United States Department of State

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FY 2015 Kenya Country Operational Plan (COP)

The following elements included in this document, in addition to "Budget and Target Reports" posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Kenya.

1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

   Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the "COP 15 Targets by Subnational Unit" sheets that follow for final approved targets.

2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the "FY 2015 Country Operational Plan Budget and Target Report."

COP 2015
Strategic Direction Summary

KENYA

September 2, 2015

Contents

Acronyms

ACT	The Accelerating Children's HIV/AIDS Treatment Initiative
APOC	Adolescent Package of Care
AGYW	Adolescent Girls and Young Women
APR	Annual Performance Report
ART	Antiretroviral Treatment
CDC	Centers for Disease Control and Prevention
CHMT	County Health Management Team
CrAg	Cryptococcal Antigen
CSO	Civil Society Organizations
DATIM	Data for Accountability Transparency Impact Monitoring
DICES	Drop-in centers
DHIS2	District Health Information System
DOD	Department of Defense
DREAMS	Determined, Resilient, AIDS-free, Mentored, and Safe
EA	Expenditure Analysis
EID	Early Infant Diagnosis
EMTCT	Elimination of Mother to Child Transmission
EMR	Electronic Medical Record System
EPP	Estimation Projection Package
FSW	Female Sex Workers
GF	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GOK	Government of Kenya
HAART	Highly Active Antiretroviral Therapy
HCW	Health Care Workers
HEI	HIV Early Intervention
HITS	HIV infected Infant Tracking (HIT) system
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
IBBS	Integrated Biological and Behavioral Surveillance Survey
IPC	Infection Prevention and Control
IATT	Inter-Agency Task Team *(*IATT*) for* Prevention and Treatment of HIV Infection in Pregnant Women, Mother and Children
IP	Implementing Partner
IPT	Isoniazid Preventive Therapy
ITT	Interagency Task Team
KASF	Kenya AIDS Strategic Framework
KAIS	Kenya AIDS Indicator Survey
KCM	Kenya Coordinating Mechanism
LTFU	Lost to Follow-Up
LTS	Long-term Strategy
MAT	Methadone Assisted Therapy
MOH	Ministry of Health
MSM	Men who have Sex with Men
NAC	Nutrition Assessment Counseling

NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
NFM	New Funding Model
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PCR	Polymerase chain reaction
PEP	Post Exposure Prophylaxis
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
SAM	Severe Acute Malnutrition
SID	Sustainability Index and Dashboard
SI	Strategic Information
SIMS	Site Improvement through Monitoring System
TB	Tuberculosis
USAID	U.S. Agency for International Development
USG	U.S. Government
VL	Viral Load
VMMC	Voluntary Medical Male circumcision
WHO	World Health Organization

Goal Statement

The PEPFAR Kenya interagency team, comprising of the Centers for Disease Control and Prevention (CDC), the Department of Defense (DOD), the Peace Corps (PC), and U.S. Agency for International Development (USAID), has worked collaboratively with the Government of Kenya (GOK), civil society, implementing partners, and multilateral representatives to develop a country operational plan (COP) to attain epidemic control in select Kenyan counties within a two-year period. To rapidly move towards sustained epidemic control, PEPFAR will support Kenya's effort as outlined in the Kenya AIDS Strategic Framework (KASF) and the UNAIDS *Fast Track Strategy* with a strategic pivot categorized into two tiers: Scale-up and Sustained. These collaborative efforts will enable PEPFAR to focus on 20 scale-up counties with **eight (8)** of these counties targeted for scale-up towards saturation by the end of FY17 and the other **12** counties for aggressive scale-up by the end of FY18. The second tier will focus on **27** sustained counties, of which **20** counties will be targeted for sustained facility activities, adherence and retention; site, district and national level quality monitoring support as well as sustained sites support consistent with current ART expansion rates. The remaining **seven (7)** counties will receive sustained commodities support with continued national support for overarching quality assurance/quality improvement (QA/QI), TA to facilities without site level support, and laboratory networks. This will be done in partnership with the Government of Kenya (GOK), with whom the PEPFAR Kenya team is working to assume full management of HIV service delivery by the end of FY16. Beginning FY17, PEPFAR plans to continue to provide commodities and national TA support to these counties as the GOK assumes full management of HIV service delivery.

Note: Kindly refer to the above provisions in reading the technical plans for the Kenya's COP 2015.

Using epidemiological data, 20 out of Kenya's 47 counties contribute to more than 80% of new HIV infections, 80% of people living with HIV (PLHIV), and 80% of unmet need. The eight FY17 saturation counties – Nairobi, Homa Bay, Kisumu, Siaya, Migori, Mombasa, Uasin Gichu and Busia – contribute to 51% of new HIV infections, 50% of PLHIV, 53% of HIV+ pregnant women, 50% of female sex workers (FSW), 58% of men who have sex with men (MSM), and 45% of ART unmet need. PEPFAR Kenya has prioritized these eight counties for saturation towards the 90-90-90 goals by September 2017. The next 12 counties capture an additional 30% of new infections, 30% of PLHIV, 29% of HIV+ pregnant women, 28% of FSW, 29% of MSM, and 36% of ART unmet need. These counties are prioritized to aggressive scale-up by end of FY18.

The 20 sustained counties contribute 19% of the national HIV burden and will receive PEPFAR support for continued care and ART for current patients and growth through passive enrollment. The seven lowest burden counties, with 1% of people living with HIV, will receive technical assistance (TA), commodities, and laboratory network support until the end of FY16. During this time, these counties will be preparing to assume management of HIV service delivery to health facilities. PEPFAR will continue to coordinate closely with national and county leadership to provide the standard package of care in line with national guidelines.

In the eight FY17 scale-up to saturation counties, an implementation approach was designed with appropriate resources to achieve 80% ART coverage, 95% ART in HIV+ pregnant women, and 95% of HIV+ key populations (KP) reached by the end of September 2017, or 60% national coverage by FY16. In FY16, PEPFAR Kenya will re-orient activities to ensure that any future growth of the OVC cohort will be targeted towards the eight FY17 scale-up to saturation counties, where the risk of children being infected with HIV is the greatest. Core, near-core, and non-core activities were re-prioritized and redirected to these eight counties. Resources were also allocated to 12 aggressive scale-up counties to accelerate scale up towards saturation by the end of FY18. HIV Care, ART, and PMTCT services will be maintained in all 27 sustained counties supported by PEPFAR. As part of the transition dialogue, facilities with fewer than 50 ART patients will be assessed to identify the best approach to provide care, treatment, and PMTCT services to clients accessing those sites beyond FY16. For PEPFAR Kenya to pivot successfully, continued dialogue and planning with the GOK coupled with consistent and additional resources (including GOK allocations) are required over the next two years.

1.0 Epidemic, National Response, and Program Context

1.1 Summary statistics, disease burden and country profile

Epidemiological profile

Kenya is a lower-middle income country with a population of 43 million and per capita GNI of $2,780 (KNBS 2009; World Bank 2013). In 2014, overall HIV prevalence was 3.8%, accounting for 1,630,000 PLHIV (NACC 2014), including children. The national prevalence among persons aged 15 and over is 5.6 - 6%, depending on the source (5.6%: KAIS 2012, ages 15-64; 6%: NACC 2014, ages 15-49). The number of new HIV infections was 98,000 versus 61,000 AIDS deaths, and the number of OVC was 2.6 million (NASCOP 2014). HIV prevalence (including children) varies widely by geographic region, ranging from 0.5% in Tana River to 15.4% in Homa Bay (NACC 2014). Eighty

percent (80%) of PLHIV are in 20 of the 47 counties, with the eight FY17 scale-up to saturation counties contributing 50% of all PLHIV.

Females are disproportionately affected by the HIV epidemic: among adults (aged 15-64) HIV prevalence is higher among women compared to men (7.5% vs. 5.6%, respectively)(NACC, 2014). Young women aged 15-24 years are particularly vulnerable to HIV infection with prevalence three times that of young men in the same age group, 3% vs. 1%, respectively, (NASCOP 2014). Among Key Populations (KP), high prevalence rates of HIV infection persist, ranging from estimates of 18% among MSM, 29.3% among FSW, and 19% among people who inject drugs (PWID) (NASCOP 2015). Notably, the top 20 counties account for 79% of FSW, 87% of MSM, and 85% of PWID in Kenya, according to current estimates. Fisherfolk around the lake region in western Kenya constitute a priority population with an estimated ~26% HIV prevalence (NASCOP, 2014; FELTPAA, 2010).

While there has been significant progress with increasing the proportion of PLHIV who know their status, 40% are still unaware of their infection (NASCOP 2014). As a result, 740,497 (45%) of all PLHIV were receiving ART in 2014, with marked geographic variation, ranging from 8% in Mandera (a low burden county) to 88% in Busia (APR2014). Although the 20 high burden counties have 79% of PLHIV on ART, they still account for 80% of unmet ART need. Based on the 2012 Kenya AIDS Indicator Survey (KAIS), 80% of adult PLHIV on ART were virally suppressed. However, considering the high level of undiagnosed infection, only 41% of PLHIV were suppressed (NASCOP 2014). A more recent cohort survey found 89% viral suppression among adults and 69% among pediatric patients (NASCOP 2013, unpublished).

Substantial barriers remain in the identification of HIV-infected children and linking them to HIV care. Based on KAIS 2012, six in ten pediatric infections were undiagnosed (NASCOP 2014) and only 71,116 (39.6%) of the estimated number of HIV+ children were receiving ART as of 2014 (APR2014). 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 80-89% among adults) and drug resistance mutations in 89% among those who were not virally suppressed (NASCOP, 2013, unpublished), indicating the need to strengthen treatment monitoring through routine viral load testing and adherence assessment as per the national guidelines.

Tremendous scale-up of PMTCT services has occurred as the number of women tested during pregnancy more than tripled from <400,000 in 2007 to 1.3 million by 2014. A total of 66,258 (85%) of the estimated 78,358 HIV+ pregnant and breast feeding women were identified in FY14 (APR14). However, only 56,137 (85%) of those identified were given ARV prophylaxis, which equates to 72% ART coverage.

Significant challenges exist in successfully delivering the continuum of care for KP. Stigmatization and criminalization of KP behavior remains a major obstacle to successful HIV prevention, care and treatment. In 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] In some areas, drop-in centers (DICES) serve the testing and treatment needs of FSW and MSM. Qualitative interviews among a priority population, the fisherfolk community with an estimated 26% prevalence, suggest that stigma, misperceptions, and logistic barriers contribute to high levels of HIV infection and low access to care and treatment (FELTPAA, unpublished).

By the end of 2013, 792,931 voluntary medical male circumcisions (VMMC) had been performed in Kenya, representing 92.2% of the 2008 – 2013 national strategic plan targets. For the 2014 – 2019 national strategic plan, 1,001,757 men aged 10-49 are targeted, of whom 227,221 were circumcised in 2014 (KASF 2014). However, uptake of VMMC services by older men (aged 25+ years), who are known to be at high risk of acquiring HIV, has been low at 30%. Demand for services is highest among younger males whose immediate risk of acquiring HIV is lower.

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

Table 1.1.1. Key National Demographic and Epidemiological Data															
	Total		**<15**						**15+**						
			Total		**Female**		**Male**		**Total**		**Female**		**Male**		
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Total Population	42,961,841		17,831,020		8,842,888		8,988,132		24,130,167		12,828,547		12,301,620		KNBS 2009 Census projections
Prevalence (%)		3.8%		0.98%		0.98%		0.98%		5.70%		6.57%		4.82%	2014 projections in 2013 National estimates
AIDS Deaths (per year)	60,715		9,254		4,592		4,622		51,461		29,307		22,154		2014 projections in 2013 National estimates
PLHIV	1,630,138		179,737		89,232		90,505		1,450,751		839,892		610,859		2014 projections in 2013 National estimates
Incidence Rate (Yr)		0.2%		0.07%		0.07%		0.07%		0.38%		0.44%		0.33%	2014 projections in 2013 National estimates
New Infections (Yr)	100,633		11,847		5,847		6,000		88,786		50,631		38,155		2014 projections in 2013 National estimates
Annual births	1,890,000														NASCOP program data
% >= 1 ANC visit		96.9%													KAIS 2012
Pregnant women needing ARVs	78,358	100%													2014 projections in 2013 National estimates
Orphans and vulnerable children aged 0-17 years[1]	2,600,000		2,020,264		978,617		1,041,648		576,657		291,034		285,623		KAIS 2012
TB cases (Yr)	89,703		8,547		4,107		4,440		81,156		31,182		49,974		National TB program
TB/HIV Co-infection	30,692	35%	2,161	25%	1,022	26%	1,139	28%	28,531	35%	13,921	44%	14,610	29%	National TB program
Males Circumcised[2]	10,055,454						641,905	21.8%					9,403,549	91.2%	KAIS 2012
Key Populations															
Total MSM	20,998														(NASCOP Consensus Report)

MSM HIV Prevalence		18.2%													IBBS 2010-2011
Total FSW	133,675														(NASCOP Consensus Report)
FSW HIV Prevalence		29.3%													IBBS 2010-2011
Total PWID	18,327														(NASCOP Consensus Report)
PWID HIV Prevalence		18.7%													IBBS 2010-2011
Priority Populations Total Fisherfolk	122,088														KEMRI RCTP 2013 Fisherfolk study
Fisherfolk HIV prevalence		26.2%													FELTP AA 2011
Total young women 15-24 years	3,520,136														KAIS 2012
Total young women 15-24 years that are PLHIV	104,788														KAIS 2012
Young women HIV prevalence		3.0%													KAIS 2012

1. This category has been modified from "Orphans" to "OVC aged 0-17 years"
2. 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.

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**In Care (#)**	**On ART (#)**	**Retained on ART 12 Months (#)[2]**	**Viral Suppression 12 Months[3]**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population[1]	42,961,187	3.79%	1,630,138	917,797	740,497	668,874	644,819	6,520,698[4]	234,706[4]	130,283
Population less than 15 years[1]	17,831,020	1.0%	179,793	88,244	71,116	59,737	49,070	905,895	15,487	15,251
Pregnant Women	1,893,896[5]	5%	78,358	66,123[6]	56,046	Data not available	Data not available	1,317,391[7]	66,123[6]	36,069[8]
MSM (NASCOP Consensus Report)	20,998	18.2%	1,827	115[9]	104	Data not available	Data not available	6,354	522	104
FSW (NASCOP Consensus Report)	133,675	29.3%	30,267	5,007[9]	4,506	Data not available	Data not available	89,976	8,502	4,506
PWID (NASCOP Consensus Report)	18,327	18.7%	1,469	164[9]	148	Data not available	Data not available	6237	768	148
Fisherfolk (FELTPAA 2010)	122,088	26.2%	32,226	3,581[9]	3,223	Data not available	Data not available	97,047	1,6113	3,223
Young Women (KAIS 2012)	6,943,868	3.0%	142,953	27,740	25,240	Data not available	Data not available	4,544,626	45,268	Data not available

1. APR14 PEPFAR data. Over 95% of HIV patients in Kenya are supported through/reported by PEPFAR.

2. ART retention data for 12 months is based on the assumption that 91% adults and 84% children on ART retained, per APR14 12-month retention results.

3. Limited data viral suppression data are available; this reflects a calculation based on the viral suppression rate patients on ART of 89% adults and 69% children. . Using a lower rate of 80% for adults the total pop, virally suppressed would be 584,574

4. This does not include PMTCT testing or women diagnosed in PMTCT.

5. Estimate provided by the Kenya National Bureau of Statistics.

6. This represents number of women who were identified as HIV+ at PMTCT (known positives and newly tested positive) suggesting that woman received some level of clinical attention though not necessarily ARVs for pregnant women.

7. This represents women in PMTCT with known status and includes those who were newly tested and with known HIV+ status.

8. The number represents women newly placed on ART in PMTCT.

9. No survey data exist for this indicator; assumes 90% of pre-ART patients in care transition to ART.

1.2 National Investment Profile

Kenya's HIV response is funded primarily by three sources—PEPFAR (64%), GOK (21%), and Global Fund (GF) (8%)—with other sources accounting for 7% (GOK, National AIDS Spending Assessment 2013). As shown in Table 1.2.1, PEPFAR Kenya's funding level has been consistent since 2012 and is not expected to decline in the near term given the epidemic context and OGAC categorization as a long-term strategy (LTS) country. In January 2014, the Kenya Coordinating Mechanism (KCM) submitted a TB/HIV concept note based on UNAIDS costing and the Kenya AIDS Strategic Framework (KASF) to access funds under the GF New Funding Model allocation. PEPFAR worked with the KCM on the concept note to eliminate duplication, maximize the USG and GF investment, and strategically align with domestic and other available resources to achieve epidemic control.

PEPFAR also supports the Domestic Resources Mobilization initiative through the Bold Vision for Sustainable Health Financing to increase host country budgetary allocation and resource commitments to health and HIV services and to improve efficiency in resource utilization. The GF Concept Note has been approved. The GOK is moving into the next stage of grant writing, requiring resource mapping to determine areas for support. GOK has steadily increased its contribution to the response; however, overall funding remains low. Clinical care, treatment and support received the bulk of GF and GOK resources. Resource mapping needs to be conducted to ensure that key commodities (ARVs, rapid test kits, condoms) are secure through December 2018.

Table 1.2.1 Investment Profile by Program Area[2]

Program Area	Total Expenditure	% PEPFAR	% GF	% 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

Table 1.2.2.: Breakdown of funding sources for key commodities. PEPFAR Kenya will continue to engage with GOK, GF and other non-governmental stakeholders to encourage an increased contribution to HIV-related

commodities. Health insurance, through both the national health insurance and private insurance providers, will also be supported to expand coverage to HIV care and services.

Table 1.2.2 Procurement Profile for Key Commodities[3]

Commodity Category	Commodity Requirements (USD)	Available Funds in USD (%)				Total Available Funds in USD (%)	Financial Gap in USD
		GoK	PEPFAR	GF	Others		
ARV (ART, PMTCT, PEP) Medicines	186,736,316	0	79,852,790 (60%)	52,330,249 (40%)		132,183,039 (100%)	54,553,277
Rapid test kits	9,050,031	0	9,027,459 (100%)			9,027,459 (100%)	22,572
Other drugs (Medicines for OIs, Methadone)	8,630,399	0	10,148,479 (100%)			10,148,479 (100%)	1,518,080 *in excess*
Laboratory reagents and accessories	32,701,637	0	17,710,281 (67%)	8,528,791 (32%)	295,891 *(1%) CHAI UNITAID*	26,534,963 (100%)	6,166,674
Nutrition	21,182,855	0		1,794,242 (100%)		1,794,242 (100%)	19,388,613
Condoms (male & female)	11,178,000	0		4,077,811 (67%)	8,442,000 *(33%) (UNFPA)*	12,519,811	1,341,811
VMMC	717,500	0		717,548 (100%)		717,548 (100%)	0
Other commodities	1,802,215	0	818,043 (68%)	344,837 (29%)	35,454 (3%)	1,198,334 (100%)	603,881
Sub-Total	271,998,953	0	117,557,052	67,793,478	8,773,345	194,123,875	77,875,078
Handling	21,759,917	0	4,302,448			4,302,448	17,457469
TOTAL	293,758,870	0	121,859,500 (61%)	67,793,478(34%)	8,773,345 (5%)	198,426,323 (100%)	95,332,547

Within USG, PEPFAR Kenya leverages various non-PEPFAR Kenya 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.

Table 1.2.3 Internal USG Program Integration and Leveraging

Funding Source	Total	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
	Non-COP Resources						
USAID MCH	$13,000,000	$13,000,000	9	$75,507,430			Support quality services for Maternal and child health

[3]NASCOP Forecasting and Quantification report 2014; PEPFAR commodity expenditure in 2014. All amounts in USD.

