ATTACHMENT 1: Local Partner Service Delivery Activity (LPSDA) - OVC Activities

A. Eligibility

The anticipated solicitation will be restricted to local partners. The final definition of local partner will be provided within the solicitation document. A draft definition follows:

A "**local partner**" may be an individual, a sole proprietorship, or an entity. However, to be considered a local partner, the applicant must submit supporting documentation demonstrating their organization meets at least one of the three criteria listed below.

(1) an individual must be a citizen or lawfully admitted permanent resident of and have his/her principal place of business in the country served by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) program with which the individual is or may become involved, and a sole proprietorship must be owned by such an individual; **or**

(2) an entity (e.g., a corporation or partnership):

i. must be incorporated or legally organized under the laws of, and have its principal place of business in, the country served by the PEPFAR program with which the entity is or may become involved;

ii. must be at 75% on September 30th, 2018 beneficially owned by individuals who are citizens or lawfully admitted permanent residents of that same country, per sub-paragraph (2)(a),;

iii. at least 75% on September 30th, 2018 of the entity's staff (senior, mid-level, support) must be citizens or lawfully admitted permanent residents of that same country, per subparagraph (2)(a), and at least 75% on September 30th, 2018 of the entity's senior staff (i.e., managerial and professional personnel) must be citizens or lawfully admitted permanent residents of such country; **and**

iv. where an entity has a Board of Directors, at least 51% of the members of the Board must also be citizens or lawfully admitted permanent residents of such country; **or**

(3) Partner government ministries (e.g., Ministry of Health), sub-units of government ministries, and parastatal organizations in the country served by the PEPFAR program are considered local partners. A parastatal organization is defined as a fully or partially government-owned or government-funded organization. Such enterprises may function through a board of directors, similar to private corporations. However, ultimate control over the organization rests with the government.

B. Summary/Synopsis of LPSDA OVC Activities – Currently in Design

I. PURPOSE

The purpose of the Local Partner Service Delivery Activities (LPSDA) for OVC services is to increase use of quality county-led social services in selected counties in Kenya. These will be service delivery activities providing key OVC and adolescents services at the county level that contribute to the attainment of the Government of Kenya's (GOK) goal of safeguarding the rights and welfare of children and adolescents impacted by Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS). Ultimately this will contribute to the global Sustainable Development Goals (SDGs) in supporting the health and overall well-being of children and adolescents. The activities will enhance the capacity of the national and local social services systems and structures to provide care and support for OVC and their families more sustainably through systematic evidence–informed graduation and transition of PEPFAR beneficiary households away from U.S. Foreign Assistance and support the Journey to Self-Reliance (J2SR). USAID/KEA's overall goal is to increase use of quality county-led health and social services.

II. OBJECTIVES

The key objectives are as follows:

1. Increased Access to quality HIV Prevention Services
2. Increased access to quality health and social services for OVC and their families

III. GUIDING PRINCIPLES

The following principles will serve as pillars for programming and implementation plans. These include incorporating tenets of key United States Government (USG) strategies and international mandates including the USAID Kenya Country Development Cooperation Strategy (CDCS), PEPFAR Country Operational Plan and PEPFAR OVC Guidance 2012.

a. Journey to Self -Reliance. USAID focuses on building countries' self-reliance -- defined as the ability of a country, including the government, civil society, and the private sector, to plan, finance, and implement solutions to solve its own development challenges. The approach fosters locally-led development, mobilization of domestic and other financial resources, and building the capacity of local partners. USAID/KEA implementing partners working at the county level will be expected to support counties' on their journey to self-reliance, aligned to USAID's approach. There will be a need for implementing partners to redefine relationships with local county partners from being beneficiaries to full-fledged partners, working closely with counties to develop self-reliance matrices, put in place strategies for transition of interventions and legacy programs, enhance financing of interventions through county budgets towards self-reliance, and promote private sector engagement both for service delivery and financing of health interventions through partnerships and or corporate responsibility. The details of this approach are reflected in the objectives and especially activity descriptions. In addition PEPFAR emphasizes enhanced sustained epidemic control through the 95-95- 95 cascade by working with and building capacity of local partners and faith-based organizations. It is envisioned that the implementing partners will work with the communities to promote citizens voice regarding the quality of services they receive and how to make it better, this will be done through innovative approaches such as exit interviews among others.

