ARV refill	HTXD HTXS PDTX	$2,000,000	13061 & 18213 (MOH) 13701 (KEMSA) PEPFAR IMs in	
Gaps in HRH numbers and capacity, patient literacy, and adherence counselling	1. >95% retention and 90% viral suppression achieved by the end of YR 3 2. National guidelines for community-based models developed and implemented by the end of YR 3	1. Implement community-based models for Test and START to promote adherence and retention. This includes task-shifting and broader utilization of community health workers cadre.	HTXD HTXS PDTX	$ 1,000,000	PEPFAR IMs in Care & Treatment	Service Delivery Score: 4.21
TOTAL				**$4,250,000**		

Table 6.2.2 New and efficient service delivery models						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP16 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Lack of policy to support alternative service delivery models	National differentiated service delivery models accepted by MOH through revised policies by the end of YR 3	1. Provide technical assistance to MOH to develop and implement differentiated service delivery approaches building on evidence-based models such as SEARCH and other promising facility and community approaches. Certain models will be included in the GOK's Test and START guidelines.	HTXS HBHC PDTX	$1,000,000	13061 & 18213 (MOH) PEPFAR IMs in Care & Treatment	Policies and Governance Score: 7.02
Lack of supporting evidence for successful, cost-efficient approaches in Kenya	At least one study conducted to demonstrate evidence-based quality and cost-efficient service delivery approaches by FY 19	1. Conduct expanded monitoring against routine indicators for determining practical service delivery models in collaboration with IMs and NASCOP	HTXS	$2,000,000	13061 & 18213 (MOH) PEPFAR IMs in Care & Treatment	Epidemiological and Health Data Score: 5.36 Service Delivery Score: 4.21

Low utilization of lab services with long TAT	1. >95% of labs meet prescribed turn-around time by the end of YR 3 2. Same day sample collection service at 100% of ART sites by the end of YR 3 3. 100% access to EID, VL and Gene Xpert through lab networking by the end	1. Support same day sample collection during the clinic visit, testing within 3 days 2. Implement sample and results tracking logs 3. Monitor use of results for clinical improved quality of care	HTXS HBHC PDTX	$1,000,000	PEPFAR IMs in Care & Treatment	Laboratory Score: 2.08
TOTAL				$4,000,000		

6.3 Proposed system investments outside of programmatic gaps and priority policies.

The table below includes all other system investments proposed for COP16 not included in either 6.1 or 6.2. These activities are essential in achieving a sustainable national HIV program.

Table 6.3 Other Proposed Systems Investments							
Systems Category* (only complete for categories relevant to country context)	**Activity**	**For each activity, indicate which of the following activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control. (Teams may select more than one.)**	**Outcomes expected after 3 years of investment**	**Budget Amount**	**Budget Code(s)**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Inst & Org Development							
	Kenya Prisons – capacity development	1st, 2nd, 3rd 90	75% of the HIV/AIDS Project's Human and financial resources are directly managed by the Kenya Prisons service. Establishment of 8 regional Sub-ACU structures aligned to	$160,000	OHSS	16687 (HealthStrat)	Policies and Governance Score: 7.02

			County and Prisons governance structures 80% of Program staff have program management capacity to plan, expend and report on program funds in a timely and accountable manner by year 5 of the project Training, mentorship and continuous technical support to program personnel to implement high quality, evidence-based HIV services Provide monthly financial reviews with related transition of project management responsibilities to Prisons program staff to support implementation Increased coverage of HIV treatment for				

			prevention from 38 prisons in 2016 to 50 prisons by 2018 Increased viral load suppression among prisoners from 85% to > 90% by 2018 Four DRTB isolation facilities created and operationalized				
	Kenya Disciplined Services (ZUIA)	1st, 2nd, 3rd 90	75% of the HIV/AIDS Project's Human and financial resources are directly managed by the Kenya Disciplined services. 80% Program staff have program management capacity to plan, expend and report on program funds in a timely and accountable manner by year 5 of the Project Uniformed services	$190,000	OHSS	16684	Policies and Governance Score: 7.02

			institutional capacity strengthened to increase coverage of HIV treatment and prevention services from 23 to 27 counties Establishment of eight regional Sub-ACU structures aligned to County Disciplined services governance structures, including establishment of strong, transparent financial management system Increased viral load suppression among uniformed officers and family members from 80% to >90% by 2018 Training, mentorship and continuous technical support to program personnel to implement high quality, evidence-based HIV services				

			Provide monthly financial reviews with related transition of project management responsibilities to Disciplined services program staff to support implementation Accreditation of National ACUs for National Youth Service and Kenya Forestry service by NACC				
Laboratory							
	EQA	1st, 2nd, 3rd 90	Ensure safe and secure transport of infectious and potentially infectious specimens in accordance to national and international regulations to facilities. Ensure coordinated distribution of EQAs prioritizing scale-up county facilities resulting in increased	$150,000	OHSS	9110 (APHL)	Laboratory Score: 2.08

			number of competent health care workers including laboratory personnel in HIV and TB related testing.				
Strategic Information							
	Strengthening public health capacity and SI systems	1st, 2nd, 3rd 90	Organize the HIV Estimates Modeling Taskforce and related three multi-county meetings re. methodology, processes and dissemination products to generate sub-national HIV estimates Conduct minimum of 4 in-person and electronic meetings to ensure that county and national partners are able to use denominator data from the HIV estimates process as part of their county and national M&E platforms Work with county and national government to	$100,000	HVSI	18262 (UNAIDS)	Epidemiological and Health Data Score: 5.36

			produce at least 10 graphs, maps and other images ("data visualizations") that show better and more intuitive understanding of sub-national HIV monitoring data Hold at least 3 in-person and electronic meetings with government officials and other stakeholders to identify methods that will provide better estimates of HIV service coverage within Nairobi informal settlements, as the current all-Nairobi estimates do not provide an accurate view of service coverage within these communities				
Systems Development							
	URC- Applying Science to Strengthen and Improve Systems	1st, 2nd, 3rd 90	County QI structures and leadership in place to ensure improvement is	$915,654	MTCT HKID OHSS	7305 (URC)	Quality Management Score: 8.48

	(ASSIST)		sustained and institutionalized; QI techniques used to strengthen HIV chronic care model and retain more adults and children in HIV care and treatment				
TOTAL				**$1,515,654**			
*Reference Appendix C for a list of activity types that fit in each category.							

7.0 Staffing Plan

Summary of Staffing Plan Analysis: The COP16 staffing plan analysis reflected the program pivot through the identification of skill sets and technical gaps required to be addressed to achieve HIV epidemic control. Agencies agreed upon a common baseline for level of effort (LOE) by program, business and administrative staff and jointly reviewed the interagency LOE analysis prior to submission.

