KENYA COORDINATING MECHANISM

GOVERNMENT CONSTITUENCY FEEDBACK MEETING/GC7 DIALOGUE REPORT

LAKE NAIVASHA RESORT

11th to 12th April 2023

Executive Summary

The Global fund grant application process requires inclusive country dialogue to take place during the funding request development stage and throughout the grant lifecycle. The Government constituency is one of the 15 different constituencies that participate in the country dialogue and it brings together different stakeholders in the Government that are involved in the fight against TB, HIV and Malaria; National Government, COG, SAGAs, regulatory bodies and Counties. As part of the GC7 grant application process, the Government constituency held it's meeting with the purpose of aligning gaps and priorities for the GC7 funding application.

Key areas of the GC7 grant application was presented during the meeting; Kenya's allocation and program split guidelines, key steps of the funding request process and the modules and priority areas for each program-TB, HIV, Malaria and RSSH with the allocation of at least 15% of the total allocation to RSSH being highlighted.

The TB, HIV, Malaria and RSSH teams used the GF GC7 guiding documents to identify critical modules and approaches for GF while focusing on activities that will have a big impact. Inclusion of Interventions that address Sexual Exploitation Abuse and Harassment, Gender and Human rights was done.

Gaps and priorities per module were identified which include; Costing for the whole health care system and not TB, HIV and Malaria only, ensuring incremental in health financing which is part of the government manifesto, Strengthening PMTCT in ASAL counties, Promotion of male engagement in different sectors to promote HIV Testing Services, protection from sexual exploitation, abuse and harassment and making services safe for all client cohorts

The Government constituency meeting which had participation from various stakeholders met its objective of identifying gaps and priorities for each disease program and RSSH.Following this, a gap analysis meeting will be held.

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Acronyms/abbreviations

C-19 RM: COVID-19 Response Mechanism

COG: Council of Governors

CSS: Community Systems Strengthening

GF: Global Fund

HIS: Health Information Systems

HMIS – Health Management and Information Systems

HPT – Health Products and Technologies

HSS: Health Systems Strengthening

KCM: Kenya Coordinating Mechanism

KEMSA- Kenya Medical Supplies Agency

M&E – Monitoring and Evaluation

MOH: Ministry of Health

NACC- National Aids Control Council

NASCOP – National AIDS Control Program

NCDs: Non Communicable Diseases

NCH - Neonatal Child Health

NMCP- National Malaria Control Program

NPHL – National Public Health Laboratories

PPB – Pharmacy and Poisons Board

PPEs: Personal Protective Equipment

RSSH: Resilient and Sustainable Systems for Health

SAGAs: Semi-Autonomous Government Agencies

TB - Tuberculosis

1.   Introduction

The Global fund grant application process requires inclusive country dialogue to take place during the funding request development stage and throughout the grant life cycle.The Government constituency is one of the 15 different constituencies that participate in the country dialogue and it brings together different stakeholders in the Government that are involved in the fight against TB, HIV and Malaria; Government, Key populations and those living with diseases, youth, among others. The Government constituency brings together different stakeholders in the Government; National Government, COG, SAGAs, regulatory bodies and Counties. As part of the GC7 grant application process, the Government constituency held it's meeting on 11th and 12th April 2023.

1.1   Purpose and Objectives of the Constituency feedback Meeting /GC7 Dialogue

The purpose of the meeting was to bring together stakeholders in the government constituency and align on gaps and priorities for the GC7 funding application.

1.2   Objectives

1.   Share the roadmap on the GC7 grant application
2.   Use data as basis for discussion on prioritization
3.   Highlight GF strategy on how it can driver bigger impacts
4.   Mobilize in country partners
5.   Identify gaps and priorities for the GC7 grant writing for TB, HIV, Malaria and RSSH

Expected output of the meeting

☐ Analyze the gaps and discuss program splits

☐ Align on programmatic gaps and prioritization for funding requests

☐ Document evidence to comply with ER 1 and ER 2

☐ Complete funding request forms and annexes

2.   Highlights of sessions covered during the meeting

The Core team chair presented the GC7 grant writing highlights; Kenya's allocation and program split guidelines, key steps of the funding request process and the modules and priority areas for

each program-TB, HIV, Malaria and RSSH. It was clarified that during the grant writing, RSSH will be embedded in each program and will later be teased out and submitted as a stand alone application. At least 15% of the total allocation is expected to be allocated to RSSH.

Highlights on the availability and conditions for accessing matching funds were also given. The documents that will be used as guidelines during the grant making were listed and shared with the teams.

The special focus of the Global fund strategy 2023-2028 was highlighted which include; An intensified focus on prevention for all the diseases, Greater emphasis on integrated, people centered services, Systematic approach supporting development of community systems for health, Pandemic preparedness and response, Stronger voice for community, Intensified action to address inequities, human rights and gender related barriers, Greater emphasis on programmatic and financial sustainability, Greater focus on accelerating equitable deployment of and access to innovations, Emphasis on data driven decision making and Clarity on the roles and accountabilities of GF partners across every aspect.

The key considerations to inform prioritization in this funding request are;

- ☐ Value for money
- ☐ Funding sources
- ☐ Lessons learned
- ☐ Opportunities for integration
- ☐ Key risk to HIV TB and malaria programs
- ☐ HIV, TB and Malaria and RSSH programmatic gaps

The Kenya Red cross presented their implementation status for GC6 grant; They work in 46 counties focusing on HIV while in Embu, they focus on COVID. Implementation is done through 65 CSOs. Lessons learnt; what did and did not work well was also highligjted.

The KCM shared with the team the six minimum criteria that all CCM must meet to be eligible for funding. KCM has ensured it aligns better with the country's structure while focusing on investment results

The Technical guidance for HIV, TB Malaria and RSSH

. Members went in to group work where

the technical guidance for each disease area was offered.

Group work

Participants worked in groups per program; TB, HIV, Malaria and RSSH. Each group was taken through presentations guiding the writing process. Key tasks were to identify current existing gaps and priorities to be put in place, current opportunities that are working and opportunities for scale up.

 - ➢ **Technical Guidance Presentation** - The teams were taken through a technical guidance presentation on the TB, HIV, Malaria and RSSH GC7 application. Each module for the 3 diseases and RSSH were shared indicating the increase in Indicators for GC7 as compared to GC6. Emphasis was put on the need for the members to familiarize themselves with the Information Notes for each disease and RSSH.
 - ➢ **C-19 RM Fund** – This focuses on pandemic preparedness and health system strengthening. The submissions for the second Wave of the Fund are ongoing and the teams were encouraged to submit their applications.

The teams were encouraged to identify critical modules and critical approaches for GF while focussing on activities that will have a big impact. The inclusion of interventions that address Sexual Exploitation Abuse and Harassment, Gender and Human rights was emphasized. The groups then identified gaps and priorities per module and presented to the plenary for discussions and inputs.

3.   Discussion/key action points/recommendations

During plenary discussions the following were highlighted:

TB
 - ● The gaps identified in all modules were drawn from the draft NSP
 - ● Prioritization and expansion of gaps was deliberated on and agreed upon
 - ● Activities to address the gaps where expanded to take care of areas that arose and may not have been clearly captured in the draft NSP

- Areas related to human resource, sample referral and community engagement/volunteers for TB were noted as gaps that require a wholesome system response and therefore recommendation done to be discussed under RSSH and CSS, including indicators
- Lessons learnt and opportunities for scale up under what worked in the current grant were discussed and used to inform activities to close the prioritized gaps

HIV

- Include Human rights and gender issues in the HIV Prevention stewardship module
- Deliberate effort and Differentiated PMTCT programming in ASAL counties and mobile populations for improved PMTCT outcomes
- Longitudinal tracking of mother to baby pair captured in the disease specific M and E module through scale up of EMR and MNCH module.
- Include management of NCDs for KP
- Sustainability of the Key population program; Transition from DICEs to integration of KP services in the existing health facilities.
- Documentation of lessons learnt from the counties already integrating KPs into health facilities and use them o inform scale up
- A holistic person centered approach for Pregnant Adolescent girls as they go back to school
- GBV; Rescue centres and safe services for adolescents and young adults such as protection from sexual exploitation, abuse and harassment and making services safe for all client cohorts
- Include engagement of parents using Parents Teachers Associations Platform
- Adapt mental health in all the documents; psycho social support becomes a component of mental health
- Include more interventions for reaching AYPs from a multi sectoral approaches
- Promotion of male engagement in different sectors to promote HIV Testing Services.

MALARIA

- Data Quality Reviews and Audit for Malaria should be done biannually if not quarterly. This could assist in use of data for decision making within the programme.
- Include provision of oversight/mentorship to Private facilities to ensure compliance with guidelines and SOPs.

- Drug resistance and Therapeutic Efficacy studies to be planned for
- Strengthen Active Case Detection or Case Based Surveillance in Elimination settings and the surveillance system through Notification Alerts, investigations and Response.
- Inclusion of malaria in Integrated Community Case Management is a plus and quality of service and compliance with SOPs and guidelines needs to be strengthened
- Include Operational studies on net durability and insecticides Resistance Monitoring..
- .Development and dissemination of messages targeting various audience and measure of changes expected.
- Streamline human rights in all points of service delivery.
- Include interventions to reach the unreached populations or those less fortunate in the community.

RSSH

- Documents developed in the current grant to inform the grant writing and activities to be implemented in the next grant
- Ensure that there is no duplication in the M&E module
- Some items to be budgeted for in the disease specific grants e.g., Gene Xpert cartridges to be budgeted for in the TB grant
- Operational research to be an area of focus
- Ensure private sector integration/involvement
- Include interventions for community monitoring on financing e.g engaging communities in planning to ensure their priorities are articulated in the county assemblies, empowerment of communities to articulate their issues
- Ensure incremental in health financing which is part of the government manifesto
- Costing should be for the whole health care system and not TB, HIV and Malaria only

4.   GC7 Constituency Priorities

Gaps and priorities were identified for each disease program and RSSH (Annexed).

5. Conclusion

The Government constituency meeting was successfully held with participation from various stakeholders. Gaps and priorities were identified for each disease program and RSSH. Inputs were given and will be incorporated and shared with the core team chair before the next meeting. A gap analysis meeting will be held from Wednesday 19th April 2023.

6. Annex (Program, work plan reports, Constituency GC7 and COP 23 Priorities, Participant's list and Photos)

6.1   Annex 1 : Program

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CONSTITUENCY FEEDBACK MEETING/GC7 DIALOGUE
PROGRAM

DAY 1

TIME	SESSION	RESPONSIBILITY
8.00 am	Registration	
8.30-9am	▪ Introductions ▪ Meeting Objectives ▪ Welcome Remarks	KCM
9-9.30am	• KCM Updates/ KCM Evolution Project / Eligibility Performance Requirements • Country Dialogue Expectations	
9.30-11am	• Update on NFM3 Performance/ Experiences/Lessons learned /Achievements/Challenges • Perspectives from Beneficiaries and SRs • Status of Implementation of PEPFAR Grants	
11-11.30am	BREAK	
11.30-1pm	Plenary	
1-2pm	Lunch	
2-4.00pm	• GC7 FR development overview/ roadmap • PEPFAR COP 23 Road map/strategic objectives/Areas/Priorities • NSP Strategic Objectives for HIV/TB/Malaria/HSS/CSS	
4.00pm-5pm	Plenary: Discuss programmatic Gaps/Risks/ Opportunities/ Priorities	
Day 2		
9-10.00am	• GF GC 7 Technical Guidance for HIV/TB/ Malaria/RSSH/CSS/ • C19RM wave 2 objectives	
10.00-10.30am	Plenary Presentations Presentation of programmatic Gaps/Risks/ Opportunities/ Priorities	
10.30-11am	Break	

11-Noon		
Noon-1pm	Plenary	
1-2pm	Lunch	
2-5pm	GC7 /COP 23 Constituency Priorities/Programmatic gaps /Constituency Feedback Meeting Report	
5-6pm	Closure	
DAY 3	Departure	