b. Invest in Kenyan leadership, capacity, and systems for long-term ownership, and sustainability. USAID/KEA places an important focus on developing, supporting, and sustaining the considerable professional talent and institutional capabilities that exist within Kenya. Similarly, PEPFAR places high priority on engaging host county leadership to foster ownership. This requires an investment of time, effort, and resources in developing individual and local organization competencies, systems and processes. Activities will continue to support government and local implementing partners' ability to improve the quality of health and social services. The effectiveness of leadership development will be reflected in program outcomes.

c. Evidence-based Interventions. The interventions must be aligned and direct respond to the needs of the people in Kenya, scaling up evidence-based models and employing proven patient-focused and family-centered approaches. The program will work with government and non-government actors to strengthen management systems to build a body of evidence to improve current and future health and social services programming.

d. Increase involvement of the private sector. The activities must ensure they leverage strategic private sector partnerships and alliances to improve on health and social service delivery. The private sector offers expertise in implementing cost-effective models that can complement access to comprehensive services, maximize efficiency and enable beneficiaries and county governments to become self-sufficient through various opportunities.

e. Ensure strategic collaboration and coordination. The 5 awards will work in their respective geographic areas to ensure strong collaboration between beneficiaries, the GOK, county governments multi-sectoral structures, community and faith based organizations (CBOs/FBOs), other USG-funded programs and other development partners. USG programs include HIV prevention, treatment and care, child survival programs, (e.g., malaria, maternal, neonatal, child health and reproductive health, nutrition, agriculture and food security as well as education and youth programs). All awards will integrate collaborating, learning and adapting (CLA) framework within, and among implementing partners, GOK, civil society, community volunteers to strengthen the discipline of development and improve aid effectiveness. They will build synergies across sectors, and leverage resources, including with major donors and agencies such as the World Bank, UNICEF, World Food Program and GOK long-standing cash transfer programs, Social Economic Inclusion Programs (KESIP), and Health Insurance Fund among others to increase access to, and complement health and social services for the vulnerable and marginalized populations, minimize duplication of effort and reduce transaction costs.

f. Gender. Both USAID and the PEPFAR Blueprint include a focus on gender equality. USAID/KEA is committed to addressing inequities and harmful gender norms including beading, Female Genital Mutilation(FGM), Child, Early Forced Marriages (CEFM), that place both males and females at-risk of disease, poor health, and violence. The activities will improve access to and uptake of evidence based health and social interventions by addressing gender based barriers and resource inequities, or other barriers to accessing and using the services. This includes working with Adolescent Girls and Young Women (AGYW), civil society(including those that are women led and those engaging men) and applying rights-based approaches; leveraging or improving demand side financing mechanisms such as savings clubs, community health insurance, or voucher schemes for food and nutrition related activities; advancing respectful and culturally competent care for women and families. Since men and women, girls and boys, access and use services differently, proposed activities will continue to use a gender sensitive lens. All interventions must align to USAID's Gender Equality and Female Empowerment Policy and the PEPFAR Gender Framework.

IV. OVERVIEW OF ACTIVITIES CURRENTLY IN DESIGN

USAID/KEA anticipates there will be 5 awards as summarized below. The awards are described in the following Clusters 1-5. Each award will be 5 years in duration.

SUMMARY of POTENTIAL AWARDS

Cluster	Counties	Types of activities	Sub Purpose	Range of total award (approximate range of total award value)
1	Kilifi	OVC/DREAMS	1 and 3	$ 7,000,000-$8,000,000
	Mombasa	OVC/DREAMS	1 and 3	$ 9,000,000-$10,000,000
Total anticipated Activity 1				**$16,000,000-$18,000,000**
2	Kiambu	OVC/DREAMS	1 and 3	$ 9,000,000-$10,000,000
	Nairobi	OVC/DREAMS	1 and 3	$ 30,500,000-$31,000000
Total anticipated Activity 2				**$39,500,000-$41,000,000**
3	Kajiado	OVC only	1 and 3	$ 1,000,000-$1,700,000
	Nakuru	OVC only	1 and 3	$ 2,000,000-$2,500,000
	Narok	OVC only	1 and 3	$ 1,000,000-$1,500,000
	Muranga	OVC only	1 and 3	$ 1,000,000-$1,500,000
	Kitui	OVC only	1 and 3	$ 750,000-$900,000
	Machakos	OVC only	1 and 3	$ 1,200,000-$1,700,000
	Nyeri	OVC only	1 and 3	$ 1,100,000-$1,600,000
	Makueni	OVC only	1 and 3	$ 1,000,000-$1,500,000
Total anticipated Activity 3				**$9,050,000-$12,900,000**