USAID TB	$5,000,000	$5,000,000	1	$2,118,187			Improve TB diagnosis, care and treatment
USAID Malaria	$35,000,000	$35,000,000	7	$69,168,037			Support Malaria prevention and treatment in select high burden counties
USAID Family Planning	$26,000,000	$26,000,000	15				Support FP services in the country
USAID Nutrition	$4,000,000	$4,000,000	8				Support nutrition interventions in the country
Peace Corps	$30,000			$30,000	$0		HIV/AIDS Prevention and Mainstream in 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	$0		Support Ministry of Health (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	$0		Tuberculosis Clinical Research
CDC DGHP	$5,821,074	$4,449,627	2	$1,371,447	$0		Global Health Protection research to KEMRI and MOH
CDC DHAP	$1,903,310	$1,659,441	1	$243,869	$0		HIV AIDS clinical research
CDC DPDM	$2,500,787	$2,412,299	1	$88,488	$0		Malaria research
CDC HDSS	$200,004	$200,004	1	-			Health and Demographic Surveillance System
CDC NCIRD	$895,667	$815,000	2	$80,667	$0		Flu research
CDC NCEZID	$50,000	$50,000	1	-	$0		Zoonotic disease research
CDC NCD/NCPIC	$37,000	$37,000	1	-	$0		Non CD Injury Prevention Survey
CDC GID	$242,422	$75,000	1	$167,422	$0		Polio eradication
CDC OD	$481,376			$481,376	$0		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	$7,500,000	*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	$123,503,157	$99,120,747	66	$149,718,448	$30,625,093		

Source: Kenya USG agencies and PEPFAR Coordination Office

1.3 National Sustainability Profile

[REDACTED]. The PEPFAR Kenya team shared the SID's aims and the tool in separate introductory meetings with the GOK, civil society, private sector and UNAIDS. Together with government, civil society, and other partners, the SID was completed. To encourage dialogue and exchange among the stakeholders as objectively as possible, the USG team's input focused on technical discussions and *[REDACTED]* the datasets provided *[REDACTED}*.

The SID process identified four main areas where the national HIV/AIDS response is currently weak and unsustainable. In response and in order to accelerate progress towards sustained epidemic control, PEPFAR Kenya has identified the following as most urgently in need of attention for sustainability:

- Health Financing: Inadequate tracking of domestic expenditures, insufficient costing and efficiency analysis of domestic HIV/AIDS investments, and limited analytics on domestic resource mobilization
- Human Resources for Health (HRH): Shortage of HIV/AIDS health care workers
- Epi/Health Data: HIV data are collected by GOK but quality, comprehensiveness, timeliness, and accuracy are still challenges. Community level data (COBAR) are collected but may not be comprehensive
- Commodities Security and Supply Chain: Deficiencies in both national-level procurement and distribution of commodities to the regional level and facility-level stock out rates in high-priority PEPFAR districts

Technical assistance to strengthen the national supply chain has been a significant focus of PEPFAR support in recent implementation years. While HRH and Strategic Information collection/analysis activities have been supported by PEPFAR in recent COPs, the aspects identified above represent critical gaps that need to be addressed. Domestic health financing stands out as an area where PEPFAR has not prioritized investments in

Kenya until now, nor has this been a direct focus of Global Fund investments, though the most recent Global Fund grant did condition a portion of financing on increased domestic resources. Although domestic contributions have steadily increased in recent years, the impressive growth of Kenya's economy since 2010 has increased the potential for more sizable national commitments, though significant support from PEPFAR and the GF is anticipated for the foreseeable future. Most recently, GOK has allocated ~$26 million in its FY16 budget to support HIV/AIDS commodities for the national supply chain, a testament to the GOK's commitment to increase Domestic Health Resources.

The SID has proven instrumental to PEPFAR Kenya's efforts to prioritize sustainability in COP 15. It has also helped to begin, in a more methodical and data-driven way than in the past, a wider dialogue with Kenyan stakeholders on the sustainability of the HIV/ AIDS response under the leadership of the GOK - NACC.

1.4 Alignment of PEPFAR investments geographically to disease burden

Figure 1.4.1 and 1.4.2 compare PEPFAR expenditures in 2014 to burden of disease by county. On average, PEPFAR spent $272 per PLHIV in Kenya ranging from $81 to $1,692 (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 northeastern region with very low burden (Wajir, Marsabit, Tana River, and Lamu counties). The total spending in those counties is low (light green shade in Fig 1.1). In COP15, PEPFAR Kenya analyzed its investments within the current geographic alignment, which resulted in an adjusted unit cost to direct more resources to scale-up counties.

Figure 1.4.1 2014 PEPFAR Expenditure Per PLHIV and Prevalence by SNU

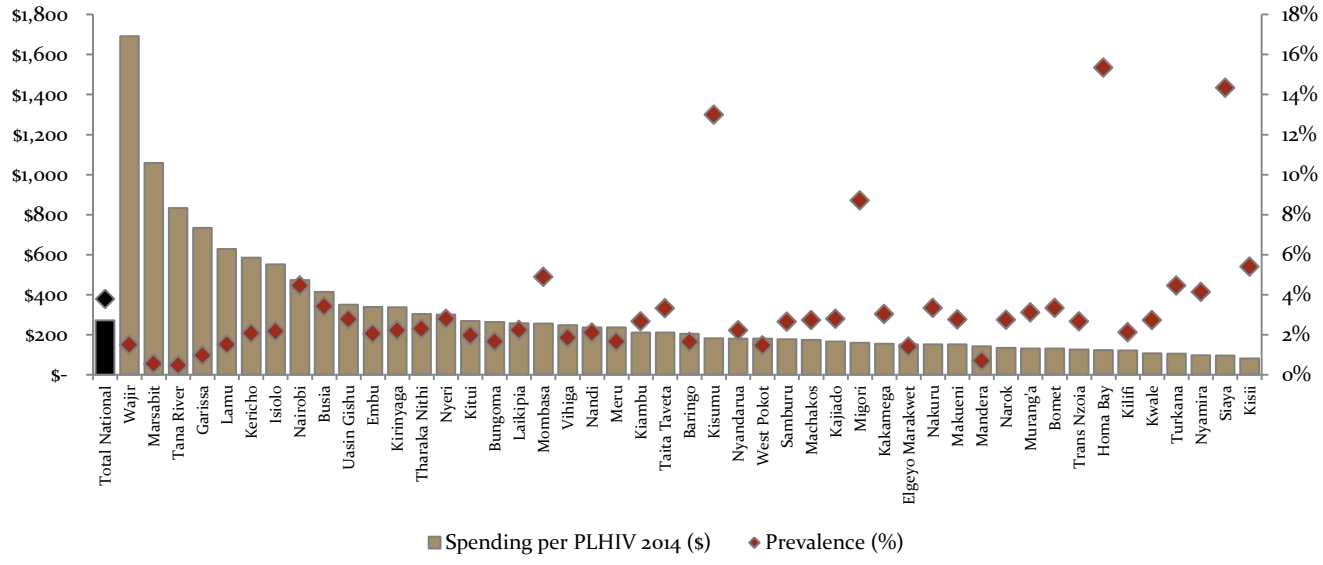
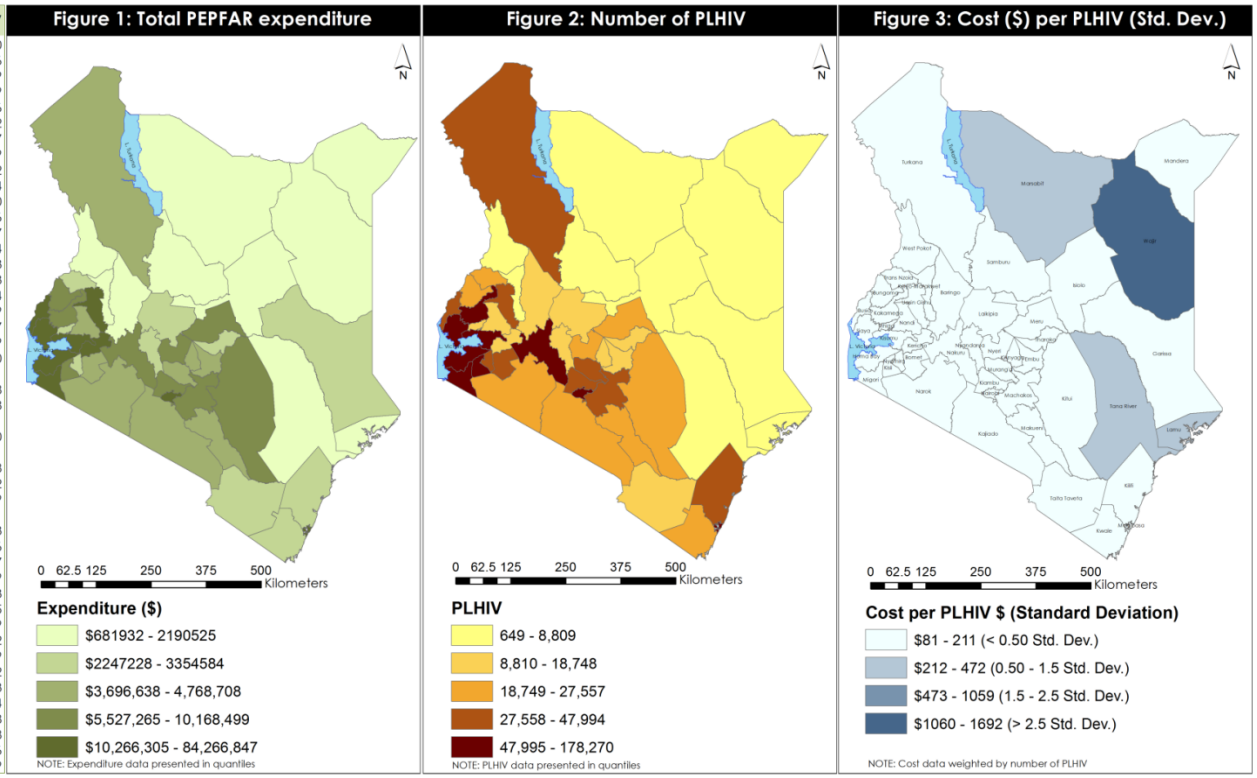


Figure 1.4.2 Total expenditure, PLHIV, and Expenditure per PLHIV by County

County	PLHIV
Nairobi	178270
Homa Bay	165366
Kisumu	140369
Siaya	134939
Migori	89356
Kisii	69902
Nakuru	62907
Kakamega	54859
Mombasa	54142
Kiambu	47994
Turkana	44950
Murang'a	32466
Machakos	31817
Uasin Gishu	29364
Bomet	28573
Kilifi	27693
Busia	27664
Nyamira	27599
Narok	27557
Makueni	25929
Trans Nzoia	25750
Bungoma	24851
Meru	23778
Kajiado	22588
Nyeri	21391
Kitui	21060
Kwale	20911
Nandi	18748
Kericho	18522
Nyandarua	14659
Kirinyaga	12921
Embu	11323
Vihiga	11136
Taita Taveta	11077
Baringo	10729
Laikipia	10503
Tharaka Nithi	8945
West Pokot	8809
Samburu	7002
Elgeyo Marakwet	6099
Mandera	4802
Garissa	4023
Isiolo	3284
Lamu	1808
Marsabit	1698
Tana River	1356
Wajir	649



DATA SOURCES:
Number of PLHIV: Estimates and projections package modeling 2014
Expenditure data: Kenya PEPFAR expenditure analysis for FY 2014

1.5 Stakeholder Engagement

Since last October, the PEPFAR Kenya team has held numerous high level briefing meetings with the Ministry of Health (MOH) and both continue to hold strategic direction and technical consultations on PEPFAR's (1) data analysis on HTC, PMTCT, and ART site yield; (2) investment approach to saturate areas of high HIV burden and prevalence with combination prevention activities in order to reach epidemic control, and (3) the identification of counties for HIV services maintenance and eventual transition of services to GOK. Civil society organizations (CSO), some of whom are also PEPFAR's Implementing Partners, were also briefed on the new PEPFAR global strategic direction to do the right thing, at the right time, at the right place as part of the new PEPFAR 3.0 presentation.

The PEPFAR Kenya team consulted and extensively engaged the CSOs in the COP 15 process. A detailed summary table on the engagement with CSOs prior to and during COP15 development as well as post COP15 submission is included in the CSO Engagement Strategy and Documentation under supplementary documents section of COP15. A working draft of the PEPFAR Kenya Civil Society COP Engagement Strategy Plan is also attached. This document will also be used to inform the PEPFAR Kenya-CSO Terms of Reference (TOR)

currently under development by the CSO leadership and their respective constituents. In relation to other development partners, the PEPFAR team worked with UNAIDS as part of the NACC-led Sustainability and Financing Technical Working Group, on the Sustainable Financing Initiative and Middle Income Country Study. In addition to recommendations of CSOs for the COP engagement, UNAIDS is also one of the stakeholders engaged in the SID process. For the Global Fund, the team engaged the Treasury and NASCOP representatives to inform the COP15 process as well as in finalizing the SID. UNAIDS and GF also made presentations on the Kenya Investment Case and Kenya GF Concept Note during the COP stakeholder engagement meetings, respectively. The private sector was engaged as part of the COP stakeholder consultations as well as in the SID process.

As part of the SID process, the PEPFAR Kenya team initiated an inclusive approach that provides an important foundation for identifying core areas for mutual dialogue to inform and help lay the groundwork for establishing a future Country Health Partnership (CHP) with GOK and key stakeholders. The MOH NACC and NASCOP leadership, together with the PEPFAR Kenya team, will finalize the roadmap to a CHP. The roadmap will take into account HIV financing, reporting, and service delivery dynamics as well as the new role of County Governments. It will further specify areas of collaborative planning and decision making within the new governance structure, the use of data for decision-making including economic and surveillance data, the need for increased public transparency of information to ensure accountability to civil society, and establishing meaningful engagement of the community and private sector in the delivery of HIV services. *[REDACTED]*

2.0 Core, Near-Core and Non-Core Activities

To define core, near-core, and non-core activities for COP15 implementation, PEPFAR Kenya reviewed the country investment portfolio, gaps and bottlenecks highlighted through the SID and SIMS data, as well as interventions necessary to achieve sustainable epidemic control. As PEPFAR is the primary funder of the national response, combination prevention activities and components of community-based care, OVC, and priority population prevention are identified as core activities, as is technical assistance to the national procurement and supply chain system. Core activities also reflect continued investment in adult and pediatric ART, PMTCT, and VMMC. Near-core activities were closely reviewed and activity transition plans to host government or other funding sources will be developed this year. Non-core activities ending in FY16 are new construction and major renovations, cervical cancer screening and treatment for HIV negative women, aspects of OVC, and home-based HTC particularly for non-priority populations in sustained counties. See Appendix A for a full list of core, near-core, and non-core activities and transition plans.

3.0 Geographic and Population Prioritization

Prioritization decisions were based upon epidemiological data as described above, and in concert with GOK stakeholders during the planning phase. PEPFAR currently maintains HIV services in all 47 counties in Kenya. To support scale-up toward epidemic control, an additional 532,840 patients will need to be initiated on ART to attain 80% ART coverage nationally, requiring significant additional investments across program areas, including HTC, laboratory and HSS. Using EA data (national costs), this translates to an additional $151 million (31% of total COP15 planned spending level) expenditure on ART alone, above the funds allocated for existing patients. Likewise, reaching the target of 80% VMMC coverage by 2016 requires an additional 400,000 VMMC procedures at a cost of $25,600,000. Given this scenario, PEPFAR Kenya will not have the resources to saturate all 47 counties. Therefore, the PEPFAR Kenya program will pivot towards scale-up to saturation (80% ART coverage by end of FY17) in the eight counties; aggressive scale-up in the next 12 counties with a high HIV burden (80% ART coverage by end of FY18)—bringing the total number of prioritized counties to 20; maintain passive support in the 20 sustained counties, and the provision of commodities, TA, and laboratory networks in the other seven sustained commodities counties (representing 1% burden), shifting to full GOK management by the end of FY16 through a mutually agreed upon phased approach.

As cited in the Goal Statement, the eight counties for scale-up to saturation of HIV services by FY17 are Nairobi, Homa Bay, Kisumu, Siaya, Migori, Mombasa, Uasin Gichu, and Busia. Nairobi County, as Kenya's capital and industrial center, has the largest burden of PLHIV and KPs. The four counties along Lake Victoria (Kisumu, Siaya, Homa Bay, and Migori) have a generalized epidemic as well as KPs and fisherfolk, major drivers of the HIV epidemic; it is also home to a traditionally non-circumcising community. Mombasa County is home to the second largest city in Kenya, the largest port in East Africa, a major tourist attraction, and has a significant population of PWID, FSW, and MSM. PEPFAR-supported HIV treatment and prevention services will target these high risk groups to ensure that each county attains 80% ART coverage (Table 4.1.1). In Uasin Gishu and Busia counties, ART coverage is currently high, but program data indicate that 21% of patients treated in Uasin Gishu are from other counties due to a national referral hospital in the county, while 32% of patients treated in Busia are from outside the county given the that it is at the Kenya-Uganda border. Based on the ART coverage achieved by September 2014, county HIV profiles, resources, and ART coverage will increase by FY16 as shown in Table 4.1.1.

The 12 counties for the next phase of aggressive scale-up (Kisii, Nakuru, Kakamega, Kiambu, Turkana, Murang'a, Machakos, Bomet, Kilifi, Nyamira, Narok, Makueni) are agricultural regions (except Turkana), major urban centers, and transport corridors. Turkana, in the arid northern region, has poor transport and health infrastructure, and hosts a traditionally non-circumcising, predominantly pastoral community. As of September 2014, ART coverage for these counties was varied, lowest in Turkana (10%) and highest in Kiambu (53%).

Although Turkana and Kisii counties have high estimated HIV burden based on EPP/Spectrum modeling, HTC yield in APR 2014 was low, consistent with KAIS 2012 data, suggesting that EPP estimates may be much higher than actual PLHIV. HIV services in all the 27 sustained counties will be offered as per the description below (Section 5.0).

Table 4.1.1 ART Targets in Scale-up counties for Epidemic Control

County	Total PLHIV	Expected current on ART (APR 2015)	Additional patients required for 80% ART coverage	Target current on ART (APR 2016)	Newly initiated in FY 16*
Nairobi	178,270	115,787	38,407	123,257	19,796
Homa Bay	165,366	75,583	64,101	101,685	36,271
Kisumu	140,369	78,278	41,707	92,380	23,340
Siaya	134,939	59,450	54,308	82,019	30,771
Migori	89,356	47,737	28,417	57,916	15,970
Mombasa	54,142	38,105	9,003	39,679	5,543
Busia	27,664	27,118	8,773	29,008	4,791
Uasin Gishu	29,364	25,773	9,073	27,905	4,922
Kisii	69,902	18,719	20,167	27,418	11,441
Nakuru	62,907	23,845	16,251	29,700	8,826
Kakamega	54,859	29,230	12,006	32,668	6,705
Kiambu	47,994	28,446	7,973	29,789	4,321
Turkana	44,950	4,678	6,965	7,912	4,025
Murang'a	32,466	9,528	10,884	14,283	6,183
Machakos	31,817	17,479	6,464	19,185	3,625
Bomet	28,573	5,793	11,912	11,456	6,809
Kilifi	27,693	15,767	5,132	16,935	2,861
Nyamira	27,599	10,491	7,083	13,177	4,004
Narok	27,557	4,904	9.350	9,314	5,341
Makueni	25,929	12,870	6,499	15,047	3,681
Total	**1,301,716**	**649,581**	**365,134**	**780,733**	**209,226**

*LTFU estimated at 10%.