6.2 Annex 2: TB GC7 Gaps and Priorities

Module	Intervention	Gaps identified	Activities to address the gaps
TB Diagnosis, Treatment and Care	TB screening and diagnosis	Over 45% of incident TB cases in the community are missed	Review and disseminate Policy guidelines, SOPs, Job aids, tools
		Only 43% of health facilities where people seek care initially had the capacity to diagnose TB	Build capacity and improve skills for TB screening and diagnosis among clinicians
		Sub-optimal implementation of TB ACF in health facilities	Implement and scale up active case finding in all service delivery points including activation of sites to perform Program Quality and Efficiency (PQE) ACF approaches.
		Suboptimal quality of TB screening with multiple losses in the presumptive cascade	Conduct bi-directional screening for TB and other co-morbidities
		Sub optimal follow up of DS-TB and DR-TB contacts identified	Ensure all diagnosed TB patients are put on treatment, notified, and reported
		Sub optimal data linkage between the laboratory LMIS and the TIBU system	Ensure all health facilities record and report ACF cascade data
		No data on surveillance in high-risk DR-TB groups	
TB Diagnosis, Treatment and Care	TB screening and diagnosis	Radiology services are largely available in only high-level facilities hence low utilization of CXR for systematic TB screening	Procure digital X-rays with CAD for Screening
			Increase coverage of community TB screening outreaches using digital CXR with CAD
TB Diagnosis, Treatment and Care	TB screening and diagnosis	Missing children with TB with a lLow contribution of children in TB	Integrate TB case finding in all pediatric service delivery points

		notification i.e., 9.6% for DS-TB in 2021 and 2-4% for DR TB between 2019-2021.	
		Low index of suspicion of childhood and adolescent TB among health care workers	Build capacity of healthcare workers including CHWs to diagnose and manage childhood tuberculosis (including strengthening the use of stool based Xpert testing, especially for kids under 5 years old)
		Low HCW confidence in clinical diagnosis	Integrate TB services to all other childhood and adolescent health services in the facilities and communities
		Inadaquate skill on specimen collection for the children to facilitate TB diagnosis	Conduct extensive TB-CI to include index children and adolescents.
			Integrate Adolescents, young people in childhood TB services.
TB Diagnosis, Treatment and Care	TB screening and diagnosis	Inconsistent supply of laboratory commodities,	Procure adequate laboratory commodities and increase the number of mWRDs to be placed in the lower facilities to expand molecular TB testing
		Sub-optimal technical support as well as biosafety/infrastructural concern at culture and LPA laboratory services both at the central and regional laboratories	Revise the implementation plan for expanded coverage of TB diagnostic tools.
		Sub-optimal engagement and coverage of the private and research laboratories in diagnostic network activities	Support for PPEs in NTRL and decentralized LPA TB diagnostic facilities,
			Support for Proper waste segregation and incineration in all sites.
			Conduct biosafety and biosecurity risk assessment for the TB lab network.
			To determine TB diagnostic network, current testing capacities, challenges, and evidence-based

			interventions, to improve access, capacity, and quality.
			Multiplexing
TB Diagnosis, Treatment and Care	TB screening and diagnosis	Only 20 of the 47 Counties have a functional sample referral system for TB	Link all level (2 to 6) Health facilities to a sample referral system
		Not all laboratories are covered with EQA and results feedback for the activities are not shared systematically with all the laboratories assessed	Increase coverage of courier services and frequency of specimen pickup
		Current mWRDs focus on Rif. DST therefore potential for missing initial INH resistant TB patients	Improve and reinforce specimen tracking and results feedback.
			Integrate the SRS guideline across the disease program
			Capacity building of the 1st and 2nd EQA controllers
			Pilot and scale up the use of non-sputum samples for testing TB in the community (swab testing, urine) using mWRDs.
TB Diagnosis, Treatment and Care	TB screening and diagnosis	Slow scale up of Fluorescent Microscopes and challenge of spares for the faulty microscopes	Improve equipment servicing and maintenance and procure SLA for equipment
		Sub optimal coverage for universal DST	Maintain annual service plan with budget to support procurement of faulty equipment parts
		Human resource challenges due to inadequacy, training/capacity building, poor retention and high turnovers contribute significantly to sub optimal diagnostic performances-To be	Increase access to Culture, 1st and 2nd line DST for all previously treated including relapses and for RR patients

		addressed under cross-cutting area/indicate government support	
			Scale up the use of low and moderate complexity WRDs for diagnosis and detection of resistance to RIF, INH and FQ
			Enhance culture and DST decentralization services across the country
TB Diagnosis, Treatment and Care	TB treatment, care and support	Low treatment success rate of 84% compared to above 95% recommended by WHO	Sustain provision of adult and pediatric quality-assured formulations for all TB patients
		Loss to follow up higher than the proportion recommended of less than 5%	
			Strengthen active TB drug safety monitoring and management (aDSM)
			Introduce new therapies-including short pediatric regimen
			Improve follow up through management of the appointment system using digital tools.
			Accelerate the scale up of Electronic Health Management system
			Improve adherence counseling and peer led support
			Improve access to services through TB mobile services and opening of new treatment facilities, and rolling out DSD
TB Diagnosis, Treatment and Care	TB treatment, care and support		Improve cross-border collaboration (inter-county and across neighboring countries)
			Enhance treatment supporters and community management of patients (Manyata's for ASAL counties)
			Raise awareness about the rights of people affected by TB.
			Introduce community-led monitoring to identify barriers to access and reduce loss to follow up
			Enhance multidisciplinary approach in the management of DS-TB Patient
			Improve evidence-based intervention (through mortality reviews)

TB Diagnosis, Treatment and Care	TB treatment, care and support	Low coverage of nutritional support among the malnourished TB patients.	Enhanced Nutrition Assessment, Counseling and Support for TB patients
			Link TB Patients to social & Economic Support services in the Community (Leverage on existing mechanisms by NGAO and county governments)
			Enhance gender equality and social inclusion (GESI) in all nutrition interventions for TB patients
			Enhance Nutrition monitoring and evaluation for TB
Drug-resistant Tuberculosis (DR TB)	DR-TB diagnosis/ drug susceptibility testing (DST)	-Sub optimal screening among high-risk groups of DR-TB including paediatric contacts	Placement of rapid molecular diagnostic equipment at primary level facilities including private facilities
	to increase DR TB case detection from 69% to 80%	-Sub optimal use and placement of rapid molecular diagnostic equipment	Procurement and distribution of equipment, reagents, and kits for DST
	-Increase proportion of DR-TB cases among children <15years of age out of the total DR TB notifications from 2.4% to 10%		Improve access to diagnostic tools for children, and scale up non invasive specimen collection methods for children
			Capacity building of the health care workers on the new & simplified paediatric diagnostic algorithms
			Conduct Culture and DST including for new and repurposed drugs (at least at referral centers and quality assurance.)
			TB specimen referral/transportation for DST, connectivity for lab results including through digital technologies/system
			Scaling up of quality improvement methods, external quality assurance programs and approaches to improve program quality and service delivery
			Training/capacity building for TB laboratory staff, x-ray technicians and salary for staff/workers engaged in DST labs.

			• Scale up of social support for DRTB contacts
Drug-resistant Tuberculosis (DR TB)	DR-TB treatment, care and support	-Sub optimal follow up of DR-TB contacts identified	Procurement and provision of treatment with second-line medicines delivered through patient centered, ambulatory, decentralized models.
	to increase treatment success for DR TB patients from 77% (2021) to 85% (2028)	-Sub optimal QOC; inaccessible ECG testing at baseline and follow up, sub optimal supervision of care & treatment delivery.	Support for DOTs delivery system and providers; provision of monthly stipends for DOTs providers
	-To Increased Treatment Success Rate of notified Childhood TB patients from 88% in 2021 to >95% by 2028.		
		-Use of longer regimens comprising of toxic medicines	• Introduction and scale-up of all-oral short term regimens (including 6-month BPaL and BPaLM and 9-month all-oral regimens under programmatic condition) as per WHO guidelines.
		-Unavailability of child friendly medicines	
		-Unavailability of child friendly medicines	-Procurement of 2nd line child friendly medicines
			Improve patient's access and adherence to treatment including digital adherence technologies (DAT), psychosocial (professional support from psychiatrists/social workers), nutritional assessment and support for prioritized groups, transport support and mobile airtime
		-Sub optimal commodity management (PSM);delayed delivery of 2nd line medicines	• Strengthen a DSM (active Drug Safety Monitoring and Management).
			• Adoption of digital technologies; multi-dose/month dispensing (e.g., during any restrictions to travel/lockdown).
			• Training / capacity building for staff working in DR-TB clinics or treatment centers.

			• Procurement of more ECG machines and strengthening Lab services to monitor treatment response
			• Delivery of palliative/end-of-life care to eligible patients including counselling, staff visit, and consumables required for palliative care in home and health care facility settings.
			• Quality improvement methods and approaches to enhance program quality and service delivery.
DS-DR TB Prevention	Screening/testing for Latent TB infection	Limited access to chest X-ray for screening and tests for TB infection	Expansion and decentralization of testing facilities for Latent TB/TB infection e.g. IGRA test and TB antigen based skin tests
			Improve access to digital CXR (with or without CAD) and mWRD to ensure adequate screening for TB before TPT initiation.
DS-DR TB Prevention	Preventive treatment	Low coverage of TPT i.e., 50% of the counties	Increase provision of TPT to eligible individuals and those at risk of TB disease (Including contacts of DRTB patients)
			Strengthen monitoring of TPT cascade in the expanded TPT eligible population
			Adoption of digital tools for contact tracing, screening, adherence, and manage adverse drug reactions for clients on TPT
		TPT provision through private providers is limited	Demand creation by sensitization and behaviour change, communication approaches to enhance acceptability of TPT among health care providers, communities and individuals who will benefit from TPT
DS-DR TB Prevention	Preventive treatment	Erratic supply of TPT commodities resulted in incomplete TPT completion	Improve commodity security for TPT among the eligible HIV negative population and those at risk of TB disease
		Lack of systematic documentation and review of the ADRs linked to TPT	Strengthen recording and reporting for management of TB infection, starting from contact identification, screening, initiation and completion of TPT and monitoring of adverse events.
		There is no national policy position on preventive therapy for DR-TB	Adoption of WHO guidance on TPT for contacts of DRTB patients
DS-DR TB Prevention	Infection prevention and control (IPC)	Lack of isolation wards to admit TB patients who need care in most counties	Enhance facility-level infection control by improved administrative and environmental interventions and ensure availability and rational use of PPE

			Support institutionalization of TB infection control through strengthening the functionality of the TB infection control committee
			Ensuring availability of TB isolation facilities
			Improve health care workers' knowledge and practices in IPC
4.Collaboration with Other Providers and Sectors	Private provider engagement in TB/DR-TB care	Suboptimal engagement of the private providers across all PPM models	Strengthen coordination of PPM at national and County level including PPM working groups for PPM oversight.
		Low suspicion index and limited capacity to diagnose TB, low of motivation, and hesitancy to provide TB services.	Scale-up the number and diversity (All PPM Models - Private sector, Workplace, Diagnostic, ISP and Chemist/Pharmacy) offering TB screening services, referral, diagnosis and treatment
		Lack of diagnostic capacity in most private facilities	Optimize provision of TB services in the already engaged private facilities by supporting the providers and demand creation
		Sub-optimal/Incomplete recording and reporting and lack of TB screening module in some EMR	Strengthen referral and linkage systems for patients and samples between public and private.
		Inadequate linkage of the private sector/facilities with community TB strategies and interventions	Strengthen Monitoring and Evaluation systems to generate evidence of PPM-TB performance
			Incentivization of the Private Providers to offer TB services
4.Collaboration with Other Providers and Sectors	Collaboration with other programs/sectors	Limited engagement of corporate and workplaces that provide health services through wellness clinics;	Review and revise the Legal framework for engagement of MOH and other departments and ministries to strengthen TB multisectoral TB services.
		Suboptimal implementation of the multi-sectoral accountability framework for TB (MAF-TB)	Implement work wellness policy that includes TB and addresses stigma

