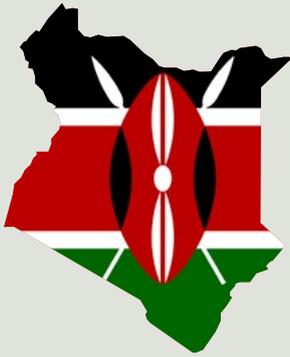


# PEOPLE'S COP21 KENYA

**COMMUNITY PRIORITY RECOMMENDATIONS**

**FOR PEPFAR KENYA IN COP21**





# INTRODUCTION

In 2021 — the third year of the People’s COP in Kenya — major strides have been taken to reach the UNAIDS 90-90-90 targets and the country remains with only 136,593 people living with HIV to find and start on treatment. However major challenges continue in linking those newly diagnosed onto treatment and retaining them in care — as evidenced by the loss of 19,000 people who tested positive and did not start treatment and 68,833 people who stopped treatment during the year.

Activists, people living with HIV, key populations, and other interested stakeholders note PEPFAR’s contribution in closing in on the 90-90-90 targets by the end of 2020, despite not meeting them. In 2020, PEPFAR Kenya increased the number of people living with HIV identified by 141,446 and initiated treatment for 122,017 (FY2020), even though viral load suppression did not meet the 90% target and only reached 82% by the last quarter<sup>1</sup>.

Today, there are an estimated 1.3 million people living with HIV in Kenya (a prevalence of 4.9 %<sup>2</sup>) — 1.1 million of those people are taking lifesaving HIV treatment. According to PEPFAR data, 90% of people living with HIV leaving are on treatment and only an estimated 136,593 people are yet to be found and offered treatment<sup>3</sup>. Mortality amongst people living with HIV remains at 25,000 people each year — and there was a reduction in HIV incidence — currently 36,000 adults each year.<sup>4</sup>

Whilst 136,593 might seem like a small number, the successes for COP21 will only be achieved if the programme goes beyond “normal” service delivery to innovative case finding. The data currently shows that the programme continues to struggle with retention and will need to work harder to ensure people living with HIV remain on treatment and become virally suppressed, supporting the long term health of PLHIV and slowing new infections. More investment in more community-led responses will be needed to find and keep people on treatment.

COVID-19 affected access to services, especially amongst women, children and adolescents. Barriers caused by the curfew hindered pregnant women from accessing the facility between 10 pm and 4 am and lead mothers to consider home births<sup>5</sup>. Violence faced by key populations, especially

amongst sex workers, men who have sex with men, and people who use drugs, drastically increased with a large number of community members reporting violence from police and inability to access health facilities and medication.

2020, also saw the PEPFAR programme backtrack on significant agreements made during the COP20 process. A key area of concern was on the index testing programme, where PEPFAR Kenya had agreed to remove targets that, as evidenced by communities of people living with HIV and civil society, served to increase violence and reduce healthcare worker capacity to honour patient requests to refuse the index testing option in cases where they were at risk of violence. By Q4, the implementation of index testing had contributed to 38% of the PLHIV identified by the programme, yet PEPFAR did not share any data on refusal rates from recipients of care despite multiple requests by civil society. Further PEPFAR had not shared any evaluation with civil society to assess the quality and safety of index testing services.

COP20 also saw a dismal response to civil society requests for PEPFAR to support point of care early infant diagnosis (POC EID) machines for children, who have been consistently failing to get their HIV test results on time. The programme only committed to supporting 6 out of 67 machines needed, none of which were set up or operating in the facilities we visited during community-led monitoring. Whilst there was a proposal by the Kenyan government to support 30 machines through the Global Fund grant, these additional machines were not costed for support for the next 3 years, leaving children behind, unable to access optimal HIV testing services.

1. POART data Q4

2. KENPHIA 2018 Preliminary Report

3. POART data Q4

4. KENPHIA 2018 Preliminary Report UNAIDS

5. Pregnant women at risk of death in Kenya’s COVID-19 curfew



The year also saw an increase in the PEPFAR funding allocation to the key population programme. However, following PEPFAR's decision to transition harm reduction programmes to the Global Fund, high performing key population organisations now face closure due to a lack of funding. This decision came despite PEPFAR's annual budget for key population programming being thrice that of the Global Fund's three-year budget, evidence of the Global Fund struggling to support the harm reduction programme alone, and also the PEPFAR supported organisation facing closure now performing well in finding new key populations living with HIV.

According to the planning letter in COP21, PEPFAR Kenya will be receiving a funding cut of US \$14,134,003. The programme needs more support, not less, to find the remaining PLHIV to get on treatment and to support long-term retention and viral suppression.

As the COP planning meeting moves to a virtual space, we emphasise the need to ensure meaningful engagement with civil society and the space to contribute to the process and deliberate on the presentations. Sharing presentations with civil society ahead of the meeting, creating a method of continuous check in throughout planning meetings, creating space for side conversations on pending areas of discussion, and finally sharing in good time the draft SDS for review by civil society (as in the previous years) outlining all the agreements, will all be key to ensuring that communities remain connected and meaningfully contribute to the process.

In support of Kenya's goal to reach the new 95-95-95 targets, we offer this "People's COP21" — outlining Kenya's

community recommendations and priorities for COP21. These recommendations were developed by people living with HIV and health activists through analysis of FY19 and FY20 data, focus group discussions with people living with HIV (*Kwale: Teens Watch Kwale, Tiwi Health Centre, Mombasa: COSWA, Nairobi: WOFAK, Kisumu: Muhoroni PLHIVs, Mbita sub-county PLHIVs*), as well as community-led monitoring in December 2020 and January 2021 to six PEPFAR-supported facilities in five high and medium burden counties: 1) Kisumu (Muhoroni Sub District Hospital, 2) Homabay (Mbita Sub County Hospital, IRDO Mbita), 3) Nairobi (Mbagathi District Hospital, Nairobi Outreach Services Trust, (NOSET), SWOP Kenya, Health Options for Young Men on HIV/AIDS/STI (HOYMAS) 4) Mombasa (Coast General Hospital, PLHIV focus groups, Mtongwe Military site, Coast Sex Workers Alliance (COSWA) 5) Kwale (Teens Watch, Tiwi PLHIV focus group), and a virtual survey with ISHTAR MSM on the effects of COVID-19 on key populations.

This mission aimed to assess the state and quality of HIV and TB service provision at the facility level, through a series of questions targeting health providers and service users. Community-led monitoring also assessed the implementation of COP19 following the cuts to the Kenya programme budgets. The results of this data collection are described below and provide not only evidence of the reality of what's happening on the ground, but also justification for our community recommendations. The People's COP21 has been further shaped following consultation with PLHIV, key populations, community-based organisations (CBOs), Non-Governmental Organisations (NGOs), and Faith-Based organisations (FBOs)—all stakeholders with collective experience at the forefront of Kenya's HIV and TB response.

# PRIORITY INTERVENTIONS FOR COP21

## 1. Funding

In last year's People's COP20<sup>6</sup>, we recommended increasing resources for the PEPFAR programme to ensure continuity of quality service delivery. Whilst programme funding was not increased to the levels recommended by civil society, there was agreement that the programme needed additional resources. This led to an increase of US\$ 4,134,003 above what was outlined in the planning level letter, shared at the beginning of the year. This year, the Kenya programme is facing a cut of US\$ 14,134,003 million, even after a review last year underlined a need for more resources and led to increased investment. Furthermore, the barriers to accessibility of quality HIV and TB services created

by the COVID-19 pandemic will require even more resource support, rather than less, to ensure that people living with HIV and key populations are supported in accessing HIV prevention or to support long term retention and viral suppression. The Global Fund has committed increased investment to mitigate the challenges of COVID-19, however, this does not fill the gap and PEPFAR needs to provide additional support.

**COP21 Target:** *Funding cuts are reversed and funding is increased by US\$10 million to ensure the maintenance of current successes in the HIV and TB response and improve the overall quality of HIV and TB service delivery.*

## 2. HIV Testing

### 2.1 HIV Test Kits

Even as the programme moves to target individuals most likely to be HIV positive for HIV testing services, additional support for testing remains critical in order to reach hard-to-reach populations and those getting newly infected. The number of PLHIV PEPFAR needs to find will require support even with reducing yields. The programme needs to maintain support for HIV testing from COP20 to ensure that gains made in reaching the first 95 targets are not reversed.

**COP21 Target:** *Maintenance of test kit support at COP20 levels to ensure continued access to HIV testing.*

### 2.2 Index Testing

Last year's People's COP20 expressed concern that the high targets set for the index testing programme, along with expectations of high positivity rates resulting from index testing, would violate human rights, PLHIV confidentiality and put people at risk of violence. Civil society also raised concerns that index testing programmes do not have adequate measures in place to prevent and monitor adverse effects associated, including intimate partner violence (IPV).

**In response, PEPFAR committed in the SDS7 to:**

- + "PEPFAR messaging to implementing partners will be devoid of a targeted % expectation from index testing. PEPFAR Kenya will communicate to all IPs that there is no longer a specific target for index testing. IPs will immediately communicate to and remove any index testing-related targets that may have been in place at

*supported sites/facilities. IPs will immediately re-orient staff that index testing is voluntary and that clients can decline the service for any or no reason. IP work plans will not include targets for index testing."* - pg. 39

- + "PEPFAR IPs will collect and report routine data on the following index testing indicators:1) # offered index testing" - pg. 40
- + "PEPFAR Kenya will support a certification process that moves quickly, in which any facility that does not meet minimum requirements will be temporarily halted from conducting index testing until these requirements are met." - pg. 41
- + "COP20 will support violence screening and identification before and after index testing services to avoid unintended violence for these index clients." - pg. 61
- + "Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established" - pg. 101
- + "All certified sites conducting HIV index testing will be supported by COP20 to conduct a mandatory inquiry for IPV on all clients offered [assisted partner notification services] aPNS. Providers will be expected to duly complete aPNS registers indicating that enquiry into IPV has been done." - pg. 67
- + Case identification will be done mainly through offering index testing at qualifying facilities" - pg.36
- + "Efficient and effective case identification strategies in COP20 will include implementation of index testing at scale with fidelity. Safety elements will be addressed and will involve intimate partner violence screening, adverse event monitoring, and reporting. Facilities and providers will be certified to conduct index testing." - pg. 39

6. <https://healthgap.org/wp-content/uploads/2020/02/Peoples-COP20-Kenya.pdf>

7. PEPFAR Kenya SDS



However, following this, PEPFAR did not actually implement any of these agreements, citing COVID-19 as a barrier to upholding people’s rights. People living with HIV continued to be subjected to index testing despite reports of violence and healthcare workers continued to complain of being unable to effectively uphold the rights of people living with HIV due to high targets. Civil society waited to be involved in the process, as promised, of site certification and assessment, however, this never came due to multiple hurdles at government and PEPFAR levels.

COVID-19 must not be a reason to flaunt the rights of people living with HIV. The programme must stop putting numbers ahead of quality service provision. PEPFAR quarter 4 data points to this drop in quality, as highlighted by the program only reaching 53,184 of the TX\_NET NEW target.

Community-led monitoring revealed that health facilities still struggled with responding to violence faced by PLHIV after index testing. All 8 facilities we monitored reported engaging in index testing and of these, all Facility Managers say that they always screen clients for intimate partner violence (IPV) as part of their index testing protocol. However, 3 of the Facility Managers who do screen for IPV still contact all the partners of clients regardless of reported violence, and 1 did not know. This is a major concern and violation of people’s safety and privacy. Only 4 said that they either don’t trace any contacts or don’t trace the contacts for which there was reported violence for HIV testing.

Worse, community-led monitoring also showed that amongst 59 PLHIV interviewed, 45 said that a healthcare worker had asked them for the names and contact information of their sexual partners so that they may be

able to test them for HIV respectively. Of these, 22 reported that they did not think they were allowed to “say no” or refuse to give the names of their sexual partners.

One Facility Manager told us ***“we refer people who have faced GBV and they still just face violence and they go away and then they come back, what do we do when we need the numbers?”***—suggesting that providing rights-based care is secondary to attaining the targets set by PEPFAR.

We stated in last year’s People’s COP that ***all index testing programmes should be immediately paused*** whilst risk mitigation and mediation efforts are put in place. Civil society rejects any PEPFAR guidance that the right of people living with HIV is secondary to attaining targets. Whilst index testing has the ability to help identify individuals who may have been exposed to HIV earlier, thereby protecting their health and interrupting onward transmission of HIV, if implemented in ways that cause harm to individuals, undermine their rights to consent, privacy, safety and confidentiality, it erodes communities’ trust of healthcare providers.