The PEPFAR interagency leadership remains committed to streamlining or repurposing positions to meet the needs of the PEPFAR pivot. A natural point for reviewing this arises as vacancies continue to emerge due to regular staff turnover or changes in agency structure. For example, with the development of CDC's HIV Service Delivery Branch, a senior leadership position was repurposed to External Partnerships Advisor, thus filling a longstanding gap in the agency's strategy and augmenting the strong external partnerships work led by the PEFPAR Coordination Office. In another example, USAID recently repurposed a Training Specialist position to address the growing interagency demand for a Gender Specialist on the Kenya team. DOD undertook significant task-shifting by transferring responsibilities from six vacant positions to existing staff and concentrating staff efforts on the highest burden counties.

PEPFAR Kenya staff percent of time and number of full time equivalent (FTEs) remain closely aligned to the core and near core activities described in the SDS; staffing responsibilities that were previously associated with near-core or and non-core decisions were shifted to core activities this past year to maximize efficiencies. The shift also allowed staff greater time for critical, cross-technical planning on a regular basis. All agencies are addressing the needs for sufficient business process coverage and intra-agency partner management through additional trainings at the inter- and intra-agency level, as well as routine sharing of best practices across agency structures. The interagency management team discussed and agreed upon all proposed positions for COP16.

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

Proposed New Positions: There are no new requests for staff positions by Peace Corps, the PEPFAR Coordination Office, DOD, or USAID in COP16. For CDC, one additional local hire is requested to support the critical work of TB/HIV treatment; this position is further aligned with priorities arising from the merging of CDC's global HIV and TB portfolios. Through the past year's pivot towards highest burden counties predominantly in Western Kenya—a region where CDC

supports the majority of program implementation—the agency also recognized a deficit in program staff for its Western Kenya team and proposed key positions to better support a comprehensive response. In COP16, the PEPFAR Coordinator position will be hired through the new Department of State limited non-career appointments (LNA) mechanism; the position has been advertised and interviews completed.

CODB: There are no major changes in CODB across agencies in COP16. Building on COP 15, the team budgeted for additional support to strengthen SIMS site visits. This includes direct oversight of high burden sites utilizing international and locally engaged staff along with a third-party institutional support contractor. Given the large number of site visits required under SIMS coupled with security concerns and infrastructure constraints limiting USG's footprint to the current staffing pattern, use of a third-party institutional contractor was proposed and approved in COP15, and will be continued in COP16.

The PEPFAR Kenya team will continue to review staffing needs to ensure that its technical and administrative footprint is optimally aligned to the new PEPFAR business model and program priorities in striving to achieve sustained HIV epidemic control in Kenya.

APPENDIX A

Clinical Services

Table A.1 Program Core, Near-core, and Non-core Activities for COP16

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	• HIV care, enrollment and ART initiation in line with Test and START Policy • Implement differentiated service delivery model both at facility and community level • Management of Opportunistic infections; TB, cryptoccocal meningitis including fungal infections among PLHIV • Provision of Cotrimoxazole PHDP activities • ART initiation • Adherence counseling, patient tracking/ defaulter tracing, • Patient education on demand creation, self-management • Linkage to care, defaulter tracing and PWP messaging (both community and facility based activities) • Nutrition Assessment and Counseling • Intensive Case Finding, Integration, immediate ARV initiation in TB/HIV co- infected • IPT,IPC in scale-up and sustained counties • HTS for TB and presumptive TB patients, Continuous Medical Education (CME), Mentorship, On-job-training (OJT) • Implement adolescent Package of Care Training • Strengthen an integrated rational system for sample networking for VL, EID, GeneXpert • Support integrated information system (lab information systems, EMRs, LMIS for commodities and clinical decision making).	• Cervical Cancer assessment and treatment for HIV+ women/mothers • STI & Hepatitis B screening in scale-up and sustained counties • Community nutritional follow ups in sustained counties • Facility-based orientation using harmonized curriculum • Minor renovations for select sites in scale-up to saturation and aggressive scale-up counties	
County level	• Technical assistance to strengthen data for decision making, quality improvement, commodity management, capacity building of county health system • Strategic planning, policies, guidelines, tools development and dissemination, and coordination in scale-up and sustained counties,		

National level	• Technical assistance to NASCOP, DRH, DCAH, NACC, NTP, NPHL • Support for strategic planning, policies, guidelines, and tools development • Strengthen supply chain system • Support improved commodity management, and pharmaceutical services at county level • Procure ARVs and CTX • Procure Lab equipment and commodities: VL, CD4, EID, HIV-DR, CRAG and related consumables • Procure nutritional commodities • Procure TB equipment and commodities: GeneXpert and Reagents • Support to NBTS on blood safety activities including QMS accreditation • Quality assessment and improvement • Impact assessments and program evaluations, ART including retention, VL suppression; • Strengthen an integrated system for sample networking for VL, EID, Gene Xpert	• Hire critical staff in high volume facilities, saturation and scale-up counties • Pre-service training • Support for advanced HIV training and regional mentorship • Procurement of INH, pyridoxine, Fluconazole, Amphotericin B, and RTKs • Procurement of ancillary equipment e.g. centrifuges • Laboratory Accreditation • Injection safety; waste management; occupational safety training; policy and guideline support • Donor notification and linkage • Blood service information systems • Targeted communication on treatment adherence and retention • Demand creation in saturation counties • Surveillance and evaluations • Creatinine for those on TDF and Hemoglobin for those on AZT	• Procurement of blood bags, testing reagents/kits and other consumables

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP15

	Core Activities	Near-Core Activities	Non-Core Activities
Care and Treatment **HIV Care**	• Enrollment, clinical assessment, in line with Test and Start guidelines and differentiated service delivery models • Management of Opportunistic infections; TB, Cryptoccocal meningitis including fungal infections among PLHIV		
OI and co morbidities screening and management	• Provision of Cotrimoxazole (septrin). PHDP activities both in scale-up and maintenance counties	• Cervical Cancer assessment and treatment for HIV+ women/mothers; STI and Hepatitis B screening both in saturation, scale-up and maintenance counties	
	• ART initiation per national guidelines in scale up to saturation, aggressive scale up and sustained counties		
ART initiation	• Adherence counseling, patient tracking/ defaulter tracing at facility and community level to support differentiated service delivery model • Hiring and training/ support of lay workers	• Facility based adherence counseling, patient tracking/ defaulter tracing within commodity support counties	