4.Collaboration with Other Providers and Sectors	Community-based TB/DR-TB care	Low community contribution to TB case finding (only at 5%)	Update policy guidelines, SOPs, Job aids, tools on community TB care and prevention inclidung contact management
		Unstructured coordination of TB services at community level.	Build capacity of healthcare workers and community actors coummity TB care
			Strengthen recording and reporting of community led activiities
5.KVP	KVP- Prisoners	Inadequate knowledge by prisoners warders on TB	Support to ex-prisoner networks to inform the design, delivery and monitoring and evaluation of TB services in prison settings
		Inadequate resources for structural adjustment in prisons for IPC	Active case finding among people in prisons/jails/detention centers
		Lack of specific guidelines on IPC in prisons	Continuous sensitization on TB and prisons for the Warden
		Low awareness of the isolation policy to prisoner	Collaborations - screening of prisoners before admission- sustainability
		Inadequate TPT commodities for prisoners	Administrative, environmental, and personal protection measures aimed at improving infection prevention and control in prisons and detention centers – Guidelines need to be developed
		Challenge in optimizing linkage in the continuum of care	Renovation and equipment for TB laboratories in the prisons.
			Specimen referral mechanisms from prisons to external laboratories
			provision of TPT as needed.
			Linkages with TB care services to ensure continuation of treatment at all stages of detention (i.e., people undergoing treatment before detention, between different stages of detention and on exit from detention)
			Sensitization of prison officers/correction officers on continuum of care and rights of TB patients in prisons, including avoidance of solitary confinement of prisoners
KVP	KVP - Mobile population	Low collaboration with organizations	Collaboration and Support to organizations and representatives of mobile populations to ensure their engagement in the design, delivery and

	(migrants/refugees/IDPs)	that deal with mobile populations	monitoring and evaluation of TB services in mobile population setting including awareness about TB among the community
		2. Screening is minimal at the points reception and entry	
			Active case finding, contact tracing, and screening of migrants for TB prior to resettlement and immigration.
			Provision of mobile outreach services including regular screening (using X-rays, IGRAs/TST), and testing using GeneXpert/Truenat assays).
		3.Inadequate outreaches using	
			Strengthen cross-border referral processes and collaboration between national programs and stakeholders including communities and community-led monitoring
		4.Inadequate funding	
KVP	TB services targeting - Miners and mining communities	1.Inadequate engagement	Support to organizations and representatives of mining communities to ensure their engagement in the design, delivery and monitoring and evaluation of TB services for mining workers and their communities.
			Community-based TB care and prevention activities through outreach for miners, ex-miners, and residents of perimining communities with engagement of representatives from the mining community.
			3.Active case finding, contact tracing and screening of miners and mining.
		2.sub optimal targeted outreaches	
KVP	TB services targeting - Miners and mining communities	4. Sub optimal collaborations	4.Provision of mobile outreach services linked to local health facilities and regular screening/testing including using X-rays with/without CAD/AI, GeneXpert/Truenat assays.
			5.Provision of treatment (FLD and SLD) and supportive activities to improve patient's access and adherence to treatment including DAT.
		5.Sub optimal contact management	

			6.Psychosocial and nutritional support with engagement of representatives from the mining community.
		6. Inadequate kwoledege on TB in the mining community	
			7.Testing for TB infection (including using IGRAs/TST) and provision of TPT as needed/recommended.
KVP	TB services targeting - Miners and mining communities	8. Inadequate advocacy	8. Capacity building for occupational health professionals in mining areas.
			9. Strengthening linkages with other health and social services.
			10. Linkage with national TB health management information system and referral.
			11. Strengthening policy, governance, and advocacy, including engagement of key political, industrial, community and labor stakeholders in the region, and fostering public-private partnerships.
KVP	KVP - Urban poor/slum dwellers	1. Inadequate engagement	1. Support to organizations and representatives of these communities to ensure their engagement in the design, delivery and monitoring and evaluation of TB services.
		2.Sub optimal ACF	2. Active case finding, contact tracing and screening among urban poor and slum dwellers.
			3. Provision of mobile outreach services linked to local health facilities and regular screening/testing including using X-rays with/without CAD/AI, GeneXpert/Truenat assays.
		3. Inadequate targeted outreaches	
			4. Psychosocial and nutritional support with engagement of local representatives.
		4. Sub optimal collaborations	5. Implementation and scale up of innovative, people-centered care approaches.
			6. Supportive activities to improve patient's access and adherence to treatment including DAT, psychosocial and nutritional support for prioritized groups.
			7. Targeted advocacy-related activities including supporting TB symptoms awareness campaigns to

			enable urban poor and slum dwellers to access TB services.
		5. Inadequate advocacy	
KVP	KVP – Others (Elderly, malnourished , Persons with mental issues, drug users etc) ,	1. Lack of networks	Support to organizations and representatives of these communities to ensure their engagement in the design, delivery and monitoring and evaluation of TB services. Active case finding. Provision of mobile outreach services linked to local health facilities and regular screening/testing including using X-rays with/without CAD/AI, GeneXpert/Truenat assays.
		2.Suboptimal case finding in regard the population	Community-based TB care and prevention; community-based sputum collection/transport arrangements; Testing for TB infection and provision of TPT where needed.
		3.Suboptimal outreaches	
		4.Inadequate equipment-CAD/AI AND X-rays	
KVP	KVP – Others (Elderly, malnourished , Persons with mental issues, drug users etc) ,	5. Lack of patient support groups	6.Supportive activities to improve access and adherence to treatment including DAT, psychosocial and nutritional and other social protection support for prioritized groups. 7. Engagement with other sectors and government to ensure undernourished people receive nutritional support including through working with World Food Program and others. 8. Support CRG TB assessments and community-led monitoring to help the NTP identify and map who the other key and vulnerable populations are in the country.
		6.Inadequate multisectoral collaborations	
		7.Mapping has NOT been done	

KVP	KVP - Children and adolescents	1. Lack of a TB screening policy for institutions of learning. Opportunity-The process has began with a zero draft developed 2. Lack of referral loop to enhance linkages and service access	Development of policy guideline for TB screening in institutions of learning
KVP	KVP - Children and adolescents	1.Lack of a TB screening policy for institutions of learning. Opportunity-The process has began with a zero draft developed 2. Lack of referral loop to enhance linkages and service access Opportunity – Existing MOH 100 tool for digitization/ automation 3.Number of children contact targets NOT met Opportunity CHV/ TB champions who trace contacts at household level for linkage 4.Inadequate awareness of available technology for TB investigation in children	2. Development of referral pathways and protocols, dissemination, and supportive supervision for their implementation at community, facility and institutions of learning 3. Contact investigation among children and adolescents for TB/DR-TB including through outreach, community-basedand led approaches. 4. Testing for TB infection (using the latest available and recommended tools/approaches) and provision of TPT including the new regimens to eligible children and adolescents in contact with TB patients.

		5.Inadequate supply of testing commodities	
		Opportunity-The innovative technology for testing is available	5.Training/capacity building on response to childhood/adolescent TB, including clinical diagnosis and specimen collection, contact tracing and prevention
		6.Inadequate capacity/ knowledge Opportunity	
		Existing guidelines	
		7.Inadequate targeted outreaches to children and adolescents Opportunity	
			6.Conducting targeted outreaches for TB case finding institutions of learning
		They are in congregate settings – so easily accessed	
KVP	KVP - Children and adolescents	1.Lack of a TB screening policy for institutions of learning.	3. Contact investigation among children and adolescents for TB/DR-TB including through outreach, community-basedand led approaches.
		Opportunity-The process has began with a zero draft developed	4. Testing for TB infection (using the latest available and recommended tools/approaches) and provision of TPT including the new regimens to eligible children and adolescents in contact with TB patients.
		2. Lack of referral loop to enhance linkages and service access	5.Training/capacity building on response to childhood/adolescent TB, including clinical diagnosis and specimen collection, contact tracing and prevention
		Opportunity – Existing MOH 100 tool for digitization/ automation	6.Conducting targeted outreaches for TB case finding institutions of learning
		3.Number of children contact targets NOT met	
		Opportunity	
		CHV/ TB champions who trace contacts at	

household level for linkage

4.Inadequate awareness of available technology for TB investigation in children

5.Inadequate supply of testing commodities

Opportunity-The innovative technology for testing is available

6.Inadequate capacity/ knowledge Opportunity

Existing guidelines

7.Inadequate targeted outreaches to children and adolescents Opportunity

They are in congregate settings – so easily accessed

KVP	KVP - Children and adolescents	Inadequate awareness of available technology for TB investigation in children Inadequate supply of testing commodities	Training/capacity building on response to childhood/adolescent TB, including clinical diagnosis and specimen collection, contact tracing and prevention
		Opportunity The innovative technology for testing is available	Conducting targeted outreaches for TB case finding institutions of learning
		Inadequate capacity/ knowledge Opportunity	
		Existing guidelines	
		Inadequate targeted outreaches to children and adolescents	
		Opportunity	

		They are in congregate settings – so easily accessed	
TB-HIV	TB/HIV collaborative interventions (Joint coordination, planning and monitoring)	Weak diagnostic and care approaches to TB/HIV and NCDs (Diabetes, Mental health and Lung Cancer)	Improve coordination of TB/HIV, Diabetes, Lung cancer,Mental health and COVID-19
	Quality TB screening, testing and diagnosis among PLHIV	Low sensitivity of symptom based TB screening among PLHIV	Improve the quality of TB symptom screening among PLHIV through facility mentorship
		Inconsistent supply of key commodities like Stockouts of HIV test kits, CRAG test, viral load tests, CD4 tests, fluconazole, and nutrition supplements	Procure and supply adequate commodities for TB/HIV screening, testing, diagnostic and monitoring tests
	Use of digital CXR with CAD as a screening tool for TB among PLHIV	Limited access to chest X-ray for screening and tests for TB infection	Procurement of CXR with CAD and Waive cost of CXR for screening of TB among PLHIV
TB-HIV	Use of digital CXR with CAD as a screening tool for TB among PLHIV	Limited access to chest X-ray for screening and tests for TB infection	Procurement of CXR with CAD and Waive cost of CXR for screening of TB among PLHIV
	Use of mWRD tests for TB diagnosis among PLHIV	Low mWRD coverage for TB diagnosis among PLHIV	Procurement and distribution of mWRDs (GeneXpert,truenat)
	Scale up use of TB LF-LAM for detection of TB among eligible PLHIV	Low levels of TB LF-LAM implementation	Procurement and distribution of LF-LAM kits in all facilities offering TB/HIV services
	TB/HIV Treatment and care	High case fatality among TB/HIV cases with advanced disease and low TSR of 78% among TB/HIV co-infected patients	Improve adherence counselling and peer led support to achieve >95% TSR

			Use of t-bu DAT to strengthen adherence among co-infected
TB/HIV	TB prevention among PLHIV	Sub optimal TPT coverage among PLHIV at 69%	Ensure at least 90% TPT coverage among eligible PLHIV
		Presence of integrated guidelines for TB and HIV management	
		Availability of TB/HIV coordination framework	

Human Rights

7. Removing Human Rights and Gender-related Barriers to TB Services	Eliminating TB-related stigma and discrimination	1.Minimal measurement, monitoring or remedies of and for TB stigma and discrimination	Conduct TB stigma assessment and community gender and rights assessment (version 2)
			Develop and operationalize a stigma reduction operation plan
	Ensuring people-centered and rights-based TB services at health facilities	1.There is no TB specific costed operational framework for gender and human rights activities	1. Coordinated approaches to leadership and management of TB human rights at National, county and community levels.
		Lack of county level strategic plans that address human rights and gender issues	Promote update of essential benefit package for TB patient
		Delays in accessing social protection packages (NHIF, monthly allowances) which is only available for DR TB clients excluding DSTB and Post TB clients	
7. Removing Human Rights and Gender-related Barriers to TB Services	Eliminating TB-related stigma and discrimination	1.Minimal measurement, monitoring or remedies of and for TB stigma and discrimination	Conduct TB stigma assessment and community gender and rights assessment (version 2)
			Develop and operationalize a stigma reduction operation plan