*5 Highest Burden Saturation, 1 medium burden nearly at saturation, 14 adjusted scale up (including 2 at saturation already however migratory population)

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for Priority Locations and Populations

To reach 80% coverage in the eight FY17 scale-up to saturation counties and aggressive scale-up in the additional 12 toward saturation by FY18 counties (described in Section 3.0 above) within two years, 209,226 HIV+ patients must be newly initiated on ART in FY16 in the 20 scale-up counties (Table 4.1.1). A cascade approach was employed in setting targets, which considered expected loss to follow-up (estimated at 10% based on current program performance), identification of new HIV+ individuals, and efficient linkages to care and treatment. Further, TB/HIV co-infection in Kenya is high as well as rates of TB-related mortality in PLHIV, the team has committed to increasing the proportion of TB-HIV co-infected patients on ART from 86 to 95% in the first year. This represents an estimated 16,368 newly initiated on ART in FY16 and will be achieved by strengthening adherence to testing protocols and integration of TB and HIV services (Section 4.7).

Equally important, PEPFAR Kenya prioritized diagnosis and ART initiation for HIV+ pregnant women. The goal in FY16 is to test 95% of pregnant mothers in scale-up counties and enroll 95% of those testing HIV+ into ART programs with an expected yield of 31,044 patients newly initiated on ART. The remaining 114,626 required to meet the target for PLHIV newly initiated on ART in 20 scale-up counties will be identified and linked to treatment mainly via provider-initiated counseling and testing, and to a lesser extent voluntary counseling and models targeted to priority populations (Section 4.5) and (Table 4.1.2). Both linkages and positivity yields are expected to improve in FY16, suggesting the total estimated number requiring testing in the 20 scale-up counties may be conservatively overstated. It is anticipated that in FY16, in the 20 scale-up counties, there will be 131,152 net new patients on ART and 780,732 current on ART.

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

Table 4.1.2 Target Populations for Newly Initiating ART Patients in Scale-up counties (Scale-up to Saturation and Aggressive Scale-Up), FY16

Target Populations	Tested for HIV	Identified Positive	Newly Initiated on ART
TB-HIV Patients not on ART	50,551	14,030	16,368*
HIV-positive Pregnant Women	1,002,846	31,044	31,044
Other priority and key populations	4,524,361	168,568	114,626
Total	**5,577,758**	**213,642**	**162,038**

* includes an estimated 2% from 'Care' who would also be started on ART

Table 4.1.3 VMMC Coverage and Targets by Age Bracket

Target Counties (Male 15-49)	Population Size Estimation (male 15-49)	Adjusted Population Size Estimation (males 15-49 years)*	Current Coverage	APR 16 Target	Expected Coverage APR 16	Expected APR17 Targets	Expected Coverage APR17
Homa Bay	219,497	219,497	40.6%	43,241	60.3%	43,241	80%
Kisumu	258,752	258,752	45.0%	45,282	62.5%	45,282	80%
Siaya	190,493	190,493	45.2%	33,146	62.6%	33,146	80%
Migori	214,692	214,692	61.3%	20,074	70.7%	20,074	80%
Turkana	254,536	254,536	56.5%	9863	60.8%	11,063	65%
Busia	105,731	105,731	79.9%	10463	90.6%	11,321	100%
Nairobi	1,200,295	196,243	92.2%	13737	93.0%	9,500	80%
Kericho	225852	110,357	86.6%	7725	90.7%	9,302	80%
Nandi	212,827	116,886	91.1%	8182	95.7%	9,884	80%
Nakuru	491,495	46,429	94.3%	3,250	95.0%	3,250	80%
West Pokot	125,482	64,814	66.0%	4,537	73.0%	4,537	80%
KDF Sites				500		500	
Total/Average	**3,499,652**	**1,778,430**	**69.27%**	**200,000**	**78.19%**	**201,100**	82.05%
National coverage					**94.8%**		**96.8%**

*Population adjusted to account for heterogeneous counties where large proportions of men are traditionally circumcised.

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimation (Scale-up counties)	Coverage Goal	APR 16 Target
MSM	18921	76% Scale-up to Saturation 24% in Aggressive Scale up	16,600
CSW	107,785	56% Scale-up to Saturation 44% Aggressive Scale up	107,785
PWID	6,874	83% in Scale-up to Saturation, and 17% in Aggressive scale up	6,874
Females 15-24	600,000	20%	120,000
Fishing community	**122,088**	**70%**	**85,462**
Military	**N/A**	**N/A**	**39,000**
Uniformed Services populations	N/A	N/A	75,000
Prisoners	170,000	24%	40,000
Total	**1,025,668**	**75%**	**490,721**

Table 4.1.5 Targets for OVC and Pediatric HIV Testing, Care and Treatment

County	Estimated # of Children PLHIV (<15)	Estimated # of OVC(KAIS and PEPFAR Program data)	Target # of active OVC (FY16 Target)	Target # of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services (FY16 Target)	Target # of children tested (FY16 Target)	Target # of children on ART
Homa Bay	19,166	170,587	51,176	14,464	14,464	7069
Kisii	8,102	104,561	15,684	13,743	13,743	2811
Kisumu	16,269	160,050	32,010	16,967	16,967	5958
Migori	10,356	97,457	29,237	8,706	8,706	3906
Siaya	15,639	107,301	21,460	10,464	10,464	5681
Busia	4,064	117,922	21,489	5,180	5,180	1024
Makueni	3,029	89,372	10,523	3,794	3,794	1117
Narok	3,157	50,164	12,076	3,602	3,602	1128
Nyamira	3,199	72,867	3,272	570	570	1181
Bomet	3,273	62,853	3,939	3,657	3,657	1172
Bungoma	3,651	58,898	19,827	2,768	2,768	1660
Kakamega	8,059	122,248	31,555	5,010	5,010	3085
Kericho	2,122	50,257	16,326	16,032	16,032	759
Kiambu	3,794	60,462	20,754	8,431	8,431	1411
Kilifi	3,193	69,849	46,202	17,960	17,960	1141
Machakos	3,717	45,563	11,798	3,803	3,803	1370
Mombasa	6,242	30,335	14,516	4,202	4,202	2235
Muranga	2,566	50,266	7,971	2,665	2,665	955
Nairobi	11,925	98,954	86,462	55,063	55,063	4361
Nakuru	7,207	115,453	29,122	7,970	7,970	2579
Trans-nzoia	2,950	95,822	3,072	2,643	2,643	1167
Turkana	5,150	26,739	4,257	1,899	1,899	1873
Uasin Gishu	3,364	19,497	13,104	10,054	10,054	1200
Baringo	1,229	19,767	6,929	3,243	3,243	442
Embu	1,323	16,500	13,718	2,836	2,836	485
Kajiado	2,588	38,165	15,487	3,490	3,490	965
Kirinyaga	1,021	39,114	1,790	786	786	383
Kitui	2,460	39,430	15,094	5,135	5,135	925
Kwale	2,411	87,921	5,919	2,546	2,546	865
Laikipia	1,203	16,773	8,874	2,274	2,274	432
Meru	2,778	53,110	16,550	4,947	4,947	1021
Nandi	2,148	85,249	6,967	2,002	2,002	783
Nyandarua	1,159	51,741	6,072	2,662	2,662	432
Nyeri	1,691	27,911	12,803	3,782	3,782	629
Taita/taveta	1,277	17,813	6,550	3,565	3,565	458
Tharaka-nithi	1,045	24,339	13,452	3,084	3,084	384
Vihiga	1,636	55,118	8,607	957	957	630
Elgeyomarakwet	699	9,234	3,409	2,858	2,858	250

4.2 Priority and key population prevention

Based on PEPFAR Kenya's geographic prioritization of HIV services for epidemic control and review of priority and key population programs and data, PEPFAR will invest in a core package of services tailored to each target population. These include condom and lubricant promotion and distribution, HTC and linkage to ART, TB screening and treatment referral, STI screening and treatment, peer education and outreach, risk reduction interventions, violence prevention and care, and structural interventions to foster an enabling environment for key populations to access health services. Targeted coverage will be 56% of FSW and 76% MSM in the eight scale-up to saturation counties and 44% FSW and 24% MSM in the 12 aggressive scale-up counties. Seventy percent of fisherfolk will be reached in five of the scale-up to saturation counties (Kisumu, Migori, Siaya, Homa Bay and Busia). Other priority populations include prisoners and uniformed personnel, including the military.

Among PWID, PEPFAR will support Medication Assisted Therapy (MAT), procurement and provision of Methadone and linkage to the Needle and Syringe Exchange Program. PEPFAR aims to reach 99% of PWID with NSP and condoms and 83% of PWID in three scale-up to saturation Counties (Mombasa, Nairobi and Kisumu) with MAT. Services will be offered primarily in safe spaces and integrated sites within public health facilities.

In the 20 scale-up counties, PEPFAR will support intensified demand creation, targeted HTC and linkage to treatment. Innovative approaches include enhanced monitoring for better tracking and retention, PLHIV peer networks, convenient working hours, and training of public health personnel in KP services. To increase linkage to care and treatment from 87% (PEPFAR Kenya APR 2014) to 95%, PEPFAR will support client escort, use of telephone and short text messages, and community follow-up by peer educators. In low and medium HIV prevalence counties, PEPFAR will collaborate closely with the GOK to maintain support to KPs on care and treatment and provide passive enrollment in FY16 to plan for increased GOK management.

PEPFAR will discontinue HIV prevention activities targeting the general population and youth but focus on reducing new HIV infections among adolescent girls and young women (AGYW) in four scale-up to saturation counties: Nairobi, Homa Bay, Siaya, and Kisumu. The core package of services is aligned with the DREAMS initiative to include school-based HIV and violence prevention, condom promotion and provision, HTC and linkage to ART, PrEP promotion and provision, promotion and linkage to expanded contraception mix, post-violence care, social asset building, educational subsidies, cash transfers, combined socio-economic approaches, community mobilization and norms change, parenting/caregiver programs, mapping of AGYW sexual networks, and linkage of AGYW male sexual partners to HTC, VMMC and ART. The service package will be offered through promotion of AGYW friendly services emphasizing empowerment. PEPFAR will support the NACC and the respective four county governments to strengthen coordination of AGYW programs. DREAMS will leverage the PEPFAR commodity budget for HTC and condom supply, USAID for contraception commodities, and PEPFAR supported VMMC and ART (including ACT) programs in four scale-up to saturation counties. The active engagement of communities and CSOs in the focus counties for KP and DREAMS is critical to address stigma and discrimination of KPs, cultural norms, and other barriers that negate the health and empowerment of priority and key populations.

4.3 Voluntary medical male circumcision (VMMC)

National circumcision coverage in Kenya is 91%, considering that the majority of Kenya's population is traditionally circumcising. However, 6 out of 47 counties have coverage below 80%; these counties include Homa Bay (40.6%), Kisumu (45.0%), Siaya(45.2%), Migori (61.3%), Turkana (56.5%), and Busia (79.9%). Five of the six counties, namely Homa Bay, Kisumu, Siaya, Migori, and Busia are among the eight counties that contribute to 50% of HIV burden and are among those that have been prioritized for 80% ART saturation by end of FY17.

PEPFAR Kenya has implemented a VMMC scale-up program focused on traditionally non-circumcising ethnic groups mainly in the six counties mentioned above. Since 2009, PEPFAR has supported 500,912 VMMC procedures among men aged 15-49 years. PEPFAR Kenya will support an estimated 177,546 VMMC by the end of FY15, bringing the cumulative number of VMMC conducted to 678,456 by end of FY15, leaving a gap of 400,000 VMMC for scale-up to saturation by 2017.

Based on EA Data, 400,000 VMMC would require approximately $25 million. Funding for VMMC has also been provided by GF and the Bill and Melinda Gates Foundation whose combined attributed target achievements are less than 1% of Kenya's VMMC results to date, and are unlikely to increase. Consequently, a target of 200,000 VMMC is set for PEPFAR support in FY 2016.

Since PEPFAR resources are insufficient to meet Kenya's national need for VMMC according to the 2014-2019 National VMMC Strategy, investments will be streamlined to achieve 80% VMMC coverage in Homa Bay, Kisumu, Siaya, Migori, and Busia by 2017, in alignment with PEPFAR's goal of supporting Kenya to achieve epidemic control through saturation of highest burden counties. The timeframe for achieving 80% VMMC coverage in Turkana is set beyond 2017 due to logistical challenges associated with providing VMMC to nomadic communities. Demand creation and service design will focus on reaching men aged 15-29 years at greatest risk of acquiring HIV, and reaching high risk sub-populations of the VMMC-eligible population among migrant workers, including clients of FSWs and military populations. The top six VMMC scale-up counties activities will include setting up sites in underserved areas, significant investment in demand creation, and accelerating campaigns including Rapid Results Initiatives.

In FY16, VMMC will also be scaled-up in non VMMC counties (Nairobi, Nandi, Kericho, Nakuru, and West Pokot) where there remain significant pockets of non-circumcising subgroups. Clients in these counties will be relatively easy to target because they are predominantly migrant workers who live in clearly defined estates or camps. Existing channels of communication within the estates and camps will be used to create VMMC demand. Additionally, only a limited number of VMMC sites established through PEPFAR funding will be supported to provide outreach services appropriate for the local context.

In summary, PEPFAR-Kenya has prioritized VMMC activities by mapping services to counties with highest HIV prevalence and lowest MC coverage in coordination with ART scale-up. The targets for FY16 reflect roughly a 14% increase in coverage in the five VMMC scale-up to saturation counties including Turkana and contribute significantly towards VMMC saturation targets by FY17. To sustain 80% VMMC coverage beyond 2017, the program focus will shift towards circumcising annual cohorts of boys aged 10-14 years and newborn males aged

0-60 days in the priority VMMC counties and transition all the non VMMC scale-up to saturation counties to the National and County governments.

4.4 Preventing mother-to-child transmission (PMTCT)

Since 2003, significant progress has been made in reducing the number of new HIV infections among children, with a 44% decrease in the number of new HIV infections observed from 2009 - 2013. However, only 53% of estimated eligible pregnant women currently receive ART (2013, UNAIDS Global Report). With the launch of Option B+ in 2014, ART coverage has expanded in this population. Of the estimated 78,358 HIV+ pregnant and breast feeding women, 66,258 (85%) were identified in FY14. Of these, 56,137 (85%) received ARV interventions, out of whom 36,096 (64%) received ART, compared to 69%, and 36%, respectively, in FY13. Despite Kenya's reduction in pediatric infections, further progress is needed to reach the national targets of 90% reduction in new pediatric infections and less than 5% MTCT rate. To move closer to these elimination goals, a greater proportion of HIV+ pregnant women must be identified and initiated on lifelong ART.

To balance the elimination goals in Kenya with epidemic control in the 20 scale-up counties, targets for the PEPFAR PMTCT program were set to reach 95% of pregnant women attending ANC with HTC and to initiate 95% of identified HIV-infected women on ART in the eight scale up to saturation counties. Based on existing data, all 20 scale-up counties have gaps in both testing and ART uptake. To increase identification, there will be targeted community activities to build demand for ANC services. In addition to the minimum service delivery package, the 20 scale-up counties will support human resource recruitment and capacity building. PEPFAR will support revision and roll-out of national reporting tools and implement national longitudinal cohort reporting to follow HIV exposed infants (HEI) and infected mothers through the end of the breastfeeding period and transitioning back to comprehensive services.

In the 20 sustained counties, PEPFAR will support routine HIV testing for pregnant and breastfeeding women in sites where there is epidemiological and program data that indicates a burden of HIV infection in pregnant women that is higher than the general population, or high volume facilities where although the prevalence may be low, the absolute number of HIV+ women identified justifies continued routine HIV testing. For the rest of the sites, most of the non-ART or low volume ART sites (<50 ART patients), PEPFAR will continue to work with GOK and other stakeholders to ensure continued support for the minimum package of care per national guidelines. Similar to the scale-up counties, 95% of identified HIV+ pregnant and breastfeeding women will be targeted for lifelong ART. Resources required to support these patients have been factored into the maintenance budget for the remaining areas (Appendix B).

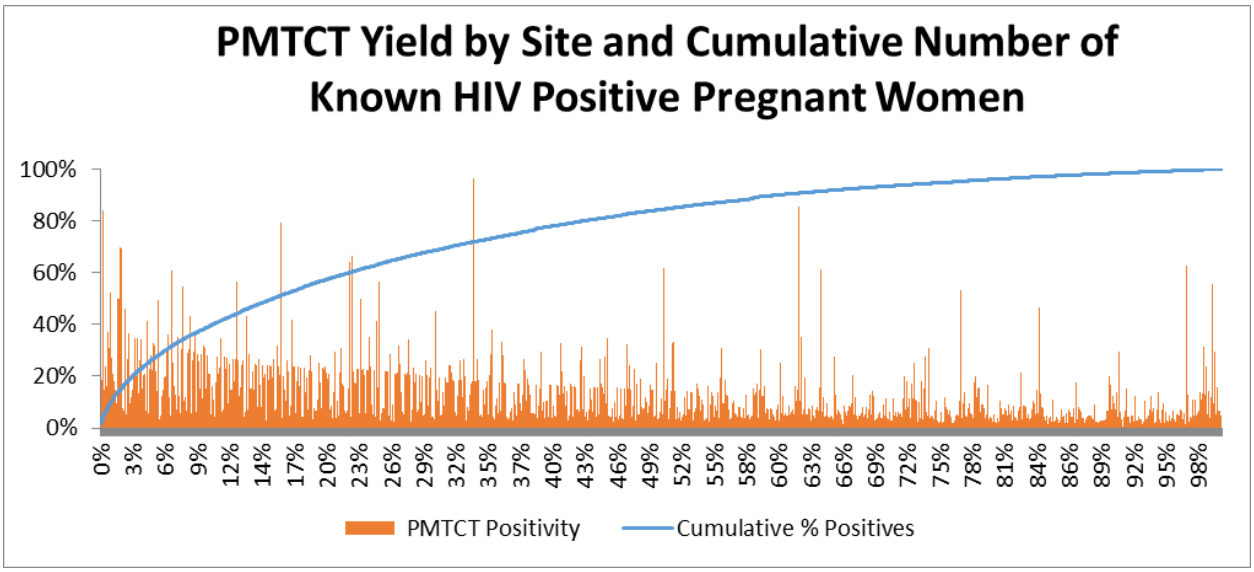
The estimated Kenyan MTCT rate at first polymerase chain reaction (PCR) is 7.1% (n=59,250), while at different ages of testing the MTCT rates are: 4% at six weeks postpartum; 17% between 9 and 18 months; and 25% at 18

months and above (NASCOP EID,2014). Of note, a much smaller number of children are tested at these later age points (from 9 months onwards) and the majority of these patients are first-time testers, mainly sick children (PITC), suggesting that they missed earlier diagnosis. Data from the NASCOP web based EID system indicate a linkage rate of 50.3% (n=4,203) to HIV care and treatment with a loss to follow up of 8.9% and a mortality rate of 5.9%. To improve monitoring of the mother-baby pair, PEPFAR supported the national program to implement longitudinal birth cohort reporting (HEI cohort registers have been shown to improve linkage to 86%) and HIV infected Infant Tracking System (HITS), which has been shown to have improve linkage to 79%, to follow HEI through the end of the breastfeeding period. FP/HIV integration services will be supported by PEPFAR in MCH and ART clinics, while MOH and other stakeholders provide the FP commodities.

Efficiency Analysis

PEPFAR Kenya will prioritize PMTCT scale-up in 20 of the 47 counties contributing 80% of the national need for PMTCT while maintaining services in collaboration with GOK in the remaining counties. Eight of the 20 scale-up counties targeted for saturation contribute 51% while the other 12 counties account for 29% of women in need of PMTCT. The new targets represent a 10% increase in testing targets despite the 2,904 centrally supported sites in early FY 15, and 11% increase in positive pregnant women to be identified, and a 24% increase in treatment targets due to the combination of increased yield from testing and intensified services for initiation and maintenance of ART.