Treatment monitoring (clinical) **Nutrition** **TB/HIV**	• M&E and coordination resulting in adherence, linkage to care, • Defaulter tracing and PWP messaging (both community and facility based activities) in saturation and scale up counties • Nutrition Assessment and Counseling; Therapeutic Feeding for eligible HIV Positive both in all counties • Intensive case finding • Integration, Immediate ARV initiation in TB/HIV co-infected in scale up, aggressive scale up and sustained counties • IPT, IPC scale up, aggressive scale up and sustained counties.	• Community nutritional follow ups for eligible HIV positive in all counties	
Renovations and construction **National /county level support** **HRH** **Training**	• Technical assistance to GOK: NASCOP, DRH, DCAH, NACC, NTP, NPHLS • Support for strategic planning, policies, guidelines, tools development, dissemination and Coordination • Hire critical staff in high volume facilities both in scale up, aggressive scale up and sustained counties to support differentiated service delivery model • CMEs, Mentorship, OJT in all counties • Support capacity building on	• Minor renovations for selected sites in saturation counties due to increased ART patient volume • Facility based orientation the harmonized curriculum • Support short term pre-service training with an aim	

	Test and Start guidelines	to transition to GOK. • Support for advanced HIV training and regional mentorship	
Commodity management and SCMS	• Strengthen supply chain system including integration of parallel supply chains, supply chain governance, information systems, inventory tracking, warehousing and distribution • Support to improve commodity management, and pharmaceutical services at county level: Building capacity of MOH at county and national levels for sustainability. E.g. procurement planning, inventory management, forecasting and quantification, quality assurance and good storage management.	• Procurement of INH, pyridoxine, Fluconazole, Amphotericin B • RTKs, Blood safety supplies	
Commodities procurement (ARV/OI)	• ARVs, CTX		
Lab commodity procurement	• VL, CD_4, EID, HIV-DR, CRAG and related consumables	• Conduct smear/culture	
Nutrition commodity procurement	• Therapeutic food	• Procurement of ancillary equipment e.g. centrifuges	
TB Commodities /Equipment	• GeneXpert Reagents		
Lab networking	• Integrated sample referral networks for baseline CD_4,VL, EID and Gene Xpert and return of results	• Laboratory accreditation	
Laboratory Equipment	Equipment placement, calibration and maintenance-VL, CD_4, Biosafety Cabinet, Gene Xpert (BSC)		

Lab quality systems **Infection control and Medical Waste Management** **Blood safety** **Quality improvements** **Communication**	• TA counties on PT, EQA, IQA, • TA to Division of Infection control • • TA to NBTS on blood safety activities; development of national policies and guidelines, QMS for accreditation • Support to continuous quality improvement activities based on Kenya HIV quality improvement framework and PEPFAR quality strategy including SIMS	• Support for injection safety; waste management; occupational safety training; dissemination of policies and guidelines and support • Donor notification and linkage Blood service information systems • Targeted communication on treatment adherence and retention in support of differentiated service delivery model • Demand creation for critical HIV services in scale up and aggressive scale up counties • Surveillance on drug adherence and pharmacovigilance • Evaluations on new lab technologies on HIV e.g., Point of care EID, Viral load	• Procurement of blood bags, testing reagents/kits and other consumables

Evaluations, surveillance and Research	• Impact Assessments and program to measure impact of interventions e.g. ART outcome measurements including retention, viral load suppression; • HIV DR surveillance • Phamacovigilance • Key OI and co-morbidity surveillance to quantify on magnitude		

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP17	Estimated Funding in COP18	# of IMs	Transition End date	Notes
Procurement of blood bags, testing reagents/kits and other consumables	Transition to GOK	$850,000		1	Sept 2017	The GOK is experiencing extreme blood shortages and thus transition of this activity has moved to FY17
Totals		**$850,000**		**1**		

Attachment A. Maternal, Newborn and Child Health

Table A.1 Program Core, Near-core, and Non-core Activities for COP16

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	• Identify women and infants • HTC services • Lab services • Support FP counseling and consent including appropriate referrals • HRH: Peer counselors and health care providers • HMIS • Quality assurance/improvement • Retention strategies • Support exclusive breast feeding education • Ensure minimum package of GBV services and referrals available at PMTCT sites • HIV Integration in MCH	• Capacity building on long-term FP services • On-site training using harmonized HIV curriculum including CME, mentorship • Private Sector engagement	• Renovation in select scale-up counties
County Level	• Strengthen strategic planning and Annual Work plan development • Joint supportive supervision • Commodity security and supply chain logistic • eMTCT county and sub-county meetings		
National Level	• Technical Assistance • Targeted Training • National commodity security reviews • Support National HMIS for data use and decision making • Evaluation and research	• Print and distribute new PMTCT Guidelines	• Print mother-baby booklet, PMTCT IEC materials and reporting tools • Pre-service training for middle level HCP

Table A.2 Core, Near-core, and Non-core Activities for COP15

	Core Activities	Near-core Activities	Non-core Activities
Identification women and infants	• Create demand through targeted community activities: index and partner HTC screening in immunization clinics; use revised EID algorithm <u>Service delivery:</u> • Identification of HIV positive women in ANC, L&D and PNC and disaggregation of age ANC attendees to identify the most vulnerable. Identify and utilize strategies for provision of adolescent friendly services. Treatment: Support		• Print and distribute PMTCT IEC materials and tools • Pre-service training for middle level health care providers, printing of PMTCT guidelines

	implementation of lifelong ART for pregnant and breastfeeding HIV+ mothers; discontinue option A & B • Retention in care and treatment, Use immunization register to track HEI and embrace use of technology to automatically provide alerts when HEIS are born (HIT system).Streamline the operationalization of EID • Gender-related norms to improvement male engagement and HIV status disclosure • Non-direct service delivery: HCW recruitment & training and development and coordination of HIV related policy at national and county level • Commodities: Technical support to ensure commodity security • Continuous QI activities and real time monitoring of PMTCT • Program evaluation and estimation of eMTCT rates at County levels		
HTC Services **Lab Services** **FP Services** **HRH: Peer counselors** **HRH: Health Care Providers** **Training and Onsite Mentorship** **HMIS** **Quality Assurance and Improvement** **Retention**	• Optimize and saturate HTC • Lab networks for EID and VL, ensure RTK security • Support FP counseling and consent including appropriate referrals • Hire peer counselors in scale-up counties based on a need basis • Hire critical staff in scale-up counties based on need • Targeted training • Support documentation, reporting and data use at all levels, strengthen EMR use. Distribution of tools including IEC materials • Implement KHQIF in all scale-up counties, Implement and conduct SIMS and quarterly support supervision • Support referral and linkage, facility and community PHDP,	• Capacity building for long-term FP services • Conduct onsite training using harmonized HIV curriculum including CME and mentorship • Support ART integration in MCH • Printing of mother-baby booklet, PMTCT IEC materials and reporting tools • Support printing and distribution of new PMTCT Guidelines	