	Ensuring people-centered and rights-based TB services at health facilities	1.There is no TB specific costed operational framework for gender and human rights activities	1. Coordinated approaches to leadership and management of TB human rights at National, county and community levels.
		Lack of county level strategic plans that address human rights and gender issues	Promote update of essential benefit package for TB patient
		Delays in accessing social protection packages (NHIF, monthly allowances) which is only available for DR TB clients excluding DSTB and Post TB clients	
7. Removing Human Rights and Gender-related Barriers to TB Services	Ensuring people-centered and rights-based law enforcement practices	1.TB services have not factored in People Living with Disability, especially those with hearing impairment 2.Most counties do not have facilities to isolate patients who have TB and may need inpatient services	Implementation of supportive laws, policies and practices
			Develop policy to enforce implementation of isolation infrastructures
	Legal literacy (" Know-Your Rights")	3.General lack of knowledge on HRG at all levels of implementation	Promote legal Literacy/know your rights in relation to TB, leprosy, and Lung health
			Create awareness on TB HRG and reduce HRG related barriers including stigma
	Increasing access to justice	No mechanism to collect data on discrimination related to TB	Conduct a legal environment assessment (CRG)
		No linkage mechanism to justice	Operational plan to link those affected to justice
7. Removing Human Rights and Gender-related Barriers to TB Services	Monitoring and reforming policies, regulations and laws	Lack of coordinated mechanism to monitor and reform policies, regulations and la	Coordinated mechanism to monitor and reform policies, regulations and laws that impede TB services including GBV

		w that impede TB service provision	
			Activate community led monitoring and evaluation of human rights sensitive TB response
	Addressing needs of people in prisons and other closed settings	Prison setups do not have isolation facilities or do not meet the minimum required standards as set out in the Isolation policy.	Establish isolation facilities at regional maximum prisons
7. Removing Human Rights and Gender-related Barriers to TB Services	Reducing TB-related gender discrimination, harmful gender norms and violence	inadequate TB intervention targeting men who are at high risk for TB at workplace	Implement TB interventions and activities targeting men who are at a higher risk for TB especially at their workplaces: Increase men involvement in TB services and care seeking behavior change communication approaches
		Social cultural barriers hindering women and children from seeking care	Address social cultural barriers hindering women and children from accessing health care
		Limited decision making and economic empowerment to women/men leading to poor seeking making.	
		●Low coverage of TB mortality audits.	TB mortality survey
			Patient cost survey
			TB prevalence survey
RSSH M&E- TB Specific	Analyses, evaluations, reviews and data use	●Limited capacity in management, analysis, use, and communication of data at all levels.	Conduct annual performance reviews
		●Unstructured TB target setting.	Review and sensitization of TIBU dashboards
		●Low coverage of TB mortality audits.	Capacity building of high TB volume facility staff on TB epidemiology
			Automation of mortality audits to strengthen data availability and use
RSSH M&E- TB Specific	Operations Research	●The last ETR established limited funding and capacity	Develop a research framework for TB and lung diseases.

		for operations research.	
		●The TB prevalence survey was last done in 2016. As per the WHO recommendation, a prevalence survey should be conducted	Reconstitute the national TB, leprosy, and lung diseases research advisory committee.
		●There is limited utilization of the aggregated KHIS data for predictive analysis and limited capacity for analysis, use, and communication of data at all levels.	Develop a national repository for research on TB, leprosy, and lung disease.
		●Other health sector impact assessments do not comprehensively include TB indicators e.g KENPHIA and DHS	Integrate TB risk indicators from DHS into KHIS.
			Integrate TB indicators in demographic health surveys, Household surveys
			Conduct inventory study
			Conduct prospective follow-up of contacts survey
	Data quality	Sub optimal data quality	Disseminate DQI/A plan at sub-national levels
			Scale up periodic sub-national data quality meetings
			Carry out Data quality assessments at all levels
	Civil registration and vital statistics	●Low coverage (41%) of VRS which underestimates mortality	Conduct mortality statistics review meetings
		●Inconsistent reporting of TB mortality statistics	Sensitize local administration on TB verbal autopsy
			Conduct TB Mortality study
TB M&E specific	Routine reporting	Existing case based TB surveillance	Dashboards

		system(TIBU and T-bu lite)	
			Integration with other systems including lab system and EMRs and DHP
			Facility based electronic systems
			Upscaling data utilization at all levels to improve data quality
		Unique identifier policy framework	TIBU enhancements to include patient identifier
Analysis, reviews and data use		Collaboration with universities	Capacity building on TB data modelling and predictive analysis

6.3   Annex 3: HIV GC7 Gaps and Priorities

Module	Intervention	Gaps identified	Activities to address the gaps
HIV	Prevention Stewardship	Sub optimal prevention stewardship	1. Develop standardized national guidelines and prevention strategies, plans and programs including target setting, costing, defining investment needs and operational planning to improve program quality and sustainability in terms of program design, monitoring etc
			2. Spell out clear roles and responsibilities of prevention stewardship that are cascaded to the sub-national level
			3. develop dynamic interactive processes, involving information exchange, policy development, and program-planning activities to allow service providers to share their expertise and resources to identify and address health issues, keeping the person in the centre, and addressing needs holistically.
		Weak Intra- and inter-sectoral action for HIV prevention for effective response	
		Un-unified HIV prevention programs (vertical programming in combination prevention - Behavioural, biomedical and structural)	Provide oversight of prevention programs, enhance coordination and review mechanisms - Conduct regular support supervision, joint review platforms(GoK and implementing partners) for best practises and challenges.

HIV	Prevention Stewardship	Weak capacity in targeting, implementation and monitoring of prevention interventions	Build programme management capacities (including building individual skills, institutional and systems capacity such as defined functions, quality-assured processes and standard operating procedures.), robust service delivery platforms, and provide staff members with the training, time and resources to perform their tasks, and enhance coordination and collaboration with partners
		Weak community (geographical and populations) engagement in leading prevention models	Strengthen community-based or community-led prevention models for outreach, social contracting and safety of programs with key populations, AGYW and ABYM
HIV	Prevention Stewardship	Current monitoring frameworks and systems do not allow comprehensive monitoring for HIV Prevention programmes especially structural and behavioral (available data is not collated and analyzed to inform the Kenyan HIV prevention picture/track impact of all prevention approaches)	Strengthen HIV prevention data management (Define key HIV prevention indicators to monitor behavioural and structural interventions for individuals across the continuum and build capacity on data for decision-making
		"blanket and standard" interventions that do not consider the diversity in epidemic typology.	Targeted advocacy and training for all actors to create an understanding of HIV epidemic typologies, modes of transmission and populations affected, and coverage gaps in programmes.
HIV	Prevention Stewardship	Vertical HIV prevention communication strategies (Behavior change communication)	integration of HIV prevention communication (Behaviour change communication) with health promotion
		Duplication of efforts that creates a negative impact on healthcare costs.	

			Coordinated efforts to HIV preventive programming more effective, efficient and sustainable.
		Minimal specific BCC packages for age appropriate, population appropriate Behavior change communication	Develop and sustain age and population specific behavior change communication/behaviour change communication packages and platforms.
			Careful analysis of the size and location of sub populations, impediments to their engagement in combined prevention communication
			Tailor HIV prevention packages, and training of the appropriate workforce to be engaged demand generation Then incentivization of health care workers to take on this role
			Develop standardized tool monitoring tools
		Lack of communication of M&E structures to conceptualize and implement the prevention continuum for specific populations at risk.	
			Capacity build key stakeholders on communication and prevention continuum
HIV	Prevention Stewardship	Existing structures in place at the National level	Conduct regular technical working groups and review meetings at national and subnational level
		Existing prevention units at the national level (inadequate clarity of roles and responsibility)	Scale up engagement the relevant stakeholders in state and non state actors dealing with social determinants of health eg education,security, planning and coordination sectors etc)
		A complex array of various determinants of health and collaborators at both the individual and broader structural levels already mapped/ identified (Social determinants of health such as poverty, social exclusion, inadequate housing, food insecurity, gender inequality, and other factors impact a person's likelihood of acquiring HIV or	Sensitization and advocacy on roles and responsibilities to be mainstreamed in various sectors eg Triple threat campaigns etc

accessing HIV prevention services)

			Conduct sustained public education
			Scale up and/or harmonization of utilization of community and national led platforms for demand creation and feedback eg Maisha Health Digital, I monitor, Ushauri, one to one , Be self sure Tibu and CLM etc
			Create best practises sharing forums
			Documentation
HIV	Prevention Stewardship	Existing successful prevention projects and demonstrations	Scale up best practises /successful projects
HIV	Prevention Stewardship	Existing government/community led organised groups and safe spaces	Strengthen community-based or community-led prevention models for outreach, social contracting and safety of programs with key populations, AGYW and ABYM
		There is a lot of data from multiplicity of multisectoral stakeholders	Conduct regular population size estimation, hotspot mapping, risk assessment, socio-behavioural surveys, market and program analytics, monitoring of prevention outcomes, program reviews, financial analysis,
		Involvement of priority populations in design, implementation and monitoring of populations-based HIV prevention programmes is critical	Scale up capacity building for KP/VP led and focused grassroot organizations for demand creation for HIV prevention services.
HIV	Prevention Stewardship	Existing Division of Health promotion and National HIV Communication TWG	integration of HIV prevention communication (Behaviour change communication) with health promotion and community health strategy
		Funding for HIV prevention in Kenya generally is less than the global recommendation of 25% of the total HIV budget.	Identify and develop/strengthen mechanisms/strategies to Increase/advocate for funding/ring fence for HIV prevention to match the demand for these programmes, considering that 96% in Kenya is HIV Negative
		Strengthen integrated service provision	Map out opportunities for integration/leverage on existing ones
			develop a standardized framework for integration of prevention interventions

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			Capacity build /develop sustainability measures to ensure scale up of integrated services
			Enhance demand creation/public education for integrated services
		Elaborate elements of Costing for prevention commodities	Identify and clearly define the costing elements that require to be implemented in the grant
HIV-Differentiated HTS Services	Facility-based testing for key population (KP) programs	Low uptake of KP HTS uptake due stigma associated to KP	Training of HCW on KP stigma reduction
		Low testing uptake due to commodity stock outs	Train HCWs on Commodity management
			Conduct proper forecasting and quantification based on program targets to ensure commodity security
			Establish and support a digitalized system for forecasting and quantification
		Low number of health workers trained on KP friendly services including HTS	Train health care workers on KP friendly services to promote integration of services
	Facility-based testing for adolescent girls and young women (AGYW) and their male sexual partners programs	Lack of youth friendly and response services	1.Create model youth friendly centers within health facilities
			2. Train more health care workers on APOC
HIV-Differentiated HTS Services	Facility-based testing outside of key population (KP) and adolescent girls and young women (AGYW) programs	Low OPD/IPD HTS optimization ; missed opportunities	1. Train and certify health care workers to offer HTS especially nurses
			2. Deploy more lay HTS providers
			3. Scale up Integration of HTS in other service delivery points e.g. TB clinics, MNCH, IPD, Special clinics

HIV-Differentiated HTS Services	Community-based testing for KP programs	Low sexual partner elicitation ratios and identification yield	1.Conduct refresher training on index testing-skills 2. Peer to peer mentorship
		Low uptake of social network-based testing.	Scale up training on SNS to service providers
	Community-based testing for AGYW and their male sexual partners programs	Low uptake of HTS services among AGYW and their male sexual partners	Create demand and mobilization for HTS in institutions of higher learning through peer mentorship model. Utilization of the youth empowerment centers to offer HIV services Utilization of existing platforms e.g. social media for advocacy
HIV-Differentiated HTS Services	Community-based testing outside of KP and AGYW programs	Low testing coverage among the general population	1. Employ more lay HTS providers 2. Develop a scheme of service for HTS providers. 3. Formulate and adopt more targeted testing strategies 4. Use data to identify priority populations for targeted testing
		Low linkage rates from community to facility	Scale up community sensitization on benefits of early ART initiation and HIV preventions services Provide adequate linkage and referral tracking tools Facilitate community follow up visits for incomplete linkages
HIV-Differentiated HTS Services	Self-testing for KP programs	Low uptake due to stock outs, myths and misconceptions	Train HCWs on Commodity management Conduct proper forecasting and quantification to ensure commodity security Sensitization to demystify myths and misconceptions provide adequate M/E tools for commodity management ;