***COP21 Target: All COP20 agreements are implemented for the remainder of COP20 and in COP21 that ensure a rights-based approach to index testing that does not subject PLHIV to risk of violence.***

***COP21 Target: All COP20 agreements are implemented for the remainder of COP20 and in COP21 that ensure a rights-based approach to index testing that does not subject PLHIV to risk of violence. Refer to the table in the index testing section in the document.***

DELIVERABLES	PEPFAR ACTION ITEM
<p>PEPFAR messaging to implementing partners will be devoid of a targeted % expectation from index testing.</p> <p>Index testing services will be offered to all eligible clients at facilities that meet the certification requirement.</p> <p>PEPFAR IPs will collect and report routine data on the following index testing indicators:</p> <ol style="list-style-type: none"> <li>1. # offered index testing</li> <li>2. # who accepted index testing after counselling</li> </ol>	<ul style="list-style-type: none"> <li>• PEPFAR Kenya will communicate to all IPs that there is no longer a specific target for index testing.</li> <li>• IPs will immediately communicate to and remove any index testing-related targets that may have been in place at supported sites/facilities.</li> <li>• IPs will immediately re-orient staff that index testing is voluntary and that clients can decline the service for any or no reason.</li> <li>• IP work plans will not include targets for index testing.</li> <li>• Although not reported in DATIM, facility index testing tools will be used to collect # of clients offered and accepted or declined index testing services. These data will be presented at quarterly review meetings with stakeholders</li> <li>• PEPFAR will work with IPs to ensure proper documentation in the index testing registers in order to enable the collection of acceptance and refusal rates per facility and IP.</li> </ul>
<p>PEPFAR IPs will monitor acceptance rates and offer technical assistance/ QI where acceptance rates are higher than best practices suggest ensuring consent is meaningful.</p>	<ul style="list-style-type: none"> <li>• IPs will report on a monthly basis on the following indicators:</li> <li>• Total # of newly-diagnosed and virally- unsuppressed individuals offered index testing</li> <li>• Total # accepted and number of contacts solicited</li> <li>• IPs will monitor acceptance rates versus safety concerns by facility and flag any site with safety concerns for immediate remedial action/steps.</li> <li>• PEPFAR Kenya will follow-up with IPs on any additional mentorship and supervision with regards to the message that index testing is voluntary and also ensure that the 5 Cs outlined in the HTS policy guideline are observed at all times.</li> </ul>
<p>PEPFAR Kenya will carry out investment in proactive monitoring for adverse events and quality.</p>	<ul style="list-style-type: none"> <li>• PEPFAR IPs will use the REDCap Index Testing Minimum Program Components Tool to assess supported sites on index testing program gaps and training needs. This will not be considered as a certification tool, as it will only be used to assess the quality of services. Data from the assessments will be shared with the Ministry of Health and other stakeholders. Ministry of Health and other stakeholders may/will participate in the assessment process as part of the stakeholder/community monitoring processes.</li> <li>• PEPFAR Kenya in collaboration with the Ministry of Health and other stakeholders will develop a multi-pronged, routine, continuous site monitoring plan covering: <ul style="list-style-type: none"> <li>» IPs role in site monitoring/QA including mentorship and supervision</li> <li>» How to leverage/refine existing SIMS index testing monitoring questions to ensure they respond to safety monitoring aspects within index testing modalities/strategies</li> <li>» County government and CHMTs' roles in quarterly monitoring of index testing programs</li> <li>» How the community-led monitoring plan will be included in the quality monitoring plan/process for index testing programs.</li> <li>» The schedule for routine monitoring by all multi-sectoral stakeholders.</li> </ul> </li> </ul>
<p>PEPFAR Kenya will support a certification process that moves quickly, in which any facility that does not meet minimum requirements will be temporarily halted from conducting index testing until these requirements are met.</p> <p><i>Note: Facilities that implement index testing are expected to meet certification criteria; however, it is noted that not every PEPFAR-supported facility will implement index testing.</i></p>	<ul style="list-style-type: none"> <li>• Participants during the certification process will include GOK, county governments, CSOs, Kenya Human Rights Watch, and other stakeholders</li> <li>• Certification goals will entail the following: <ul style="list-style-type: none"> <li>» An index testing services' certification tool for the facilities/sites adapted by counties and stakeholders from the PEPFAR draft certification document</li> <li>» Index testing certification for counsellors, including a minimum of at least 1-year experience, aligned to GOK counsellor certifications, and based on a stakeholder-adapted PEPFAR draft certification document</li> <li>» Index testing certification for index testing supervision and mentorship</li> </ul> </li> </ul>
<p>PEPFAR Kenya will share data on index testing cascades with GOK and other stakeholders as part of the monitoring system for all facilities moving forward.</p>	<ul style="list-style-type: none"> <li>• PEPFAR Kenya will report aggregated index testing services data starting with high volume facilities (e.g. those identifying &gt;20 HIV positive per month)</li> <li>• Monthly reporting for each facility includes: <ul style="list-style-type: none"> <li>» Aggregated # of clients aged &gt;15 years offered index testing services (aggregated both newly diagnosed, and clients virally suppressed)</li> <li>» Aggregated # of clients aged &gt;15 years accepting index testing services (aggregated both newly diagnosed, and clients virally suppressed)</li> <li>» Of those clients aged &gt;15 years accepting index testing services, number of contacts listed by ages &lt;15 years and &gt;15 years.</li> </ul> </li> <li>• If a facility reports &lt;20 clients offered index testing services in that month, a blank facility report with the note "low numbers reported" will be submitted</li> <li>• PEPFAR will itself continue to assess sites with low volumes of clients offered index testing services (&lt;20 clients per month). This will enable a phased approach by stakeholders by strategically focusing on facilities that report significant findings.</li> <li>• Quarterly reporting for each facility will entail the following variables aggregated for clients aged &gt;15 years across the entire index testing cascade <ul style="list-style-type: none"> <li>» # of clients offered index testing services</li> <li>» # of clients who accepted index testing services</li> <li>» Of those accepted, # of contacts elicited by age disaggregation of ages &lt;15 years and &gt;15 years</li> <li>» Of the contacts elicited by the above age groups, # contacted, # known positive, # eligible for testing, # newly-diagnosed HIV positive, # HIV negative, and # HIV positives linked to care.</li> </ul> </li> </ul>

## 3. COVID-19

### 3.1 COVID-19 preventive measures at the health facility

COVID-19 has shifted how services are provided at health facilities. New restrictions have changed the time health facilities are open, introduced regulations to ensure people are still able to be protected from COVID-19 infection as they access services, and introduced social distancing measures, amongst others. Community monitoring efforts unearthed a series of challenges caused by the new COVID-19 restrictions.

Firstly, people are not allowed into health facilities without masks which we agree is an important measure to curb the spread of COVID-19. However, many people (including PLHIV, key populations, pregnant women, and those attempting to access HIV prevention) cannot afford to buy masks, meaning that they are restricted from accessing the health facilities, and cut off from service delivery—including collecting ART refills, TB treatment, or HIV prevention and testing, impacting the overall success of the HIV and TB response.

In a focus group with people who use drugs, participants explained how they had to share masks in order to still be able to access methadone at the facility because without it the facility denied access to patients coming to get any services.

Secondly, in terms of prevention measures at the facility level, monitoring at 7 facilities showed that there was a lack of hand sanitiser in 6 sites, no screening for COVID-19 in 4 sites, not enough PPE for healthcare workers in 4 sites, no water and soap in 2 facilities, healthcare workers not wearing masks in 4 sites, and no physical distancing outside the gates in 2 sites. Whilst new water dispensers and soap stands were available in most sites, often there was no water and soap in them.

**COP21 Target:** *Reusable masks procured and distributed to all PEPFAR supported sites to be provided to any healthcare user arriving at the facility to access services who does not have access to a mask in COP21 and the remainder of COP20.*

**COP21 Target:** *Water and soap are available through installed dispensers at all PEPFAR supported sites.*

### 3.2 Nutritional support

An increase in unemployment<sup>8</sup> and reduction in new employment opportunities have seen many people in Kenya descend into poverty since the COVID-19 pandemic began in the country. A survey carried out by Health GAP and ISHTAR MSM from June to November 2020 on the effects of COVID-19 on key populations showed that 57.3% of the respondents (472 out of 879) hailing from all over the country stated that their income had reduced since COVID-19 began.

Further, focus group discussions with PLHIV and sex workers revealed challenges people are facing accessing food during this time, leading to challenges in treatment adherence. Pregnant and breastfeeding mothers interviewed struggled with accessing food and as such had to give their children medication on an empty stomach. This can lead to various challenges of babies refusing the medicines altogether, babies

who take the medicines vomiting, or caregivers stopping trying to give the medicines because of the difficulties. As COVID-19 continues to affect the country, people living with HIV and key populations will continue to be hard hit by reducing economic opportunities and will need support to continue prioritising their health. As part of psychosocial support, PEPFAR needs to provide nutritional support through food parcels/vouchers to those most affected.

**COP21 Target:** *Food parcels/vouchers are provided as part of psychosocial support to PLHIV and key populations most vulnerable.*

### 3.3 Service disruptions

Support groups, health talks and community interventions were greatly affected by COVID-19 restrictions.

Firstly, support groups and health talks taking place at a facility level were discontinued in order to adhere to physical distancing measures. Whilst we agree it is important to maintain physical distancing to prevent the spread of COVID-19, instead of simply stopping these services, the PEPFAR programme should be thinking innovatively about how to maintain support groups as well as health talks that offer HIV and TB prevention and treatment literacy, so integral to support long term adherence and viral suppression. For instance, innovative thinking such as reducing the number of people in the support groups and financing additional smaller support group meetings would allow health facilities to maintain these much-needed convenings, whilst protecting support group members.

Secondly, community outreach for those who have disengaged from care was halted, leaving people living with HIV without support at the facility or at the community level. Thirdly, community healthcare workers and key populations-led organisations providing services at the grassroots have been unable to continue due to a number of rules and restrictions: rules prohibiting gatherings; strict curfew restrictions requiring travel passes for anyone working outside these hours (that were only offered to formal healthcare workers); and a lack of personal protective equipment (PPE), that has only been provided to healthcare workers considered as part of the “system”. This has drastically reduced the capacity of CHWs and KP-led organisations to offer critical HIV and TB services to hard to reach populations during this time.

**COP21 Target:** *All community service delivery agents (including CHWs, peer educators and health workers from KP-led organisations) receive passes to be able to continue providing community-level and outreach services past curfew hours.*

**COP21 Target:** *All community healthcare workers and community organisations receive personal protective equipment (PPE) in order to continue providing direct support to people living with HIV and key populations.*

**COP21 Target:** *Communication issued to all service delivery sites to revive support groups using innovative thinking that maintains safety to ensure that people living with HIV and key populations continue to be supported even during the COVID-19 pandemic.*

8. Kenya: Rising unemployment leads people to line for dirty jobs



## 4. ART Continuity

As stated in the introduction and supported by the Kenya planning letter, the Kenya PEPFAR programme continues to struggle with continuity in care amongst those diagnosed with HIV. Whilst the programmes overall retention improved from last year, it still lost a significant number of people living with HIV.

Community-led monitoring revealed some of the challenges that lead to people disengaging in care including:

- + Lack of access to transport or transport money to get to the facility;
- + Being shouted at or treated badly by healthcare workers for missing appointments;
- + Lack of or misinformation on HIV and TB prevention and treatment literacy to meet the needs of PLHIV and children.

### 4.1 6MMD

Introduction of multi-month dispensing (MMD) to those newly initiated can provide an opportunity for people to take charge of their health. According to Q4 data, the Kenya PEPFAR programme has achieved a 71% transition to 3MMD, which is commendable. However, we need more people to be transitioned to longer dispensing, especially now that COVID-19 restrictions might hinder people's access to facilities. The MMD transition should be done together with community support to ensure continuity of care.

To ensure a quality transition that ensures continuity of care, PEPFAR should strengthen and support the supply chain to ensure scale-up of MMD and decentralised drug distribution (DDD) to ensure extended ART refills for all populations (children over 2 years, adolescents, key populations) and support for people to access their refills outside of the health facility in differentiated service delivery models

MMD needs to be accompanied by treatment education and support at the community level to ensure that those with challenges including acceptance of their status, storage of medicines, disclosure, and continual and ongoing support with affirming messaging on the importance of keeping clinic appointments and adhering to medication.

An increasing proportion of women living with HIV who become pregnant are established on treatment and may be accessing their HIV care and treatment through a differentiated service delivery model. Women living with HIV who become pregnant and in a DSD model should have the choice to continue receiving their HIV care and support within the DSD model or to have their HIV care provided with their antenatal and postnatal care. Women living with HIV who become pregnant require more frequent clinical contact during pregnancy and the postpartum period. However, extending their ART refills will support uninterrupted treatment during pregnancy and post-partum. Therefore, ART refills should not be used as a tool to insist women return to the health facility.

It is important to reiterate that 6MMD should not be used **instead of** differentiated service delivery models (DSD), especially those offering critical peer and psychosocial support like Community ART Clubs. Rather 6MMD should be offered **within** any of the DSD models. It is simply one component.

**COP21 Target:** 50% transition of PLHIV to 6MMD.

**COP21 Target:** Strengthened and supported supply chain to ensure scale-up of MMD and decentralized drug distribution (DDD).

**COP21 Target:** Extended ART refills are made available for all populations (including children over 2 years, adolescents, key populations).

**COP21 Target:** 3000 lay providers are hired, trained and equipped to support group models of care.

**COP21 Target:** 50% of people on MMD supported in group models by lay counsellors in decentralized drug distribution (DDD) and community-based models.

**COP21 Target:** All women should be transitioned to multi-month dispensing irrespective of pregnancy status.

### 4.2 HIV + TB Prevention and Treatment Literacy

In an era of immediate treatment initiation and as PLHIV are provided with MMD from initiation, we need a far better approach to ensuring PLHIV starting care are well prepared for adherence from the start. By becoming as informed as possible, people are empowered to take control of their own health and sex lives. Treatment literacy improves linkage and retention rates as people understand the importance of starting and remaining on treatment effectively.

However, community-led monitoring showed gaps in knowledge amongst PLHIV about what an undetectable viral load test means. Only 24/59 of participants living with HIV reported that they know their viral load. Further, only 38/51 agreed with the statement; "having an undetectable viral load means the treatment is working well" and only 30/51 agreed with the statement "having an undetectable viral load means a person is not infectious." 51/59 of participants had gotten a VL test in the past year and of those, only 33 said that a healthcare provider had explained the results.

Community-led monitoring also showed gaps in the information given to PLHIV when transitioned to TLD. In focus groups, PLHIV told us that the clinicians told them that the main reason for moving to TLD was because TLE was no longer in stock. A large number of PLHIV also did not know what medication they were on when interviewed.