Strategies	defaulter tracking services, Patient education		
NACS including Breast Feeding	• Support exclusive breast feeding education	• Provide pre-service training for middle level health care providers	
Private Sector Engagement	• Private sector engagement and support: Support high yield/volume private facility: HIV related trainings and supplies of reporting tools, commodities		
Gender	• Ensure minimum package of GBV services and referrals available at PMTCT sites; Male involvement advocacy and Screening for GBV (training, advocacy, linkage to care and legal, safe space, community reach)		
HIV Integration in MCH			
County Technical Support			
Joint Supportive Supervision	• TA to County and sub-national HMTs: strategic planning in relation to HIV (KASF and AOP); support annual work plan development; planning and coordination of PMTCT services; county eMTCT progress review meetings training and mentorship; KHQIF implementation, address gender-related barriers that affect PMTCT services • Joint participation in SIMS		• Renovation in select scale-up counties
Technical Assistance	• Participate in stakeholder review forums; support NASCOP, DRH and DCH in program reviews and improvement		

Policy and Guideline Reviews **National Commodity Security Reviews** **Support National HMIS and data use for decision making** **Evaluation and Research**	• Support revision of HIV related policies and guidelines • Participate in national HIV related pharmaceutical and non-pharmaceutical reviews; and support supply chain systems and logistics meetings • Provide TA for revision of indicators and reporting tools • Support national and regional PMTCT program evaluations		

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP17	Estimated Funding in COP18	# of IMs	Transition End date	Notes
Printing and distribution of new Guidelines, IEC materials and tools such as mother baby booklets,	Transition to GOK or donor	$250,000	0	1	Sept 2017	Printing of mother baby booklets will be undertaken by the Department of Reproductive Health
Renovation in select scale-up counties	Transition to GOK	$815,765	0	25	Sept 2017	Minor Renovations to facilities in select high volume sites
Pre-service training for middle level HCP	Transition to GOK	$100,00	0	1	Sept 2017	In support of high volume sites
Totals		**$1,165,765**		**27**		

Prevention

Table A.1 Program Core, Near-core, and Non-core Activities for COP16

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site Level	**Scale-Up to Saturation and Aggressive Scale-up Counties** • HTS demand creation • PITC, Home-based and mobile HTS outreach • Link HIV+ clients care/treatment & test and START • Hire HTS counselors • Support quality improvement initiatives for rapid HIV testing • Peer education in hot spots for KPs and priority populations (PP) • Promote and distribute male and female condoms and lubricants • Linkage to ART for KPs living with HIV • Procure and provide methadone and other Medically Assisted Therapies MAT • HTS community mobilization • Implement QA/QI system • Stigma and discrimination reduction activities • Conduct VMMC rapid results initiative (RRI) and identify demand creation • VMMC mobile outreach and equip facilities • Strengthen school and community based HIV prevention and violence prevention • Map AGYWs sexual networks • KP and PP Sexual and Gender-Based Violence Prevention and Response activities	• Provide training and refreshers of HCPs • Link HIV- clients to other HIV services • Post Exposure Prophylaxis for exposed persons and AGYWs • Evidence-informed Behavioral Interventions (EBIs) targeting adolescents and guardians • Introduction of Pre Pex device for male circumcision • Promote and distribute male and female condoms and compatible lubricants for PPs and KPs • RRI / Routine VMMC sites	• OR to improve uptake in older males • NIH bridging studies • EIMC acceptability studies in circumcising communities • Safe MC in traditionally circumcising communities
County Level	**Sustained Counties** • Provide Diagnostic Testing and Counseling in OPD and IPD settings • Test walk in clients	• Support GOK county level HIV prevention • Engage GOK and donors promotion of male and female condoms and lubricant	

National Level	requesting HIV test • Provide quality HTS services • Test index client family members • Link HIV+ clients to care/treatment and Test and START • Support VMMC service delivery personnel • Provide HTS and active referral of HIV+ individuals to care and treatment • Engage county governments to create enabling environment to improve KP HIV prevention and treatment services • Engage GOK and CSOs to improve HIV KPs prevention and treatment services • Hire staff in saturation and scale up counties for HTS to KPs and AGYWs • Support QI activities • Demand creation for HTS, VMMC, condoms, and MAT • Condom social marketing	distribution to KPs • Support GOK national HIV prevention activities • Procure RTKs in saturation counties • Support review HTC guidelines • Targeted communications around new guidelines, protocols including dissemination • Create enabling environment to improve access to health services	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP15

	Core Activities	Near-core Activities	Non-core Activities
<u>HTS</u> **Scale-up to Saturation**	• Intensify demand creation for uptake of HTS services • Conduct home-based HTC • Provide mobile/outreach HTS services to KPs, fisher folk, AGYWs • Provide PITC in OPD (80%) and IPD (100%) • Conduct home and facility HTS of children and sexual partners of index clients • Implement QA/QI system for monitoring and improvement of HTC quality safety and services • Link HIV + clients to	• Procure RTKs • Train HCPs to provide HTS • Provide HTS counselors with refresher/new algorithm training • Link HIV - clients to other HIV services • Train HTS providers on new guidelines	

	care/treatment and Test and START via CHWs, telephone follow up, expert patients, and HTS counselors • Hire HTS counselors • Support quality improvement initiatives for rapid HIV testing • Test walk in clients requesting HTS		
Aggressive Scale-up Counties **Sustained counties**	• Intensify demand creation for HTS uptake • Provide mobile/outreach HTS for KPs, fisher folk, AGYWs • Provide PITC in OPD and IPD • Provide facility HTS for children and sexual partners of index clients • Implement QA/QI system for monitoring and improve HTS safety and service quality • Link HIV+ clients to care and treatment by use of CHWs, phone follow up, expert patients, HTS counselors • Hire HTS counselors • Test walk-in clients requesting HTS • Provide Diagnostic Testing and Counseling in OPD and IPD settings • Test walk in clients requesting HIV test • Provide quality HTC services • Test index client family members • Link HIV positive clients to care and treatment using CHWs, telephone follow up, expert patients, HTC counselors, etc.		
<u>Key Populations</u> **Scale-up to Saturation and Aggressive Scale-up Counties**	• Promote peer education and hotspots /community based outreach for risk reduction and condoms distribution • Provide STI education, screening and treatment • Promote and distribute male and female condoms and compatible lubricants • Offer Mobile, Safe spaces (DICEs), hotspot and community HTS • Roll out KP monitoring and reporting tools to account for	• Engage national GOK to review policies and regulations for enabling environments to improve access to health services • Post Exposure Prophylaxis for exposed persons • Training of HCPs to provide KP friendly services • Provide psychiatric assessment for PWID	