	Self-testing for AGYW and their male sexual partners programs	Sub-optimal HIVST delivery approaches and accessibility	Train Private sector on HIVST commodity management and distribution
			Avail adequate vending machines
HIV-Differentiated HTS Services	Self-testing outside of KP and AGYW programs	Low HIV testing coverage among men than women	Scale up advocacy , communication and social mobilization on HIVST among men
			Target men using HIVST-workplace , through their sexual partners
			Capacity build CHVs to promote uptake and distribution of HIVST
			Male engagement fora to formulate more effective startegies
	Human rights in HTS provision	Sub optimal identification of adverse effects of the HTS strategies	Scale up training on safe and ethical index testing strategy.
		Interruption of HTS among other essential services for KP due to social values	Sensitize the political leaders on the KP program mandate in context of fundamental human rights and public health
HIV-Differentiated HTS Services	Implementation of 2022 HTS guidelines	Lack of adoption of the three-test algorithm is followed for rapid diagnostic test-based diagnosis of HIV	1. Identification and procurement of the 3 assays
			2. Training and roll out of the three test algorithm
	Early Infant Diagnosis	Long Turn Around Time for EID results	Invest in POC EID testing (multiplexing)
		Erratic supply of POC EID commodities	Digitalize forecasting and quantification to ensure commodity security
Prevention Package for Men Who Have Sex with Men (MSM) and their Sexual Partners	Condom and lubricant programing for MSM	72% MSM received a condoms for HIV prevention (Source KHIS Feb 2023)	Targeted condom distribution, including to non-traditional outlets through WhatsApp
			Demand creation through peer outreaches
			Social media marketing activities through champions targetted information on correct, consistent use of condoms e.g Tiktok,Instagram

		Integration with and referrals to other HIV prevention and HIV testing services
		Information and communication on safer sex and condom use at community level by use of CHVs
	33% MSM received lubricants as at Feb 2023	Proper forecasting and quantification of lubricants
	Stock out of commordities	Proper forecasting and quantification of condoms both male and female
		Issuance of condoms per need based on the estimates per typology
		Procurement of condoms and lubricants
		Co packaging of Condom and lubricant
	Lack of reporting tools	Develop condom and lubricants reporting tools
Pre-exposure prophylaxis programming for MSM	5% of Active HIV Negative MSMs are o Prep(source KHIS)	Develop subcounty specific Prep targets using Prep IT tool
	40% of MSM are continuing on Prep(Source KHIS)	Adherence support using MSM Prep Champions
		Integrate Prep services in different service delivery poitns including pharmacy,chemists etc.
		Prep information and demand creation at community level using community strategy also using Prep Champions
		Differentiated model e.g Community dispensing of prep either peer led or HCW led
		Integration of Prep services in GOK and Private facilities to improve HIV prevention,testing, treatment and clinical monitoring
HIV prevention communication, information and demand creation for MSM	Lack of targeted HIV prevention information accessible in internet or social media platforms	Targeted internet-based information, education, communication, including social media.
		Social marketing based information,education and communication
	Suboptimal MSM reached with peer education	Venue-based outreach.
		Distribution of HIV self test kits to their sexual partners

	Most of MSM HIV prevention and treatment services are offered in DICEs	Capacity HCW in health facility on HIV prevetion and communication for MSM
		One-on-one and group risk reduction activities at facility and outreach level
Community empowerment for MSM	Unreached MSM population	Engagement of local CSO in KP programme implemetation-MSM led organizations
		Provision of safe spaces
		Conduct multisectoral stakeholders engagement forums/dialogues at different levels
		Conduct training to county leadership,HCW,peers and MSMs on HIV,SRH and sexuality
		Formation of TWG at national and county level with participation of MSM community
Sexual and reproductive health services, including sexually transmitted infections (STIs), hepatitis, post-violence care for MSM	78% of MSM were screened for STI in Dec 2022-Feb 2023	Scale up HCWs training on STI screening prevention and treatment
		Sensitize MSMs on routine STI check ups
		Expand access to diagnostics for STIs and VH including use of dual or triple test kits.
		Ensure uninterrupted commodity supply and requisite laboratory support for STI
	Inability to access HEP C treatment due to financial contraints	Incooperate Procurement of Hepatitis C drugs in the grant
	Inadequate supply of Hepatitis B vaccines	Proper forecasting and quantification of Hepatitis B vaccines
	Only 79% of MSMs received post violence care and support	Capacity build different stakeholders e.g police on post violence management
		Integration of HIV prevention services in all SDPs in the facility.
Removing human rights_x0002_related barriers to	Punitive Penal code	Advocacy for legal and policy reforms, including decriminalization.

prevention for MSM			
		stigma and discrimination	Legal support, human rights and legal literacy and legal empowerment of MSM
			Sensitization/training of law enforcement and health care providers on Human Rights-related Barriers to HIV/TB Services
		anti LGBTQ discrimination discussin in country	Anti-homophobia campaigns, access to justice and linkages to other services.
			Engagement of top leadership on the KP programming in line of the 2010 constitution of The right to the highest attainable standard of health
		Only 79% of MSMs received post violence care and support	Documenting violence and other human rights violations and referral to redress and support.
Prevention Package for Sex Workers, their Clients and Other Sexual Partners	Condom and lubricant programing for Sex workers	74% Sex workers received a condoms for HIV prevention (Source KHIS Feb 2023)	Targeted condom distribution, including to non-traditional outlets through WhatsApp
			Demand creation through peer outreaches
			Social media marketing activities through champions targetted information on proper use of condoms e.g Tiktok,Instagram
			• Integration with and referrals to other HIV prevention and HIV testing services
			Information and communication on safer sex and condom use at community level by use of CHVs
		Forecasting and quatification of lubricants for Sex workers	Proper forecasting and quantification of lubricants
		Erractic Suppy of condoms	Proper forecasting and quantification of condoms both male and female
			Issuance of condoms per need based on the estimates per typology
			Procurement of condoms
		Lack of reporting tools	Develop condom reporting tools
	Pre-exposure prophylaxis programming for MSM	10% of Active HIV Negative Sex workers are on Prep(Source KHIS)	Develop subcounty specific Prep targets using Prep IT tool

	63%% of Sex workers are continuing on Prep(Source KHIS)	Adherence support using Sex workers Prep Champions
		Integrate Prep services in different service delivery poitns including pharmacy,chemists etc.
		Prep information and demand creation at community level using community strategy also using Prep Champions
		Procurement of PrEP commodities including different formulations such as oral (daily and event driven), vaginal ring and injectable
		Integration of Prep services in GOK and Private facilities to improve HIV prevention,testing, treatment and clinical monitoring
HIV prevention communication, information and demand creation for Sex workers	Lack of targeted HIV prevention information accessible in internet or social media platforms	Targeted internet-based information, education, communication, including social media.
		Social marketing based information,education and communication
	Suboptimal Sex workers reached with peer education	Venue-based outreach.
		Distribution of HIV self test kits to their sexual partners
	Most of MSM HIV prevention and treatment services are offered in DICEs	Capacity HCW in health facility on HIV prevetion and communication for Sex workers
		One-on-one and group risk reduction activities at facility and outreach level
Community empowerment for SEX WORKERS	Unreached Sex workers population	Engagement of local CSO in KP programme implemetation-MSM led organizations
		Provision of safe spaces
		Conduct multisectoral stakeholders engagement forums/dialogues at different levels
		Conduct training to county leadership,HCW,peers and Sex workerss on HIV,SRH and sexuality
		Formation of TWG at national and county level with participation of MSM community

Sexual and reproductive health services, including sexually transmitted infections (STIs), hepatitis, post-violence care for Sex workers	78% of MSM were screened for STI in Dec 2022-Feb 2023	Scale up HCWs training on STI screening prevention and treatment
		Sensitize MSMs on routine STI check ups
		Expand access to diagnostics for STIs and VH including use of dual or triple test kits.
		Ensure uninterrupted commodity supply and requisite laboratory support for STI
		Incooperate STI commordity reports in FCDRR for ARV commodities
	Inability to access HEP C treatment due to financial contraints	Incooperate Procurement of Hepatitis C drugs in the grant
	Inadequate supply of Hepatitis B vaccines	Proper forecasting and quantification of Hepatitis B vaccines
	Only 79% of sex worker received post violence care and support	Capacity build different stakeholders e.g police on post violence management
		Integration of HIV prevention services in all SDPs in the facility.
Removing human rights_x0002_related barriers to prevention for Sex workers	Punitive Penal code	Advocacy for legal and policy reforms, including decriminalization.
		Community-led and other advocacy for reforms to laws, policies and practices that hinder prevention efforts, including decriminalization and police practices.
		Legal support, human rights and legal literacy and legal empowerment of sex worker
	stigma and discrimination	Participation of sex workers in activities to sensitize/train law enforcement and health providers on human right related to Health for sex workers

			Campaigns for the rights and dignity of sex workers, access to justice and linkages to other services.
			Assessments of the gender-responsiveness of all prevention programing for sex workers and activities to change
		anti LGBTQ discrimination discussion in country	Anti-homophobia campaigns, access to justice and linkages to other services.
			Engagement of top leadership on the KP programming in line of the 2010 constitution on The right to the highest attainable standard of health
		Only 81% of MSMs received post violence care and support	Documenting violence and other human rights violations and referral to redress and support.
Prevention Package for transgender peoples, their Clients and Other Sexual Partners	Condom and lubricant programing for transgender peoples	XXX transgender peoples received a condoms for HIV prevention (Source KHIS Feb 2023)	Targeted condom distribution, including to non-traditional outlets through WhatsApp
			Demand creation through peer outreaches
			Social media marketing activities through champions targeted information on proper use of condoms e.g Tiktok,Instagram
			Integration with and referrals to other HIV prevention and HIV testing services
			Information and communication on safer sex and condom use at community level by use of CHVs
		Forecasting and quatification of lubricants for transgender peoples	Proper forecasting and quantification of lubricants
		Erractic Suppy of condoms	Proper forecasting and quantification of condoms both male and female
			Issuance of condoms per need based on the estimates per typology
			Procurement of condoms
		Lack of reporting tools	Develop condom reporting tools
	Pre-exposure prophylaxis programming for MSM	XXX of Active HIV Negative transgender peoples are on Prep(Source KHIS)	Develop subcounty specific Prep targets using Prep IT tool

	XXX% of transgender peoples are continuing on Prep(Source KHIS)	Adherence support using transgender peoples Prep Champions
		Integrate Prep services in different service delivery poitns including pharmacy,chemists etc.
		Prep information and demand creation at community level using community strategy also using Prep Champions
		Procurement of PrEP commodities including different formulations such as oral (daily and event driven), vaginal ring and injectable
		Integration of Prep services in GOK and Private facilities to improve HIV prevention,testing, treatment and clinical monitoring
HIV prevention communication, information and demand creation for transgender peoples	Lack of targeted HIV prevention information accessible in internet or social media platforms	Targeted internet-based information, education, communication, including social media.
		Social marketing based information,education and communication
	Suboptimal transgender peoples reached with peer education	Venue-based outreach.
		Distribution of HIV self test kits to their sexual partners
	Most of MSM HIV prevention and treatment services are offered in DICEs	Capacity HCW in health facility on HIV prevetion and communication for transgender peoples
		One-on-one and group risk reduction activities at facility and outreach level
Community empowerment for transgender peopleS	Unreached transgender peoples population	Engagement of local CSO in KP programme implemetation-KP led organizations
		Provision of safe spaces
		Conduct multisectoral stakeholders engagement forums/dialogues at different levels
		Conduct training to county leadership,HCW,peers and transgender peoples on HIV,SRH and sexuality
		Formation of TWG at national and county level with participation of MSM community

Sexual and reproductive health services, including sexually transmitted infections (STIs), hepatitis, post-violence care for transgender peoples	XXX of Transgender were screened for STI in Dec 2022-Feb 2023	Scale up HCWs training on STI screening prevention and treatment
		Sensitize transgender on routine STI check ups
		Expand access to diagnostics for STIs and VH including use of dual or triple test kits.
		Ensure uninterrupted commodity supply and requisite laboratory support for STI
		Incooperate STI commordity reports in FCDRR for ARV commodities
	Inability to access HEP C treatment due to financial contraints	Incooperate Procurement of Hepatitis C drugs in the grant
	Inadequate supply of Hepatitis B vaccines	Proper forecasting and quantification of Hepatitis B vaccines
	Only XXX of transgender people received post violence care and support	Capacity build different stakeholders e.g police on post violence management
		Integration of HIV prevention services in all SDPs in the facility.
	Inability to access SRH services in Health facilities	Contraception/family planning information and services.
		Pregnancy testing
		Gender affirming care.
Removing human rights_x0002_related barriers to prevention for transgender peoples	Punitive Penal code	Advocacy for legal and policy reforms, including decriminalization.
		Community-led and other advocacy for reforms to laws, policies and practices that hinder prevention efforts, including decriminalization and police practices.