As shown in Figure 4.4.1, 3,384 facilities will be targeted after the recent transitions. As shown below, 20% of sites identified 80% of HIV+ pregnant and breastfeeding women. Of the sites identifying the remaining 20%, 67 are located in scale-up counties and will be prioritized for SIMS visits to identify constraints, increase partner performance, and assess testing models/practices. For the 11 sites with HIV-positivity that is lower in PMTCT than the general HIV prevalence in that county, but where there are >50 ART patients, routine PITC will continue. This decision is based on analysis indicating that focusing on prevalence alone could lead to significant missed opportunities for PMTCT, especially in the large urban facilities.



4.5 HIV testing and counseling (HTC)

In accordance with the geographic and priority population focus outlined above, targets for HTC were calculated based on cascade analysis to meet the target number of new treatment slots in the 20 scale up counties (Section 4.1). To reach targeted treatment coverage, county data on HTC positivity were used to calculate the number of new HIV diagnoses, as well as estimates of LTFU (10%) and linkage to/enrollment in HIV care (90%). Table 4.1.1 outlines targets allocated by the scale-up and sustained counties. The approaches and scale of coverage shall be specific to these distinct geographical prioritization categories. For FY17 scale-up to saturation counties, PEPFAR will support universal provider-initiated testing and counseling (PITC) in all supported sites, home-based HTC in high density, high prevalence areas, testing of PLHIV family members, and HTC outreach to key and priority population hotspots. For the 12 aggressive scale-up by FY18 counties, PEPFAR will support prioritized PITC in health facilities, family member testing of PLHIV, and targeted HTC outreach to key/priority populations in hotspots.

PEPFAR Kenya will support HTC services in the 20 sustained counties for those who request HTC services according to the national guidelines including pregnant women, TB patients, patients with other opportunist infections (OI), and children of HIV+ individuals. PEPFAR will ensure coordination with GOK to maintain seamless PITC service delivery at the facility level. From these counties, approximately 905,958 will be tested in order to identify a total of 24,331 HIV positive individuals.

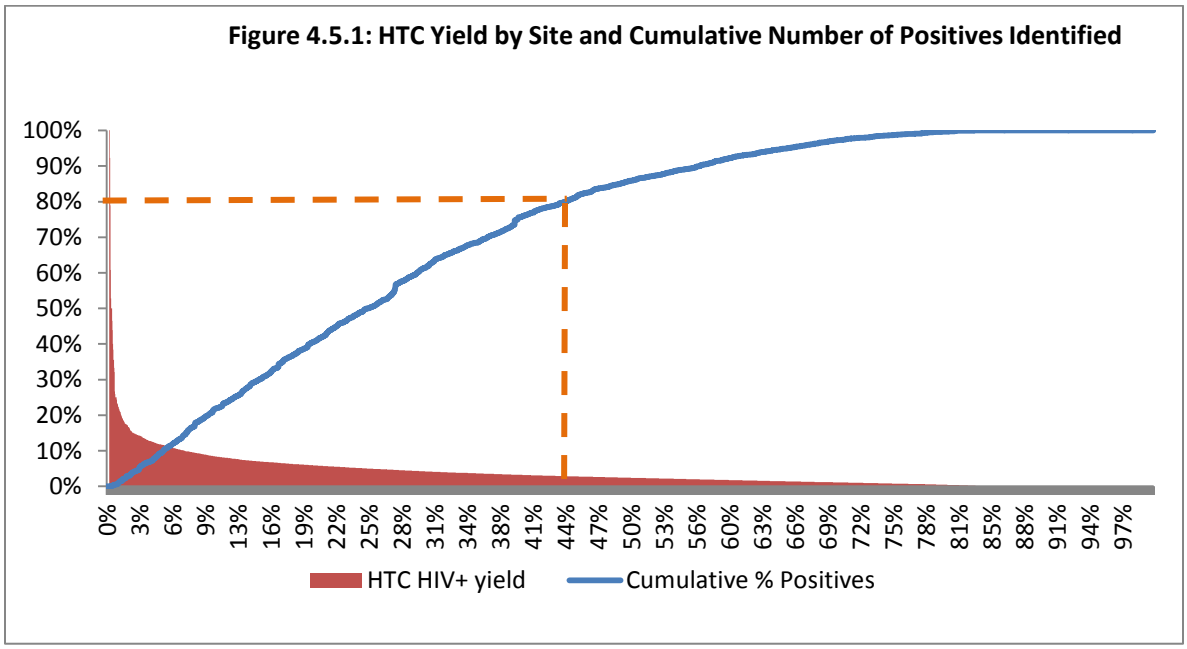
Using the EA data by mechanism and by county, PEPFAR Kenya determined the 2014 average expenditure per test of $3 in facility based HTC and $5 for community-based HTC as being adequate (Appendix B). In addition, the results of the efficiency analysis, as described below, show that redirecting support away from 2,244 low yield sites towards 3,700 of the higher yield sites could save between $200,000- $750,000, even as the number of tests and HIV positives identified increase. These cost savings will be reinvested in HTC in scale-up counties

concentrating on diagnosing harder-to-reach PLHIV and improving linkage and enrollment to care and treatment.

Efficiency Analysis

PEPFAR Kenya supported HTC services at 5,944 sites in 2014, of which 999 reported zero positives and 1,246 reported 1 – 4 positives during APR 14. Eighty percent (80%) of these sites are located outside of the 20 scale-up counties. As of December 31, 2014, all PEPFAR-supported zero and low yielding sites (1-4 positive per year) were transitioned to GOK. PEPFAR support for HTC services in sites that had more than four positives identified in the last 12 months but are in non-scale-up counties will continue to offer only basic HTC diagnostic and counseling services through PEPFAR in FY 16, however, PEPFAR will ensure coordination with GOK to maintain seamless PITC service delivery at the facility level.

With improved HTC focus and targeting, quality assurance and quality control will be enhanced. Review of the national HTC guidelines is ongoing and revised guidelines are expected by July 2015. The guidelines will address the new WHO recommendations for retesting of HIV+ patients before enrolling in care.



Source: Kenya Data Pack, March 18, 2015

4.6 Facility and community-based care and support

PEPFAR Kenya will continue to support a standard package of care and support services in the eight scale-up to saturation and 12 aggressive scale-up counties, including TB screening, Isoniazid preventive therapy (IPT), nutrition assessment counseling (NAC) and therapeutic feeding for severe acute malnutrition (SAM), provision of cotrimoxazole, cryptococcal screening and assessment of ART eligibility by CD4 and the WHO clinical classification by stage at each visit. Positive Health, Dignity, and Prevention (PHDP) will also be provided. The

same package of care and support services will continue for currently enrolled patients in the 20 medium and seven low burden counties to be defined by PEPFAR Kenya and the GOK. See Sections 4.8 and 5.2 for more detail.

Efforts are in place to improve and measure linkages to care from HTC, currently averaging 89% among those who know their status (KAIS 2012), and from facility to community-based services, as indicated in the initial SIMS visit results. Current data reveal a five times higher LTFU of patients who are not on ART compared to those on ART (NASCOP 2014). Improving retention in care for both ART and pre-ART patients remains a high priority, and PEPFAR Kenya utilizes community support groups and other innovative strategies to retain people in care and ensure they begin ART when eligible. Efforts are underway with the MOH to develop national guidelines and tools for tracking linkages between services.

With the 2013 adoption of WHO guidelines that recommend ART eligibility at CD4 ≤ 500, it is anticipated that a large proportion of the COP 14 treatment targets will be reached by enrolling newly eligible patients currently in care. Implementing partners reported limited access to CD4 testing due to stock outs of reagents, which was confirmed during recent SIMS assessments. TA support for forecasting and distribution of lab reagents will be provided to address this gap. 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). Additionally, PEPFAR-Kenya will invest in piloting innovative models for extending care and support services to priority populations who report difficulty accessing traditional clinical platforms. These will include developing 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 both national and county governments are working on a HRH transition plan to absorb hired health care workers into civil service.

4.7 TB/HIV

Kenya is a high TB burden country with an estimated prevalence of 130/100,000 and 80% case detection rate for all TB cases. In FY14, 89,703 of the WHO estimated 120,000 incident TB cases were notified and 34% of these were HIV infected including 18,415 newly testing positive. The majority (78%) of TB/HIV cases are within the 20 scale-up counties accounting for 80% of PLHIV and 68% of all TB patients; 50% are in the eight counties earmarked for scale-up to saturation by end of FY17. In Kenya, 94% of TB patients identified are tested for HIV and 86% of HIV/TB patients are on ART during TB treatment (Kenya TB program data 2014). TB and HIV services are integrated in 75% of PEPFAR-supported sites. TB screening has been institutionalized in PEPFAR-supported ART sites, but the low yield (2%) suggests the need to address the quality of screening.

Recently, the GeneXpert®MTB Rif test was made the initial diagnostic test for PLHIV presumed to have TB. A total of 70 GeneXpert® machines (including 35 PEPFAR-procured) were installed in Kenya and a specimen

referral network was established to cover all HIV treatment sites countrywide. Efforts are underway to optimize machine utilization. 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 where 58 (68%) facilities were noted to require urgent TB IPC remedial action.

Kenya recently launched IPT for PLHIV on a national scale, targeting to reach 80% national coverage by end of FY16. The MOH prioritized five counties for initial scale up including four counties earmarked by PEPFAR for scale-up to saturation.

In FY16, PEPFAR Kenya will focus on the following core TB/HIV activities to reach universal ART coverage among HIV-infected TB patients:

- Universal HIV testing for patients with presumed or diagnosed TB, and timely access to ART with HIV infection.
- Integration of ART in TB clinics in priority/scale-up counties will be used to decrease continued challenges of linkage to care.
- Strengthen TB IPC in health care settings in anticipation for higher numbers of patients in care.
- Support TB screening in HIV, MNCH, and prison clinics and diagnostic work-up and appropriate management as per the national TB guidelines.
- Expand and strengthen specimen referral network for GeneXpert to ensure early TB case detection and management among PLHIVs. GOK expects to procure an additional 50 GeneXpert machines in FY15 from GF.
- Support to ensure that 80% of HIV patients screening negative for TB are initiated on IPT, followed-up, and reported. Monitoring and evaluation, including implementation of the TB web-based surveillance system.

4.8 Adult treatment

In mid-2014, Kenya adopted the 2013 WHO clinical guidelines and recommendations for expanded ART eligibility. This revision has expanded treatment eligibility to CD4 ≤ 500 cells/mm3, lifelong ART for all pregnant and breastfeeding women, all HIV patients with TB infection, and all children < 10 years. National ART coverage is about 45% based on CD4 ≤ 500 cells/mm3. Kenya's new KASF was developed to guide HIV service delivery for the period 2015-2019 to achieve the 90-90-90 targets that are fundamental to acceleration of HIV prevention, care and treatment.

In line with the KASF, PEPFAR Kenya aims to initiate 245,018 new patients in FY 16 and support a total of 964,132 patients on treatment by APR 16, an increase of 30 percent from APR 14. This includes 126, 148 newly initiated

ART patients in scale-up to saturation counties and 118,871 in both aggressive scale-up and sustained-counties. This assumes an 18% increase due to passive enrollment in sustained-counties with a target of 35,793 adults. PEPFAR will focus on increasing ART coverage for patients with TB/HIV, young women, adolescents, and children to reach treatment targets given the significant gaps in ART coverage in these populations.

According to KAIS 2012, linkage to care services in adolescents and adults who knew their HIV status was at 89%. From a 2012 cohort analysis, retention in care at 12 months for adults was estimated at 75% and this improved to 80% in the past year. However, limited data suggest ART coverage is lower among some priority populations, including FSW and migrant workers.

The majority of ARVs are procured through GF and PEPFAR with GF procuring all pediatric drugs. Based on current funding, planned procurements, and national and PEPFAR treatment targets, there are no anticipated ARV shortages through December 2018.

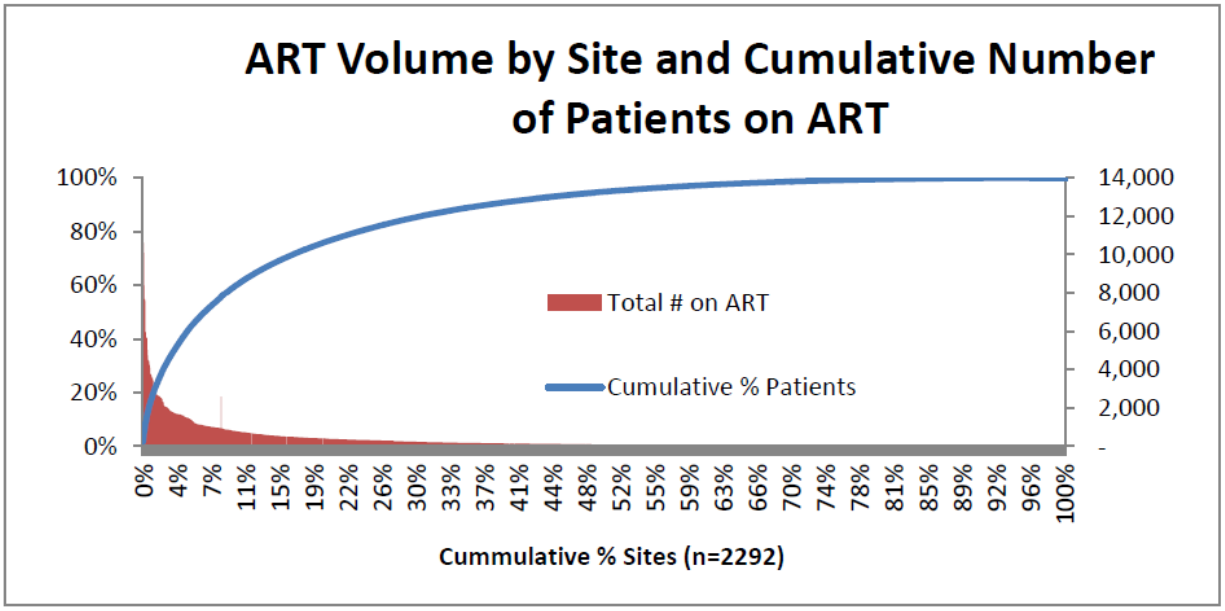
Updated national guidelines recommend monitoring of ART patients with viral load (VL). PEPFAR Kenya is working with MOH and other stakeholders to develop a national strategic plan for scale-up of VL monitoring. PEPFAR Kenya procures VL reagents for patients at PEPFAR-supported sites, as well as support for the development of a sample transport network for EID and VL specimens. Despite this roll-out of routine VL testing, some patients will be prioritized for VL testing including patients suspected of treatment failure, pregnant and breastfeeding women, and children. Treatment costs will increase with the additional VL, which must be factored into projections in this cycle. Rates of treatment failure are currently 10%, but a national HIVDR survey is being planned for FY15.

In addition to support for developing the sample transport network for EID and VL, other HSS activities critical to the treatment program include: 1) Technical assistance at the county level for forecasting, procurement, and distribution of HIV commodities; 2) Support to distribute ARVs and lab commodities to the site level; 3) QA for HIV rapid testing and lab technicians; and 4) in-service training for nurses and clinicians on HIV testing and clinical management.

Efficiency Analysis

In 2014, of the 2,292 PEPFAR supported ART sites, none reported zero patients; 80% (583,545) of ART patients were seen in 69% (1,587) of PEPFAR supported ART sites, the majority in the 20 scale-up counties. Patient volume analysis revealed that 64% of sites (1,457) ranged between 50 and 13,323 patients, while 826 sites reported less than 50 patients, consisting of 518 and 306 located in scale up and sustained counties (medium and low HIV burden counties), respectively. In FY16, PEPFAR Kenya and the GOK will conduct detailed county specific ART

volume analyses of the 306 low volume ART facilities to better understand the context and dynamics in designing county plans for improved efficiencies of investment. See Section 5.2 for more details.



4.9 Pediatric treatment

By December 2014, an estimated 180,000 children aged 0-14 and approximately 13,198 adolescents aged 15-19 years were living with HIV in Kenya, representing 12% of PLHIV countrywide. Similar to the adult HIV burden, 80% of all children and adolescents living with HIV are in 20 of the 47 counties. Implementation of Kenya's new guidelines, (ART for all children < 10 years and adolescents with CD4 ≤ 500 cells/mm3) since mid-2014, led to rapid treatment scale up with 72,571 HIV-infected children receiving ART by December 2014, an increase of 12% from 2013. However, this only represents 40% ART coverage nationally and 43% in the 20 scale-up counties. Retention at 12 months is 89% for all children on ART, but much lower for the very young (<2 years) and adolescents.

Kenya is a beneficiary of additional funding through the Accelerating Children's HIV/AIDS Treatment Initiative (ACT), which aims to increase the number of children on ART to 107,693, or 60% coverage by FY16, in line with KASF. To achieve this ambitious target, PEPFAR will, in collaboration with the MOH, expand high yield pediatric testing efforts (EID and PITC), improve follow-up of the mother-baby pairs through longitudinal cohort tracking (HEI Cohort Analysis and electronic HEI Tracking System), expand availability of LPV/r-based regimens for children < 3 years, use HTC linkage register, and improve reporting of age disaggregated data. Key priorities for pediatric and adolescent care and support include OI screening and prevention with universal provision of CTX and IPT, NACS, strengthening of psychosocial support systems and defaulter tracking to improve retention. The program will support rollout of the MOH adolescent package of care (APOC) through training of HCWs to

implement adolescent friendly services, support adherence and address sexual reproductive health issues, ultimately increasing adolescent access to ART, improving treatment outcomes, and facilitating effective transition to adult care services.

Given the high risk of treatment failure, as evidenced by a recent national survey which reported viral suppression rates (<1000 copies/mL) of 69% among children 0-14 years (compared to 90% among adults) and drug resistance mutations 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.

The PEPFAR program continues to support GOK to optimize the pediatric ARV formulary to be consistent with the IATT Optimal Formulary List; currently only 7% of children <3 years are on a PI-based 1st line regimen, but this is expected to increase to 60% by 2016 following the operationalization of the 2014 Kenya ART guidelines. There have been no reported ART stock outs for the last two years. During FY 16, GF will support procurement of 1st line and 2nd line pediatric ARVs, and in conjunction with Janssen pharmaceuticals, provide 3rd line ARVs for children.

4.10 Orphans and Vulnerable Children

Kenya has an estimated 2.6 million OVC (KAIS 2012), of whom approximately 1.1 million are orphaned due to AIDS related deaths (UNAIDS 2013). The UNAIDS data does not provide the number of children vulnerable as a result of HIV/AIDS. Further, the projected number of AIDS related deaths of approximately 60,000 annually up until 2020 shows that with the current level of interventions, the number of AIDS orphans in Kenya is set to rise over time (UNAIDS 2014).

In FY16, PEPFAR will reach the majority 467,005 (68.3%) of the overall OVC target of 683,531 children residing in the 20 scale-up counties for epidemic control (see Appendix A, Section 5.1). Support to non-core activities has been phased out except for roughly 255 (99%) girls accessing tertiary education that will be gradually transitioned by end of FY17. In the scale-up counties, focus will be on core interventions informed through active enrollment and case management. Emphasis will be on family-centered socio-economic activities critical to mitigating the impact of HIV/AIDS on children and address priority needs across four areas (Healthy, Safe, Stable, Schooled/education). Access to health services will include HTC and linkage of HIV-infected children and adolescents to care and treatment services. Strong linkages will be forged to initiatives such as the ACT and DREAMS. As part of the Kenya ACT strategy, universal testing of OVC enrolled in care under the PEPFAR Kenya program will be undertaken and their status documented as part of the core package of services. The program will engage community based organizations (CBO/FBOs) and adult caregivers to support the psychosocial and other needs of OVC under the care of elderly caregivers or child headed households.