	complete HIV services cascade • Provide HIV+ KPs with ART and Test and START based on guidelines at both safe spaces and referral facilities • Procure and provide PWID methadone and other Medication-Assisted Treatment (MAT) for HIV-negative PWID • Promote harm reduction for PWIDs (NSP, MAT) • Stigma and discrimination reduction through trained HCWs and Peer outreach workers and other relevant stakeholders e.g. police, judiciary • Refer for high impact interventions (VMMC for HIV negative, PMTCT and ART) • Refer for TB screening and treatment • Empower community to mobilize individuals to improve HIV service uptake, in micro-planning, implementation, monitoring and reporting of activities, and take leadership in violence prevention and response • Engage county governments to create and support functional channels for 100% condom policy, mitigate and respond to violence (homophobia/transphobia and SGBV), review policies and regulations, for enabling environments to improve KP access to HIV prevention and treatment services • Create an enabling legal environment for KP programming • Implement QA/QI systems for monitoring and improvement of safety and service quality for MAT and KP interventions	• PrEP for KP • Build capacity of KP services providers to provide comprehensive services	
Sustained		• Promote and distribute male and female condoms and compatible lubricants • Engage GOK and donors to promote and distribute male and female condoms and	

		compatible lubricants to KPs	
<u>VMMC</u> **Scale-up to Saturation, Aggressive Scale-up, and Busia and Turkana counties**	• Intensify VMMC demand creation for males aged 15-29 years • Provide VMMC as a standard package of service for eligible males aged 10-14 and over 30 years traditionally non-circumcising communities • Conduct rapid results initiative (RRI) • Conduct mobile and outreach services • Equip facilities • Provide personnel for service delivery • Provide HTS and refer HIV+ individuals to care and treatment • Implement internal and external QA/QI system for monitoring and improvement of safety and service quality for VMMC • Post procedure follow up and systematic assessment for adverse events	• Introduction of PrePex device for male circumcision • Provide VMMC standard package of service for eligible males aged 0-60 days, in traditionally non-circumcising communities	• OR to improve uptake in older males • NIH bridging studies • EIMC acceptability studies in circumcising communities • Safe MC in traditionally circumcising communities
Sustained counties	• Support of service delivery personnel • Provide HTS, active referral of HIV+ individuals to care and treatment • Implement internal and external QA/QI system for monitoring and improvement of safety and service quality for VMMC • Post procedure follow up and systematic assessment for adverse events	• RRI coordinated from neighboring counties/ Routine VMMC sites	
<u>Adolescent Girls</u> **Scale-up to Saturation and Aggressive Scale-up Counties**	• Provide Adolescent Friendly Sexual and Reproductive Health services: Condoms, HTC, GBV response • Strengthen school and community based HIV prevention, violence prevention and norms change • Strengthen assets of girls, young women and families (parenting/care giver programs, social protection- cash transfers, educational subsidies and economic approaches) • Map male sexual partners and	• Conduct small group level EBIs targeting adolescents aged 10-14 years to delay sexual debut through knowledge and skills to negotiate sexual abstinence, negative peer pressure, other risky situations, and avoid and provide skills to address child sexual abuse • Target parents and guardians of	

	link with high impact interventions (HTS, VMMC and ART) • PrEP provision	adolescents aged 9-12 using EBIs to increase knowledge of HIV risks for young people, promote positive parenting, mentoring, and effective adult-child communication on sexuality, sexual risk reduction and child sexual abuse • Support national and county GOK levels to develop policies, guidelines and protocols for HIV prevention	
Fisher folk	• Conduct HTS • Conduct Peer outreach • Condom promotion and distribution • Conduct mobile outreach services	• STI screening and testing	
Military, Uniformed/Disciplined Services	• Condom promotion and distribution • Provide HTS services and linkage to care and treatment, VMMC • Risk Reduction Counseling (e.g., addressing harmful gender norms, engagement with sexual partners) • Sexual and Gender-Based Violence Prevention and Response • "Basic Training" on HIV prevention, care and treatment		
Prisoners	• Provide HTS • SGBV prevention and response • Condoms promotion and distribution targeting staff and families STI prevention, screening and treatment • Peer education among inmates • Distribute condoms to post release prisoners	• Post Exposure Prophylaxis • Support for policy review for HIV services enabling environment	

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP16	Estimated Funding in COP17	# of IMs	Transition End date	Notes
All non-core activities identified in COP15 will be transitioned by Sept 2016. No additional non-core activities were identified for transition in COP16.						
Totals						

Orphans and Vulnerable Children (OVC)

Table A.1 Program Core, Near-core, and Non-core Activities for COP16

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	• Case Management: Standardize case management age appropriate, disability and gender responsive procedures for identifying, assessing, enrolling and monitoring children, adolescents, and families who are vulnerable by HIV/AIDS while protecting the rights of children. • Conduct child & family socio-economic status assessment across essential services (health, schooling, safe, stable). • Develop case management plans for children and their families and monitor complete referrals to include exit/transition plans for enrolled families. • Access to health and HIV services for children and adolescents receiving OVC services (HTS, treatment and care). • Support early identification and enrolment of HIV positive children and adolescent to clinical care and treatment services including ART. • Forge linkages with other initiatives e .g. DREAMS, All In! through community involvement and engagement in mobilization, sensitization, education and generating demand for HIV services including retention and linkage to interventions including social services. • Support ECD activities in coordination with pediatric treatment and PMTCT. • Integrate ECD into HIV care and treatment for under-fives. • Education support to at risk OVC to facilitate access to primary and secondary education. • Safe Protection and Psychosocial Support for OVC and caregivers. • Provision of positive parenting skills to caregivers • Succession planning and access to basic legal documentation. • Economic strengthening for caregivers through group-based savings and loan initiatives. • Link caregivers and adolescents to available resources including social protection programs. • Implement special studies/surveys to identify gaps in OVC	• Strengthen partners' capacity in case management • Vocational training for adolescents and caregivers. • Access to primary and secondary education for girls through long-term subsidies. • Provision of household supplies to most vulnerable HH when referrals are not possible • Community based support and monitor adherence and retention in care	• Scholarships for tertiary/university education

	programming and assess impact		
County	• Mobilize and support county and sub-county child protection structures e.g., AACs and LAAC. • Nutrition assessment, counseling and support (NACS) and therapeutic feeding for severely malnourished OVC. • Nutrition assessment, counseling support (NACS) and therapeutic feeding.	• Map services within communities and develop services & provider Directory. • Capacity building for the Department of Children Services county and sub-county staff on prevention, response and facilitate complete referrals to child protection services.	
National level	• Support Child Protection Policies: influence policy, guidelines/standards, and implementation and strategies reviews. • Support select studies and assessments, e.g. household impact.	• Strengthen mechanisms/systems for cross referrals • Strengthen GOK/Department of Children Services case management systems to prevent and respond to child abuse and support family placement. • Improve safety mechanisms to protect children from violence	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP15