At a facility level, during the COVID-19 pandemic, HIV and TB prevention and treatment literacy took a back seat. PLHIV no longer have access to support groups or health talks that improve knowledge that is critical to ensure treatment adherence and to support long term retention and viral suppression.



**COP21 Target:** Health talks are offered at all PEPFAR supported facilities to ensure that PLHIV and other patients waiting for services are educated on key aspects of HIV and TB prevention and treatment literacy.

**COP21 Target:** 15 community organisations supported to provide HIV and TB prevention and treatment literacy for people living with HIV and key populations through material development and training.

### 4.3 Support Groups

*In COP20, PEPFAR Kenya commits to “work together with communities of PLHIV, young people, and KP to set up community level-support groups that allow PLHIV to be supported both at the facility level, as well as at community level. This will be a continuation of COP19’s commitment to work with communities to scale up retention.” (SDS pg. 53)*

As the programme struggles with retention of people living with HIV—as highlighted in only reaching 27% of the TX\_NET\_NEW for COP19 and previous years of limited success in retention—communities of people living with HIV who have networks on the ground reaching people at the community level have offered for the last four years to partner with the PEPFAR programme to aid in improving retention by reaching people at the community level.

In the last planning process, PEPFAR committed to meaningfully involve people living with HIV (MIPA) in implementation and working with communities of PLHIV, young people and key populations to set up support groups at the community level as a continuation of the COP19 commitment. No organisations of people living with HIV have since received any calls to provide this support.

Retention and viral suppression will rely on communities, especially now that people will be going to facilities less and less and more are transitioned to MMD and other differentiated service delivery models.

Furthermore, people living with HIV above the age of 50 face additional burdens and need care and support to stay on lifetime treatment. Multi-month dispensing and COVID-19 prevention measures, amongst others, are reducing the level of support people who have been on treatment for many years receive at the facility. As such, care should be considered at the community level through optional support groups.

**COP21 Target:** 25 PLHIV community organisations inclusive of AGYW organisations funded to revive support groups for community members in need of education and support in at least five high burden regions of the country.

### 4.4 Opening hours

6 out of 7 PEPFAR supported sites monitored through community-led monitoring were not open on Saturdays. This means people living with HIV must access services during the week, whether they work or not. The sites had no options for people unable to attend the clinic during the week, such as those working full-time. It also often negatively impacts pregnant and breastfeeding women who need to access services over the weekend, who are often linked to HIV services through antenatal services. PEPFAR needs to ensure that facilities have the staffing and other needs to extend facility opening hours from 5 am to 7 pm and open on Saturday’s.

**COP21 Target:** Opening hours at all PEPFAR supported facilities are from 5am to 7pm on weekdays and 8am to 4pm on weekends.

## 5. Dolutegravir (DTG)

One of the recommendations in the last People's COP was for PEPFAR to track the increase in weight as part of routine check-ups at the health facility as more people are started on or transition to DTG. At the time, information received seemed to indicate that DTG was causing weight gain amongst, predominantly, black women.

Since then, increasing data has been released that now presents a different picture—although there is still considerable debate. Now, it seems that in fact, PLHIV who metabolised efavirenz more slowly developed a build-up of the drug in their bodies, blunting weight gain. In addition, it seems that tenofovir disoproxil fumarate also blunts weight gain. As these PLHIV are moving to DTG now, the gain in weight would therefore be a return to their normal weight trajectory, a result of stopping EFV. Much more still needs to be understood about this evidence, however, one thing is clear, some PLHIV are putting on significant weight leading to clinical obesity and the risk of numerous non-communicable diseases (NCDs) associated with obesity.

In addition to challenges associated with NCDs, there could also be challenges with retention especially amongst

young women and adolescent girls might struggle with the increases in weight and could discontinue care as a result.

**COP21 Target:** PEPFAR institutes tracking of weight gain amongst PLHIV, especially as more people transition or start on DTG. Where problematic weight gain is identified, clinicians refer PLHIV to a dietician in order to properly support the individual with information on diet. Further, PLHIV are screened for other NCDs associated with obesity.

**COP21 Target:** In conjunction with meaningful inputs from PLHIV, people-friendly topics are developed regarding weight and nutrition to be rolled out in all PEPFAR supported support groups across the country.

## 6. Key Populations

PEPFAR Kenya's key population programme has had a steady increase in funding to ensure that 90/90/90 targets for all key populations—including men who have sex with men (MSM), transgender people, people who use drugs (PWUD), and sex workers—are achieved. Key populations, however, continue to be at high risk and often are restricted from accessing services due to stigma, discrimination and criminalisation. Key population testing has been high with collaborative efforts between PEPFAR and key population led organisations.

In the third year for the People's COP, advocates for the key population programme struggle to track key population services that are offered in the general facilities. All interviews of general facilities on the service provision to key populations result in referrals to key population-led sites and/or a response that they do not offer service to key populations. When civil society has asked PEPFAR about the level of key population resources allocated to general sites, we see worrying responses. The programme is unable to identify if these key population-specific resources actually provide services to key populations in these general sites.

Despite a push for increased investment in the harm reduction programme, PEPFAR has been in negotiation with the Global Fund and the Government of Kenya to transition the harm reduction programme despite the Global Fund only having a third of the resources that PEPFAR has for service delivery, leaving organisations without adequate resources to provide service. The latest Global Fund allocation shows that the KP programme, supported under the Red Cross, has higher targets but fewer resources compared to the previous grant.

COVID-19 curfews have led to increased violence faced by key populations and a reduction in income amongst community members. Sex workers and people who use drugs have increasingly been assaulted by police and arrested<sup>9</sup>.

### 6.1 Key Population Investment Fund (KPIF)

For the last 2 years, Kenya has benefited from funds from the Key Population Investment Fund (KPIF) that have enhanced the quality of services provided to key populations and supported a host of innovative community interventions and activities that would not ordinarily be funded by the traditional COP process. These interventions had great value in increasing the quality of services for key populations. KPIF supported activities spanned from capacity strengthening on financing and organisational strengthening, violence prevention and response, advocacy by community organisations and support to enhance human rights objectives (paralegal and legal support). Most of the recipients of the funds who were or had received both KPIF and COP resources appreciated the flexibility and innovativeness of the fund. Organisations that would not have been funded under the traditional PEPFAR process had their capacity strengthened through KPIF resources and were certified as organisations that would qualify to access PEPFAR funding. Key population led organisations had the chance to benefit from funding to address violence that proved timely during COVID-19 where the rates of violence faced by key populations soared. Organisations were also able to test more key populations across the constituencies and offer services.

Given that the funding under KPIF is soon coming to an end, PEPFAR needs to provide clear written guidance

9. Health GAP and ISHTAR MSM COVID Survey 2020

on the plans to incorporate KPIF activities into the COP. Activities funded under the KPIF must be absorbed into the COP to ensure continuity of the successes in the KPIF.

**COP21 Target:** *Absorb the KPIF funded activities into COP21.*

**COP21 Target:** *Absorb capacity built key population led organisations under KPIF into the COP to increase the success of key population programmes.*

**COP21 Target:** *5% of the \$5,700,000 earmarked for GBV response allocated to the key population programme to support violence deterrence and response.*

## 6.2 Key population funding levels targets

A large number of key population led organisations have suffered the fate of implementing KP programmes with a budget that is not commensurate with the increased targets. In the last couple of COP planning cycles, key population led organisations complained of the inadequate resources that were being provided to community organisations and recommended an increase in funding as well as targets. Whilst the funding increased on paper, the key population led organisations did not see an increase in funding that supported the numbers of people they were required to find and retain. KP sub-partners continued to struggle to provide quality services for community members. The resources that could have been channelled to improve services and accelerate reach and impact in the key population led service delivery points were channelled to the mainstream service delivery sites where key populations are unable to receive services from peers and are not able to be tracked.

Key populations led organisations also faced a lot of challenges accessing funding for service delivery in 2020. Contracts were delayed and organisations were forced to pay for the services offered before the signing of their contracts out of pocket. For some organisations, that amounted to months of services to community members by organisations that were not funded. USAID key population led organisations were (and currently still are) only receiving funds as refunds after spending their own resources, submitting the receipts to the IPs and the receipts being vetted and approved before they receive a refund. Most organisations do not have the resources to spend and await approval of allowable cost and refunds. The organisations have ended up streamlining the support to the community to only the things that were 100% sure will be refunded by the IPs stifling all innovation at a critical time when they needed to innovate because of COVID-19.

**COP21 Target:** *Provide a breakdown of the resources allocated to key population led organisations (by organisation) in the last 3 years and the number of targets allocated to those organisations and review funding allocations where necessary.*

**COP21 Target:** *Guidance sent to implementing partners on prioritisation and sub granting to key population led organisations.*

**COP21 Target:** *Review of processes of funding allocation and distribution by IPs to community-led organisations to ensure that the organisations are fully equipped to provide services.*

## 6.3 Resource allocation to KP organisations

Key populations led organisations have faced a year of change in how the PEPFAR programme provided resources for service delivery. Instead of periodic/full grant disbursements, KP-led sub-partners have been forced to sign short term grants that span between 3 to 6 months that are inefficient for organisational planning and service delivery. In order to ensure the provision of quality services, organisations need to be fully resourced. Provision of piecemeal funding creates missed opportunities, a lack of innovation and an unhealthy cycle of mistrust between implementing partners and sub-partners, resulting in poor outcomes as seen in the Q4 data<sup>10</sup>. Various reasons provided by the agencies included reviews of poorly performing sites for which support for poorly performing sites does not need to have a militant approach to be effective. PEPFAR key population team leads can organise more check-ins with these programs to provide increased support and share tips on successes from other programmes that are performing better.

Transition to new implementers which has also been a key barrier to continuous service delivery was also provided as a reason, however, shorter contracts with little to no information from the agencies on a transition plan of organisations and transition to new implementing partners only leads to poor planning and messy transitions.

**COP21 Target:** *Restore the previous funding mechanism that ensured that key population led organisations are fully funded to provide quality services to community members.*

**COP21 Target:** *Create a transition manual for future transition to ensure continued seamless service delivery.*

## 6.4 Key population service provision in general facilities

In recent years PEPFAR has begun investing key population programme resources into the general service delivery points, however, our monitoring of sites for that period revealed that only 1 general population site was offering any KP specific services. All other sites responded that key populations went to key population led sites to receive services and did not identify themselves in the general facilities as key populations.

For key populations to receive quality services, they need spaces that are safe enough to disclose that they are key populations without fear of poor attitude, discrimination and/or arrest. Sex workers in the Mombasa described the general facilities as places where sex workers were yelled at and reprimanded for being sex workers. The true efficiency of service provision for key populations in general facilities needs to be evaluated. Spending money on the provision of services in spaces where key populations are not getting the services they need requires a revision.

Some key population led organisations offering services to key populations have gone as far as to even purchase centrifuge machines to ensure that viral load samples can now be collected and stored at the DICs. The programme should be using those resources to expand these kinds of innovation, especially given that Q4 data is showing the only half of key populations receive a viral load test.

10. PEPFAR Kenya Q4 data slide 14-15

**COP21 Target:** *During SIMS, PEPFAR will review the number of KPs receiving services in all the PEPFAR general facilities in order to assess the success of KP funding being directed to general health facilities—and if found to be ineffective based on the number of KPs supported or response that “KP do not identify as KPs”, this funding should be redirected to KP specific sites.*

**COP21 Target:** *PEPFAR funds innovation by key population led organisations to ensure better continuity in care for KPs.*

**COP21 Target:** *Provide a list of sites where the programme had successfully integrated key population services to civil society.*

## 6.5 Transgender Programming in Kenya

In 2018 and 2019, NACC and NASCOP spearheaded the process of reviewing and evaluating the Kenya AIDS Strategic Framework (KASF). This process has resulted in the identification and reclassification of transgender communities as key populations, creating avenues to re-engage trans communities without the linkage to MSM communities. The programme is relatively new within the Kenyan HIV response and whilst partners are racing to gain a better understanding of the needs of the trans community, and how best to provide gender-affirming HIV and health services, transgender populations in Kenya have not been meaningfully engaged in service provision. Service delivery components for trans persons under PEPFAR have been led by mainstream partners who lack the basic understanding of transgender people and transgender issues. Implementing partners have been transphobic and dehumanising to the trans communities.

The ability of the programme to meet trans targets depends on how well and how much PEPFAR prioritises the engagement of transgender populations. PEPFAR should support trans communities to establish and implement three trans-led

centres of excellence in Nairobi, Mombasa and Kisumu Counties. The centres of excellence would allow trans persons to model the delivery of gender-affirming services that can be replicated in Government and private facilities in various parts of the country, and the larger sub-Saharan region.

It is vital that PEPFAR supports the biomedical behavioural and structural issues that impact and impede service delivery to transgender persons. PEPFAR must support the development and operationalisation of policies, standards and guidelines that accelerate access to gender-affirming HIV services for transgender persons.

**COP21 Target:** *Three established functioning and trans-led centres of excellence in Nairobi, Mombasa and Kisumu Counties.*

**COP21 Target:** *Transgender persons-led organisations funded in COP21 to find and retain community members and increase demand for services.*

**COP21 Target:** *Support for 3,282 transgender persons to receive service in the PEPFAR programme.*

## 6.6 Lubricants for key populations

Key populations have struggled to access condoms and lubricants due to persistent stockouts in the country. The programme currently only supports routine commodity forecasting and the Kenya Medical Supplies Authority (KEMSA), but not the actual commodities. In the USAID condom funds, there is a possibility to use some of those resources to support condom and lubricant purchase to reduce the stockouts.