Partnerships will be strengthened between HIV clinics and local partners with a designated focal person in the clinic to link HIV infected and exposed infants to OVC services. Similarly, efforts will be made to link children receiving clinical care with the existing OVC programs in the community to enhance adherence. To support the DREAMS strategy, the program will engage in mobilization activities, referrals and linking vulnerable girls to prevention, treatment and care services, social safety net programs and other protection resources for both in- and out-of school girls.

The program will also promote referrals to nutrition and integrate ART adherence into routine household monitoring for family members with HIV and support interventions that prevent and mitigate maltreatment of children and adolescents, promote positive parenting and provide psychosocial support to affected households. In addition, OVC caregivers will be empowered to access economic strengthening services to ensure households are resilient to economic shocks. These activities will include access to group savings and loans as well as linking caregivers to social protection programs (cash transfers, education bursaries, health insurance, and food subsidies). Education support will be provided to OVC by helping caregivers address barriers to education, enrollment, attendance, and progression as well as those that address developmental delays for under-fives through Early Childhood Development (ECD) interventions.

In the 20 scale-up counties, system level support will include participation in the development and review of relevant policies, guidelines, strategies and quality standards through dissemination and institutionalization. The capacity of county government social service staff and CBO/FBO partners will be strengthened to better plan, budget, implement, monitor OVC responses, and advocate for resources. Support child protection structures (e.g., Area Advisory Councils - AAC) will also be targeted to improve prevention and response to protection issues. PEPFAR Kenya will support outcome monitoring through biannual household surveys and by strengthening overall case management. Similarly, current 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 to Maintain Support for Other Locations and Populations

5.1 Maintenance package of services outside the priority locations and populations

The 27 sustained counties account for 40% of the Kenyan population, but only 20% of the PLHIV, 21% of HIV-infected pregnant women, and 17% of new HIV infections. In these 27 counties, HTC services will only be provided to symptomatic clients and to patients requesting a test. Specific strategies include:

1. Diagnostic HTC only for symptomatic patients presenting in PEPFAR-supported high yield sites. This will include HTC for patients with opportunistic infections such as TB, PCP, Cryptococal meningitis; Herpes

Zoster, Kaposi's Sarcoma, etc. or other chronic conditions that the health workers deem fit to conduct a HIV test for diagnostic purposes.

2. All presumptive TB cases will be offered HTC services.
3. Clients presenting at health facilities requesting HTC services.
4. Children of HIV positive individuals who attend HIV care and request HTC.
5. Partners of HIV positive individuals requesting an HIV test.

Current patients on treatment and newly enrolled patients will be provided a minimum package of care for PLHIV as previously described. No patient will be denied treatment, so if a person presents for PMTCT services and requests HIV testing, or presents with an OI, testing and treatment will be provided as needed.

As per the guidance to continue supporting programs until arrangements for transition are made, OVC currently served with core interventions—primarily promotion of HTC and confirmatory HIV testing, clinic-based child abuse, and GBV response—will continue, while working with the county government and other local providers to take on current and newly identified at need OVC. There will be no active enrollment of OVC or replacement of children aging out of the program. Current children accessing secondary school will be supported to complete and/or link to bursaries where appropriate and psycho-social support will be provided to targeted households in order to ease the transitioning process. Extremely vulnerable households initiated on or with ongoing household economic activities for a period of less than 2 (two) years will be targeted to work towards graduation on a rolling basis as they show progress towards reduced economic vulnerability. PEPFAR will intensify referrals and linkages to health and other social protection programs and existing resources. The number of OVC receiving the minimum package of services in the sustained counties will decrease by 11%, and these resources will be redirected to the 20 scale-up counties.

The gradual withdrawal of resources from centrally supported and sustained areas will enable increasing investment in scale-up counties and ensure that the most vulnerable children and households are targeted. All attrition from these counties will be used to increase targets in the scale-up counties.

Furthermore, and only in FY16, PEPFAR support for VMMC will be limited to specific focus on migrant non-circumcising populations in four counties: Nandi, Kericho, West Pokot, and Nakuru. Existing condom distribution programs will be maintained, but local promotion programs will be discontinued. Regarding KPs, HIV prevention services, STI screening and HIV care and treatment services will be transitioned to the National and County governments in the 20 sustained counties, with a focus on integration with the existing health system for efficiency and sustainability gains.

The expected volume of patients needing the minimum package of services in these areas has been calculated by county (Table 5.1.1). The expected number to be tested through PMTCT sites was derived based on assumptions

noted above. Based on these calculations a modest increase (4%) in the number of pregnant women tested for HIV is expected; however, it will not be a result of active mobilization.

Expected volumes for current on care and current on ART were derived using historical program data. Overall, HTC will decline by 42%, from 1,565,541 in FY14 to 905,958 in FY16, but the decline in yield will be more modest due to improved targeting within facilities. Passive enrolment of 18% is expected in PEPFAR-supported ART sites, but only a modest increase (5%) in net new on ART (lower than 9% net increase in FY15) as a result of the above considerations. Further, there will be a decline (53%) in patients receiving care, but not yet initiated on ART, largely due to the initiation of existing care patients on ART based on updated treatment guidelines.

Resources required to support maintenance in these counties are projected at $67 million using adjusted EA data. These activities were budgeted for prior to setting final targets for scale-up counties.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services Outside the Scale-up counties

Maintenance Volume by Group	Expected result APR 15	Expected result APR 16	Percent increase (decrease)
HIV testing in PMTCT sites	514,212	536,992	4%
HTC (only maintenance ART sites in FY 16)	1,565,541	905,958	(42%)
Current on care (not yet initiated on ART)	42,555	20,029	(53%)
Current on ART	171,243	180,261	5%
OVC	243,839	216 526	(11%)

5.2 Transition plans for redirecting PEPFAR support to priority locations and populations

Transition of PEPFAR support from low volume (0-4 HIV positives) PMTCT and HTC sites was initiated during FY15. Based on a recent request from the GOK, PEPFAR will continue to provide test kits to these 2,071 PMTCT and HTC sites. The monitoring of these sites will be the sole responsibility of the GOK. As part of ongoing discussions with GOK, plans for transition of PEPFAR support from sustained counties will be implemented during FY16. Specifically, low volume (<50 ART patients) sites in all 27 sustained counties will be transitioned to GOK by the end of FY16. In addition, all sites in the seven sustained commodities counties will be transitioned 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. Beginning in late FY15, PEPFAR Kenya and the GOK will conduct detailed county specific ART volume analysis of the 306 low volume ART facilities in the 27 sustained counties during FY16. ART volume assessment will examine geospatial analysis 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 increase overall investment across all counties.

The seven lowest burden counties - Mandera, Garissa, Isiolo, Lamu, Marsabit, Tana River, and Wajir - account for 1% of the HIV burden, representing 6,667 individuals on ART. PEPFAR Kenya will continue to provide TA, commodities, and laboratory network support to CHMTs to further strengthen capacity to assume full management of HIV service delivery in the seven counties by the end of FY16.

Discussions continue with GOK and other stakeholders to best facilitate these transitions, including detailed plans to specify TA needs, activities and timelines, ensuring that counties are empowered and are able to manage HIV services by the end of FY16. Plans will also include indicators to monitor a facility's readiness for transition, quality of care, consolidation options, and innovative service delivery models.

To ensure increased investment in the high burden counties, PEPFAR will work closely with GOK and other stakeholders to develop and implement a phased plan in COP15 to gradually to transition OVC support in low burden counties by the end of FY16 and throughout FY17. The plan will graduate children and families on a rolling basis starting in the seven lowest HIV burden counties. In addition; PEPFAR will work to transition out of low burden sites in the 20 sustained counties and transfer the most vulnerable families to other providers to prevent interruption of services. PEPFAR will support capacity building of the local OVC partners, communities and target counties to identify and graduate children and families as they show progress towards reduced economic vulnerability, intensify referrals and linkages to health and available resources including to social protection programs. In these counties, PEPFAR will discontinue active enrollment of new children and families.

HRH support will be transitioned to GOK and a system for provision of ARV drugs to the few pregnant women identified as HIV-infected will be developed either through referral to ART clinics or mobile outreach. Most ART sites and high yield PMTCT sites will be maintained in the sustained counties during FY16, with a plan to transition to GOK in FY 17.

Support currently provided at the national level for supply chain and the sample transport network will be maintained; however, specific site and county-level activities will be transitioned to GOK by the end of FY16. CSOs are engaged to assist with developing innovative ways to support services beyond FY16 without direct PEPFAR support.

6.0 Cross-cutting Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

PEPFAR Kenya will support laboratory services that are necessary to achieve epidemic control. Support will be provided to eight reference laboratories and 230 laboratories in high volume ART sites, of which 82% are within the 20 scale-up counties. PEPFAR laboratory resources will be aligned to support scale-up counties to meet their targets for treatment scale-up. PEPFAR will also provide minimal TA to 1,562 laboratories at low volume ART

sites and in ART sites within sustained counties. There will be support for quality management systems (QMS) through the stepwise laboratory quality improvement process towards accreditation (SLIPTA) for 140 labs including 53 newly enrolled. All newly enrolled SLIPTA labs will be in the 20 scale-up counties.

To improve access, quality, and coverage of HIV related testing, PEPFAR Kenya will focus on providing essential laboratory commodities, quality assurance for HIV testing, CD4, EID, VL, and TB, national equipment maintenance program, technical assistance activities including HIV Drug Resistance testing for surveillance, laboratory networking, HIV impact assessment surveys, and evaluation of new technology including point of care testing. Kenya adopted the WHO Guidelines on ART in 2014 that recommend patient monitoring using viral load; PEPFAR Kenya will support a smooth transition from CD4 to routine viral load guided by the National Viral Load scale-up strategic plan.

Additionally PEPFAR Kenya will support blood safety activities to ensure availability of safe blood for PLHIV and ART/PMTCT sites. Biosafety and integrated infection control measures will be supported in scale-up counties with expected high patient volumes to minimize nosocomial transmission of TB, HIV and other blood borne pathogens.

Activities	Impact on Clinical Cascade					Sustainability Index Elements	Deliverables		Budget codes	Associated IMs
	HIV Testing	In Care	On ART	Retention	Adherence		2015	2016		
Infrastructure										
Support to 8 reference/molecular diagnostic labs	X	X	X	X	X	O	Support general infrastructure; QA programs; general maintenance, HIV testing –VL, DR and EID. Additionally support TB cultures and HIV-DR	Support general infrastructure; QA programs; general maintenance, HIV testing - VL and EID	HLAB	MOH KEMRI DOD/WRP AMPATH KEMSA
Support to 1,562 facility-based labs	X	X	X	X	X	O	Support QA programs: Testing, sample /commodity management, data/information management and biosafety for HIV, CD4, TB and OI testing	Support QA programs: Testing, sample /commodity management, data/ information management and biosafety for HIV, CD4, TB and OI testing	HLAB	FOA Partners
Support national equipment maintenance program	X	X	X	X	X		Train MOH staff on equipment maintenance and calibration for key machines and ancillary equipment supporting HIV related lab testing. Biosafety Cabinet certification.	Full in-country implementation of equipment maintenance and calibration program. Biosafety Cabinet certification.	HLAB	KMOPHS FOA Partner AIHA APHL
Policy										
Work with MOH counties in scale-up counties to adopt National laboratory policy and develop laboratory strategic plan for Viral load scale up	X	X	X	X	X		Policies finalized and launched	Policy disseminated and adopted by scale-up counties	HLAB	FOA Partners EGPAF
Training										
Conduct trainings of laboratory personnel: specimen collection & management, IPC, Biosafety and quality assurance, use of CD4 machines and HIV rapid tests, viral load, EID, HIVDR and Gene Xpert testing	X	X	X	X	X		Quality HIV diagnostic and monitoring results for all patients tested	Quality HIV diagnostic and monitoring results for all patients tested	HLAB HTXS	FOA Partners KEMRI CLSI UON- COE EGPAF

HIV Related Diagnostic Testing										
Support testing services and provide reagents for HIV rapid testing, CD4, viral load and EID, CrAg	X	X	X	X	X	X	Lab testing performed for HIV diagnosis of adults/pediatric and infants; monitoring of patients in care and on ART	Lab testing performed for HIV diagnosis of adults/pediatric and infants; monitoring of patients in care and on ART	HLAB, HBHC, PDCS, MTCT,HVCT	KMOPHS APHL KEMRI KEMSA EGPAF FOA partners
Quality assurance										
Support quality assurance programs for rapid HIV testing, CD4, VL, EID, Gene Xpert and TB smear microscopy	X	X	X	X	X		Provide integrated EQA and DTS PT panels; test kit lot-lot validation, post-market surveillance, and HTC site support.	Provide integrated EQA and DTS PT panels; test kit lot-lot validation, post-market surveillance, and HTC site support.	HLAB	KMOPHS APHL KEMRI KEMSA
Support POC evaluations and uptake										
Support POC evaluations and uptake	X	X	X	x	x		Evaluate POC for CD4, EID and VL technologies	Evaluate POC for CD4, EID and VL technologies	HLAB	KEMRI UON-COE
Quality management systems										
Support 120 laboratories in continuous quality improvement projects through the SLIPTA process	X	X	X				Improved QMS at laboratories serving high volume ART facilities leading to international standard accreditation/ recognition.	Improved QMS at laboratories serving high volume ART facilities leading to international standard accreditation/ recognition.	HLAB	CLSI FOA Partners UON- COE ASLM
HIV Impact assessment										
Support HIV impact assessments and surveys to evaluate progress toward epidemic control and quality of the program	X	X	X	X	X		Technical assistance on specimen collection, laboratory testing, QA, data analysis and dissemination of findings to MOH, program and clinicians. Obtain country-specific HIV/TB epidemic information, such as prevalence, incidence and viral load suppression, TBDR and HIVDR.	Technical assistance on specimen collection, laboratory testing, QA, data analysis and dissemination of findings to MOH, program and clinicians. Obtain country-specific HIV/TB epidemic information, such as prevalence, incidence and viral load suppression, TBDR and HIVDR.	HLAB, HTXS, HBHC HVTB	KMOPHS KEMRI UON-COE
Blood safety										
Support screening of blood for HIV and other transfusion transmissible infections.	X						Technical assistance for national blood transfusion service, QA, data/information management, hemovigilance and	Technical assistance for national blood transfusion service, QA, data/information management, hemovigilance and impact assessment surveys	HMBL	KNBTS KEMSA

							impact assessment surveys			
Infection control										
Support integrated infection control in care, treatment and prevention programs	x	X	x	x			Safe injection practices, enhanced occupational safety and health- including post-exposure prophylaxis, improved medical/sharps waste management. Reduce medical transmission of HIV	Safe injection practices, enhanced occupational safety and health- including post-exposure prophylaxis, improved medical/sharps waste management. Reduce medical transmission of HIV	HMIN	KMOPHS HLAB FOA partners

6.2 Strategic Information (SI)

PEPFAR Kenya will continue to support the GOK to strengthen integrated SI to inform national and county level progress towards HIV epidemic control. PEPFAR Kenya will continue to work with the GOK to better coordinate national and county level M&E activities to improve reporting, including provision of technical assistance for routine data quality assessments, cohort analysis, capacity building and mentorship of HCWs on M&E, data dissemination and utilization. Evaluation studies for core interventions and among priority populations will be supported to assess impact.

PEPFAR will also continue strengthening the GOK in the use of DHIS2, DATIM and other existing subsystems to facilitate MER reporting. EMR maintenance and upgrades are critical in strengthening cohort analysis and increasing data demand and utilization. Scaling up of 'm-health solutions' in scale-up counties will help increase efficiencies in service delivery. Piloting of a Unique Personal Identifier system in two scale-up counties to enhance patient linkages between points of service will also be prioritized. The use of geospatial data and spatial analysis will be increased, both within the interagency PEPFAR team, Implementing Partners, and with GOK, to support the identification of efficient and effective targeting of services.

Existing surveillance systems will continue to provide a comprehensive epidemiologic profile of the HIV epidemic, including HIV case-based surveillance to monitor progress and identify gaps along the clinical cascade; population-based longitudinal bio-behavioral survey to monitor change in HIV prevalence and incidence over time; coverage and uptake of HIV services; fisherfolk study to assess prevalence, incidence, service utilization and coverage, and viral suppression; and mortality surveillance to provide information on HIV cause-specific deaths. PEPFAR Kenya will assist in the development of a critical new model for HIV estimates as the need for accurate population-based and county estimates of the HIV burden increases.

Activities	Impact on clinical cascade:					Sustainability Index Elements	Deliverables		Budget Codes	Associated IMs
	HIV testing	In Care	On ART	Retained	Adhering		2015	2016		
Monitoring and Evaluation										
Overall coordination of M&E, HIS, Surveys and surveillance activities to facilitate availability and accessibility of quality strategic information to inform overall national and count level HIV response:	**X**	**X**	**X**	**X**	**X**	**3-Q1 score 6**	Increased availability and accessibility of high quality strategic information at the national and county levels	Increased availability and accessibility of high quality strategic information at the national and county levels	HVSI	KMOPHS,AFYA IN TBD, UCSF
Build national, county, facility, and community capacity in M&E. Training and mentorship of County health care workers on M&E tools including cohort analysis within the 5saturation Counties as well as in the adjusted scale up counties to ensure accurate data collection, review aggregation, analysis and reporting on progress towards epidemic control. This includes support to national level reporting.	**X**	**X**	**X**	**X**	**X**	3-Q2 score 4	2500 HCWs in scale-up counties trained on M&E tools processes, data review, reporting , dissemination and utilization within the paper based and electronic systems	2501 HCWs in scale-up counties trained on M&E tools processes, data review, reporting , dissemination and utilization within the paper based and electronic systems	HVSI	M&E TBD and AFY
Integrate and harmonize M&E tools at facility and community level to support both facility and community based reporting of PEPFAR activities. This is critical in providing data for both facility	**X**	**X**	**X**	**X**	**X**	3-Q1 score 6	Facility and community based tools integrated and harmonized to facilitate PEPFAR reporting	Strengthen availability and accessibility of both facility and community based program data	HVSI	M&E TBD, Measure KMOPHS

based and community based program interventions within the saturation and the adjusted scale up counties in line with the proposed scale up approach for Kenya										
Maintain and update Master Health Facility Lists to support unique site identification in DHIS and DATIM. With the advent of DATIM and IPSL, ,there is need for proper identification and matching of site both in national M&E system (DHIS) and the new PEPFAR data base (DATIM)	**X**	**X**	**X**	**X**	**X**	3-Q1 score 6		Updated MFL to support unique identification of sites at the facility and community level	HVSI	AFYAINFO,M&E T
Support development and review of the national M&E curriculums, protocols, SOPs, training materials, standards and guidelines to standardize M&E processes and procedures across all county clusters:	**X**	**X**	**X**	**X**	**X**	3-Q3 score 0		National M&E curriculums, protocols, SOPs, training materials, standards and guidelines revised and rolled out	HVSI	M&E TBD and LM
Support Coordination and implementation of RDQAs/RDQIs in both saturation and adjusted scale up Counties to improve on the overall quality of data: This includes both paper based and electronic data collection and	**X**	**X**	**X**	**X**	**X**	3-Q3 score 0		Implement 3 RDQAs in saturation Counties and 1 in adjusted scale up counties	HVSI	M&E TBD, KMOPI Kisumu west, Soutl

aggregation systems in mainstream GOK facilities as well as in military facilities										
Implement program evaluations and operational research. This will vary from one program area to the next but specifically is needed to measure outcomes and impact the program is having on the target population. E.g. in ART, PMTCT, Key population and DREAMS program areas	**X**	**X**	**X**	**X**	**X**	**3-Q2 score 4**		3 program evaluations conducted in PMTCT, ART and among adolescent and young women	HVSI	AFYAINFO,M&E T
Support capacity building in geo spatial analysis: This is to facilitate geographical mapping of the HIV to further guide intervention focus.	**X**	**X**	**X**	**X**	**X**	**3-Q2 score 4**		All USG Si team trained on geo spatial analysis	HVSI	M&E TBD
Coordinate data dissemination and data use at the national level (e.g., data review meetings, best practices forum, data synthesis). SI plans to continue supporting dissemination of M&E products at deferent forums to strengthen data utilization at different levels of programming to inform program quality improvement path, policy, innovative approaches for future best practices.	**X**	**X**	**X**	**X**	**X**	3-Q2 score 4		Conduct 7 County level data review and disseminations forums in saturation and in adjusted scale up counties and 1 national data dissemination and utilization forum	HVSI	KMOPHS and M&E