4	Bungoma	OVC only	3	$ 3,000,000-$3,500,000
	Busia	OVC only	3	$ 5,000,000-$6,000,000
	Kakamega	OVC only	3	$ 4,500,000-$5,500,000
	Kisumu	OVC/DREAMS	1 and 3	$ 36,500,000-$37,500,000
	Siaya	OVC only	3	$ 6,000,000-$6,500,000
Total anticipated Activity 4				**$55,000,000-$59,000,000**
5	Homabay	OVC/DREAMS	1 and 3	$ 28,500,000-$29,500,000
	Kisii	OVC only	3	$ 3,500,000-$4,200,000
	Migori	OVC/DREAMS	1 and 3	$ 13,000,000-$13,500,000
Total anticipated Activity 5				**$45,000,000-$47,200,000**

Cluster 1:
This cluster will be implemented in Kilifi and Mombasa counties and will cover OVC program in both counties. Mombasa is a high HIV burden and incidence county and will therefore implement DREAMS. The OVC partner will integrate DREAMS by incorporating a service package targeting AGYW (9-24 years) who are at the highest risk of HIV infection.

Cluster 2:
This cluster will be implemented in Kiambu and Nairobi counties. These are both high HIV burden and incidence counties. They will carry out OVC activities and integrate with DREAMS in Kiambu county. The OVC program will incorporate the DREAMS component, and provide a service package targeting AGYW (9-24 years) who are at the highest risk of HIV infection.

Cluster 3:
This cluster is an OVC stand-alone program covering Kajiado, Nakuru, Narok, Muranga, Kitui, Machakos, Nyeri and Makueni counties. These are high burden counties at various levels of ART coverage and unmet need and also with a high number OVC. This model enables the implementer to focus on the delivery of quality OVC services that combine household economic strengthening activities with proven effectiveness and efficiency to facilitate a clear process of transition as well as using case management approaches to ensure access to the full range of age-appropriate health services. For children living with HIV (CLHIV), this includes enhanced ART adherence and retention, viral suppression, disclosure and positive living.

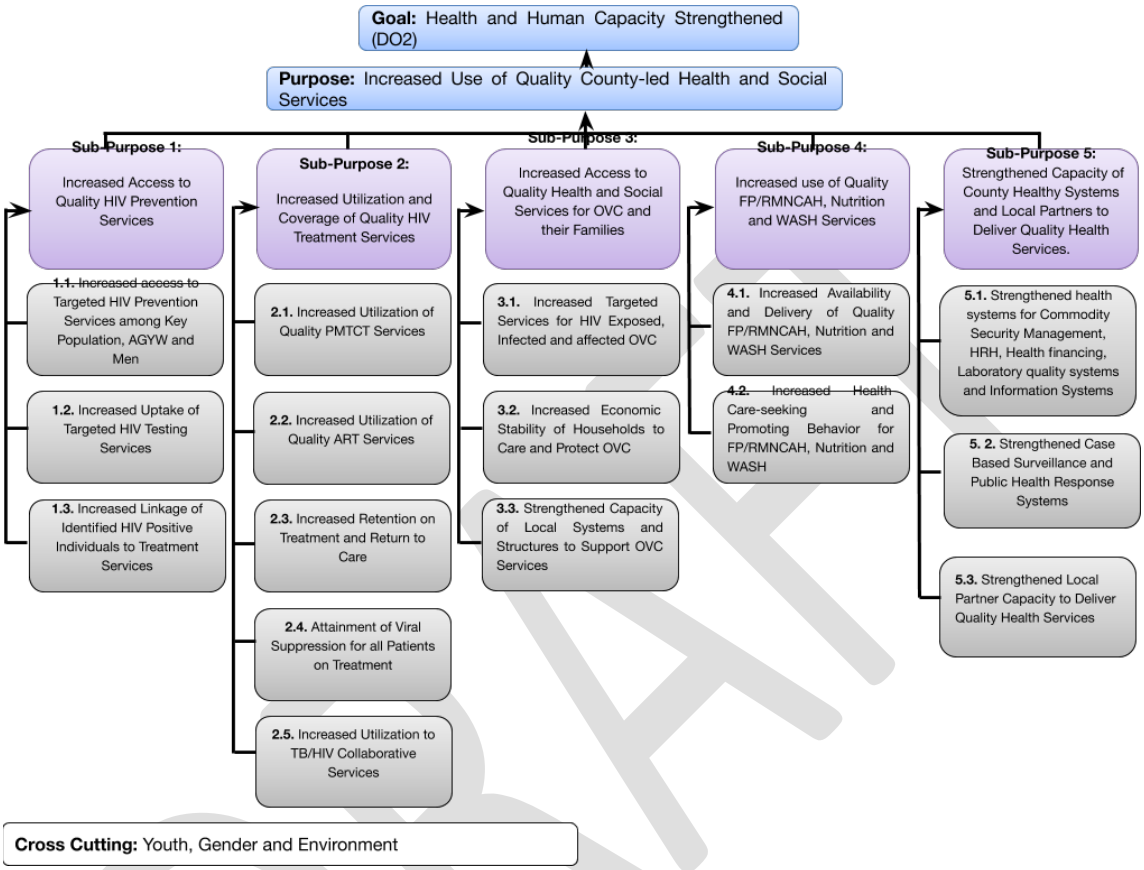
Cluster 4:
This is basically a stand-alone OVC program in the counties of Bungoma, Busia, Kakamega Kisumu, and Siaya. These are high burden counties at various levels of ART coverage and unmet need and also with a high number OVC. Kisumu being a high HIV burden and Incidence County, the OVC program will incorporate the DREAMS component, and provide a service package targeting AGYW (9-24 years) who are at the highest risk of HIV infection. This model enables the implementer to focus on the delivery of quality OVC services that combine household economic strengthening activities with proven effectiveness and efficiency to facilitate a clear process of transition as well as using case management approaches to ensure access to the full range of age-appropriate health services. For CLHIV, this includes enhanced ART adherence and retention, viral suppression; disclosure and positive living.