**COP21 Target:** *PEPFAR procures condoms and lubricants to be provided in all PEPFAR supported sites, to ease stockouts of the commodity.*

## 7. People who use drugs

As PEPFAR moves to prematurely transition its harm reduction programme to the Global Fund, leaving organisations stranded and unable to continue service delivery due to lack of funding, the harm reduction programmes have been struggling with purchase of key items required to provide services such as dispensing cups. The harm reduction programme has also been unable to expand due to lack of resources, even as the PEPFAR programme continually struggles to meet its methadone treatment target despite high demand for services by people who use drugs.

PEPFAR needs to support the harm reduction programme beyond the mobilisation of clients for MAT services. Quality service requires investment in the labour to provide services, negotiating with the government to ensure that methadone, as well as policy change to ensure uptake of buprenorphine, is provided to people who use drugs throughout the day, or, with appropriate counselling and support, take-home doses, such as weekly, biweekly, or 30-day supply, to minimise clinic visits during COVID-19, so as to allow people not to miss vital life-saving medication. Support needs to also include the creation of opportunities for continued enrollment of new clients into the MAT programme, which has not happened for some time. The programme needs to support policy change for overdose

treatment (e.g. naloxone) to be provided at a community level especially now when curfews are a huge barrier to hospital access. Development of policies for take-home doses is also key to the retention of clients in MAT. Community organisations are poised and willing to take up more tasks that can not be easily provided by the government, yet support is either minimal or being taken away by PEPFAR with no cause as the demand for harm reduction services continue to increase. The difficulty of negotiating how to provide harm reduction service with the government should not be the reason to close down the programme that is providing vital services, community groups working on harm reduction have been working with the government and can be a conduit for negotiation and additional capacity support.



### 7.1 Harm reduction programme transition and organisations closure

People who use drugs have benefited greatly since the introduction of the PEPFAR initiated and jointly (PEPFAR and Global Fund) supported harm reduction programme. A large number of men and women using drugs were initiated into the life-saving methadone programme that now spans Nairobi, Mombasa, Kwale and Kisumu. The programme has helped the community change and save lives. Not only did the programme give a chance to people who use drugs to get an alternative to the harmful drugs they were using, they also got the chance to know their HIV status and access to ART consistently for those who were found to be HIV positive.

The government and PEPFAR programme responses have also benefited from support by the community-led service delivery

organisations who have been funded to create demand for the methadone service and have gone far and beyond to provide the necessary HIV prevention and treatment to community groups and even created areas for people who use drugs to take baths and eat meals they would not be able to afford, all in a bid to retain those who need services in the programme and entice newcomers to join the programme. By COP20, communities of key populations continued to seek the expansion of the harm reduction programme and proposed innovative ways of expanding it that included mobile clinics and increased investment in community-led service delivery and community outreach.

Despite the many successes during initiation to date, the harm reduction programme still faces numerous challenges that continue to plague the programme and need an urgent response and ongoing support.

CHALLENGES AT THE FACILITY	CHALLENGES HIGHLIGHTED BY THE COMMUNITY MEMBERS
<ul style="list-style-type: none"> <li>+ People going to methadone sites are unable to access anything other than methadone and ART treatment. People who use drugs at the site have no access to other services such as hepatitis B and C care, urine toxicology, SRH, support for PPE for community members etc.</li> <li>+ There is only one doctor dispensing per facility, yet some facilities have more than 1,000 MAT patients</li> <li>+ The methadone service delivery points are lacking basic equipment such as dispensing cups/ measuring cups.</li> <li>+ Investment in human resources for the MAT clinics is less than 50% of the needs of the people.</li> <li>+ Budgets currently prescribed for the methadone programme are unable to support increases in the number of people receiving service or improve the quality of services</li> <li>+ There is no nutritional support for people who use drugs</li> <li>+ There is no defaulter tracing support for those whose treatment has been interrupted due to shortage of counsellors.</li> <li>+ There is no psychosocial support provided for people using drugs who are on ART in the general service delivery sites, unlike in the general facility.</li> <li>+ Methadone sites open at 6 am and close by 12 noon leaving a large number of MAT clients without services. Some MAT sites have not been enrolling clients for over a year.</li> </ul>	<ul style="list-style-type: none"> <li>+ Referrals to other hospitals to access services is costly as it is out of pocket and a lot of people end up not going due to the cost</li> <li>+ A large number of people who use drugs are still yet to have access to the methadone programme despite community organisations overflowing with requests from those hoping to get a chance to receive the service.</li> <li>+ Complaints from community members that it is impossible to provide services to everyone currently enrolled on the methadone programme before noon as directed by the programme.</li> <li>+ People who use drugs have no access to toilets at the facilities.</li> <li>+ People who use drugs are facing a lot of discrimination at the government-run methadone facilities especially in the Nairobi sites (Mathare and Ngara).</li> <li>+ People who use drugs are suspended from methadone for between 6 months to a year at the will of clinicians and losing access to life-saving treatment for drugs and ART.</li> <li>+ There is no access to naloxone for overdose treatment in the community and no access to hospitals passed curfew.</li> <li>+ There are no masks provided to people who use drugs at the facility leading to mask sharing. There are no hand sanitisers.</li> <li>+ There is no access to take-home doses for methadone.</li> </ul>

The challenges listed above are just some of the many issues raised by community members and service providers showing the programmes are not ready for the transition and need scale-up of resources. The key population led service delivery sites PEPFAR wants to transition from are facing closure due to lack of funds and communities of people who use drugs risk losing safe spaces where they get support beyond methadone and store their ARVs. PEPFAR also risks losing a programme that has actually been fulfilling the requirements of the programme to find KPs living with HIV. The transition will only leave people who use drugs without access to services and close down long-standing well-performing service delivery sites. PEPFAR needs to re-evaluate the needs of people who use drugs together with the gaps and reevaluate the decision to transition.

**COP21 Target:** PEPFAR retracts decision to transition harm reduction programmes and immediately funds organisations facing closure due to the transition for the remainder of COP20 and into COP21.

**COP21 Target:** In collaboration with community groups, PEPFAR reviews the quality of services offered to people who use drugs to ensure quality service delivery for people who use drugs.

## 7.2 Methadone take-home doses

Since the COVID-19 curfew and lockdown, people who use drugs have been struggling to access the methadone they needed. Most people moved from the counties they were living in to be closer to family members, however in the counties, they moved to, there were no sites that provide methadone and the facilities did not allow people to get access to take-home doses forcing those who travelled to revert back to the use of heroin. Given that COVID-19 curfews and lockdown are not likely to end soon the programme needs to be able to make contingencies for those still in need of methadone but without easy access.

**COP21 Target:** PEPFAR supports policy and implementation, with appropriate counselling and support, take-home doses, such as weekly, biweekly, or 30-day supply, to minimise clinic visits for people who use drugs to ensure that there is no interruption in service delivery for patients in the methadone programme.

## 7.3 Quality services

Conversations with service recipients at the Ngara, Mathare and Kombani methadone sites led to many complaints about the quality of services provided. During a number of focus groups, people who use drugs complained that there was no provision of masks available at methadone sites, leading them being forced to share masks in order to access sites. Further, the sites lack COVID-19 screening protocols including temperature checks. The sites have challenges providing services that are confidential and community members felt unable to share challenges above the methadone needs with clinical staff. The service recipients complained of being suspended from services for 6 months to a year depending on the “gravity of the mistake” clinical staff felt was committed by the service recipients—leading people to lose access to methadone and ART at the sites and treatment interruptions for service recipients who refused to go back

because of how they were treated. There were a lot of complaints by service recipients that clinical staff arrived at the facility late. Service recipients do not have access to toilets, nor do they have access to water, those are reserved only for the staff members.

**“There was an older man who came to the facility and he was having problems with his stomach, but we do not have access to a toilet as people who use drugs. The man was unable to get access to the toilet and had an accident on himself. The clinicians made him pick it up with his hands out of the facility and made him clean the area after. We have never seen him again.”**

**“We prefer to get services at community organisations. We feel supported at the community organisations. We are treated with dignity; the sites are conveniently placed and we receive peer education.”**

There were also complaints of harassment from the security teams at the facility as well as clinical staff arriving late at the facility, despite service recipients arriving at 6 am, leading to job losses for service recipients needing to arrive early to work.

**“We are not able to access any other medication for other diseases like HIV or TB. We refuse the medication because of lack of privacy.”**

**“I was given a one-year suspension for being late. When we are late, we are suspended for 6 months to a year and are asked to write an apology letter.”**

**“We are denied medication in Mathare if we come after 12 noon but the doctors themselves come late to deliver services.”**

**“There are no kits for measuring the drugs being dispensed.”**

**“I was a street boy and a thief, but methadone has helped me a lot. I don’t take HIV medication in Ngara because of stigma. There is no privacy at Ngara and the building is not made for confidentiality.”**

**COP21 Target:** An immediate review of the quality of services provided at the Ngara, Kombani and Mathare sites to ensure that people who use drugs have access to quality services.

**COP21 Target:** Immediate steps taken to improve service delivery by increasing the number of site visits to every quarter to evaluate the quality of services at the site level.

## 7.4 Harm Reduction Mobile Clinics

In COP20, PEPFAR commits that “PWID *medically-assisted therapy (MAT) services will be scaled up by adopting a mobile outreach model to increase access to high-risk injecting drug users unable to access the established static sites*” - (SDS, pg. 65)

The recommendation for mobile clinics has been long requested by key populations yet to date none have been supported. During the lockdown, there was limited access to MAT clinics and mobile clinics would have gone a long way in providing services to people who use drugs closer to where they are. PEPFAR needs to ensure that communities of people who use drugs are effectively supported, even during lockdowns.

**COP21 Target:** Purchase and maintenance of the mobile van (Nairobi) agreed to in COP20 to increase service provided to people who use drugs at a community level.



**COP21 Target:** Purchase and maintenance of an additional 3 vans (2 in Mombasa and 1 in Kwale) for the expansion of the community methadone programme.

**COP21 Target:** Collaboration with community organisations where people who use drugs visit to bring services provided in the mobile truck closer to the people.

## 7.5 Women who use drugs

Women who use drugs face additional challenges in accessing healthcare services. In the beginning, PEPFAR prioritised women who use drugs to ensure that they were not left behind as

the programme responded to the needs of PWUDs. However, currently, the methadone sites only provide for methadone and ART. Other needs amongst women who use drugs such as access to sexual and reproductive healthcare and services required for children of women who use drugs are not integrated.

**COP21 Target:** Comprehensive integrated services, including sexual and reproductive health services, are offered for women who use drugs at all PEPFAR supported methadone sites.

**COP21 Target:** PEPFAR disaggregates data of people who use drugs to track the services offered to women who use drugs specifically.



## 8. Mothers + children

### 8.1 Vertical Transmission of HIV

HIV infection during pregnancy and breastfeeding is still driving new HIV infections amongst children. HIV negative mothers still continue to be at risk of HIV infection, even during pregnancy and breastfeeding. PEPFAR should immediately support the rollout of PrEP for pregnant and breastfeeding women. Policy barriers that are currently obstructing adolescent and young girls from accessing PrEP, such as the age of consent, must be removed immediately to ensure women have protection from HIV infection.

**COP21 Target:** *PrEP will be supported for all HIV negative women, including pregnant and breastfeeding women.*

**COP21 Target:** *Policy barriers changed to ensure young women below 18 have access to PrEP.*

### 8.2 Point of care paediatric testing

In the COP20, PEPFAR Kenya committed support for only 6 point-of-care early infant diagnosis (POC EID) machines as the response to two years of activism by people living with HIV and civil society captured in the People's COP 2019<sup>11</sup> and People's COP 2020<sup>12</sup>. The 6 machines that will be supported by PEPFAR were part of the<sup>13</sup> UNITAID-funded, CHAI and EGPAF implemented project that ended in 2019 that brought 67 POC EID instruments: Alere Q (39); GeneXpert (28) to tackle Kenya's challenges of diagnosis leading to increased initiation of treatment of children with HIV from 43% to 93%.

As PEPFAR supports 6 machines, the Kenya government is yet to confirm support for any POC- EID machines. The recently submitted Global Fund Application did not have any support for POC-EID despite protest by civil society and machines in the country remain dormant as mother to child HIV transmission continues to rise.

As part of the SDS 20, PEPFAR included an appendix on paediatric support that heavily focused on the cost of implementation rather than the quality of service and the need to support timely diagnosis for children living with HIV. The analysis prioritised cost over the lives of children in a program that is failing to find children and offer treatment on time. Turnaround time was

only calculated to show the time between the facility and the lab leaving out the critical time it takes to get results back to the caregiver and the caregiver getting back to the facility.

**COP21 Target:** *Support provided for the remaining POC-EID machines to ensure that children across the country have access to timely diagnosis (61 machines).*

### 8.3 Optimised paediatric treatment

COP21 minimum requirements recommend rapid optimisation of ART by transitioning to DTG-based regimens for children who are >4 weeks of age and weight >3 kg, and removal of all NVP- and EFV-based ART regimens. The planning level letter also requires programmes to move forward with the introduction and broad use of paediatric DTG formulations in FY21 (COP20), with full implementation expected to occur during the first quarters of FY22 (COP21).

COP20 included the optimisation of treatment regimens to more efficacious and durable regimens: Dolutegravir (DTG) for adults and children >20kgs which is commendable. Communities agree and support that the programme needs to ensure that COP 21 ensures that all eligible children are offered treatment regimens.