Printing and Distribution of HIV tools to help HIV/MER reporting.SI strongly thinks that this activity should be taken over by GOK. However, the recent revision was necessitated by the fact that PEPFAR requires finer data elements as captured in the MER guidance which is currently missing in the MOH HIV M&E tools. Because this activity is happening as per PEPFAR request, we plan to support this activity in COP 15 with the hope that this will be finally be transitioned to MOH going forward	**X**	**X**	**X**	**X**	**X**	**3-Q1 score 6**		All HIV M&E tools printed and distributed to all PEPFAR supported sites to support reporting	HVSI	KMOPHS
Health information systems										
Support scale-up of M-Health solutions (EID to reduces the turnaround time for results using SMS printers, PEP for healthcare workers to improve on reporting and adherence among HCWs , Logistics management for KEMSA)	X	**X**	**X**	**X**	**X**	**3-Q3 score 0**	mHealth systems scaled up in efficient use and capacity built for sustainable use.	mHealth systems scaled up in efficient use and capacity built for sustainable use. Other mHealth innovations that increase coverage, access, and efficiencies identified for further implementation on priority program activities along the clinical cascade of HIV/AIDS.	HVSI	CDC Foundation
Strengthen National and sub-national HIS (Coordinate the maintenance and upgrading of DHIS2; Support	X	**X**	**X**	**X**	**X**	**3-Q1 score 6**	Review and roll out of national HIS policies and standards. Upgrade the existing national data systems. Create a national data warehouse	Review and roll out of national HIS policies and standards. Upgrade the existing national data systems. Create a national data	HVSI	AFYA INFO, ITEC, KMOPHs

implementation of LIMS, CHIS; Support integration of sub-systems (DATIM,LIMS, TIBU, MFL, EMR, HRIS, DHIS2,CHIS) ;Coordinate implementation of National Unique Persons Identifiers; Strengthen National HIS policies/standards (e.g. interoperability);							through integration of subsystems. Ensure interoperability and data exchange between systems. Pilot NUPI in 2 scale-up counties	warehouse through integration of subsystems. Ensure interoperability and data exchange between systems. Pilot NUPI in 2 scale-up counties		
Strengthen functionality of EMRs (Coordinate legacy data migration, EMR upgrades to POC, reporting, strategic scale-up with relevant stakeholders.) to clinical decision support, overall patient management, increase availability and accessibility of data for decision making at national and County levels.	**X**	**X**	**X**	**X**	**X**	**3-Q2 score 6**	Mature EMR systems in active and optimum use in all facilities in scale-up counties.Comprehensive LIMS deployed and optimally used in reference laboratories and facility laboratories within the scale-up counties. Complete and accurate data used for automated reporting and patient management by facility and county staffs. pilot NUPI in 2 scale-up counties	Mature EMR systems in active and optimum use in all facilities in scale-up counties.Comprehensive LIMS deployed and optimally used in reference laboratories and facility laboratories within the scale-up counties. Complete and accurate data used for automated reporting and patient management by facility and county staffs. Counties and the national government are able to store health data at a national repository for decision making and patient management.	HVSI	ITEC and Futures G
Surveys and surveillance										
National/sub-national population-based surveys in general such as KAIS and DHS and KPs (HIV Impact Assessments ;Regional	**X**	**X**	**X**	**X**	**X**	**1-Q3 score4.6**	Documentation of lessons learned from implementation of KAIS II; Initial plans for KAIS III and stakeholder engagement	Development of plans for 2017 KAIS III, TA, TDY, meetings, coordination	HVSI	Measure DHS,UCS

longitudinal surveys using population-based platforms to provide focused data in high burden Counties; Integrated bio-behavioral surveillance among KP)										
HIV case-based surveillance (Longitudinal facility-based surveillance that monitors each stage of the clinical cascade from diagnosis, linkage to care, ART, viral suppression, and death) to measure ART and PMTCT impact)	**X**	**X**	**X**	**X**	**X**	**1-Q3 score 4.6**	Pilot system for individual case-based surveillance (coordination/analysis)	Implement case-based surveillance in 2 counties	HVSI	KEMRI,UCSF,KMC
HIV drug resistance surveillance (Directly relates to the treatment and viral suppression elements of the cascade and will also measure impact)			**X**	**X**	**X**	**1-Q3 score 4.6**	N/A	Assessment of rates of HIV drug resistance among ART patients	HVSI	KMOPHS,UCSF
Mortality surveillance (Last step of clinical cascade and provides information on: 1) impact of HIV infection on death; 2) impact of ART/viral suppression on death; 3) changes in HIV prevalence/incidence, 4) state of vital statistics/civil registration)		**X**	**X**	**X**		**3-Q2 score 4**	N/A	Assessment of HIV infection rates among deaths in community in western Kenya	HVSI	KEMRI,UCSF,UNC
Special studies to understand	**X**	**X**	**X**	**X**	**X**		N/A		HVSI	UCSF

qualitative concerns along the clinical cascade (e.g., adherence, loss-to-follow-up)										
Generation of new model for HIV estimates: Support and consultation to work toward development of a new 2017 HIV estimates and projection model for Kenya using local inputs.	**X**	**X**	**X**	**X**	**X**	**1-Q5 score 1.2**	N/A	Facilitate stakeholder meetings and consensus workshops to develop model for HIV estimates	HVSI	KMOPHS
Support for analysis and scientific productivity -- Analysis and writing workshops, scientific writing skills to ensure the use of data to produce high quality analyses and lessons learned (as well as formal scientific outputs).	**X**	**X**	**X**	**X**	**X**	**2-Q4 score 1.25**	Develop online manuscript writing training materials; conducted several writing workshops	Data use for policy and programming through writing/analysis workshop and ultimately manuscripts by partners and MOH in saturation counties	HVSI	UCSF

6.3 Health System Strengthening (HSS)

To address health systems bottlenecks in delivery of HIV services, PEPFAR Kenya's HSS activities focus on: 1) HRH; 2) supply chain management; 3) health financing and policy; 4) leadership and governance; and 5) service quality improvement.

Kenya has four HRH-related limitations that directly impact scale-up and quality of HIV services:

- High vacancy rates of clinical staff in high-volume sites, resulting in limited treatment scale-up
- Low capacity for health worker production, hence overall low numbers of key cadres
- Poor HRH management capacity at county level following the functional devolution to county governments, affecting attraction, performance, and retention of staff
- Weak Human Resources Information Systems (HRIS) and their use to inform HRH decision making, especially forecasting and budgeting

The high clinical staff vacancy rates are driven by inadequate resource allocations to attract, hire and retain staff especially in resource poor counties. SIMS site-level data indicate a significant vacancy rate of 60% of clinical staff particularly physicians, nurses, and clinical officers. In COP15 PEPFAR Kenya will continue contracting staff to meet staffing gaps in scale-up to saturation and aggressive scale-up counties. PEPFAR has developed a health worker transition plan targeting county governments. Low capacity for clinical cadres' production has an effect on the overall low numbers of clinical staff. PEPFAR will continue supporting pre-service activities focused on increasing the numbers of clinical cadres. With the HRH function devolved to the county governments, weak forecasting, planning, budgeting, and retention strategies are major challenges to staffing. PEPFAR will support the HRH management capacity development of the county teams for effective attraction, performance, deployment, and retention of the health workers in the high disease burden counties. Lack of personnel data is also a challenge for effective HRH planning and budgeting. PEPFAR will continue supporting the HRIS rollout and use at the county level. PEPFAR will support task shifting/sharing policy development and community workforce training to ensure high retentions in care/ART/PMTCT.

PEPFAR will provide TA in supply chain and health commodity management at the national level and to the 20 scale-up counties, with the limitation based on available resources for OHSS in COP 15. At the national level, efforts will strengthen the capacity of the program for overall HIV

commodity security. Activities will include quantification, pipeline monitoring, commodity tracking and reporting, and management and use of strategic information for decision making. At county level, PEPFAR will further strengthen capacity of county commodity security teams to provide effective oversight to commodity management systems at the sub-county and facility levels. Specifically, capacity of the CHMT in high burden counties will be enhanced to effectively quantify HIV/AIDS commodity requirements. Expected results at the county level include reduced stock outs of key HIV/AIDS commodities, improved planning and oversight by the county health management teams for HIV/AIDS commodities, and improved reporting and accountability for HIV/AIDS commodities.

Kenya is among the countries where PEPFAR investments will be used to support Domestic Resources Mobilization (DRM) interventions. The approach at the national level is to work with NACC to advocate for efficiencies in resource utilization and increased resource allocation for HIV interventions. At county level, the approach is to strengthen the county budget process that includes HIV as a line item. PEPFAR Kenya will continue supporting the annual National Health Account (NHA) for expenditure tracking, which will be used in planning and HIV resource allocation discussions with GOK and ongoing, national expenditure analysis to determine unit costs and identify allocative and technical efficiencies.

Weak leadership and governance of limited health resources is a bottleneck for scale up as it leads to resource wastage and lack of accountability. PEPFAR will target key national and county leadership to build their governance capacity, with an aim to increase prioritization of health interventions; hence, more resources for health infrastructure, manpower and supplies in high burden counties.

PEPFAR will foster QI directed nationally and to the counties to enhance the quality of HIV service delivery and the care of OVC. This is expected to result in institutionalization of QI at the national and priority county level through development of appropriate structures at county level. These structures include QI Teams and Work Improvement Teams. Through TA to county governments these teams will strengthen and improve the HIV chronic care model, with an expected result of more adults and children enrolled and retained in HIV care and treatment.

Activities	Impact on clinical cascade:				Sustainability Index Elements	Deliverables		Budget Codes	Associated IMs
	In Care	On ART	Re-tained	Ad-hering		2015	2016		
HRH									
Pre-service education for Health Care Workers (HCW) (Doctors, Nurses, Cos, Lab Techs, Records Off, Nutritionists, Pharmacists)	x	x	x	x	• 2.2 – HRH	• 30% increase of new graduates supported by PEPFAR resources in high burden counties.	• 30% increase of new graduates supported by PEPFAR resources in high burden counties	OHSS	Funzo Kenya, FELTP, UON-Fellowship
HRH Management (Hiring, Retention, Remuneration and Planning)	x	x	x	x	• 2.2 – HRH	• Less than 10% of PEPFAR supported facilities with staff shortage for PEPFAR services in high burden counties.	• Less than 10% of PEPFAR supported facilities with staff shortage for PEPFAR services in high burden counties.	OHSS and all other ITTs	HRH Capacity Bridge
HCW Transition Plan to County Governments Payroll	x	x	x	x	• 2.2 – HRH	• 30% of PEPFAR contracted health workers transitioned to county government payroll during the year	• 30% of PEPFAR contracted health workers transitioned to county government payroll during the year	OHSS	HRH Capacity Bridge
In-service Training to enhance Performance	x	x	x	x	• 2.2 – HRH	• 40% of health workers in high burden counties attended HIV/AIDs related in-service training at least once during the year	• 40% of health workers in high burden counties attended HIV/AIDs related in-service training at least once during the year	OHSS, and all other ITTs	Funzo Kenya, HJF, KMOPHS. UON-Fellowship (other IMs also support mentorship)
Human Resource Information System (HRIS)	x	x	x	x	• 2.2 – HRH	• HRIS rolled out to 60% of PEPFAR high burden counties. • 90% of the CHMTs in HRIS rolled out counties show evidence of using HRIS data for decision making	• HRIS rolled out to 60% of PEPFAR high burden counties. • 90% of the CHMTs in HRIS rolled out counties show evidence of using HRIS data for decision making	OHSS	HRH Capacity Bridge and Emory University
Regulatory bodies support	x	X	x	x	• 2.2 – HRH	• 4 of the 8 key regulatory bodies supported by PEPFAR funds using CPD points for re-licensure.	• 4 of the 8 key regulatory bodies supported by PEPFAR funds using CPD points for re-licensure.	OHSS	Funzo Kenya and Emory University
Supply Chain Management									
Supply Chain Management Support at National level	x	x	x	x	• 2.3 – Commodity Security and	• Commodity stocked rates reduced by 60% in PEPFAR supported high	• Commodity stocked rates reduced by 60% in PEPFAR supported	OHSS HLAB HTXS	Health Commodity and Services

					Supply Chain • 3.4 – Technical Efficiency	disease burden counties. • Annual commodity quantification done in all PEPFAR supported counties. • 10% Increase in budget allocation for commodity procurement in all PEPFAR supported high disease burden counties.	high disease burden counties. • Annual commodity quantification done in all PEPFAR supported counties. • 10% Increase in budget allocation for commodity procurement in all PEPFAR supported high disease burden counties.		management (HCSM)
Commodity Management Support at County level	x	X	x	x	• 2.3 – Commodity Security and Supply Chain • 3.4 – Technical Efficiency	• 60% of high disease burden Counties with Commodity management Technical Working Groups (TWGs) • 30% County Health Commodity TWG trained/Mentored on Commodity Management oversight • 30% County Health Facilities trained on Commodity Management	• 60% of high disease burden Counties with Commodity management Technical Working Groups (TWGs) • 60% County Health Commodity TWG trained/Mentored on Commodity Management oversight • 50 % County Health Facilities trained on Commodity Management	OHSS HLAB HTXS	Health Commodity and Services management (HCSM)
Health Financing and Policies									
Domestic Resource Mobilization (DRM)	x	X	x	x	• 3.1 – Resource Generation • 3,2 –Resource Commitment	• Proportion of domestic funds allocated to HIV/AIDs services increased by 10% in DRM target counties	• Proportion of domestic funds allocated to HIV/AIDs services increased by 10% in DRM target counties	OHSS	Health Policy and Planning (HPP)
Capacity building for County Government planning and budgeting	x	X	x	x	• 3,2 –Resource Commitment	• 60% of DRM target counties using Program Based Budgeting (PBB)	• 70 % of DRM counties using Program Based Budgeting (PBB)	OHSS	Health Policy and Planning (HPP)
Financing Evidence Generation (National Health Accounts (NHA), Public Expenditure Tracking (PET) National AIDs Spending Assessment (NASA)	x	X	x	x	• 1.2 – Financial and Expenditure Data	• 100% of PEPFAR supported Reports on financial expenditures made available for public view.	• 100% PEPFAR supported Reports on financial expenditures made available for public view.	OHSS	Health Policy and Planning (HPP)
Support Policy and strategy Development	x	x	x	x	• 5.1 – Policies Laws and	• 100% of policies supported by PEPFAR	• 100% of policies supported by PEPFAR	OHSS	Health Policy and Planning

Process					Regulations	tracked using Policy Tracking Table	tracked using Policy Tracking Table		(HPP)
Leadership and Governance									
Support Leadership and Governance skills development at County Level	x	X	x	x	• 5.2 - Leadership	• 60% County Health Management Team (CHMT) in high disease burden counties trained/Mentored on Leadership and Governance • 20% HCW in leadership positions trained on Leadership and Management	• 70% County Health Management Team (CHMT) in high disease burden counties trained/Mentored on Leadership and Governance • 40% HCW in leadership positions trained on Leadership and Management	OHSS	Leadership management and Sustainability (LMS) FELTP, UON – fellowship, Kenya Disciplined services, Kenya Prison Services
Health Services QI/QA									
Support the quality assurance for the HIV/AIDs services	x	X	x	x		• Quality assurance initiatives being implemented in 30% of PEPFAR supported sites	• Quality assurance initiatives being implemented in 40% of PEPFAR supported sites		ASSIST project

*N=national; SN = sub-national; S=site/facility

7.0 USG Management, Operations, and Staffing Plan to Achieve Stated Goals

[REDACTED]

APPENDIX A: Program Core, Near-core, and Non-core Activities for COP 15

APPENDIX A: Orphans and Vulnerable Children (OVC)

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	• Case Management: Standardize case management procedures for identifying, assessing, enrolling and monitoring children, adolescents, and families made vulnerable by HIV/AIDS. • 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 (HTC, treatment and care). • Link HIV positive children and adolescent to clinical care and treatment services including ART. • Forge linkages with other initiatives e .g. ACTS, 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	• Strengthen partners' capacity in case management • • Vocational training for adolescents and caregivers. • Access to primary and secondary for girls through long-term subsidies. • Provision of household supplies to most vulnerable HH when referrals are not possible • Conduct activities to address linkages, adherence, retention to care and treatment.	• Long term support household supplies • Direct IGA funding • Scholarships for tertiary/university education. • Supplemental feeding for mild malnutrition • Establish or support business cooperatives for caregiver groups.

	protection programs. • Implement special studies/surveys to identify gaps in OVC 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.	• Support large scale child rights and awareness campaigns
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	• Support large scale child rights and awareness campaigns

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

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)		• Provide long term HH supplies such as blankets and mattresses • Provide long-term food packages/ nutritional support

	• 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	• Support large-scale child rights awareness campaignscare facilities
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	• Directly support IGAs with funds and other inputs • Support non-market driven vocational skills and IGAs. • Establish or support business cooperatives

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 COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
Support large-scale child rights awareness campaigns	Phased out	$0	$0	0	End of FY15	No specific mechanism directly funded for this activity
Support non-market drive vocational skills and IGAs	Phased out	$0	$0	0	End of FY 15	No specific mechanism directly funded for this activity
Establish or support business cooperatives	Phased out	$0	$0	0	End of FY 15	No specific mechanism directly funded for this activity
Support tertiary education (university subsidies and scholarship)	Phasing out	$600,000	$268,420	1	August 2017	No specific IM directly funded for this No activity
	Phased out	$0	$0	0	End of FY 15	No specific IM directly funded for this activity
Provide long term HH supplies such as blankets and mattresses	Phased out	$0	$0	0	End of FY 15	
Provide long-term food packages/ nutritional support						
Totals		**$600,000**	**$268,420**	**1**		

APPENDIX A: Prevention

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site Level	**Scale-Up to Saturation and Aggressive Scale-up Counties** • HTC demand creation • PITC, Home-based and mobile HTC outreach • Link HIV+ clients to care and treatment • Hire HTC counselors • 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 • HTC community mobilization • Implement QA/QI system • Stigma and discrimination reduction • 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 PrePex device for male circumcision	• Stand-alone HTC for general public • KP income-generating activities • Procurement of needles and syringes • Engage traditional circumcising communities for safer procedures and prevention messages • Post-prisons release condoms promotion
County Level	**Sustained Counties** • 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	• Promote and distribute male and female condoms and compatible lubricants for PPs and KPs • RRI / Routine VMMC sites	• Intensified demand creation • Home-based HTC
National Level		• Support GoK county level HIV prevention	

	• Link HIV+ clients to care and treatment • Support VMMC service delivery personnel • Provide HTC 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 HTC to KPs and AGYWs • Support QI activities • Demand creation for HTC, VMMC, condoms, and MAT • Condom social marketing	• Engage GOK and donors promotion of male and female condoms and lubricant 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	• Support policy for comprehensive condoms and lubricants programming and empowering community