OVC	**Core Activities**	**Near-core Activities**	**Non-core Activities**
Case Management	• Standardize OVC LIPs (CBO/FBOs) procedures to identify, assess, enroll and monitor HIV/AIDS vulnerable children, adolescents, and families at service delivery point/sites • Conduct child & family socio-economic status assessment across essential services (e.g. health, schooling, safe and stable environment) • Develop case management plans for children and families and monitor complete referrals to include exit/transition plans • Implement special studies/surveys to identify gaps in OVC programming and assess impact.	• Map services within communities and develop service directories • Support development of national MIS • Strengthen case management skills (including LTFU)of CHV and children's officers in saturation and scale up counties	
Healthy (Access to Health/ HIV Services)	• Link and refer OVC Households to facility and community-based services (e.g., HTC, pediatric care and treatment, TB services - ICF for family members of index clients- ,nutrition and food security programs, child survival services including immunization for <5s) • Link identified adolescents to other prevention and treatment services including sexual reproductive health services and initiatives e.g., ACTS, DREAMS, All In!		

	• 100% of enrolled children and adolescents know their HIV status, including supporting EID. • Link 100% of HIV-infected children and adolescents to HIV clinical care and treatment including ART and other care services • Facilitate and monitor complete referrals including nutrition, food security and PSS programs • Integrate adherence assessment, counseling and support into routine OVC HH support • Promote psychosocial health among children and caregivers through individual and intensive counseling		
Safe (Protection)	• Address psycho-social health among children and their caregivers through individual and group-based activities. • Support positive parenting skills including discipline, communication on adolescent risk, HIV disclosure (e.g. Families Matter Program - EBI), child development, health and nutrition, • Develop succession planning, permanency support and basic legal documentation for inheritance e.g. birth certificates and identification cards, • Support basic skills on child protection and prevention in all forms of abuse, including GBV, and referrals to other service providers,	• Support advocacy and policy efforts to improve safety of children from violence. • Mobilize and support child protection community-level committees/structures (AAC, LAAC) • Disseminate child protection laws, guidelines, SOPs to CSOs/OVC service providers • Support M&E System for national child protection management information system	
Stable (inc. Economic Strengthening)	• Facilitate OVC caregivers to access group-based savings and loan initiatives. • Link OVC and caregivers to available resources including social protection programs e.g., cash transfers, education bursaries, food subsidy, fee waivers, health insurance fund, youth and women enterprise funds/schemes • Support CBOs/FBOs to assist caregivers to develop transition plans	• Support market-linked vocational training for adolscents and individual HES activities. • Carry out market assessments for IGA and create linkages businesses/agricultural projects to markets. • Provide IGA funds and support • Targeted food security initiatives	

Schooled (Education)	• Facilitate OVC access to primary and secondary education through targeted support for scholastic materials e.g., uniforms, school fees • Link school age OVC to other available education support/ bursaries (GOK and other partners). • Support school-based PSS for children and teachers through training and related activities • Support ECD activities with Pediatric treatment and PMTCT • Integrate ECD into HIV care and treatment for children under-five	• Support community education councils including PTAs for OVC support • Facilitate access to primary, secondary and ECD education centers through long term or open ended subsidies	• Support tertiary education (university subsidies and scholarship)

Table A.3 Transition Plans for Non-core Activities: OVC

Transitioning Activities	Type of Transition	Funding in COP15	Estimated Funding in COP16	# of IMs	Transition End date	Notes
Support tertiary education (university subsidies and scholarship)	Phasing out	$600,000	$380,386	1	August 2017	Global Give Back Circle award ends August 2017
Totals		**$600,000**	**$380,386**	**1**		

APPENDIX A: Strategic Information

Table A.1 Program Core, Near-core, and Non-core Activities for COP15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site Level **County Level**	▪ EMR upgrades to POC, increase intra facility service area, reporting, Data transmission, analysis and feedback loop • Facility Identification number for DHIS and DATIM. • Standardize M&E policies, guideline and SOPs • Coordinate paper-based and electronic data quality assessments of programmatic data in saturation and scale up counties • Data utilization and dissemination to improve quality programming and best practices. • Geospatial mapping and analysis • Scale-up of M-Health (EID) in saturation and scale-up counties • Health Information system strengthening: DHIS2, LIMS, and CHIS and integration of sub-systems: DATIM,LIMS, TIBU, MFL, EMR, HRIS, DHIS2,CHI	• Support EMR installation to mirror geographical prioritization of PEPFAR investment • • Improve quality programming and innovative best practices. • Build M&E capacity of HCWs on M&E tools, SOPs, and guidelines in sustained counties • STI Surveillance and surveys • HIV Drug resistance surveys	
National Level	• Support enhancement of national/County M&E reporting systems (Integrated analytic and visualization) • Design/Integrate/harmonize/print/Distribute M&E tools with balanced EMR enhancement to POC • Support DQA/DQIs, Support Implementation of PHEs, BPEs, IEs, IS and ORs related to 90-90-90 • Support data analysis, dissemination and data use • Support M&E capacity building at national, county, facility, and community • Build capacity in geospatial analysis to routinely map HIV disease burden and PEPFAR supported services • Support strengthening of National and sub-national HIS o Evolution of DHIS2, integration and interoperability of sub-systems (DATIM,LIMS, TIBU, MFL, EMR, HRIS, DHIS2,CHIS, COPBAR,ADT) o Build capacity in geocoding and mapping for USG, national and counties. • Strengthen functionality of EMRs and National data warehouse o EMR upgrades to POC, increase intra facility service area, reporting, Data transmission, analysis and feedback loop • Support M-Health solutions (EID, KP database, adherence, Linkage)	• Develop Key Population centralized data base • Reproduction and distribution of HIV and PEPFAR reporting tools	

	• Carry out National/sub-national population-based surveys (HIV Impact Assessments, Focal surveys, triangulation/ size estimation for KP) • Conduct HIV case-based HIV case-based surveillance to monitors each stage of the clinical cascade • Conduct mortality surveillance : 1) impact of HIV infection on death; 2) impact of ART/viral suppression on death; 3) changes in HIV prevalence/incidence, 4) Role of vital statistics/civil registration(ICD 10)		