	stigma and discrimination		Legal support, human rights and legal literacy and legal empowerment of transgender people
			Participation of transgender peoples in activities to sensitize/train law enforcement and health providers on human right related to Health for transgender peoples
			Campaigns for the rights and dignity of transgender peoples, access to justice and linkages to other services.
			Assessments of the gender-responsiveness of all prevention programing for transgender peoples and activities to change
	LGBTQ discrimination discussions in country		Anti-homophobia campaigns, access to justice and linkages to other services.
			Engagement of top leadership on the KP programming in line of the 2010 constitution of The right to the highest attainable standard of health
	XXX transgender received post violence care and support		Documenting violence and other human rights violations and referral to redress and support.
Prevention Package for People Who Use Drugs (PUD) (injecting and non_x0002_injecting) and their Sexual Partners	Needle and syringe programs for PWID	Current KP size estimates as at Dec 2022 for PWID is 26,672. However only 55% are receiving NSP	programing.
			Procurement of needles and syringes, including low dead space syringes and other safe injecting commodities.
			Provision of basic healthcare and injecting-related first aid, including wound care and treatment of skin infections
			Referral and link to behavioral interventions, HIV testing, care and treatment and primary health care (PHC) services.
			Prevention, screening, testing and treatment for hepatitis B and hepatitis C. Referrals to vaccination for hepatitis B
	Opioid substitution therapy and other medically assisted drug dependence	There are only 11 MAT sites verses estimated 26,672 PWID	Scale up of OST sites

	treatment for PWID		
			Procurement and distribution of OST, including provision of take-home doses e.g use of Buprenophine
			Recruitment and Training of service providers
			Integration of other HIV services like HIV testing and counselling and care and treatment
			Prevention, screening, testing and treatment for hepatitis B and hepatitis C. Referrals to vaccination for hepatitis B
			Development of OST protocols and policies that address the needs of pregnant clients and drug interactions for those on OST and ART/TB medications
			Consitent commordity supply esp of Urine toxicology kits
	Overdose prevention and management for PWID	Inconsitent supply of Naloxone	Information and education about preventing overdose and strategies for minimizing overdose risk.
			Procurement of naloxone and support for distribution and administration by first responders, for example peers, partners, family, NGOs/CBOs.
EMCT of HIV, Syphillis, Hep B	1. Integrated Testing of Pregnant Women for HIV, Syphillis and Hep B	Commodity Insecurity: RTKs, DUO, HepBsAg	Strengthen supply chain management: commodity receipt, documentation, reporting and quantification from facility to the national level
			Introduction of trio-test kit to include HIV.Syphillis. HepB
			Prioritizing and ring fencing funding for PMTCT commodities RTKs, prophylaxis, nutritional supplements
		No guidelines for Hep B Testing and management	Develop guidelines for Hep B testing and management
		Suboptimal adherence to testing guidelines	HCW continuous capacity building on fidelity to guideline implementation
			Develop an indicator for retesting within the current MoH reporting tools
		Missed opportunity for testing because of legal interpretation of skills	Review MOH task shifting policy to include HIV testing services

	requirement for HIV testing	
	Suboptimal linkage of diagnosed PMTCT clients	Scale up PMTCT sites to include all HTS only sites
		Scale up use of case management (mentor mothers, peer champions, expert mothers) for psychosocial support of newly diagnosed clients
	Gaps in ANC uptake- worse at ANC 4 and skilled delivery	Incentivize mothers to improve ANC uptake (mama gift packs, transport reimbursement)
		Community involvement and political championing through structured engagement packages
		Incentivize TBAs to be referal agents
		Multi-stakeholder collaborations to enhance security for access of health facilities in areas with insecurity
		Conduct targeted outreaches and scale up use of CHEWs to increase coverage in line with UHC, CHS.
		Advocate for community ANC services delivery model using CHEWs, Family physicians for those with access challenges
	Lack of structured engagement packages	Develop packages/ guidelines for engaging non-health stakeholders in PMTCT e.g politicians, males, community gate keepers, influencers, religious leaders
	Inadequate private sector engagement and collaboration	Capacity build private sector HCWs to offer PMTCT services
		Provide appropriate tools to promote quality reporting
		Provide regular support supervision and mentorships to improve service provision
	Long distances to facilities	Avail mobile facilities for sparsely populated areas to reach mothers that are in far flung areas
	Inadequate data capture due to lack of data element provisions in exisiting tools- Hep B	Review of tools to incorpote relevant data elements
2. Prevention of incident HIV among pregnant and	Poor Prep uptake in MCH	Incorporate Risk assessment (RAST) in MCH for all MCH client

breastfeeding
women

		Expand options to include new formulations of Prep in the market e.g vaginal ring, injectable prep
		Friendly packaging of prep to distinguish it from ARVs: improve labelling, resolve rattling sound
		Incorporate prep within MCH reporting tools
		Continuous Capacity building of HCWs on Prep
		Increase community awareness on prep through social marketing, integration into other service delivery points
	Inadequate Partner involvement	Adopt and scale up use of service package of care for male partner involvement at MCH
		Adopt model of care that incorporates male champions
	Lack of community awareness on HIV prevention strategies especially among adolescents and young people	Provision of HIV information at MCH through various modalities e.g Health talks, TV adverts
		Community advocacy through community gatekeepers and community forums e.g political leaders, chief barazas, CHVs, religious leaders
		Develop a engagement package for Education sector stakeholders
		Develop combined prevention integrated communication for specific populations
	Negative cultural beliefs and practices e.g cultures that encourage extramarital affairs hence exposing the MCH mother	Engage opinion leaders to support community advocacy against negative cultural practices
	Lack of guidelines on special and/or vulnerable groups in PMTCT e.g AYP, KPs, PWUDs, PLWDs	Develop guidelines on PMTCT for special and/or vulnerable
		Develop differentiated service delivery models for special/ vulnerable groups in PMTCT e.g outreaches to schools for pregnant AYPs
3. Post-natal infant prophylaxis	HCW knowledge gap	Capacity build HCWs on PMTCT guidelines

	Commodity insecurity: ARV Prophylaxis	Strengthen supply chain management: commodity receipt, documentation, reporting and quantification from facility to the national level
	Non-disclosure among PMTCT clients	Capacity build HCWs, peers on supporting disclosure
4. Early infant diagnosis and follow-up HIV testing for exposed infants	Long turn around time for results	Scale up POC for EID
	EID Commodity insecurity: catridges, filter papers, sample bottles	Strengthen supply chain management: commodity receipt, documentation, reporting and quantification from facility to the national level
		Prioritizing and ring fencing funding for PMTCT commodities
	Infant testing after 2 months	Strengthen appointment management in MCH e.g Ushauri
		Capacity build to adhere guidelines, address HCW attitudes
		Awareness creation among PMTCT clients/ couples on importance EID
		Disclosure and psychosocial support for PMTCT clients
5. Retention support for pregnant and breastfeeding women (facility and community)	Unflexible guideline on alternative infant feeding for non-suppressed clients	Review guidelines to allow for alternative infant feeding for non-suppressed clients e.g formula, breast milk bank donations etc
		Provide alternative infant feeding for non-suppressed mothers
	Non-disclosure among PMTCT clients	Scale up PSSG
	Inadequate knowledge and skills to support disclosure and stigma reduction	Continuous capacity building of service provider: training and mentorship especially in ASAL counties
		Strengthen and scale up use of peers for PSS
	Long intervals for VL monitoring	Reduce VL monitoring interval from 6 to 3 monthly
	Poor retention among PMTCT clients especially amongst special/ vulnerable	Adopt innovative approaches e.g use of champions, influencers, social media platforms (whatsapp groups)

groups e.g AYPs, KPs, PWUD, PLWDs

		AYP inclusion in community awareness and advocacy activities
		Strengthen appointment management in MCH using technologies e.g Ushauri
	Limited access to other PMTCT related services like radiological and lab investigations where indicated	Promote NHIF enrollment beyond Linda Mama initiative among PMTCT clients.
	Lack of intergration on PMTCT services with CHS	Continuous supervision and mentorship to CHVs on PMTCT
		Leveraging on sensitized and mentored CHVs to trace PMTCT defaulters
		Advocate for peers, mentor mothers to be incorporated in the CHS
	Food security issues at household level	Multi-stakeholder engagement towards sustainable food security strategies e.g reintroduction of kitchen gardens and IGAs among PMTCT mothers
		Provision of nutritional supplements/ commodities for malnourished clients
	Weak longitudinal mother-baby pair follow up	Adopt and scale up longitudinal case based surveillance for PMTCT clients
	Increase in incidences of GBV/ IPV in communities	Increase community awareness and advocacy against gender based violence/ intimate partner violence and strenghten response and refererral systems for the same
	Lack of comprehensive PMTCT service provision	Full integration of PMTCT service provision with other MCH services-
Crosscutting	Inadequate capacity amongst various service providers: interns, newly posted staff, rotating staff	Provision of job AIDs
		Adoption/ development of simplified, interactive orientation packages for different service provision points
	Challenges and technicalities in using innovative approaches such as engaging social	Flexible budgeting models to accommodate innovative approaches

influencers, lobbying with politicians			
Inadequate program leadership and coordination		Operationalize/ strenghthen PMTCT TWGs	
		Institutionalize facility level PMTCT champions	
		Counties to develop last mile strategic plan to guide EMTCT implementation	
		Engage non-health partners to support PMTCT agenda. E.g companies, banks, local businesses through corporate social responsibility	
Over-reliance on partner support for PMTCT		Advocate for increased county government allocation for PMTCT activities	
		Advocate for county HRH to support PMTCT service provision	
Multiple data collection systems with increased workload		Harmonization of data collection systems and alignments with data protection laws and policies	
		Scale up use of PMTCT module in Kenya EMR	
Lack of Hep B Vaccination Guidelines		Develop HepB vaccination guidelines, commodities, reporting structures	

6.4   Annex 4: Malaria GC7 Gaps and Priorities

Module	Intervention	Gaps identified	Activities to address the gaps
Vector Control	ITN distribution – Mass campaign.	Mass campaign for 2026/2027.	Procurement (forecasting &quantification, tendering and evaluation)
			In country distribution (National & county level planning, trainings, HH registration, distribution & oversight).
	Routine distribution of nets.	Post distribution survey (PMLLIN survey).	Procurement and distribution of routine nets.
	Indoor residual spraying	IRS campaign targeting lake endemic region	Procurement and distribution of Insecticides, spraying exercise
	Larval source management	LSM in target areas	Procurement and distribution of larvicides and spraying exercise
	Entomological surveillance	Ento-surveillance in sentinel sites across all counties	procurement of ento-consumables and equipment; training of county level ento-teams; facilitate ento-surveillance in sentinel sites
		Durability studies and Insecticides resistance monitoring	Procurement of the consumables and bio-assays; Facilitate fieldwork at sentinels sites.