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

	Core Activities	Near-core Activities	Non-core Activities
HTC **Scale-up to Saturation**	• Intensify demand creation for uptake of HTC services • Conduct home-based HTC • Provide mobile/outreach HTC services to KPs, fisher folk, AGYWs • Provide PITC in OPD (80%) and IPD (100%) • Conduct home and facility HTC 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 care and treatment via CHWs, telephone follow up, expert	• Procure HTC RTKs • Train HCPs to provide HTC services • Provide HTC counselors with refresher/new algorithm training • Link HIV - clients to other HIV services • Support guideline review and development	• Stand-alone HTC services to general public in Sustained counties

	patients, and HTC counselors • Hire HTC counselors • Test walk in clients requesting HTC		
Aggressive Scale-up Counties	• Intensify demand creation for uptake of HTC services • Provide mobile/outreach HTC services for KPs, fisher folk, AGYWs • Provide PITC in OPD and IPD • Provide facility HTC for children and sexual partners of index clients • Implement QA/QI system for monitoring and improvement of safety and service quality for HTC • Link HIV+ clients to care and treatment by use of CHWs, phone follow up, expert patients, HTC counselors • Hire HTC counselors • Test walk-in clients requesting HTC		
Sustained counties			• Home-based HTC • Intensify demand creation
	• 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 home-based HTC	• 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	• Procure needles and syringes. • Income generating activities • Provide viral hepatitis screening, vaccination, treatment and care, family planning, post abortion care, cervical screening and treatment, screening for anal and other cancers, and emergency contraception

	• Link KPs HIV+ to ART • 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 • 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 floras 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 • Implement QA/QI systems for monitoring and improvement of safety and service quality for MAT and KP interventions	• Provide psychiatric assessment for PWID	
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 Turkana and Busia counties**	• Intensify VMMC demand creation for males aged 15-29 years • Continue to 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 HTC 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		• Operational research to improve VMMC uptake by older men • Bridging studies funded by NIH on PrePex to guide special population including HIV + men, nomadic communities, and adolescents • Operational research to assess acceptability and safety of EIMC in traditionally circumcising communities; and treatment of suspected lesions • Engage traditionally circumcising communities to improve safer procedures and incorporate HIV prevention messages
Sustained counties		• Introduction of PrePex device for male circumcision • Provide VMMC as a standard package of service for eligible males aged 0-60 days, in traditionally non-circumcising communities	
	• Support of service delivery personnel • Provide HTC, 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	• 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	

	change • Strengthen assets of girls, young women and families (parenting/care giver programs, social protection- cash transfers, educational subsidies and economic approaches) • Map sexual networks to target partners with high impact interventions (VMMC and ART)	risky situations, and avoid and provide skills to manage child sexual abuse • Target parents and guardians of adolescents aged 9-12 using EBIs to increase knowledge of HIV risks for young people, promote positive parenting, mentoring, and effective adult-child communication of sexuality, sexual risk reduction and child sexual abuse • Support national and county GoK levels to develop policies, guidelines and protocols for HIV prevention	• Income generating activities • Provide STI Screening and treatment
Fisher folk	• • • • • Conduct HTC • Conduct Peer outreach • Condom promotion and distribution • Conduct mobile outreach services	• STI screening and testing	
Military, Uniformed/Disciplined Services	• Condom promotion and distribution • Provide HTC services • 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 HTC services • SGBV prevention and response • Condoms promotion and distribution targeting staff and families STI prevention, screening and treatment • Peer education among	• • • • Post Exposure Prophylaxis • Support for policy review for HIV services enabling environment	

inmates
- Post release distribution of condoms to prisoners

- Package of behavioral, biomedical and structural services

Truckers

Table A.3 Transition Plans for Non-core Activities

Prevention

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
Stand-alone HTC for general public	Transition to Government	$0	$0	0	Immediately	MoH through NASCOP continues to support the activity
Income generating activities for KPs	Self-Help Groups and KP Community	$0	$0	0	Immediately	Support groups formed table banking initiatives and are now able to run on their own
Procurement of needles and syringes for KPs	Transition to Government	$0	$0	0	Immediately	NASCOP through GF will procure needles and syringes. PEFPAR will only promote use of sterile syringes and needles
Post-prisons release condoms promotion and provision for prisoners	Transition to Government	$0	$0	0	Immediately	MoH through NASCOP continues to support the activity
Engage traditionally circumcising communities to improve procedure safety and incorporate HIV prevention messages	National and County Governments	$0	$0	0	Immediately	Devolved MOH structures together with provincial administration will support the activity
Support policies to include comprehensive condoms and lubricants programming, and empower community to take ownership and	Transition to Government	$0	$0	0	Immediately	MOH through NASCOP continues to support the activity

leadership of violence prevention and response						
Package of behavioral, biomedical and structural services for truckers	Transition to GOK and USAID regional program for truckers	$0	$234,000	2	Immediately	The program is currently in transition to the GOK and USAID regional truck driver program
Totals		**$0**	**$234,000**	**2**		

APPENDIX A: Strategic Information

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site Level	• Strengthen EMR system in current facilities	• Support EMR installation in scale-up counties	• Track tool distribution and utilization
County Level	• 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 • Strengthen EMR system • 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	• Improve quality programming and innovative best practices. • Coordinate paper-based and electronic data quality assessments in sustained counties • Build M&E capacity of HCWs on M&E tools, SOPs, and guidelines in sustained counties • Support EMR installation • Develop Key Population centralized data base • Surveillance and surveys •	• Support development of Cervical cancer database • Support allied program surveys/surveillance, e.g. family planning • HIV clade analysis
National Level	• Strengthen and standardize M&E policies, guidelines, SOPs, and data collection tools for all levels • Strengthen EMR system • Facility Identification number for DHIS and DATIM. • Coordinate paper-based and electronic data quality assessments of programmatic data in saturation and scale up counties • Operational research and program evaluations • Improve quality programming and innovative best practices. • Strengthen data utilization and dissemination to improve quality programming and identify innovative best practices • Geospatial mapping and analysis • Health Information system	• Develop Key Population centralized data base • Reproduction and distribution of HIV and PEPFAR reporting tools • Support hospital wide ICT infrastructure	• HIV clade analysis • Development of Cervical cancer database • Development of GBV database

	strengthening DHIS2, LIMS, and CHIS and integration of sub-systems: DATIM,LIMS, TIBU, MFL, EMR, HRIS, DHIS2,CHI • Scale-up of M-Health (EID) in scale-up counties • Surveillance and surveys		

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

	Core Activities	Near-core Activities	Non-core Activities
Monitoring and Evaluation	• Strengthen national M&E policies by developing guidelines, protocols, SOPs, and data collection tools • Maintain national list of health facilities for unique site identification in DHIS and DATIM • Harmonize M&E tools for facility and community levels to support PEPFAR reporting • Coordinate paper-based and electronic data quality assessments of programmatic data for saturation and scale up counties • Implement program evaluations and operational research • Coordinate and strengthen data utilization and dissemination to improve quality programming and identify innovative best practices. • Strengthen M&E capacity of health care workers on tools and cohort analysis in 5 saturation counties and adjusted scale up counties to track epidemic control • Build capacity in geospatial analysis to routinely map HIV disease burden and PEPFAR supported services	• Print and distribute HIV and PEPFAR reporting tools • Coordinate paper-based and electronic data quality assessments to ameliorate programmatic data in sustained counties • 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	• Support a system to track tool distribution and utilization
Health Information Systems	• Support scale-up of M-Health solutions (EID) to reduce the turnaround time. • Strengthen National and sub-national HIS, DHIS2, LIMS, and CHIS • Support integration of sub-systems (DATIM,LIMS, TIBU, MFL, EMR, HRIS, DHIS2,CHIS) • Strengthen EMR system for legacy data migration, upgrades, reporting, strategic scale-up for clinical decisions, and patient management for	• Support development of Key Populations centralized database • Support hospital wide ICT infrastructure • Support EMR installation	• Support development of Cervical cancer database • Support development of GBV database

	decision making at national and county levels	
Surveys and surveilllance	• Conduct National/sub-national population-based surveys in general such as KAIS and DHS and KPs , and HIV Impact Assessments • Conduct HIV case-based Longitudinal facility-based surveillance monitoring each clinical cascade stage • Conduct HIV drug resistance surveillance • Conduct mortality surveillance • Implement special studies to understand qualitative concerns along the clinical cascade (e.g., adherence, loss-to-follow-up) • Develop generation of new project model for HIV estimates using Kenya local inputs. • Support analysis and scientific productivity	• Implement HIV clade analysis to understand HIV-related sexual networks to inform prevention activities • Support allied program surveys/surveillance, e.g. family planning

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
Support a system to track and distribute utilization of tools	Transition to Government	$0	$0	1	2015	All activities are $0 funded in COP 15
Support development of Cervical cancer database	Transition to Government	$0	$0	1	2015	PEPFAR is not uniquely positioned to continue supporting cervical cancer program. All activities are $0 funded in COP 15
Support development of GBV database	Transition to Government	$0	$0	1	2015	All activities are $0 funded in COP 15
Support implementation of	Phased out	$0	$0	1	2015	All activities are $0 funded in

HIV clade analysis to understand HIV-related sexual networks and inform prevention activities						COP 15
Support allied program surveys/surveillance, e.g. family planning	Phased out	$0	$0	1	2015	These activities have indirect impact to the HIV clinical cascade. All activities $0 funded in COP 15
Totals		**$0**	**$0**	**5**		

APPENDIX A: Health Systems Strengthening

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

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 • 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 • Leadership, management and governance practices	• Pre-service training support in saturation counties • Capacity building of peer health educators in saturation counties • Retention schemes at site level in saturation and scale up counties • Roll out of Human Resource Information Systems • Provide select training in saturation and scale up counties • Use of technology approaches for refreshers to reduce absences.	
National Level	• Domestic resource mobilization • Health financing assessments and surveys • Health financing policy and strategy development • 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 saturation counties • Use of technology for refreshers to reduce absences. •	• Hire additional health care workers in sustained counties • Appropriate communication on PEPFAR new strategies, and realignment • Capacity building of journalists and reporters to disseminate scientific information

Table A.2 HSS Core, Near-core, and Non-core Activities for COP 15

	Core Activities	Near-core Activities	Non-core Activities
Health Financing and policy	• **Bold Vision for Domestic Resources Mobilization (DRM)** towards sustainable	• **Health Insurance coverage:** Explore health insurance coverage for HIV/AIDS services by both	

Kenya is selected for Bold Vision interventions in Africa	health financing. 1) National Level: Work with NACC for resource advocacy 2) County level: work with counties to develop annual plans with more resources toward health, specifically HIV/AIDs interventions • **Conduct Health financing assessments and surveys** to inform decision making e.g., National Health Accounts (NHA) and National Aids Spending Analysis (NASA) will be supported. • **Support HIV policy and strategy development** (e.g. Health Bill, KASP, KHSSP, and County Strategic Plans) • Provide TA to implement and monitor progress at National and County levels.	NHIF and private health insurance providers to ensure more domestic resources available for HIV/AIDS interventions • **Private sector engagement** 1) Engage private sector providers in provision of HIV/AIDS services. 2) Support PPP initiatives to increase HIV funding through private resources.	
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	• Hire staff on contract in saturation counties to meet gaps • Support retention	• Hire additional health care workers in sustained counties

	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 **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	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	
	Improve health worker performance in scale-up counties • Continue process to support in-service training (IST) system • Support comprehensive integrated courses to enhance efficiency • 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 efficacy and reduce absences.	• Community Strategy trainings that are not aligned to PEPFAR interventions.
Supply Chain systems	• **Strengthen supply chain at 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' capacit y 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	

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	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
Hire additional health care workers in Sustained counties	Phasing out	$0	$0	Service delivery mechanisms	End-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.
Totals		$0	$0			

APPENDIX A: Maternal, Newborn and Child Health

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

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	• CX screening of HIV - commodity and equipment procurements e.g., HB meters and ANC profile reagents • Support community units and CHWs in advocacy and communication • Hotel-based trainings; academic scholarships • Cervical cancer screening of HIV+ pregnant women •
County Level	• Strengthen strategic planning and Annual Work plan development • Joint supportive supervision • Commodity security and supply chain logistic	• Support supply chain systems and logistics	
National Level	• Technical Assistance • Training • National commodity security reviews • Support National HMIS for data use and decision making • Evaluation and research	• Print and distribute new PMTCT Guidelines • Pre-service training for middle level HCP	• Develop, disseminate and implement of non HIV related policies • Print mother-baby booklet, PMTCT IEC materials and reporting tools

Table A.2 Core, Near-core, and Non-core Activities for COP 15

	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		• Support of community units and CHWs for advocacy and communication
PMTCT	<u>Service delivery:</u> • Identification of HIV positive women in ANC, L&D and PNC • Treatment: Support implementation of lifelong ART for pregnant and breastfeeding HIV+ mothers; phase out option A & B • Retention in care and treatment • Gender-related norms to	• Private sector engagement and support. • Capacity building at long term FP services • On-site training using harmonized HIV training curriculum	• Support community units and CHW • Advocacy and communication • Procure commodities and equipment (e.g., HB meters and ANC profile reagents) • Hotel-based trainings; academic scholarships • Cervical cancer screening and

	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 • Program evaluation	including CME, mentorship. • Support supply chain systems and logistics • Pre-service training for middle level health care providers, printing of PMTCT guidelines	treatment for HIV negative women • Print and distribute PMTCT IEC materials and tools •
HTC Services	• Optimize and saturate HTC		
Lab Services	• Lab networks for EID and VL, ensure RTK security		
Cervical Cancer screening			• CX screening of HIV- and + commodity and equipment procurements of HB meters and ANC profile reagents
FP Services	• Support FP counseling and consent including appropriate referrals	• Capacity building for long-term FP services	
HRH: Peer counselors	• Hire peer counselors in scale-up counties based on need		
HRH: Health Care Providers	• Hire critical staff in scale-up counties based on need	• Conduct onsite training using harmonized HIV curriculum including CME and mentorship	• Hotel-based training and academic scholarship
Training and Onsite Mentorship	• Support documentation, reporting and data use at all levels, strengthen EMR use. Distribution of tools including IEC materials		
HMIS	• Implement KHQIF in all scale-up counties, Implement and conduct SIMS and quarterly support supervision		
Quality Assurance			

and Improvement		
Retention Strategies	• Support referral and linkage, facility and community PHDP, defaulter tracking services, Patient education	• Support high yield/volume private facility: HIV related trainings and supplies of reporting tools, commodities
NACS including Breast Feeding	• Support exclusive breast feeding education	
Private Sector Engagement	• Ensure minimum package of GBV services and referrals available at PMTCT sites	
Gender	• Support ART integration in MCH	
HIV Integration in MCH	• 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	• Renovation in select scale-up counties
County Technical Support		
Joint Supportive Supervision	• Joint participation in SIMS	
Commodity security and supply chain logistic	• Technical support to ensure commodity security	• Support supply chain systems and logistics
Technical Assistance	• Participate in stakeholder review forums; support NASCOP, DRH and DCH in program reviews and improvement	
	• Support revision of HIV related policies and guidelines	

Policy and Guideline Reviews		• Support printing and distribution of new PMTCT Guidelines	• Development, dissemination and implementation of non-HIV related policies
National Commodity Security Reviews	• Participate in national HIV related pharmaceutical and non-pharmaceutical reviews; and support supply chain systems and logistics meetings		
Support National HMIS and data use for decision making	• Provide TA for revision of indicators and reporting tools	• Provide pre-service training for middle level health care providers	
			• Printing of mother-baby booklet, PMTCT IEC materials and reporting tools
Evaluation and Research	• Support national and regional PMTCT program evaluations		
Training			

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
Support of community units and CHWs	Phased out	$0	$0	0	-	Projects will support community health activities that directly translate into identification, retention and defaulter tracing of HIV+ clients
Advocacy and communication	Transitioning to other donors	$0	$0	1	Sept 2015	To be led by Global Fund and UN partners
Commodity and equipment procurements	Phased out	$0	$0	0		Counties can now procure commodities and equipment
Hotel-based trainings and academic scholarships	Phased out	$0	$0	0	Sept 2015	Training and mentorship occur onsite
Cervical cancer screening and treatment for all pregnant women and general population	Phased out	$0	$0	0	Sept 2015	Led by Ministry of Health

Printing and distribution of new Guidelines, IEC materials and tools such as mother baby booklets,	Phased out	$0	0	0	Sept 2015	Printing of mother baby booklets will be undertaken by the Department of Reproductive Health
Development, dissemination and implementation of non HIV related policies	Transition to GoK	0	0	1	Sept 2015	Led by Ministry of Health
Totals			0	2		
	0					

APPENDIX A: Clinical Services

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	• HIV care enrollment, clinical assessment, and staging • Management of Opportunistic infections; TB, cryptoccocal meningitis including fungal infections among PLHIV • Provision of Cotrimoxazole (septrin). PHDP activities • ART initiation • Adherence counseling, patient tracking/ defaulter tracing • 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 • Continuous Medical Education (CME), Mentorship, On-job-training (OJT)	• • STI screening in scale-up and sustained counties • Facility based adherence counseling, patient tracking/ defaulter tracing in Sustained counties • Community nutritional follow ups Sustained counties • IPT,IPC in scale-up and sustained counties • Facility-based orientation using harmonized curriculum • Minor renovations for select sites in saturation and scale-up counties	• Cervical Cancer assessment & treatment for HIV- women • Community unit components such as stipends and support • Supplementary feeding for mild malnourished clients • Hotel-based training, academic scholarships • New construction and major renovations; only ongoing construction where funding has been obligated should be completed • Cervical Cancer assessment and treatment for HIV+ women/mothers • Hepatitis B screening
County level	• Technical assistance in scale-up counties	• Strategic planning, policies, guidelines, tools dissemination and coordination in scale-up and sustained counties	
National level	• Technical assistance to NASCOP, DRH, DCAH, NACC, NTP, NPHL • Strengthen supply chain system • Support improved commodity	• Support for strategic planning, policies, guidelines, and tools development	• Support to non-HIV service delivery staff • Hotel-based training, academic scholarships • Routine chemistry, hematology, blood safety supplies • Supplemental feeding for mild

	management, and pharmaceutical services at county level • Procurement of ARVs and CTX • Procurement of Lab equipment and commodities: VL, CD4, EID, HIV-DR, CRAG and related consumables • Procurement of nutritional commodities • Procurement of 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;	• Hire critical staff in high volume facilities, 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	malnutrition • Screening of blood for HIV, HBV, HCV, Syphilis

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

Care and Treatment	Core activities	Near-core Activities	Non-core Activities
HIV Care	• Enrollment, clinical assessment, staging both in scale-up and sustained counties		
OI and co morbidities screening and management	• Management of Opportunistic infections; TB, cryptoccocal meningitis including fungal infections among PLHIV • Provision of Cotrimoxazole (septrin).	• ; STI both in saturation, scale-up and sustained counties	• Cervical Cancer assessment and treatment for HIV+ and - women • Hepatitis B screening

ART initiation	PHDP activities both in scale-up and sustained counties	• Facility based adherence counseling, patient tracking/ defaulter tracing within the sustained counties	• Community unit components such as stipends and support
Treatment monitoring (clinical)	• ART initiation per national guidelines in scale-up and sustained counties • Adherence counseling, patient tracking/ defaulter tracing • Training/ support of lay workers/ • M&E and coordination resulting in adherence, linkage to care,		
Nutrition		• Community nutritional follow ups for eligible HIV positive in all counties	• Supplementary feeding for mild malnourished clients
TB/HIV	• 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 and sustained counties	• IPT,IPC in scale-up and sustained counties	