**COP21 Target:** *Optimisation of all eligible children to DTG based regimens.*

### 8.4 Support during and after pregnancy.

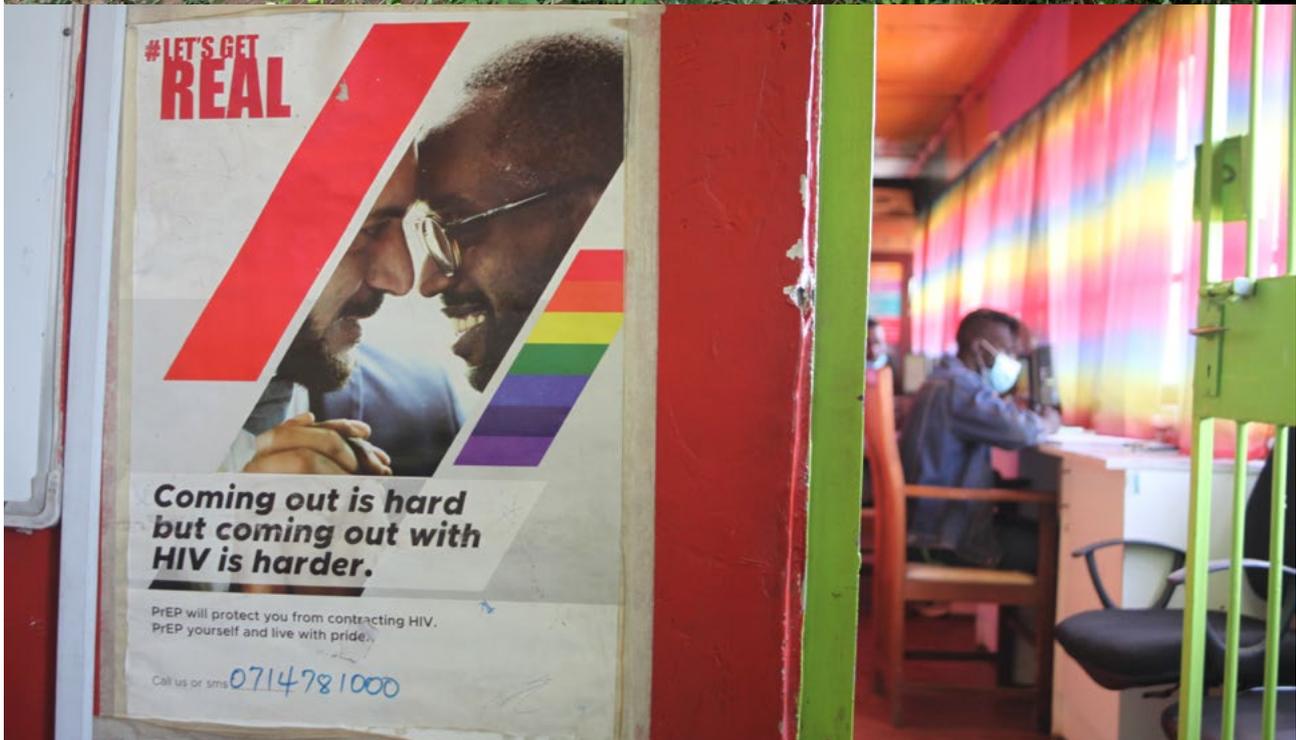
1,036,345 women were tested for HIV through the PMTCT programme in FY20. Whilst the number has remained relatively stable across the years, there are mothers who traditionally do not visit the facility for pre and post-natal services. PEPFAR should consider supporting outreach services to find these mothers at a community-level to ensure that all mothers are receiving the services they need for prevention and treatment, for themselves and their children.

**COP21 Target:** *PEPFAR supports targeted non-facility based care for pregnant and breastfeeding mothers and their children.*

11. Kenya People's COP 2019. Available at: <https://healthgap.org/wp-content/uploads/2019/03/Kenya-Peoples-COP19.pdf>

12. Kenya People's COP 2020. Available at: <https://healthgap.org/wp-content/uploads/2020/02/Peoples-COP20-Kenya.pdf>

13. Point-of-care Early infant Diagnosis Data Dashboard



## 9. Men

For the last two years, PEPFAR has been reviewing their support for human resources in Kenya, in an effort to ensure quality service delivery. However, certain recommendations made in the guidance and by civil society are yet to be supported. Communities have recommended the increased support of healthcare workers including male health staff escorts as recommended in the guidance<sup>14</sup>, but this has not been implemented.

Community monitoring efforts showed that only one facility out of 7 monitored offered male clinic days. Male tailored support at the facility that ensures that men receive support from male peers—from testing to initiation to treatment—was still not provided. PEPFAR's own quarterly data shows the need to increasingly provide services specific to men to ensure an increased uptake in testing, linkage and continuity in care. As the country moves toward finding the last of the people living with HIV, prioritisation of services that ensure retention is key especially amongst communities that are difficult to find.

**COP21 Target:** 2 additional male healthcare workers per PEPFAR supported site are recruited and hired by PEPFAR supporting an increase in the numbers of men tested, initiated into care and retained.

**COP21 Target:** All PEPFAR supported facilities offer male clinic days at least once a week that support men with long term retention and viral suppression.

14. PEPFAR Guidance 2021 pg 331

## 10. Comorbidities

### 10.1 TB Preventive Therapy

In COP20, PEPFAR committed to supporting GoK with improved documentation, reporting capacity, and strengthened pharmacovigilance to ensure that all eligible PLHIV cohorts were on TPT. The country finalised and launched the new TPT policy and related guidelines to support the introduction of 3HP. The transition plans from IPT to 3HP started in April 2020, with the training package being concluded together with LTBI guidelines. Further, in FY20, PEPFAR supported the introduction of short-course TB preventive treatment through procurement of 54000 courses of 3HP<sup>15</sup>. The latest Global Fund grant also included 3HP starting July 2021 for 3 years expected to support HIV negative populations.

In terms of performance, by the end of FY20, the 2,102 reporting facilities reported an underperformance in relation to initiating TPT. Only 7.88% (90,458) of the TB\_PREV target of 1,148,339 was reached by Q4. This is a major decrease as compared to the 95,901 PLHIV initiated on TPT out of a target of 153,454 in FY19<sup>16</sup>. In FY20, PEPFAR made a commitment to supporting the incorporation of TPT (including 3HP) within DSD models of HIV service delivery.

In COP21 PEPFAR recognises that TPT initiations slowed or were delayed in the wake of COVID-19, these countries will need to implement aggressive TB “catch-up” plans in order to achieve full TPT coverage<sup>17</sup>.

The COP21 Guidance offered that “*all PEPFAR-supported care and treatment programs should be fully engaged in aggressive TPT scale-up with clear timelines to 100% coverage, focusing on rifampentine-based regimens. If PLHIV are enrolled in a DSD program for ART, TB treatment or TPT should also be integrated into DSD*”<sup>18</sup>.

In FY21, there will be an improved supply chain of both the Sanofi 3HP single tablets and Macleods FDC will be available without delay. The price of 3HP using both the Sanofi and Macleods regimens will remain at \$15 per patient course. In FY21, 3HP transition plans need to be scaled and initiation of 3HP (both Sanofi and Macleods) products needs to be fast-tracked. The IMPAACT4TB project will avail 20,79322 379 patient courses in Q1 of Fy21 and 38 604 in Q3. In FY21, PEPFAR will procure 37 548 patient courses of 3HP in Q2. Delivery of the Macleods FDC remains uncertain in Q1 but should improve in Q2 of COP21.

**COP21 Target:** 1,148,339 PLHIV (including children and adolescents) be initiated and complete TPT within COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. Of these, at least 70% should receive rifampentine based therapy.

**COP21 Target:** GoK should aggressively scale up TPT, both with the use of IPT (ensuring sufficient stocks of VitaminB6) as well as 3HP as part of Kenya’s “TPT catch-up plan”.

### 10.2 TB screening and testing

One key driver of excess morbidity and mortality amongst people living with HIV (PLHIV) is that symptoms of TB or other risk factors are often overlooked by clinics and healthcare workers and that the opportunity for early TB diagnosis and treatment is missed.

In COP20, PEPFAR Kenya committed to “*prioritize TB prevention and treatment through optimized TB screening... [and] improved diagnosis using GeneXpert and TB-LAM*” (pg. 19), and to factor “*Procurement of TB diagnostic commodities, specifically TB LAM... into the budget*” (pg. 68).

In COP21, Kenya should further expand its commitment to reduce preventable morbidity and mortality amongst PLHIV and their close contacts by implementing TB screening at every clinical encounter followed by TB diagnostic testing using urine-LAM and rapid molecular testing according to WHO guidelines and algorithms. As such, Kenya should ensure that urine-LAM is universally available in all inpatient and outpatient settings where PLHIV present to care, that rapid molecular testing for TB is available at or near the point of care for rapid turnaround times to results and that sufficient quantities of urine-LAM and rapid molecular test commodities are procured.

To improve rates of TB detection amongst PLHIV in the PEPFAR programme in Kenya in COP21, clinics, hospitals, and other PEPFAR sites should universally screen PLHIV, including children living with HIV (CLHIV), at every clinical encounter for TB symptoms and other risk factors, using the WHO four-symptom screen or other WHO-recommended screening tools including chest X-ray, C-reactive protein (CRP), or rapid molecular tests (Xpert MTB/RIF Ultra or Truenat MTB Plus and MTB-RIF Dx). PEPFAR Guidance states that “*All PLHIV must be screened at every clinical encounter for TB symptoms and using available technologies consistent with international guidelines*” (pg. 354).

PEPFAR Guidance also states that “*For individuals who screen positive for TB symptoms, a WHO-recommended rapid molecular diagnostic test (e.g., Xpert MTB/RIF Ultra, Truenat MTB Plus and Truenat MTB-Rif) should be used in conjunction with LF-LAM, if appropriate,*” and that “*LF-LAM should be performed in parallel to molecular diagnostic tests*” (pg. 348-349). Clinics, hospitals, and other PEPFAR sites should ensure that both urine-LAM and rapid molecular testing is available on-site and implemented upon first presentation to care for all PLHIV, including CLHIV, with TB signs and symptoms, who are seriously ill, or who have low CD4 counts <200 cells/mm<sup>3</sup>, in both inpatient and outpatient settings. In line with WHO guidance, TB treatment should be initiated immediately following positive urine-LAM results, while awaiting confirmatory results from rapid molecular testing. Whenever an individual is believed to be at risk of or is diagnosed with TB, PEPFAR Kenya should ensure contact tracing is conducted amongst their household and other close contacts.

In COP21, PEPFAR Kenya should support training for healthcare workers on TB symptom screening and the use of other WHO-recommended screening tools; and on sample collection

15. IMPAACT4TB project update, August 2020

16. [https://mer.amfar.org/location/Kenya/TB\\_PREV](https://mer.amfar.org/location/Kenya/TB_PREV)

17. PEPFAR COP21 Guidance Pg 366

18. PEPFAR COP21 Guidance Pg 367

and preparation for urine-LAM and rapid molecular testing with Xpert MTB/RIF Ultra or Truenat MTB Plus and MTB-RIF Dx, including stool sample processing for CLHIV. PEPFAR Guidance states that “Where appropriate, programs should ensure WHO-recommended rapid molecular TB diagnostic testing for children is done using both sputum and non-sputum specimen types (including stool) according to the WHO policy guidance for each test type” (pg. 359). Where TB tests are inconclusive but risk factors and the likelihood of TB are high, especially amongst children, PEPFAR Kenya should support clinical/empirical TB diagnosis and treatment initiation. Additionally, PEPFAR Kenya should commit to positioning rapid molecular testing platforms (GeneXpert, Trueprep/Truelab) as close as possible to the point of care at peripheral health centres in order to ensure rapid turnaround times to results and rapid linkage to appropriate TB treatment within five days of the first presentation to care.

To ensure that TB screening and both urine-LAM and rapid molecular testing are being implemented in all settings where PLHIV present to care in COP21, PEPFAR Kenya should set ambitious targets for TB screening and testing amongst PLHIV. PEPFAR Guidance states that “Procurement quantities of LF-LAM should exceed the number of PLHIV, including CLHIV, who present to care with signs and symptoms of TB or advanced HIV disease in inpatient and outpatient settings, and sufficient budget should be allocated accordingly” (p361). The PEPFAR planning letter reiterates this, stating that “Countries should budget adequately for commodities including urinary LAM” (pg. 17).

PEPFAR Kenya should allocate sufficient budget to support the procurement of commodities required for urine-LAM testing (e.g., TB LAM urine assays, urine cups, pipettes, pipette tips, timers) and rapid molecular testing (e.g., test cartridges/chips, sample cups, sample processing kits including stool processing kits for children, pipettes, and pipette tips), in quantities that each exceed 47,000, the number of PLHIV, including CLHIV, estimated to present to care at PEPFAR-supported sites with advanced HIV disease in COP21. If a more sensitive urine-LAM assay becomes available and receives WHO endorsement during COP21, PEPFAR Kenya should support its use. PEPFAR Guidance states that “In the meantime, programs should scale-up and implement the currently available LF-LAM test” (pg. 361), Abbott’s Determine TB LAM Ag test.

**COP21 Target:** 100% of PLHIV, including CLHIV, are screened for TB upon presentation to care at every clinical encounter.

**COP21 Target:** 100% of PLHIV, including CLHIV, who present to care with signs and symptoms of TB or advanced HIV disease in inpatient and outpatient settings receive both urine-LAM and rapid molecular testing (including the use of stool samples among CLHIV) upon their first presentation to care.

**COP21 Target:** 100% of PLHIV, including CLHIV, with positive urine-LAM results immediately initiate TB treatment, while awaiting confirmatory rapid molecular test results.

**COP21 Target:** 100% of PLHIV, including CLHIV, who are co-infected with TB receive confirmatory diagnostic test results and are linked to TB treatment in less than five days after their first presentation to care.

**COP21 Target:** Procurement quantities of commodities required for urine-LAM and rapid molecular testing should each exceed 47,000, the estimated number of

*PLHIV, including CLHIV, expected to present to care at PEPFAR-supported sites with advanced HIV disease in COP21 (according to PEPFAR data [individuals newly testing positive for HIV] and WHO estimates that 1 in 3 PLHIV present to care with AHD).*

### 10.3 Viral hepatitis

Co-infections of HIV with HBV and HCV significantly contribute to morbidity and mortality within populations of people who are living with HIV. Addressing HIV/HCV co-infection amongst key populations is also important because HIV infection can lead to the reduced spontaneous clearance of HCV, higher viral loads of HCV, and more rapid liver disease progression, which can cause advanced cirrhosis, liver cancer, and liver failure.