Case management	Facility-based treatment	Commodity availability;	Quantification of commodity needs for facility and community; Procurement of case management commodities (test kits; anti-malarials for facility and community level; consumables for lab services); Oversight and mentorship at county and national level; Case management capacity development and Mentorship (inpatient and outpatient) including private sector; Capacity development and Mentorship (inpatient and outpatient) including private sector.
		Oversight and mentorship	
	Community case management	Capacity of CHVs	Capacity-development of CHVs and link facilities
			Oversight and mentorship at county and national level
	Quality Assurance	Quality assurance for diagnostics.	Inclusion of mRDTs as part of the overall RSSH – Post-market surveillance
	Epidemic Preparedness and Response (Case Mgmt.)	Commodities for EPR – test kits, Buffer stocks, insecticides.	Inclusion of requisite commodity needs for buffer stocks within the Forecasting and Quantification exercise
Case Management	Elimination	Implementation of Active Case detection and response	Capacity-development of county, sub-county, facility and community-level on Elimination
			Facilitate active case detection, notification, investigation and response (logistics, PPEs, communication)
	Therapeutic Efficacy Studies	Information of efficacy of first-line treatment for malaria	Protocol development and approval; Training of field teams; logistics for fieldwork; data management; sample transportation; PCR analysis; Report-writing and dissemination
	•HRP2/3 gene deletion survey	Information on extent of HRP2/3 gene deletion in Kenya	
Specific Preventive Interventions	Social Behavior Change	Uptake of malaria interventions to optimal levels	Awareness creation at all levels; tailoring messages for different audience
		Coordination of SBC activities	Engagement of key stakeholders at national, county and community-level; facilitate development of county–specific SBC action plans
		Multi-sectoral collaboration and integration	Development of multi-sectoral framework and guidelines; Dissemination of multi-sectoral guidelines; facilitate regular engagement with stakeholders at national and county-level
		Availability of malaria messages	Development of messages for target audience at all levels; Production and distribution of messages for various channels (Radio, TV, Print, Social Media); analysis of SBC messaging

		Monitoring SBC delivery channels and mechanisms	Conduct operation research for SBC; undertake Omnibus surveys (inclusive of KAPC surveys)
	IPTp	Availability of commodity for IPTp-SP.	Inclusion of SP requirement as part of malaria commodity forecasting and quantification; procurement and distribution of SP to target facilities
		Uptake of IPTp in target areas	Facility and community based mentorship; capacity-development (CHV and H/workers); Oversight and mentorship; sustained messaging at community-level.
RSSH/M&E Malaria Specific	Commodity Management	Visibility of malaria commodity tracking at sub-county and facility level	Capacity-development for facility and sub-county staff on commodity management; Enhancing visibility of commodity status at facility level; Bi-annual malaria commodity review;
	Ensuring Drug and diagnostic kits quality	Post-Market surveillance for malaria diagnostics and anti-malarials	Undertake Post-marketing Surveillance in collaboration with PBB and NQCL (public and private sector)
	Data for Decision-making	Availability of quality data to inform decision-making at all levels	Conduct Data Quality assessments; facilitate development of data quality improvement plans at county-level; Conduct health facility assessment; Malaria Indicator Survey; Capacity-development for h/workers on in-patient data capture and reporting; scale up the implementation of the Malaria data repository/information hub.
		Disaggregated data for reporting (age; gender)	Facilitate participation in the HIS data tools review process
		Availability of current reporting tools	HIS to facilitate the availability of reporting tools
Human Rights and Gender (Cross cutting – All malaria modules)	Human rights and Gender mainstreaming	Mainstreaming Malaria Matchbox assessment onto malaria policy, strategy and implementation programming as applicable	Development of gender and age specific behavior change communication strategies
			Identify vulnerable and marginalized population groups (Preg women, children under 5, person living with disability, refugees, displaced persons, elderly, socio-cultural disadvantaged, person in correctional facilities, Adolescent girls, other Vulnerable population groups) and address barriers for malaria services
			Inclusion of recommendation of matchbox assessment into the next Kenya Malaria Strategy

6.5 Annex 5: RSSH GC7 Gaps and Priorities

Module	Interventions	Gaps	Priority Areas	Activities
Health Sector Planning, leadership, and Governance	Strengthening national health sector strategy, policy, and regulations:	National health sector strategy, policy guidelines& regulations in need of review for example KHSSP and PHC	National health sector strategy, policy guidelines& regulations development	KHSSP https://www.health.go.ke/wp-content/uploads/2022/01/KHSSP-MTR-Syntheis-Report2021.pdf and PHC https://www.health.go.ke/wp-content/uploads/2020/07/Kenya-Primary-Healthcare-Strategic-Framework-Signed.pdf Development and Dissemination
	Integration and cross-programmatic efficiency and equity:	Siloed approaches to patient management and care	Integrated patient care guidelines according to service delivery level.	Development and dissemination of integrated patient care guidelines according to service delivery level. http://guidelines.health.go.ke:8000/media/clinical_guidelines_vol_I.pdf
		Limited joint sectoral planning	Improve intergovernmental engagements, multisectoral and Stakeholder collaborations- Joint Health Sector Advisory Committee (JHSAC) & HISC, IGF, IBEC, Interagency coordinating committees	Hold regular meetings for coordination and undertake technical assistance and mentorship activities
			Integration and coordination of programs and divisions with the aim of achieving efficiency, equity, planning and implementation	Hold joint policy, strategic plan, and AWP development meetings.
	Policies and regulations supporting private sector engagement:	Kenya Public Private Collaboration Strategy 2020 not disseminated. Lack of enforcement mechanisms for ensuring the private sector complies with health regulations in service delivery	Implement Kenya Public Private Collaboration Strategy 2020	Health partnership arrangements, County sensitization on PPPs with an aim of collaboration and supporting private sector engagement https://www.health.go.ke/wp-content/uploads/2021/11/The-Kenya-Health-Public-Private-Collaboration-Strategy-2020.pdf

Community Systems Strengthening	Community led monitoring	Suboptimal mechanisms for community feedback on the quality of primary health care service	Support community health units to implement the community scorecard for social accountability of primary health care services	
		Community Health Strategy does not include non-state or private sector actors	Review the national Community health strategy and institutionalize private and non-state community health actors	
		Lack of national policy and framework for managing community-led service providers	Develop and disseminate a framework for the engagement of community-led service providers with primary health care networks	
	Community led research and advocacy	Lack of a framework for community-led research	Develop and disseminate a framework for community-led research	
		Low capacity of community health units for health advocacy	Strengthen community health advocacy	
	Community engagement, linkages and coordination	Suboptimal quality of community health services	Scale up roll out of e-CHIS to strengthen community health support supervision and mentorship	
			Scale up the implementation of the Kenya Quality Model for Health for community health	
		High attrition of CHWs due to low motivation and incentives	Develop, and disseminate a framework for financial and non-financial incentives for community health workers	
		Poor quality community health data	Support counties to roll out of electronic community health information system	
			Support Community Health performance reviews	
		Poor community-to-facility-community referral and linkages	Develop and disseminate a framework for community to facility-community linkages in health sector	
			Strengthen community participation in health through community dialogue and community health action days	
	Capacity building and leadership development	Suboptimal competencies of CHWs on integrated community health service delivery	Review and validation of the national CHW registry	
			Build capacity of community health workers to deliver quality community health services	

			Build capacity of community health champions to create resilient communities during pandemics and emergencies	
		Limited capacity for supply chain of the community health commodities	Integrate supply chain for community health commodities in broader sector HPT strategies and plans	
Health Financing	Health Financing strategies and planning	Inadequate resource mobilization and allocation	Increase domestic resource mobilization • Tax regimes (Direct and Indirect taxes) • OnSource Revenue • Socio-economic profiling of Households by CHVs • Private Sector Financing for Health	
		Donor Transition Framework- Dissemination and roll-out	• Stakeholder Validation • Stakeholder Engagement • Support for county specific transition plan	
		Ring -fencing of Health Funds	• Enactment of FIF Bill at National and County level • Implementation of FIF Guidelines (Financial and Technical Support)	
		Increase Health Insurance coverage and pre-financing mechanisms	• Advocacy for Amendment of the NHIF Act and its regulation and strengthen its implementation • Enforcing Mandatory contribution by all • Targeting, identification and netting of the Informal sector	
		Fragmented financing pools resulting in allocative and operational inefficiencies	Functional county health fund Pooling of resources (Framework) • Put in place a comprehensive legal and regulatory framework for establishment and functioning of the county health funds, aligned to constitutional county government functions • Pooling of resources	

		Public Financial Management	Inadequate capacity on PFM planning, budgeting (MTEF, PBB), Budget execution and reporting	• Build capacity on better understanding of the PFM Act, resource mobilization, pooling and strategic purchasing • Joint and aligned planning (CDIP, HSWP) and budgeting (Bottom-up approach) • Develop capacity in performance-based budgeting • Strengthen capacity for resource tracking at all levels	
		Routine Financial Management Systems			
		Community-Led Advocacy and monitoring of domestic resource	Lack of public awareness on Health Financing Lack of capacity on Health Financing	Improving transparency and accountability in health financing systems and delivery at all levels (Strong governance and regulation structures by Governments, NHIF, PCNs, HCPs, Communities) • Advocacy and demand creation to increase community uptake of Health Services and Insurance for health • Increase community feedback and verification of service provision • Social accountability…Display boards,advertisements	
		Social Contracting			
		Health Financing data and analytics	Inadequate and timely data for informed decision -making	Increase coverage for biometric registration	
				Improve the processing and analysis of claims through an e-Claim platform	
				Establish a Centralized Health Care System across all HFs, Pharmacies etc	
				Conduct assessments/surveys- Public Expenditure Tracking System, Kenya Health Household Expenditure & Utilization Survey	
		Blended Financing Arrangements	Inadequate capacity for strategic purchasing (Knowledge, Skills)	Strengthen capacity across the various elements of strategic purchasing • Review of Benefit package	

			(Currently biennial) • Costing of Health Services • Contracting of providers (accreditation, penalties, assessment of facilities) • Incentivize health seeking behavior and health provision through appropriate provider payment mechanism • Performance/outcome measurement (Linking Finances to Outcomes/outputs)	
Health products manageme nt systems (HPM)	Policy, strategy and governance	• Limited capacity for local production of HPTs (for HIV, TB and Malaria) • Inadequate application of policies, strategies and guidelines	• Development and review of policies, strategies and guidelines • Dissemination of policies and guidelines • Supportive supervision • Monitoring • Capacity building (training and mentorship) • Support to local manufacturing	
	Storage and distribution capacity, design and operations	Inadequate storage and distribution capacity	• Assessment of supply chain maturity • Development of guidelines and SOPs on storage, distribution and inventory management • Material handling equipment (for KEMSA warehouses) • Improvement of storage, distribution and associated infrastructure	
	Planning and procurement capacity	Inadequate capacity in terms of human resources, tools, and skills for planning, quantification, forecasting and procurement	• Capacity building for planning, quantification and forecasting for HPT • Development and implementation of KEMSA ERP • Development and Deployment of e-procurement at KEMSA • Enhancement of procurement efficiency and supplier performance metrics	
	Regulatory and QA support	Inadequate capacity for PMS, PV and QC	• Capacity building to conduct PMS and PV • Capacity building to conduct QC for health products at NQCL and KEMSA • Conduct joint- PMS surveillance for HPT	

	Avoidance, reduction and management of health care waste	Weak systems for waste management	• Assessment of waste management in the supply chain • Develop and update the national plan for management of health care waste • Capacity building to increase awareness and improve competency in waste management practices	
	Supply chain information systems	• Inadequate information sharing across the various systems – KHIS (DHIS 2), KEMSA LMIS and EMRs • Fragmented systems for supply chain information management	Establishment of an end-to-end visibility system (KEMSA, MOH, PPB, Counties) – including track-and-trace solution	
	Augmenting national supply chain system with outsourcing	Sub-optimal national supply chain system	Assessment of current operations and needs	
Human Resources for Health (HRH) and Quality of Care	1. HRH planning, management and governance including community health workers (CHWs)	Inactive integrated HRH data base	Strengthen HRH management Systems for improved service delivery	Upgrade HRH database modules to inform health workforce numbers, distribution per cadres, specialization, deployment, attrition rate among other HRH parameters
		Inadequate and inequitable distribution of health workforce including specialist		Undertake workload staff indicator Numbers assessments Develop Skills Competency Framework
		Inadequate leadership and management capacity among health workers		Capacity build of HR managers and facility managers leadership and governance
		Poor implementation of Performance Management Systems		
		Weak HRH coordination structures at National and County levels		Establish platform for HRH coordination and information exchange with two levels of governments and key stakeholders
		Prolonged labour disputes and industrial unrests		
		Lack of policy guidelines on management of Non-Regulated cadres	Strengthened HRH Policy and guidelines	Review, disseminate & implement HRH policy /guidelines: -HRH Norms & standards 2018; KHRH strategic plan 2019-2023; Training policy/guidelines ,2016
		Expired HRH policy documents and guidelines		

2. Education and production of new health workers (excluding community health workers)	Training of Health workers is not based on Country's and Counties disease burden	Training of Health workers	Sponsor more health workers on need-based production and capacity development for market-ready and fit for purpose
	Inadequate number of trained specialists and sub-specialists' health worker		
3. Remuneration and deployment of existing/new staff (excluding community health workers)	Lack of Career guidelines for existing/new staff	Health workers (GOK/partner) Transition	Streamline the contract worker transition process to ensure continued quality of care
	No clear transition guidelines in handling partner supported healthcare workers on exit		
1. In-service training (excluding community health workers)	Lack of framework for tracking training plans, projections and HRD budget	Strengthened HRD systems	Upgrade iHRIS system for tracking health workers IST
1. Integrated supportive supervision for health workers (excluding CHWs) QOC module lead	Counties are at different levels of implementation of eKQMH	Improve the quality of care- Support supervision, Implement the eKQMH	
1. Quality improvement and capacity building for quality of care QOC module lead			
1. Community health workers: selection, pre-service training and certification CHSS module lead			
1. Community health workers: contracting, remuneration and retention CHSS module lead			
1. Community health workers: In-service training CHSS module lead			