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP15

	Core Activities	Near-core Activities	Non-core Activities
Monitoring and Evaluation	• Support national and County M&E (policies, guidelines, curriculum, leadership and governance, MFL) • Support enhancement of national/County M&E reporting systems (Integrated analytic and visualization) • Design/Integrate/harmonize/print/Distribute M&E tools with balanced EMR enhancement to POC • Support DQA/DQIs, Support Implementation of PHEs, BPEs, IEs, IS and ORs related to 90-90-90 • Support data analysis, dissemination and data use • Support M&E capacity building at national, county, facility, and community • Build capacity in geospatial analysis to routinely map HIV disease burden and PEPFAR supported services	• Support EMR installation to mirror Geographical prioritization of PEPFAR investment • Increase M&E capacity of HCWs on M&E tools, SOPs, Guidelines and curriculums in sustained counties • Coordinate county data reviews, demand and utilization in sustained counties	

Health Information Systems	• Support strengthening of National and sub-national HIS
	  o Evolution of DHIS2, integration and interoperability of sub-systems (DATIM,LIMS, TIBU, MFL, EMR, HRIS, DHIS2,CHIS, COPBAR,ADT)
	  o Build capacity in geocoding and mapping for USG, national and counties.
	• Strengthen functionality of EMRs and National data warehouse
	  o EMR upgrades to POC, increase intra facility service area, reporting, Data transmission, analysis and feedback loop
	• Support M-Health solutions (EID, KP database, adherence, Linkage)		

Surveys and surveilllance	• National/sub-national population-based surveys (HIV Impact Assessments, Focal surveys, triangulation/ size estimation for KP) • Conduct HIV case-based HIV case-based surveillance to monitors each stage of the clinical cascade • Mortality surveillance : 1) impact of HIV infection on death; 2) impact of ART/viral suppression on death; 3) changes in HIV prevalence/incidence, 4) Role of vital statistics/civil registration(ICD 10) • Implement Special studies to understand concerns along the clinical cascade (e.g., Repeat positive testers, adherence, loss-to-follow-up) • Build local capacity for Modeling and estimation	• STI Surveillance and surveys • HIV Drug resistance surveys	

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP15	Estimated Funding in COP16	# of IMs	Transition End date	Notes
All non-core activities will be transitioned in COP 15, Sept 2016; no additional non-core activities were identified for transition.						
Totals		**$0**	**$0**	**0**		

Health Systems Strengthening

Program Core, Near-core, and Non-core Activities for COP16

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site Level	• None	• Improve health care provider performance	• Community Strategy trainings that are not aligned to PEPFAR interventions.
County Level	• Domestic resource mobilization • Health financing policy and strategy development • Strengthen HR capacity with mix of skill-sets • Strengthen county government HRH management systems to enable attraction, equitable deployment, retention and motivation of workforce. • Policy and guidelines on HRH implementation at county level • Sustainable HRH financing support at county level • Improve health care provider performance • Bolster health commodities regulatory framework, supply chain governance, and logistics information systems • Leadership, management and governance practices	• Pre-service training support in line with PEPFAR 3.0 pivot • Retention schemes at site level in saturation and scale up counties • Roll out of Human Resource Information Systems • Support use of the HRIS for decision making at the county level	• Provide in-service training in saturation and scale up counties – activity moved to service delivery partners • Use of technology approaches for refreshers to reduce absences-activity moved to service delivery mechanisms
National Level	• Domestic resource mobilization • Health financing assessments and surveys • Health financing policy and strategy development • HRH for HIV services assessment • Strengthen HR capacity with a mix of skill-sets • Regulation and accreditation of training and enhance standards of quality services • Policy and guidelines on employment and recruitment • Sustainable HRH financing support at county level • Improve health care provider performance • Bolster health commodities regulatory framework, supply chain governance, and logistics information systems • Service delivery, Quality Assurance • Impact Assessments Evaluations • Leadership, management and governance practices	• Health insurance coverage • Private sector engagement • Pre-service training support in support of PEPFAR pivot	

Table A.2 HSS Core, Near-core, and Non-core Activities for COP15			
	Core Activities	**Near-core Activities**	**Non-core Activities**
Health Financing and policy Kenya is selected for Bold Vision interventions in Africa	• **Sustainable Financing (DRM)** towards sustainable health financing. 1) National Level: High level advocacy for increased allocations to HIV/AIDS services in National Budget County level: Strengthen County capacity on planning and budgeting; evidence generation to inform advocacy activities for increased resources for HIV 2) **Financial Risk pooling (National and Counties):** Support health financing reforms (resource mobilization, risk pooling and purchasing) including exploring possibilities of health insurance coverage for HIV/AIDS services by NHIF and private health insurance to increase funding for HIV/AIDS from domestic sources 3) **Support evidence generation (County and National**): built evidence to inform: Advocacy activities for increased resources for HIV/AIDS; planning and budgeting; policy and strategy development as well as implementation (e.g. National and County Health Accounts, health policy/Bill, Expenditure tracking, Budget Analysis, , KASP, KHSSP, health financing strategy, County Strategic Plans etc.)	**Private sector engagement to increase financing and provision:** Facilitate private sector engagement to enable them participate in increasing funding for HIV/, pooling, purchasing and in providing HIV/AIDS services.	
Human Resources for Health Aligned to the 5 objectives in the PEPFAR HRH strategy for impacting PEPFAR-supported in scale-up counties	• **Assess HRH capacity needs to deliver HIV/AIDS services (prevention, care, and treatment**), and other areas of the health system (e.g., reference laboratories).		
	• **Support appropriate mix of skill-sets of health workers to deliver HIV/AIDS services.** • Continue to review opportunities in task shifting in care and treatment in saturation and scale-up counties.	• Provide pre-service training support to institution to faculty and students to increase number of new graduates in saturation counties • Support training programs for lay /peer health workers for	

		HIV/AIDS interventions • Garner regulatory bodies support to ensure regulation and accreditation of training and enhance standards of quality services. Focus on key bodies supporting PEPFAR programs (e.g. doctors, nurses, clinical officers, pharmacists, nutritionist, and laboratorians.)	
	Review current recruitment, deployment, and retention strategies designed to ensure a consistent and sustainable supply of trained health workers • Strengthen county government HRH management systems for effective recruitment, deployment and retention of health workers. Build capacity of CHMT on HRH management and systems. • Assess and work w/national and county governments to address above-site policy and guidelines on employment and recruitment	• Support retention schemes at site level in saturation and scale-up counties • Roll out Human Resource Information Systems (HRIS) to the county and by County Health Management Teams (CHMT) in decision making and budgeting processes	• Hire contracted health care workers – activity shifted to service delivery mechanisms
	Sustainable HRH financing support at county level • TA support and advocacy for adequate HRH budgetary allocation at the county level • Continue engagement with the county government for transitioning of PEPFAR contracted health workers in to the county payroll in both high and moderate burden counties. • Develop plan for alignment of cadres not recognized by MOH and supporting their integration into the health system		
	Improve health worker performance in scale-up counties • Continue process to support in-service training (IST) system • Support continuous assessment of specific capacity gaps, to inform in-service-training • Support clinical mentorship and supportive supervision in health facilities	• Support interventions to enhance institutional based trainings in saturation and scale-up counties. • Support coordinated training national and county government involving all stakeholders to minimize and eliminate duplication and competition • Support use of technology and approaches that enhance efficiency and reduce absences.	• Community Strategy trainings that are not aligned to PEPFAR interventions. • Support comprehensive integrated courses to enhance efficiency. Activity shifted to service delivery mechanisms
Supply Chain	• **Strengthen supply chain at**		