HIV/HBV co-infection promotes:

- + increased HBV replication and rates of HBV reactivation,
- + acute liver failure,
- + increased rates of occult HBV (i.e., detection in blood or liver and associated with higher rates of HBV infection and liver disease),
- + chronically, newly acquired HBV infections,
- + accelerated progression to liver scarring and liver disease,
- + liver cancer (HCC) occurs at a younger age and is more aggressive,
- + increased risk of ART hepatotoxicity, and
- + ART-related immune reconstitution hepatitis (i.e., increased liver enzymes and sometimes symptomatic hepatitis).

HBV (HBsAg) modelled prevalence is estimated at 2.95%. There is also a low HCV RNA prevalence (1.21%)<sup>19</sup> in the general population, however, reports have suggested that between 22% and 70% of people who inject drugs are anti-HCV positive. Data on HIV/HCV co-infection among PWID in Kenya are scarce, but according to some studies its prevalence appears to be 18–32%. On average, only 9 syringes are provided per person who injects drugs each year.

In 2019, HBV killed over 3,000 people and HCV killed over 3,500 people in Kenya. Viral hepatitis and harm reduction priorities in Kenya are to reduce viral hepatitis transmission and related mortality among people living with HIV by upscaling interventions aimed at preventing, diagnosing, and linking people to treatment and care, ensuring the full supply of HBV birth dose, HBV preventative vaccines, pan-genotypic direct-acting antivirals (DAAs), and increasing provision of prevention and harm reduction materials. In particular, programs should increase needle/syringes per person who inject drugs per year, at a minimum to 2030 targets (300 sterile needles/syringes per person who injects per year), or at an optimal level of 1 needle/1 syringe for each injection for people who inject drugs.

**COP21 Target:** Integrate the administration of HBV birth dose in all PEPFAR-funded perinatal clinics.

**COP21 Target:** Integrate the HBV preventative vaccine and generic, pan-genotypic DAA treatment for HCV in all health settings serving key populations, including people living with HIV and people who use drugs.

19. IMHE; and CGHE



## 11. Community-led monitoring

For the last two COP cycles, Kenya has been allocated resources to support community-led monitoring to monitor the quality of HIV and TB services offered. The call for funding recently put out by PEPFAR took away from communities the capacity to:

- + Decide whether to apply individually or as collective to enhance cohesion amongst organisations and maximise expertise;
- + Decide the number of partners to be part of their community-led monitoring efforts and prescribed the number of organisations to apply negating the previous alignment by communities of people living with HIV and key populations to work cohesively together;
- + The call for funding prescribed for community organisations that resources should go to meetings with the government despite funding in the PEPFAR budgets to hold quarterly meetings and resources for data collection without allowing the organisations collecting the data to determine how best to collect and store these data.

As currently structured, the CLM will also face challenges of alignment of the data collected which has been a great success on CLM done by other countries. The call does not allow the organisation to come up with a joint application.

All countries that have successful community-led monitoring have been allowed to determine at a community level how to use the resources from inception. As currently structured the CLM prescribed by the PEPFAR team takes away the ability to have a *community-led process* and shows distrust in the communities ability to make decisions on behalf of communities.

Countries that have been allowed to plan for themselves have succeeded as they have been the ones that determined where the greatest need is and planned to monitor based on that. PEPFAR teams that have been supportive have provided the community with data on sites that are performing well and those that are performing poorly. This allowed communities to decide themselves on where monitoring is most needed, rather than prescribe sites, counties and districts to communities. Communities in Kenya should be allowed more flexibility to determine the community-led monitoring model that works for them, like Ritshidze<sup>20</sup> in South Africa<sup>20</sup> and “Ly’abantu” in Uganda.

PEPFAR needs to reopen discussion with civil society on the best way to ensure effective community-led monitoring in

Kenya and reach out to partner countries that have successful CLM programmes that are truly community-led, such as South Africa. As stated in the last People’s COP, we propose a system of community-led monitoring in the following manner:

- + Consistent quarterly monitoring of selected PEPFAR supported facilities to collect robust data using standardised observational, patient/PLHIV, and healthcare worker surveys.
- + Ad hoc fact-finding missions to assess the state of other facilities less consistently monitored where issues are brought to our attention that needs follow up.
- + Surveys will monitor the quality of HIV and TB service provision at the facility, waiting times, staffing complements and shortages, staff attitudes, stockouts & shortages of health technologies (including diagnostics, treatments, and prevention methods), facility cleanliness and the state of infrastructure, TB infection control at the facility, as well as other key issues related to HIV and TB.
- + Monitoring results to be collated, cleaned, coded and published in a simple data dashboard model for tracking the state of service delivery managed by civil society organisations.
- + Monitoring results to be linked to a model of accelerated response by MOH and PEPFAR and implementing partners to address issues outlined. Widespread and repeating issues to be presented at national level meetings in order to attempt to generate systemic solutions.
- + Data collection tools should be adopted from countries such as South Africa that have created and tested the tools to ensure community data collected across countries has the same baseline for review to track similarities across countries.

**COP21 Target:** PEPFAR allows civil society to determine the CLM model that works for them including by:

- Allowing civil society to pick partners with whom to collect data;
- Allowing communities to create and maintain their own data platforms; and
- Ensuring the reporting is done at a national level to ensure the inclusion and review by all stakeholders.

20. <https://ritshidze.org.za>



# PRIORITY INTERVENTIONS

PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS	COP 2020 & DATA, COP 2021 PLANNING LETTER	LANGUAGE TO INCLUDE IN COP 2021	TARGET
	<b>1. FUNDING</b>		
	<p>"The PEPFAR Country/Regional Operational Plan (COP/ROP 2020) national budget is \$375,000,000 inclusive of all new funding accounts and applied pipeline. COP20 Total Planning Level total spend is \$379,134,003" SDS 20</p> <p>"The PEPFAR Country/Regional Operational Plan (COP 2021) notional budget for Kenya is \$365,000,000 inclusive of all new funding accounts and applied pipeline." PLL pg. 3</p>	<p>COP21 will restore COP20 funding levels and increase funding by an additional \$10 million to support the health system to improve the quality of service delivery.</p>	<p><b>COP21 Target:</b> Funding cuts are reversed and funding is increased by US\$10 million to ensure the maintenance of current successes in the HIV and TB response and improve the overall quality of HIV and TB service delivery.</p>
	<b>2. HIV TESTING</b>		
	<b>2.1 HIV Test Kits</b>		
	<p>Total expenditure on HIV rapid test kits is \$7,208,387 SDS pg. 21</p> <p>"procurement of rapid test kits will be significantly reduced, while procurement of HIV self-test kits and rency kits will be increased to support case-finding." SDS pg. 68</p>	<p>COP21 will maintain testing support from COP20 levels to ensure that the programme does not reverse gains made in the first "95" target.</p>	<p><b>COP21 Target:</b> Maintenance of test kit support at COP20 levels to ensure continued access to HIV testing.</p>
	<b>2.2 Index Testing</b>		
	<p>PEPFAR messaging to implementing partners <u>will be devoid of a targeted % expectation from index testing</u>. PEPFAR Kenya will communicate to all IPs that there is <u>no longer a specific target for index testing</u>. IPs will immediately communicate to and remove any index testing-related targets that may have been in place at supported sites/facilities. IPs will immediately re-orient staff that index testing is voluntary and that clients can decline the service for any or no reason. IP work plans will not include targets for index testing." SDS pg. 39</p> <p>"COP20 will support <u>violence screening</u> and identification <u>before</u> and after <u>index testing</u> services to avoid unintended violence for these index clients." SDS pg. 61</p> <p>"Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established" SDS pg. 101</p> <p>"All certified sites conducting HIV index testing will be supported by COP20 to conduct mandatory inquiry for IPV on all clients offered [assisted partner notification services] aPNS. Providers will be expected to duly complete aPNS registers indicating that enquiry into IPV has been done." SDS pg. 67</p> <p>Case identification will be done mainly through offering index testing <u>at qualifying facilities</u>" SDS pg.36</p> <p>"Efficient and effective case identification strategies in COP20 will include implementation of index testing at scale with fidelity. <u>Safety elements will be addressed and will involve intimate partner violence screening</u>, adverse event monitoring, and reporting. <u>Facilities and providers will be certified to conduct index testing</u>." SDS pg. 39</p>	<p><i>Refer to the table in the index testing section in above.</i></p>	<p><b>COP21 Target:</b> All COP20 agreements are implemented for the remainder of COP20 and in COP21 that ensure a rights-based approach to index testing that does not subject PLHIV to risk of violence. Refer to the table in the index testing section in the document.</p>

PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS	COP 2020 & DATA, COP 2021 PLANNING LETTER	LANGUAGE TO INCLUDE IN COP 2021	TARGET
	<b>3. COVID-19</b>		
	<b>3.1. COVID-19 preventive measures at the health facility</b>		
	<p>"PEPFAR is also closely monitoring the rapidly evolving strains on the global pharmaceutical and non-pharmaceutical supply chain that have resulted from the COVID-19 pandemic, which may impact the timely availability of commodities." SDS pg. 68</p>	<p>To support ART continuity and access to HIV prevention, PEPFAR will procure cloth reusable masks to be provided to any healthcare user without a mask at all PEPFAR supported sites in order to be able to access HIV, TB and other health services.</p> <p>PEPFAR will work together with GoK to ensure that all supported sites observe COVID-19 prevention measures properly including through procurement and provision of hand sanitizer, soap and water at all PEPFAR supported sites in COP21 and the remainder of COP20.</p>	<p><b>COP21 Target:</b> Reusable Masks procured and distributed to all PEPFAR supported sites to be provided to any healthcare user arriving at the facility to access services who does not have access to a mask in COP21 and the remainder of COP20.</p> <p><b>COP21 Target:</b> Water and soap are available through installed dispensers at all PEPFAR supported sites.</p>
	<b>3.2. Nutritional support</b>		
	N/A	COP21 will provide nutritional support for key populations and pregnant and breastfeeding mothers to ensure continuity of care and continue to offer nutritional assessment counselling.	<b>COP21 Target:</b> Food parcels are provided as part of psychosocial support to PLHIV and key populations most vulnerable.
	<b>3.3. Service disruptions</b>		
	N/A	<p>COP21 will ensure that all community service delivery agents receive passes to be able to continue providing community-level and outreach services past curfew hours.</p> <p>COP21 will support all community health workers and community organisations to receive Personal Protective Equipment (PPE) in order to continue providing direct support to people living with HIV and key populations.</p> <p>COP21 will revive support groups at all PEPFAR supported sites and allow innovation to ensure that people living with HIV and key populations continue to be supported even during the COVID-19 pandemic.</p>	<p><b>COP21 Target:</b> All community service delivery agents (including CHWs, peer educators and health workers from KP-led organisations) receive passes to be able to continue providing community-level and outreach services past curfew hours.</p> <p><b>COP21 Target:</b> All community healthcare workers and community organisations receive personal protective equipment (PPE) in order to continue providing direct support to people living with HIV and key populations.</p> <p><b>COP21 Target:</b> Communication issued to all service delivery sites to revive support groups using innovative thinking that maintains safety to ensure that people living with HIV and key populations continue to be supported even during the COVID-19 pandemic.</p>

PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS	COP 2020 & DATA, COP 2021 PLANNING LETTER	LANGUAGE TO INCLUDE IN COP 2021	TARGET
	<b>4. ART CONTINUITY</b>	<b>4.1. 6MMD</b>	<p>“For males ages 25 and older, the implementation of 6MMD should be pursued.” planning letter pg. 6</p> <p>“Shift in policy environment to enable recipients of care to have options on multi-month dispensing (MMD) of up to 6 months” SDS pg. 6MMD not recommended for PBFW - Q4 data slides</p>
<b>4.2. HIV + TB Prevention and Treatment Literacy</b>	<p>“As part of patient-centred care, treatment literacy will continue to be offered to stable patients in differentiated models. SDS Pg 18</p> <p>In COP20, Kenya will intensify and scale up PHDP interventions and patient literacy to all PLHIV aged &gt;15 years and their caregivers at HIV clinical settings and in the community to prevent onward transmission of HIV, as well as to maintain the health of patients.” SDS pg. 18</p> <p>“Both healthcare workers and peer-led psychosocial groups will be utilized for treatment literacy and knowledge. SDS pg 53</p> <p>Additionally, they support health facility navigation especially in public health facilities, and treatment literacy (especially by the peer navigators). SDS pg 64</p> <p>A human rights- based approach will be adopted to ensure that all interventions address stigma and discrimination. Through meaningful involvement of KP living with HIV, COP20 will address leaks in the prevention and treatment cascade through improved linkage, adherence, and patient literacy.” SDS pg. 65</p>	<p>In COP21, PEPFAR will fund an aggressive expansion of HIV and TB prevention and treatment literacy across all PEPFAR supported districts run by, and for, communities living with HIV and key populations. This will include a community lead component (material development and dissemination to all PEPFAR sites, support groups as well as trainings at community level) and a healthcare worker component (through health talks, when providing viral load test results, when transitioning PLHIV to DTG, and in any other patient consultations). PEPFAR will fund 10 community organisations to engage in HIV and TB prevention and treatment literacy.</p>	<p><b>COP21 Target:</b> Health talks are offered at all PEPFAR supported facilities to ensure that PLHIV and other patients waiting for services are educated on key aspects of HIV and TB prevention and treatment literacy.</p> <p><b>COP21 Target:</b> 15 community organisations supported to provide HIV and TB prevention and treatment literacy for people living with HIV and key populations through material development and training.</p>