	1. Community health workers; Integrated supportive supervision CHSS module lead			
Laboratory Systems (including national and peripheral)	National laboratory governance and management structures	Lack of policy and standards to support efficient service delivery	Policy & standard guidelines Implementing Kenya health act.2017/2030 and data protection Act.2019 Stakeholders and technical working groups (TWGs) on key issues	
		Lack of awareness by the public of services offered	NPHL visibility to promote efficient access to specialized laboratory services by institutions and patients	
		Weak digital infrastructure for Laboratory service delivery	Strengthen ICT and M&E structures to track implementation of Lab strategic plan	
	Inter-governmental dialoque space creation	Lack of County legislation to increase FIF re-allocation of laboratory diagnostic revenues to support system investments	Intergovermental forums for bills preparation & ratification by Counties	
	Laboratory-based surveillance	Lack of prioritization; MOH-MTEP to support Laboratory surveillance system	Pathogen surveillance Strengthen and scale up AMR Surveillance Waste water based epidemiological surveillance ART/TB Toxicity Monitoring ART/TB/Malaria Metabolite adherence monitoring Micronutrient, food additives, heavy metals, aflatoxin and GMO surveillance Enhance outbreak investigation using conventional and mobile Lab. Approaches Water microbiological and chemical surveillance Vector surveillance Onco-genomics for precision medicine and hereditary diseases in HIV/TB Co-infection	
		Lack of standardized environmental controls necessary to inform laboratory testing of priority pathogens incriminated in outbreaks & pandemics	Laboratory infrastructure	

		specimen referral and transport system	Current integrated sample referral system does not cover all diseases and national coverage is low	Integrated Sample Referral System Multi-disease testing approaches Decentralize HIV/EID, and TB molecular services	
		Network optimization and geospatial analysis	Lack of end to solution for tracking patient samples in a referral, testing network and clinical interphase	Diagnostic network optimization	
		Quality management systems and accreditation	Need to transit to new ISO 15189:2022 Standard Accreditation coverage not in all labs Susteinance of accredited labs Lack of implementation of QA support in ASAL regions	Transition to new ISO 15189 2022 standard Maintainance for National Reference Laboratories and County Laboratories Scale up Implementation of ISO 15189 standards towards attainment of accreditation in high volume and ASAL regions ISO accreditation Susteinance support ISO 15189, 17025 and 17043	
			Manual production at the EQA COE Low EQA / QC coverage/ intervention	Automation of EQA COE production Scale up production /scope expansion of Integrated EQA Scheme and QC material Increased enrolment of laboratories into EQA	
			Inadequate Continuous Quality Improvement across all laboratory levels	Implementation of Laboratory Continuous Quality Improvement (LCQI) guideline	
			Weak/No PMS for the IVD's	Post market surveillance IVD Validations/ verification Panel detection score	
			Inadequate equipment management as per Iso standard	Expansion of Equiment COE to accomodate more scopes	
				Sustainance of current LIMS Adoption and implementation of LIMS standards Development of disease specific laboratory translational dashboards Digitization of laboratory services to ensure patient centric needs are achieved (Sample remote login, test result submission etc) Laboratory data quality	

			audits Strengthening and scale up of remote logging services Interoperability, interfacing and automation	
	Laboratory Information Systems	·Coverage of LIMS in all county referral facilities No integrated laboratory dashboard to support lab-based disease surveillance No standardized guidelines for LIMS at national and subnational level Data quality issues on the national platform (KHIS) Systems working in silos	Sustainance of current LIMS Development of integrated laboratory translational dashboard Digitization of laboratory services to ensure patient centric needs are achieved Adoption of LIMS standards Laboratory data quality assessment Strengthening and scale up of remote logging services Interoperability, interfacing and automation	
	Biosafety and biosecurity, infrastructure and equipment	No integrated sample biobank Challenges in management of molecuar waste	Digitization of NPHL Biobank/Biorepository Insectorate Biorepository Laboratory waste management (Chemical, cassettes, liquid chemical waste) management	
		Animal house for research, Lack of equipment service contracts	Infrastructure for NPHLS Biobank, Animal house for operational research NPHLS equipment Service contract Procure of Laboratory Auxiliary Equipment Dust reduction at NPHL to protect highly sensitive molecular equipment	
	Laboratory inventory and logistic system	Weak laboratory testing data to inform procurement forcasting and quantification, No Linkage of supplies to test outcomes through consumption tracking	Laboratory inventory management system, Capacity on quantification and projection of laboratory reagents & consummables, Digitize storage and issuance of supplies and track consumption	
Medical Oxygen and Respiratory Care System	Bulk oxygen supply	Inadequate supply of oxygen for management of medical emergencies	Procurement of PSA, bulk liquid oxygen storage, oxygen cylinders, manifolds	
	Oxygen distribution and storage	Inadequate medical oxygen and oxygen distribution infrastructure in health facilities	• Piping infrastructure • Distribution and supply of medical oxygen in cylinders, bulk liquid oxygen supply	

	Oxygen delivery and respiratory care	Inadequate equipment and supplies for oxygen delivery	Procurement and supply of oxygen delivery equipment and supplies e.g., nasal cannulas, nasal prongs, pulse oximeters, oxygen splitters	
	Oxygen support systems	Inadequate knowledge and skills on oxygen management and patient management	Training and refresher trainings for the health workforce in the management of respiratory disease based on international standards and WHO guidance on supply, distribution and delivery of medical oxygen	
RSSH: Monitoring and Evaluation LaSystems	Routine Reporting	● Inadequate data-collection and reporting tools (paper and electronic) at the service delivery points ● There exists several disease based electronic data collection/patient management systems for HIV, TB, NCDs and which do not share data with the DHIS ● lack of communication support for dealing with emerging data reporting and data quality issues. ● Lack of regular cleaning updating and meta data review in KMHFL ● Lack of Capacity of KMHFL system framework to support current Functionalities (libraries no longer supported) ● customization of locally developed enhancement to run on higher versions of DHIS2 ● lack of alignment of metadata ● in the national reporting systems and in its shared health resources lack of integration among the existing national reporting systems	● Strengthen mechanisms of collecting quality data from service delivery points. ● Strengthen data sharing across the systems ● strengthen communication by the national data teams to support regions on emerging data quality issues. ● Strengthen Regular Metadata review and cleaning ● Transit KMHFL to system framework with supported libraries to support current Emerging functionalities ● meta -data cleaning of the national reporting systems and in shared health resources integration of the different national reporting system	● Review existing data collection tools and opportunities for digitization ● Printing and distribution of the data collection tools ● Fast track roll out national unique patient identifier. ● Rollout the Digital Health Platform (AFYA-KE) ● roll out of in-built data quality apps within KHIS to flag out and alert on data quality issues ● Hackathon workshop to solve bug issues that emerge due to DHIS2 software upgrades ● Meta data cleaning and review for KMHFL System ● Upgrade current version of KMHFL to support new functionalities ● Meta data cleaning and updating of shared health resources workshops to work on integration among the different national reporting systems.
	Data quality	● Data generated from the reporting systems is often of poor quality and routine data quality audits are done carried out ● Poor knowledge and	● Develop and adopt a data quality improvement plan at all levels ●	● Implement data quality protocol via annual data quality audits ● Implement the Data analytic guidelines by training HCWs at all levels on data

		skills among HCWs data management including analytics to make data useful ● Lack of proper action plans by facility incharges to address gaps/weaknesses identified in a DQA activities ● Lack of regular data quality review meetings		management including analytics ● Implement data quality protocol to sub national levels
	Surveys	● Access to care and coverage for services has increased as evidenced by recent surveys ● A large gap in quality of care exists leading to stagnation of health outcomes (Mortality, life expectancy) ● Data on readiness and availability of services offered in health facilities is not collected routinely while it is important for planning at both County and National levels ● Burden of NCDS has risen as seen from the routine data and surveys	● Implement strategies to regularly identify gaps in quality of care in all facilities to allow plans for improvement ● Implement strategies to collect health facilities readiness and availability of services ● Implement strategies to prevalence of NCDs and their risk factors	● Implement regular (annual) Quality of Care assessments/Joint facility assessments in sentinel facilities to keep track on quality on a routine basis ● Implement a nationwide Harmonised Health Facilities Assessment (HHFA) ● Implement the STEPS Survey
	Analyses, evaluations, reviews and data use	● The National health strategic plan needs review during its implementation to inform any adjustments to achieve targets as well as inform planning of the next strategy	● Review the progress of the implementation of the KHSSP 2023-2028	● Conduct a Mid- term Review of the KHSSP 2023-2028
	Surveillance for priority epidemic-prone diseases and events	● Updated guidelines for emerging and re-emerging diseases ● challenges in capacity for diagnosis of priority disease pathogens commonly causing outbreaks ● Need to scale up the roll out of Event Based Surveillance, (EBS)	● Build the capacity of the health care workers towards excellence in prediction, preparedness, early detection, and efficient response to events of public health importance. ● Revise case definitions for additional priority diseases ● Strengthen the capacity of county laboratories to confirm epidemics ● Scale up Influenza surveillance ● strengthen and scale up EBS to cover the 47 counties	● Capacity building of health care workers on the 3rd Edition IDSR Technical Guidelines ● Develop Standard case definitions for the additional diseases/conditions or events ● Development of Disease Specific Surveillance Guidelines ● Assess the capacity of county laboratories to confirm epidemics ● Develop training materials for sample collection, packaging transportation and referral for all the priority pathogens ● Sensitize health management teams in all the 47 counties to appreciate EBS

		● Currently, there are no governance systems at the sub national level . ● lack of a data governance framework ● lack of data sharing guidelines ● Lack of guidelines to implement Terminology Service		for ownership and close monitoring (EBS is a fairly new concept) ● Scale up EBS implementation in remaining counties ● Initiate all forms of EBS in the all the implementing counties (CEBS, MEBS, HEBS & PEBS) ● Expansion of SARI surveillance
	Strengthen data governance systems	● Currently, there are no governance systems at the sub national level . ● lack of a data governance framework ● lack of data sharing guidelines ● Lack of guidelines to implement Terminology Service	● Provide adequate support to sub national levels to strengthen HIS/M&E governance systems ● development and rollout of data governance framework ● Development of Implementation guideline for Terminology service	● Implement the M&E institutionalization guidelines through assessments and mentoring on M&E ● develop and roll out the data governance framework ● Implement Terminology Service
	Administrative data sources	● Outdated HIS strategic plan 2014-2018 for data governance and health system strengthening ● Lack of a National digital health strategy and policy that governs development,implementation and management of all the existing health information systems (LMIS, IHRIS, TIBU, KMHFL, KHIS, IFMIS)	● Review of HIS strategic plan in line with KHSSP and UHC roadmap ● Ensure there is a comprehensive digital health strategy that governs all Health information systems (both existing and to be developed)	● Review of HIS strategic plan in line with KHSSP and UHC roadmap ● Develop an integrated National digital health strategy and policy guidelines ● Sensitize all relevant stakeholders on the Digital National health strategy ● Conduct a Health systems compliance survey to determine compatibility/compliance of existing digital health systems to the digital national health strategy ● Align non compliant systems to the digital national health strategy .
	Civil registration and vital statistics	● Inadequate information on causes of morbidity and mortality events ● Low reporting on verbal autopsy for cause of death in community deaths ●	Strengthen collaboration between MOH and department of Civil Registration enhance the capacity of the KHIS tracker to capture verbal autopsy reports from the community.	● Capacity building on medical certification and reporting of vital events at community and health facilities ● roll out of comprehensive verbal autopsy reporting in all community units for community deaths
	Operational research	● Lack of adequate information on burden of NCDs among HIV TB patients ● Lack of information on quality of care offered in integrated program e.g HIV and NCDs		● Conduct survey on KAP, physical and biochemical measures of NCDs among PLWHIV and TB ● Conduct quality of care study on integrated care delivery models

data use	● Lack of enhancement of the integrated service and commodity dashboards	● Enhancement of khis inbuilt integrated commodity and service dashboards	● Workshops to build enhancements in existing integrated commodity and commodity dashboards in KHIS