systems	**above-site level,** including support to national and county levels for health commodities regulatory framework, quantification, supply chain governance, logistics information systems and inventory tracking • **Support for supply chain systems capacity at national and county levels** through training and performance improvement activities of cadres with supply chain competencies • Support commodity management in saturation and scale-up counties to absorb and ensure quality		
Service delivery Quality assurance	• Strengthen systems at national and county government levels to support institutionalization of quality improvement in health sector service delivery and the care of OVC 1. Develop national quality improvement policy, standards and syllabus 2. Improve and develop systems that allow for its scale up and institutionalization 3. Institutionalize quality improvement in child protection and programs for OVC 4. Build county governments' capacity for quality improvement and apply quality improvement techniques to meet health service goals in HIV care and treatment		• Appropriate communication on PEPFAR new strategies, and realignment. • Build capacity of journalists and reporters to disseminate scientific information to general public on HIV/AIDS public health interventions
Leadership and Governance	• Support interventions to enhance leadership, management and governance knowledge and skills of health workers in management positions at county level • Support CHMT to institutionalize leadership, management and governance practices to enhance efficiencies and reduce wastage • Support Leadership and governance interventions at national institutions such as prisons and uniformed service forces.		

Health Information Systems	**Impact Assessments Evaluations** • Support program evaluation to measure impact of HSS interventions to inform future planning • Evaluate HRH transition process to monitor and improve outcomes for sustainability		

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition		Estimated Funding in COP16	# of IMs	Transition End date	Notes
Hire additional health care workers in Sustained counties In service training for health workers at site level	Phasing out		$0	Service delivery mechanisms (multiple)	End of 2017	No new staff will be hired in Sustained counties. Staff in Sustained sites will be transitioned to county governments in line with PEPFAR Kenya Transition plan.
In service training for health workers at site level	Phasing out		$0	Service delivery mechanisms (multiple)	End of 2017	No in-service training activities for health workers at site level will be supported by HSS mechanisms, the activity will be undertaken by Service delivery mechanisms
HRIS support to county and regulatory bodies	Transition to GOK			2	End of 2018	The HRIS systems will be transitioned to regulatory bodies, national and county governments by the end of COP17
University fellowship program	Phasing out			1	End of 2017	The fellowship program will not take new students. The current students will be supported until completion.
Totals			$0	$0		

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total
$2,348,131	$497,651,869	$500,000,000

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount allocated
MTCT	Mother to Child Transmission	26,862,317
HVAB	Abstinence/Be Faithful Prevention	2,040,000
HVOP	Other Sexual Prevention	16,599,477
IDUP	Injecting and Non-Injecting Drug Use	3,628,578
HMBL	Blood Safety	2,500,000
HMIN	Injection Safety	1,500,000
CIRC	Male Circumcision	13,535,000
HVCT	Counseling and Testing	32,139,280
HBHC	Adult Care and Support	19,354,551
PDCS	Pediatric Care and Support	4,631,845
HKID	Orphans and Vulnerable Children	31,624,043
HTXS	Adult Treatment	150,495,952
HTXD	ARV Drugs	92,000,000
PDTX	Pediatric Treatment	13,462,845
HVTB	TB/HIV Care	8,826,111
HLAB	Lab	13,600,000
HVSI	Strategic Information	23,500,000
OHSS	Health Systems Strengthening	8,000,000
HVMS	Management & Operations	35,700,000
TOTAL		**500,000,000**

Appendix B2: Resource Projections

Various inputs and methods were used to calculate required resources for implementation of COP16. Unit costs were estimated based on the analysis of FY15 UEs and the required program inputs to sustain epidemic control according to PEPFAR prioritization categories. These categories are: 16 scale-up to saturation counties being supported to reach saturation by FY17, 11 aggressive scale-up counties being supported towards saturation by FY18 and closing coverage gaps, 13 sustained counties, and seven central support counties. However, different cost adjustments were made based on need within these three categories.

1. Maternal and Neonatal Child Health; HIV Care and Treatment

	Maternal and Neonatal Child Health		**Clinical Services**
Per Patient	*HTC cost*	*ART cost*	*ART cost*
Scale-up to saturation counties	$7.7	$196	$119.58
Aggressive scale-up counties	$7.7	$196	$119.58
Sustained and central support counties	$3.5	$139	$119.58

Clinical services costs were derived from 2015 EA data, which cited $324.93 (with drugs and other commodities) average cost per patient on ART. From a clinical services (not including PMTCT) budget of ~$288 million, about $24 million will be used to support community based treatment activities and innovative care delivery models and $130,709,102 will be used for commodity procurement. The remaining balance will be used to support facility based service delivery.

Adjustments to unit expenditure were made to account for anticipated programmatic changes (pivot and differentiated care models) in the coming implementation year including:

- Ensuring quality ART services through the minimum package of services for all patients.
- Increased community activities to support differentiated care models and ensure achievement of the third 90, through improved treatment adherence.
- Analysis of the treatment cascade to ensure that men, children, adolescents and key populations treatment coverage are improved.

2. Prevention

Cost of prevention interventions do not vary from region to region.

- A similar package of services to key and priority populations will be offered in priority counties.
- Young people aged 10-14 and 15 - 24 will be offered a

Key and Priority Populations	**Unit Expenditure**
FSW	$49.7
MSM	$111.68
Fisherfolk	$13.57
Prisoners	$13.57
PWID	$116.26

comprehensive package of services aligned with DREAMS interventions. The comprehensive package UE for HVAB is $233 and AGYW is $264.

- HTS UE averages $2.7
- VMMC UE is $50.37
- The unit costs for FSW, MSM and PWID was increased to cover for gender based activities.

Type of HTS	Unit Expenditure
Facility PITC	$2.6
VCT	$2.8
Other HTC	$3.37
Community door to door	$14.29
Community/Outreach	$8
RTK: $1.01	

3. Orphans and Vulnerable Children

OVC cost is estimated at $44 in priority counties and $30 in sustained counties per child.