COP 2020 & DATA, COP 2021 PLANNING LETTER	LANGUAGE TO INCLUDE IN COP 2021	TARGET
<b>4.3. Support Groups.</b>		
<p>“PEPFAR Kenya will also work together with communities of PLHIV, young people, and KP to set up <u>community level-support groups that allow PLHIV to be supported both at facility level, as well as at community level.</u> This will be a continuation of COP19’s commitment to work with communities to scale up retention.” SDS pg. 53</p>	<p>COP21 will fund community support groups for people living with HIV at the community to improve ART continuity and treatment literacy levels for people living with HIV. Further, in COP21 PEPFAR will ensure that newly diagnosed PLHIV, PLHIV returning to care, or PLHIV struggling with adherence are provided with the option to be linked to these support groups.</p>	<p><b>COP21 Target:</b> 25 PLHIV community organisations inclusive of AGYW organisations funded to revive support groups for community members in need of education and support in at least five high burden regions of the country.</p>
<b>4.4. Opening hours</b>		
<p>“Clinic operating hours will be extended beyond the 8-5 time period to open early and close late to serve populations working or in school during the official working hours. In addition, weekend clinics will be operated to serve those busy or out-of-location during weekdays.” SDS pg. 17</p>	<p>PEPFAR will provide the staffing and other needs to support sites to extend opening hours to 5:00 -19:00 on weekdays and 8:00-16:00 on Saturdays. ART refill collection will be available on any day of the week during these extended opening hours at all PEPFAR supported sites. All sites will be reviewed to ensure that they adhere to these extended operational hours in order to better serve populations working or in school and only able to visit the facility early, late or during the weekend.</p>	<p><b>COP21 Target:</b> Opening hours at all PEPFAR supported facilities are from 5am to 7pm on weekdays and 8am to 4pm on weekends.</p>
<b>5. DOLUTEGRAVIR (DTG)</b>		
<p>N/A</p>	<p>A greater focus will be placed upon ensuring that all PLHIV are offered TLD within the context of informed choice and are provided with all the information before transition. PEPFAR will institute tracking of weight gain amongst PLHIV. Where problematic weight gain is identified, clinicians will refer the PLHIV to a dietician in order to properly support the individual, further the PLHIV will be screened for other NCDs associated with obesity.</p> <p>In conjunction with meaningful inputs from PLHIV, people friendly materials and topics will be developed to help people in diet and nutrition In COP21, all PEPFAR supported sites will provide information outlined in these topics as part of health talks, support group discussions, and group models of care.</p>	<p><b>COP21 Target:</b> PEPFAR institutes tracking of weight gain amongst PLHIV, especially as more people transition or start on DTG. Where problematic weight gain is identified, clinicians refer PLHIV to a dietician in order to properly support the individual with information on diet. Further, PLHIV are screened for other NCDs associated with obesity.</p> <p><b>COP21 Target:</b> In conjunction with meaningful inputs from PLHIV, people friendly topics are developed regarding weight and nutrition to be rolled out in all PEPFAR supported support groups across the country.</p>
<b>6. KEY POPULATIONS</b>		
<b>6.1. Key Population Investment Fund (KPIF)</b>		
<p>“In COP20, there will be intensified efforts to institutionalize innovations implemented for the 90-90-90 goal via funding from both COP19 and the Key Populations Investment Fund (KPIF) to achieve 95-95-95 by 2025.” SDS pg. 63</p> <p>“The PEPFAR Kenya KP program has aligned KPIF investment to the COP20 geographic and accelerated case identification, treatment optimization, and high impact prevention interventions. In COP20, KPIF resources will also be aligned with the OGAC funding landscape expectation of 70% for local implementing partners (LIPs) including sub-granting to local KP-led organizations.” SDS pg. 65</p>	<p>In COP21, PEPFAR will absorb activities and organisations funded in the KPIF into the PEPFAR COP to ensure continuity of quality service provision.</p>	<p><b>COP21 Target:</b> Absorb the KPIF funded activities into COP21.</p> <p><b>COP21 Target:</b> Absorb capacity built key population led organisations under KPIF into the COP to increase the success of key population programmes.</p> <p><b>COP21 Target:</b> 5% of the \$5,700,000 earmarked for GBV response allocated to the key population program to support violence deterrence and response.</p>

PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS

PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS	COP 2020 & DATA, COP 2021 PLANNING LETTER	LANGUAGE TO INCLUDE IN COP 2021	TARGET
	<b>6.2 Key population funding levels targets</b>	<p>“In COP20, there will be intensified efforts to institutionalize innovations implemented for the 90-90-90 goal via funding from both COP19 and the Key Populations Investment Fund (KPIF) to achieve 95-95-95 by 2025.” SDS pg. 63</p> <p>“The PEPFAR Kenya KP program has aligned KPIF investment to the COP20 geographic and accelerated case identification, treatment optimization, and high impact prevention interventions. In COP20, KPIF resources will also be aligned with the OGAC funding landscape expectation of 70% for local implementing partners (LIPs) including sub-granting to local KP-led organizations.” SDS pg. 65.</p>	<p>In COP21, PEPFAR will review the funding allocations to key population led organisations alongside the targets allocated, as part of the review of the key population program, to ensure that communities are equipped with enough resources to offer quality service to key population community members and meet targets set out.</p>
<b>6.3 Resource allocation to KP organisations</b>	<p>“In COP20, PEPFAR Kenya, in consultation with KP community groups, will support service providers in ensuring that KPs are offered options at sites where they feel comfortable to get treatment and prevention services. To do this, the KP program in COP20 shall expand its reach through partnering with the KP community in the delivery of services through outreach models and DICEs (e.g. KP-specific stand alone and integrated drop-in centers and safe spaces).” SDS pg. 62</p>	<p>In COP21, PEPFAR will review implementing partner funding plans to ensure that sub-granted partners have enough resources to effectively reach community members and develop a transition plan for future transition needs.</p>	<p><b>COP21 Target:</b> Restore the previous funding mechanism that ensured that key population led organisations are fully funded to provide quality services to community members.</p> <p><b>COP21 Target:</b> Create a transition manual for future transition to ensure continued seamless service delivery.</p>
<b>6.4 Key population service provision in general facilities</b>	<p>“COP20 will scale up the peer outreach model at KP hot spots and safe spaces and strengthen integrated public health facility approaches to ensure optimal reach and program sustainability.” SDS pg. 63</p>	<p>COP21 will review the successes of services provided to key populations at general health facilities and review support based on success in service delivery to key populations.</p>	<p><b>COP21 Target:</b> During SIMS, PEPFAR will review the number of KPs receiving services in all the PEPFAR general facilities in order to assess the success of KP funding being directed to general health facilities—and if found to be ineffective based on the number of KPs supported or response that “KP do not identify as KPs”, this funding should be redirected to KP specific sites.</p> <p><b>COP21 Target:</b> PEPFAR funds innovation by key population led organisations to ensure better continuity in care for KPs.</p> <p><b>COP21 Target:</b> Provide a list of sites where the programme had successfully integrated key population services to civil society.</p>

PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS	COP 2020 & DATA, COP 2021 PLANNING LETTER	LANGUAGE TO INCLUDE IN COP 2021	TARGET
	<p><b>6.5 Transgender Programming in Kenya</b></p> <p>“In COP20, PEPFAR will continue working with the Ministry of Health to create an enabling environment for KPs to access health services through policy development and review especially targeting the transgender community. In addition, PEPFAR will continue building strong partnerships with the KP Consortium, and Trans* organizations through structured periodic engagements to ensure the KP program is owned and managed by KPs.” SDS pg. 10</p>	<p>In COP21, PEPFAR will increase the target number of transgender persons receiving services and partner with transgender organisations to ensure safe and stigma free service delivery.</p>	<p><b>COP21 Target:</b> Three established functioning and trans-led centres of excellence in Nairobi, Mombasa and Kisumu Counties.</p> <p><b>COP21 Target:</b> Transgender persons-led organisations funded in COP21 to find and retain community members and increase demand for services.</p> <p><b>COP21 Target:</b> Support for 3,282 transgender persons to receive service in the PEPFAR programme.</p>
<p><b>6.6 Lubricants for the key population</b></p> <p>“In addition, PEPFAR will routinely forecast site-specific commodity needs and work closely with Kenya Medical Supplies Authority (KEMSA) to ensure service delivery points (SDPs) receive uninterrupted supplies, e.g. rapid test kits, condoms, lubricants, and methadone.” SDS pg. 70</p>	<p>In COP21, PEPFAR will fund condoms and lubricants for key populations as part of the prevention package at all PEPFAR supported sites.</p>	<p><b>COP21 Target:</b> PEPFAR procures condoms and lubricants to be provided in all PEPFAR supported sites, to ease stockouts of the commodity.</p>	
<p><b>7. PEOPLE WHO USE DRUGS</b></p>			
<p><b>7.1 Harm reduction program transition and organisations closure</b></p>			
<p>“In COP20, 95% of FSW, MSM, and PWID based on the NASCOP 2018 KP size estimates will be targeted in 24 counties.” SDS pg. 62</p> <p>“PWID medically-assisted therapy (MAT) services will be scaled up by adopting a mobile outreach model to increase access to high-risk injecting drug users unable to access the established static sites” SDS pg. 65</p> <p>“In COP20, PEPFAR Kenya is targeting to reach 136,297 FSWs, 80,064 MSMs, 1,635 PWIDs (with 7,936 on MAT), and 1,641 TG with HIV prevention and treatment services in 24 HIV high and medium burden counties.” SDS pg. 65</p>	<p>COP21 will continue to fund harm reduction programs by working with key population led organisations to support harm reduction services. PEPFAR will strengthen collaboration with county governments to ensure that barriers to service delivery for people who use drugs are addressed. In collaboration with community groups, PEPFAR reviews the quality of services offered to people who use drugs to ensure quality service delivery for people who use drugs.</p>	<p><b>COP21 Target:</b> PEPFAR retracts decision to transition harm reduction programmes and immediately funds organisations facing closure due to the transition for the remainder of COP20 and into COP21.</p> <p><b>COP21 Target:</b> In collaboration with community groups, PEPFAR reviews the quality of services offered to people who use drugs to ensure quality service delivery for people who use drugs.</p>	
<p><b>7.2 Methadone take home doses</b></p>			
<p>N/A</p>	<p>COP21 will work with national government on policy to ensure that stable PWUDs enrolled into the MAT program have access to take home dose for methadone, to decongest the facility, to ensure there is no interruption in service delivery for PWUDs, and to ensure continued access to methadone for those who need to travel.</p>	<p><b>COP21 Target:</b> PEPFAR supports policy and implementation, with appropriate counselling and support, take-home doses, such as weekly, biweekly, or 30-day supply, to minimise clinic visits for people who use drugs to ensure that there is no interruption in service delivery for patients in the methadone programme.</p>	

PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS	COP 2020 & DATA, COP 2021 PLANNING LETTER	LANGUAGE TO INCLUDE IN COP 2021	TARGET
	<b>7.3 Quality services</b>		
	N/A	COP21 will carry out a quality assessment on the service delivery at the Mathare, Kombani and Ngara methadone sites to ensure that patients are treated with respect and offered quality services. The program will assess staff attitudes and community members' satisfaction levels with the service provided at the sites. The assessment will be carried out in collaboration with community harm reduction organisations. Where issues are shown in this evaluation, immediate steps will be taken to improve service delivery.	<p><b>COP21 Target:</b> An immediate review of the quality of services provided at the Ngara, Kombani and Mathare sites to ensure that people who use drugs have access to quality services.</p> <p><b>COP21 Target:</b> Immediate steps taken to improve service delivery by increasing the number of site visits to every quarter to evaluate the quality of services at the site level.</p>
	<b>7.4 Harm Reduction Mobile Clinics</b>		
	"PWID medically-assisted therapy (MAT) services will be scaled up by adopting a mobile outreach model to increase access to high-risk injecting drug users unable to access the established static sites" SDS pg. 65	COP21 will purchase 4 mobile vans (one in Nairobi, two in Mombasa and one in Kwale) for the provision of mobile methadone services. The vans will enable the harm reduction program to take services closer to people who use drugs and will be working in close collaboration with community organisations reaching people who use drugs at the grassroots level to ensure community members are reached successfully.	<p><b>COP21 Target:</b> Purchase and maintenance of the mobile van (Nairobi) agreed to in COP20 to increase service provided to people who use drugs at a community level</p> <p><b>COP21 Target:</b> Purchase and maintenance of an additional 3 vans (2 in Mombasa and 1 in Kwale) for the expansion of the community methadone programme.</p> <p><b>COP21 Target:</b> Collaboration with community organisations where people who use drugs visit to bring services provided in the mobile truck closer to the people.</p>
	<b>7.5 Women who use drugs</b>		
	"In COP20, PEPFAR Kenya is targeting to reach 136,297 FSWs, 80,064 MSMs, 1,635 PWIDs (with 7,936 on MAT), and 1,641 TG with HIV prevention and treatment services in 24 HIV high and medium burden counties." SDS pg. 65	<p>In COP21, the PEPFAR program will increase focus on women who use drugs and support comprehensive integrated services, including sexual and reproductive health services alongside access to methadone and ART at all PEPFAR supported methadone sites.</p> <p>In COP21 PEPFAR will disaggregate data of people who use drugs to track the services offered to women who use drugs specifically.</p>	<p><b>COP21 Target:</b> Comprehensive integrated services, including sexual and reproductive health services, are offered for women who use drugs at all PEPFAR supported methadone sites.</p> <p><b>COP21 Target:</b> PEPFAR disaggregates data of people who use drugs to track the services offered to women who use drugs specifically.</p>

PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS	COP 2020 & DATA, COP 2021 PLANNING LETTER	LANGUAGE TO INCLUDE IN COP 2021	TARGET
	<b>8. MOTHERS + CHILDREN</b>		
	<b>8.1. Vertical Transmission of HIV</b>		
	<p>"Based on the Spectrum estimates, 91% of infant HIV infections were due to mothers dropping off ART (47%, thus highlighting the importance of improving retention in PMTCT programs), acquiring HIV infection during the pregnancy or breastfeeding period (23%), or not initiating ART (21%). SDS pg 6</p> <p>Due to high MTCT rates observed during breastfeeding, COP20 will work closely with OVC partners to follow up breastfeeding women who are newly enrolled, unsuppressed, have a history of lost to follow-up, and AGYW as a priority at household level. SDSpg 61</p> <p>COP20 will support collaboration with PMTCT to identify pregnant and breastfeeding adolescents and link them to Operation Triple Zero in a way that caters to the pregnant adolescent." SDS pg. 61</p>	<p>In COP21, PEPFAR will work with the GoK to review the policy barriers hindering adolescent girls and young women (AGYW) from accessing PrEP.</p> <p>PEPFAR will support PrEP for all HIV negative women, including pregnant and breastfeeding women.</p>	<p><b>COP21 Target:</b> PrEP will be supported for all HIV negative women, including pregnant and breastfeeding women.</p> <p><b>COP21 Target:</b> Policy barriers changed to ensure young women below 18 have access to PrEP.</p>
	<b>8.2 Point of care paediatric testing</b>		
	<p>"Currently, there are 67 POCs dedicated to VL and EID that are underutilized or frequently stocked out. In COP19, only 0.5% of all VL tests and 14% of EID tests were performed at POCs. In the lab optimization activities of COP20, PEPFAR Kenya will work with other stakeholders toward increasing efficiencies in equipment placement and utilization. This process will work toward adding value to sustainability purposes in the transition to domestic financing." SDS pg. 76</p> <p>"PEPFAR's POC support will span 6 sites (3-CDC, 2 USAID and 1 to DOD), and 82 networked sites as indicated above at an average cost of \$50,000. PEPFAR/Kenya currently anticipates directly supporting six EID PoC instruments through September 2023 and will support assessing the impact of this investment." SDS pg. 115</p> <p>As of 2020, the Overall % of EID samples processed on POC instruments was just 4.8%. COP says it will fund 6 POC sites with 85 networked sites, suggesting POC will only be a 7% (6/85) sites.</p>	<p>In COP21, PEPFAR will support an additional 61 POC EID machines to ensure children have access to timely diagnosis.</p>	<p><b>COP21 Target:</b> Support provided for the remaining POC-EID machines to ensure that children across the country have access to timely diagnosis (61 machines).</p>
	<b>8.3. Optimised paediatric treatment</b>		
	<p>"Kenya is already using DTG for the pediatric population and nevirapine phase out is well underway with the very small number of clients currently on nevirapine expected to transition to appropriate regimens by the start of COP20." SDS Pg 19</p>	<p>COP21 will ensure that all eligible children are offered optimised treatment regimens through rapid transition to DTG based regimen for all infants and children who are ≥ 4 weeks of age and who weigh ≥ 3 kg and remove all NVP- and EFV-based ART regimens, in FY21 (COP20), with full implementation expected to occur during the first quarters of FY22 (COP21). Treatment literacy led by HIV positive caregivers and other directly impacted communities will be funded by PEPFAR to be provided for mothers of children living with HIV and other caregivers to improve case finding, treatment adherence and retention to care.</p>	<p><b>COP21 Target:</b> Optimisation of all eligible children to DTG based regimens.</p>

PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS	COP 2020 & DATA, COP 2021 PLANNING LETTER	LANGUAGE TO INCLUDE IN COP 2021	TARGET
	<b>8.4 Support during and after pregnancy</b>		
	<p>"The program will support development of client-centered high-risk categorization and management and improve ART cohort register documentation including reporting." SDS pg 54</p>	<p>In COP21, PEPFAR will support targeted outreach to pregnant and breast feeding women in the community.</p>	<p><b>COP21 Target:</b> PEPFAR supports targeted non-facility based care for pregnant and breastfeeding mothers and their children.</p>
	<b>9. MEN</b>		
	<p>"Ensuring men are diagnosed and treated early (testing positive and new on treatment (linkage surrogate)) PPL pg 3 In order to increase the number of men returning to treatment, we recommend the use of a peer to peer support program/ escorted linkage for men (ideally by another man). Clients should have access to responsive support structures and peer networks throughout the entire journey to help them reach and maintain viral suppression. Data suggest that 95% of men return to care with the support of a man living with HIV serving as a coach or linkage facilitator. In addition, peer navigation programs can be strengthened by specific training on empathy and effective, compassionate engagement of the issues that men commonly face (e.g., fear, specific logistic challenges, disclosure, etc.). Kenya should invest resources in COP21 in a male peer to peer/coach program." planning letter pg. 10</p>	<p>In COP21, HRH programming will add at least two additional male healthcare workers to each PEPFAR supported site, additive to existing HRH complements, as a way to urgently increase the number of men initiated on treatment and being virally suppressed. The male healthcare workers will at a minimum engage in male clinic days on a weekly basis as well as supporting outreach and community testing models, to improve linkage and retention amongst men.</p>	<p><b>COP21 Target:</b> 2 additional male healthcare workers per PEPFAR supported site are recruited and hired by PEPFAR supporting an increase in the numbers of men tested, initiated into care and retained. <b>COP21 Target:</b> All PEPFAR supported facilities offer male clinic days at least once a week that support men with long term retention and viral suppression.</p>
	<b>10. COMORBIDITIES</b>		
	<b>10.1 TB Preventive therapy</b>		
	<p>In COP20, Kenya met its minimum programme requirement on TPT. "Kenya is meeting this requirement. It has a policy in place and implementation in progress with over 90% of all PLHIV in care and treatment having been initiated on TPT" SDS pg. 101 "In COP20, the country will focus on ensuring capacity within the GOK to mop up the remaining cohort of PLHIV eligible for TPT, ensuring improved documentation, reporting, and strengthening of pharmacovigilance. The country will also focus on finalization of policy change and guidelines and introduction of 3HP" SDS pg. 101 "In addition, COP20 will prioritize TB prevention and treatment through optimized TB screening, use of newer, efficacious and shorter regimens such as 3HP, improved diagnosis using GeneXpert and TB-LAM, and IPT among all eligible PLHIV. It will contribute to both pharmacovigilance and HRH strengthening." SDS pg. 19</p>	<p>In COP21, GoK will prioritize 3HP/TPT. PEPFAR will work with GoK to implement a "TPT catch up plan". Implementing partners will be expected to scale up TB preventive therapy to reach 1,148,339 PLHIV including children and adolescents — of these, at least 70% should receive 3HP and 30% should be on IPT. All contacts of PLHIV with TB, including children and adolescents, should be traced and all those eligible will be initiated on TPT. TPT will be incorporated within DSD models of HIV service delivery, even with IPT/TPT. Where indicated, cotrimoxazole will be fully integrated into the HIV clinical care package at no cost to the patient.</p>	<p><b>COP21 Target:</b> 1,148,339 PLHIV (including children and adolescents) be initiated and complete TPT within COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. Of these, at least 70% should receive rifampentine based therapy <b>COP21 Target:</b> GoK should aggressively scale up TPT, both with the use of IPT (ensuring sufficient stocks of VitaminB6) as well as 3HP as part of Kenya's "TPT catch-up plan".</p>

COP 2020 & DATA, COP 2021 PLANNING LETTER	LANGUAGE TO INCLUDE IN COP 2021	TARGET
<b>10.2 TB screening and Testing</b>		
<p>"In addition, COP20 will prioritize TB prevention and treatment through optimized TB screening, use of newer, efficacious and shorter regimens such as 3HP, improved diagnosis using GeneXpert and TB-LAM, and IPT among all eligible PLHIV." - pg. 19</p> <p>"Procurement of TB diagnostic commodities, specifically TB LAM and cultures for drug sensitivity testing (DST) have also been factored into the budget." - pg. 68</p> <p>"In an effort to ensure the quality of HIV/TB-related testing, PEPFAR will continue to support integrated external quality assessment (EQA) for HIV/TB diagnostics including for GeneXpert Ultra, TB LAM, RHT, VL and EID." - pg. 79</p>	<p>COP21 will prioritize TB prevention and treatment through optimized TB screening at every clinical encounter, use of newer, efficacious and shorter regimens such as 3HP, improved diagnosis using both TB LAM and rapid molecular tests (GeneXpert/Truenat) upon first presentation to care in inpatient and outpatient settings according to WHO guidance, with immediate TB treatment initiation following positive urine-LAM results while awaiting confirmatory rapid molecular test results (utilizing stool samples for rapid molecular testing among children living with HIV), improved linkage to TB treatment in less than five days of first presentation to care, and IPT among all eligible PLHIV.</p> <p>Procurement of TB diagnostic commodities, specifically TB LAM and rapid molecular tests (GeneXpert/Truenat), in quantities that each exceed 47,000, the estimated number of PLHIV, including CLHIV, expected to present to care at PEPFAR-supported sites with advanced HIV disease in COP21, and cultures for drug sensitivity testing (DST) have also been factored into the budget.</p>	<p><b>COP21 Target:</b> 100% of PLHIV, including CLHIV, are screened for TB upon presentation to care at every clinical encounter.</p> <p><b>COP21 Target:</b> 100% of PLHIV, including CLHIV, who present to care with signs and symptoms of TB or advanced HIV disease in inpatient and outpatient settings receive both urine-LAM and rapid molecular testing (including the use of stool samples among CLHIV) upon their first presentation to care.</p> <p><b>COP21 Target:</b> 100% of PLHIV, including CLHIV, with positive urine-LAM results immediately initiate TB treatment, while awaiting confirmatory rapid molecular test results.</p> <p><b>COP21 Target:</b> 100% of PLHIV, including CLHIV, who are co-infected with TB receive confirmatory diagnostic test results and are linked to TB treatment in less than five days after their first presentation to care.</p> <p><b>COP21 Target:</b> Procurement quantities of commodities required for urine-LAM and rapid molecular testing should each exceed 47,000, the estimated number of PLHIV, including CLHIV, expected to present to care at PEPFAR-supported sites with advanced HIV disease in COP21 (according to PEPFAR data [individuals newly testing positive for HIV] and WHO estimates that 1 in 3 PLHIV present to care with AHD).</p>

PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS	COP 2020 & DATA, COP 2021 PLANNING LETTER	LANGUAGE TO INCLUDE IN COP 2021	TARGET
	<p><b>10.3 Viral hepatitis</b></p> <p>N/a</p>	<p>Prevention services should promote health and treatment literacy about viral hepatitis transmission and prevention, should offer linkage to viral hepatitis testing, DAA treatment, and HBV vaccination for people at highest risk, including people who use and inject drugs. In addition, prevention services should advocate and implement a comprehensive package of harm reduction interventions.</p> <p>Include “Addressing viral hepatitis co-infections can prevent liver cancers.”</p> <p>Include “Addressing HBV can prevent hepatitis D (which only occurs in people who already have HBV)--in which there’s no treatment or vaccine.”</p> <p>PEPFAR will cover the purchase of GeneXpert HCV cartridges, ABBOTT RealTime, and Roche Cobas Taqman HCV assays, sample transport, and laboratory network strengthening to integrate viral hepatitis testing using existing HIV infrastructure. PEPFAR will cover training and support for the National AIDS Program and National Viral Hepatitis Program to update national guidance on diagnostics to move towards simpler, decentralized diagnostics algorithms that include point-of-care testing.</p> <p>Community-Based Testing programs should consider incorporating and registering HIV and HCV antibody self-testing and rapid viral load, dried blood spot tests into community-based testing strategies where appropriate.</p> <p>With highly effective and safe pangenotypic direct-acting antivirals, people with HCV can effectively be cured and not transmit the virus if accurate, appropriate prevention education and access to harm reduction materials are in place. Linkage to early HCV treatment for people who are HIV/HCV can prevent further liver damage and liver cancer and improve HIV and health outcomes.</p> <p>Integrate viral hepatitis into HIV diagnostics algorithm. This includes utilizing unused capacity on GeneXpert and other multi-disease diagnostics platforms to run HBV and HCV tests.</p>	<p><b>COP21 Target:</b> Integrate the administration of HBV birth dose in all PEPFAR-funded perinatal clinics.</p> <p><b>COP21 Target:</b> Integrate the HBV preventative vaccine and generic, pangenotypic DAA treatment for HCV in all health settings serving key populations, including people living with HIV and people who use drugs.</p>
<p><b>11. COMMUNITY-LED MONITORING</b></p> <p>In COP20, communities through community-led monitoring will provide further oversight to all HIV services provided by USAID. To this effect, USAID will in COP20 (although beginning COP19), embrace county and community input in program planning as well monitoring to foster a stronger partnership around HIV/TB and social, client-centered service delivery.” - pg. 81</p>	<p>In COP21, PEPFAR will ensure that civil society is at the forefront of determining the structure of community led-monitoring in Kenya to ensure that it is inclusive and community led. This will include allowing civil society to pick partners with whom to collect data, allowing communities to create and maintain their own data platforms, and ensuring that reporting is done at a national level to ensure the inclusion and review by all stakeholders.</p>	<p><b>COP21 Target:</b> PEPFAR allows civil society to determine the CLM model that works for them including by:</p> <ul style="list-style-type: none"> <li>Allowing civil society to pick partners with whom to collect data;</li> <li>Allowing communities to create and maintain their own data platforms;and</li> <li>Ensuring the reporting is done at a national level to ensure the inclusion and review by all stakeholders.</li> </ul>	