Renovations and construction		• Minor renovations for selected sites in saturation counties due to increased ART patient volume	• New construction and major renovations - Only ongoing construction where funding has been obligated will be completed
National /county level support	• Technical assistance to GoK: NASCOP, DRH, DCAH, NACC, NTP, NPHLS	• Support for strategic planning, policies, guidelines, tools development, dissemination and Coordination	• Support to non-HIV service delivery staff
HRH	• CMEs, Mentorship, OJT in all counties • Strengthen supply chain system including integration of parallel supply chains, supply chain governance, information systems, inventory tracking, warehousing and distribution	• Hire critical staff in high volume facilities both in scale-up counties	
Training	• Support to improve commodity management, and pharmaceutical services at county level: Building capacity of MoH at county and national	• Facility based orientation the harmonized curriculum	• Hotel-based training, Scholarships

Commodity management and SCMS	levels for sustainability. E.g. procurement planning, inventory management, forecasting and quantification, quality assurance and good storage management. • ARVs, CTX • VL, CD4, EID, HIV-DR, CRAG and related consumables • Therapeutic food • GeneXpert Reagents	• Support short term pre-service training with an aim to transition to GOK. • Support for advanced HIV training and regional mentorship	
Commodities procurement (ARV/OI) **Lab commodity procurement** **Nutrition commodity procurement** **TB Commodities /Equipment** **Lab networking**	• Laboratory networking for Viral load,CD4 and EID. • Equipment placement and Sustained-VL, CD4, Biosafety Cabinet (BSC) • TA counties on PT, EQA, IQA, • TA to Division of Infection control	• INH, pyridoxine, Fluconazole, Amphotericin B, • RTKs, Blood safety supplies	• Routine chemistry, hematology • Supplemental feeding for mild malnutrition
Laboratory Equipment **Lab quality systems** **Infection control and Medical Waste Management**	• TA to NBTS on blood safety activities; development of national policies and guidelines, QMS for accreditation	• Conduct smear/culture • Procurement of ancillary equipment e.g. centrifuges • Laboratory accreditation	
Blood safety	• 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	• Screening of blood for HIV, HBV, HCV and Syphilis

Quality improvements	• Impact Assessments and program to measure impact of interventions e.g. ART outcome measurements including retention, viral load suppression;	and linkage
Communication		• Blood service information systems
Evaluations and Research		• Targeted communication on treatment adherence and retention. • Demand creation for critical HIV services in saturation counties • Surveillance on drug adherence and pharmacovigilance • Evaluations on new lab technologies on HIV e.g., Point of care EID, Viral load

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
Cervical Cancer assessment and treatment for HIV+ and -women	Phasing Out	$0	$0	2	2015	This activity is not supported for the HIV-negative women by PEPFAR; however GoK may continue supporting it as part of reproductive health services.
Other components of Community strategy e.g. stipend,	Transition to government	$0	$0	1	2015	Government is implementing the community strategy. County government will support this activity
Community Units support	Transition to other organizations	$0	$0	1	2015	Activity supported by UNICEF, Feed the Children
Supplementary feeding for mild malnourished clients						
Hepatitis B screening	Phasing out	$0	$0	0	2015	GoK may continue supporting it as part of reproductive health services.
Procurement of blood bags,	Transition to government	$850,000	$400,000	1	2017	Activity is partially supported by

testing reagents and kits and other consumables				Global Fund and Government. PEPFAR will transition this to Government in next two years.
Totals	**$850,000**	**$400,000**	5	

APPENDIX B: Budget Profile and Resource Projection

Appendix B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$763,200	$489,236,800	$490,000,000

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	$27,422,907
HVAB	Abstinence/Be Faithful Prevention	$2,000,001
HVOP	Other Sexual Prevention	$17,048,980
HMBL	Blood Safety	$2,500,000
HMIN	Injection Safety	$1,500,000
IDUP	Injection and Non-Injecting Drug Use	$2,439,040
CIRC	Male Circumcision	$13,535,000
HVCT	Counseling and Testing	$30,623,966
HBHC	Adult Care and Support	$44,999,999
HTXS	Adult Treatment	$112,584,971
PDCS	Pediatric Care and Support	$7,799,999
PDTX	Pediatric Treatment	$14,999,999
HVTB	TB/HIV Care	$14,999,999
HTXD	ARV Drugs	$90,000,000
HKID	Orphans and Vulnerable Children	$31,021,068
HLAB	Lab	$14,425,000
HVSI	Strategic Information	$24,100,000
OHSS	Health Systems Strengthening	$8,000,000
HVMS	Management and Operations	$29,999,069

Appendix B2: Resource Projections

Various inputs and methods were used to calculate required resources for implementation of COP 15. Unit costs were estimated based upon the three pivot levels for prioritization and to sustain epidemic control. Various inputs and methods were used to calculate required resources for implementation of COP 15. Unit costs were estimated based upon the three pivot levels for prioritization and to sustain epidemic control. These levels are: eight scale-up to saturation counties being supported to reach saturation by FY17, 12 aggressive scale-up counties being supported towards saturation by FY18 and 27 sustained counties. However, within these three categories different cost adjustments were made based on need.

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	$6.0	$200	$175
Aggressive scale-up counties	$4.78	$170	$167
Sustained counties	$4.2	$130	$125
Hard to reach			$150
Pre-ART patient			$95

Clinical services costs were derived from 2014 Expenditure Analysis data, which cited $283.75 average cost per patient on ART. From the total Clinical Services budget of ~$285 million, $13,275,035 was deducted for central non-direct clinical support and $121,168,544 for central clinical support. With the remaining balance of $150,541,393 for service delivery, the average unit cost came to $140.53 (without drugs).

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

- Geographic focus - identified scale-up to saturation, aggressive scale-up, sustained and centrally supported counties. Savings from sustained counties were re-invested into the scale-up counties to address increased patient volume and associated costs including psychosocial support, heath care workers, capacity building, technical assistance, anticipated minor renovations and HRH.

- Use of baseline UE from costing study to develop unit costs for the scale-up and sustained counties.
- Continuation of quality services through the minimum package of services
- Factors for geographically hard-to-reach counties:
    - Turkana, West Pokot, Samburu, Mandera, Garissa, Lamu, Marsabit, Tana River and Wajir

A breakdown of the clinical unit cost per patient is below.

Partner breakdown	ART patient		
	Scale-up to Saturation	Aggressive Scale-up	Sustained
Unit cost	175	167	125
TB/HIV	10	10	10
Lab support	10	10	10
Psychosocial/retention support	25	25	20
Capacity building of HCWs	15	14	10
Monitoring and Evaluation	10	10	10
Technical assistance	50	50	40
Renovations	25	20	0
HRH	30	28	25

2. Prevention

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

Key and Priority Populations	Unit Expenditure
FSW	$34
MSM	$139
Fisherfolk	$40
Prisoners	$7
Military	$7

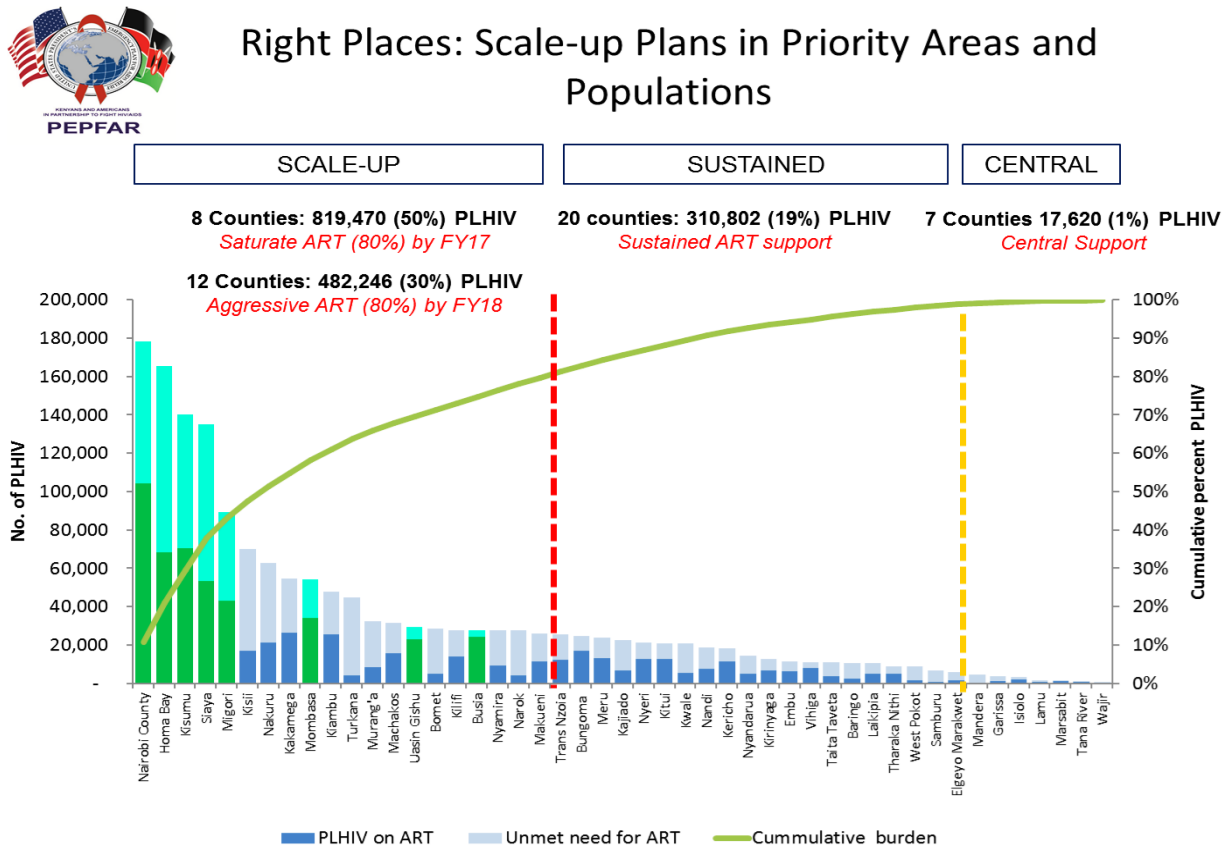
- A similar package of services to key and priority populations will be offered in scale-up counties.
- Young people aged 10-14 and 15 - 24 will be offered a comprehensive package of services aligned with DREAMS interventions. The comprehensive package UE for HVAB is $233 and AGYW is $264.
- HIV Testing and Counseling (HTC) UE is $3.
- VMMC is UE is $64.

Type of HTC	Unit Expenditure
Facility	$3
Community/Outreach	$5
RTK: $1.01	

3. Orphans and Vulnerable Children

OVC cost is estimated at $40 per child and is applied to both children in the adjusted scale-up and sustained counties.

APPENDIX C: Kenya county HIV burden and ART coverage



DRAFT: Sustainability Analysis for Epidemic Control: Kenya *[REDACTED]*

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Kenya COP15 Targets by County: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Baringo	31,394	851	3,038	593	2,731
Bomet	292,506	5,241	12,059	5,816	12,619
Bungoma	80,020	3,765	23,719	1,279	20,714
Busia	86,371	2,725	32,468	3,556	28,738
Elgeyo Marakwet	26,629	637	2,084	475	1,918
Embu	44,154	1,438	8,279	1,398	7,452
Garissa	30,312	282	1,439	275	1,387
Homa Bay	1,016,293	38,577	114,703	36,222	102,073
Isiolo	8,514	479	2,646	511	2,389
Kajiado	64,342	2,337	8,702	1,746	7,832
Kakamega	100,136	5,657	34,159	6,528	32,472
Kericho	115,026	3,117	17,038	892	14,259
Kiambu	77,051	3,004	33,262	4,371	29,954
Kilifi	32,901	1,145	15,172	2,338	15,273
Kirinyaga	49,019	1,124	9,020	1,431	8,137
Kisii	592,853	10,775	30,008	11,277	27,025
Kisumu	454,849	22,615	100,458	22,612	89,398
Kitui	83,162	2,456	16,665	2,944	14,999
Kwale	23,620	1,166	4,767	3,980	7,012
Laikipia	25,757	652	4,153	729	3,705
Lamu	1,402	217	1,045	288	1,013
Machakos	77,929	3,217	21,316	3,526	19,168
Makueni	147,044	3,583	16,718	3,681	15,048
Mandera	17,630	42	266	50	239
Marsabit	25,765	175	1,838	497	1,791
Meru	89,188	2,663	14,942	2,539	13,570
Migori	359,191	16,324	63,834	16,283	58,189
Mombasa	39,402	2,583	34,607	4,893	39,670
Murang'a	298,095	6,077	15,868	6,252	14,516
Nairobi County	381,260	15,378	135,727	20,127	123,877
Nakuru	192,094	7,812	32,931	8,830	29,703
Nandi	54,411	1,959	9,865	1,711	9,137
Narok	321,045	4,455	10,128	5,332	9,314
Nyamira	277,536	4,061	15,071	3,670	12,439
Nyandarua	43,459	1,523	9,783	1,582	8,528
Nyeri	52,371	1,415	16,235	2,369	14,740
Samburu	12,303	280	1,023	204	920
Siaya	695,825	32,619	90,694	30,770	82,020
Taita Taveta	13,949	641	4,760	877	6,458
Tana River	8,119	132	905	195	814
Tharaka Nithi	30,202	1,066	8,830	1,427	7,987
Trans Nzoia	26,633	1,867	16,309	650	14,518
Turkana	260,459	3,156	8,772	4,003	7,705
Uasin Gishu	82,256	3,851	29,952	5,956	27,955
Vihiga	39,442	2,715	13,352	2,526	11,703
Wajir	8,009	40	288	45	259
West Pokot	40,994	543	1,855	405	1,883
Other_ Kenya	18,611	231	3,487	670	5,500
Total	**6,849,533**	**226,668**	**1,054,240**	**238,331**	**968,751**

Kenya COP15 Targets by County: Clinical Cascade

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Baringo	-	-	6,956
Bomet	639	3,322	1,896
Bungoma	1,294	3,374	23,330
Busia	733	5,909	22,868
Elgeyo Marakwet	-	-	3,166
Embu	3,956	851	14,216
Garissa	-	-	30
Homa Bay	83,525	2,500	62,832
Isiolo	1,631	-	6,960
Kajiado	3,303	11	15,710
Kakamega	8,746	6,212	32,148
Kericho	6,928	2,998	16,563
Kiambu	800	11,779	21,261
Kilifi	1,145	7,028	38,766
Kirinyaga	990	-	1,836
Kisii	2,154	5,848	16,110
Kisumu	51,364	10,341	60,622
Kitui	2,650	221	15,132
Kwale	-	-	4,262
Laikipia	-	-	8,910
Lamu	-	-	7,381
Machakos	3,097	6,418	11,915
Makueni	1,500	2,738	10,554
Mandera	-	-	2,517
Marsabit	-	-	6,636
Meru	5,874	-	16,606
Migori	12,609	3,834	30,370
Mombasa	8,948	24,396	17,008
Murang'a	1,041	1,658	3,301
Nairobi County	75,085	31,662	116,513
Nakuru	27,608	12,705	29,216
Nandi	663	-	6,370
Narok	673	2,940	12,467
Nyamira	-	1,242	3,306
Nyandarua	-	-	5,968
Nyeri	8,598	287	18,484
Samburu	500	-	6,138
Siaya	73,099	3,328	52,086
Taita Taveta	3,813	155	9,049
Tana River	-	40	3,069
Tharaka Nithi	-	-	13,482
Trans Nzoia	3,157	-	3,385
Turkana	603	1,929	3,821
Uasin Gishu	4,464	3,894	12,503
Vihiga	-	315	10,053
Wajir	-	-	3,723
West Pokot	-	-	2,228
Other_ Kenya	39,000	-	276
Total	**440,190**	**157,935**	**791,999**

Kenya COP15 Targets by County: Clinical Cascade

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Baringo	21,363	274
Bomet	37,687	546
Bungoma	64,178	1,265
Busia	30,416	1,719
Elgeyo Marakwet	15,425	281
Embu	14,671	413
Garissa	9,864	64
Homa Bay	38,639	9,313
Isiolo	7,645	206
Kajiado	37,721	893
Kakamega	100,632	2,675
Kericho	42,617	1,197
Kiambu	52,567	2,201
Kilifi	37,442	1,718
Kirinyaga	14,386	321
Kisii	43,332	1,824
Kisumu	39,274	7,925
Kitui	38,229	864
Kwale	26,552	1,226
Laikipia	13,261	292
Lamu	4,067	171
Machakos	41,390	1,150
Makueni	33,301	910
Mandera	13,359	14
Marsabit	10,551	55
Meru	39,548	911
Migori	38,095	4,993
Mombasa	71,108	2,331
Murang'a	23,319	630
Nairobi County	172,558	10,146
Nakuru	66,052	2,840
Nandi	25,176	487
Narok	49,529	1,234
Nyamira	38,575	1,100
Nyandarua	17,986	435
Nyeri	18,329	472
Samburu	9,321	68
Siaya	34,599	7,553
Taita Taveta	25,705	468
Tana River	9,734	137
Tharaka Nithi	14,531	331
Trans Nzoia	34,789	919
Turkana	34,780	859
Uasin Gishu	56,388	1,556
Vihiga	18,150	716
Wajir	12,081	9
West Pokot	22,060	151
Other_ Kenya	3,355	130
Total	**1,624,337**	**75,993**

Kenya COP15 Targets by County: Clinical Cascade

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Baringo	383	101
Bomet	589	154
Bungoma	1,838	721
Busia	2,333	858
Elgeyo Marakwet	253	73
Embu	977	244
Garissa	1,198	42
Homa Bay	3,954	2,445
Isiolo	313	78
Kajiado	824	263
Kakamega	2,703	984
Kericho	1,780	530
Kiambu	2,807	1,025
Kilifi	1,747	542
Kirinyaga	684	268
Kisii	1,674	634
Kisumu	3,782	2,148
Kitui	1,690	473
Kwale	929	440
Laikipia	326	122
Lamu	145	50
Machakos	1,986	595
Makueni	1,493	449
Mandera	368	49
Marsabit	613	55
Meru	2,198	433
Migori	2,800	1,252
Mombasa	3,802	1,211
Murang'a	1,302	409
Nairobi County	11,428	4,306
Nakuru	2,249	872
Nandi	936	323
Narok	528	176
Nyamira	883	354
Nyandarua	792	281
Nyeri	1,638	498
Samburu	114	32
Siaya	3,018	2,053
Taita Taveta	598	190
Tana River	275	30
Tharaka Nithi	1,206	267
Trans Nzoia	1,489	544
Turkana	691	177
Uasin Gishu	2,298	954
Vihiga	632	295
Wajir	283	8
West Pokot	486	63
Other_ Kenya	163	17
Total	**75,198**	**28,088**

Kenya COP15 Targets by County: Clinical Cascade

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
Baringo	-
Bomet	-
Bungoma	-
Busia	9,582
Elgeyo Marakwet	-
Embu	-
Garissa	-
Homa Bay	43,596
Isiolo	-
Kajiado	-
Kakamega	-
Kericho	7,724
Kiambu	-
Kilifi	-
Kirinyaga	-
Kisii	-
Kisumu	45,282
Kitui	-
Kwale	-
Laikipia	-
Lamu	-
Machakos	-
Makueni	-
Mandera	-
Marsabit	-
Meru	-
Migori	20,075
Mombasa	-
Murang'a	-
Nairobi County	9,679
Nakuru	3,250
Nandi	8,182
Narok	-
Nyamira	-
Nyandarua	-
Nyeri	-
Samburu	-
Siaya	33,146
Taita Taveta	-
Tana River	-
Tharaka Nithi	-
Trans Nzoia	-
Turkana	9,863
Uasin Gishu	-
Vihiga	-
Wajir	-
West Pokot	4,537
Other_ Kenya	500
Total	**195,416**