Cluster 5:
This cluster covers the South Nyanza counties of Homabay, Kisii and Migori with OVC activities. These are high burden counties at various levels of ART coverage and unmet need and also with a high number OVC Homabay and Migori are high HIV burden and incidence counties and the OVC program will incorporate the DREAMS component, and provide a service package targeting AGYW (9-24 years) who are at the highest risk of HIV infection. This model enables the implementer to focus on the delivery of quality OVC services that combine household economic strengthening activities with proven effectiveness and efficiency to facilitate a clear process of transition as well as using case management

approaches to ensure access to the full range of age-appropriate health services. For CLHIV, this includes enhanced ART adherence and retention, viral suppression; disclosure and positive living.

V. SUB-PURPOSES

The below graphic describes multiple USAID/KEA activities, not just those described in this summary. The OVC activities anticipated would be under Sub Purpose 1 and 3.



1. Increased Access to Quality HIV Prevention Services

USAID seeks to improve the synergies between OVC and prevention programs for adolescent girls and key populations. The goal of the DREAMS Kenya Program is to reduce new HIV infections, reduce violence and response to violence among adolescent girls and young women (AGYW), aged 9-24 years. The program provides a tailored, comprehensive evidence-informed package of biomedical, behavioral and social protection interventions that address individual, familial, community and structural factors that increase girls' HIV risk. The program also provides educational and economic opportunities to the AGYWs to help safeguard their future.

1.1 Increased Access to Targeted HIV Prevention Services among Key Population, AGYW and Men

The OVC projects will increase access to prevention programs for Adolescent Girls and Young Women (AGYW), particularly in counties that implement the DREAMS initiative (Clusters 7,8,10 and 11). In Kenya, the initiative is implemented in seven counties - Homabay, Siaya, Kisumu, Migori, Nairobi and Mombasa, and Kiambu. In target areas the implementer will enhance the quality of the comprehensive package for AGYW ensuring optimal coverage, HIV testing, linkage of identified HIV positive individuals to treatment, treatment retention and viral suppression. The package of interventions includes HTS and linkage to ART; PrEP promotion and provision; Condom education and provision; contraceptive method mix; post-violence care; school and community-based HIV and violence prevention; social asset

building; educational subsidies; parenting/caregiver programs, combined socio-economic approaches; community mobilization and norms change and characterization of male sexual partners (MSP) of AGYW ages 15-24 and linkage to Condoms, HTS, VMMC and ART.

Illustrative Interventions:

- Provision of a comprehensive package of services to AGYW includes evidence based behavioral interventions, Condom use, PrEP, PEP, innovative targeted HIV testing approaches, optimal linkage of identified HIV positive of OVC and AGYW, retention and viral suppression of individuals on treatment with attention to critical enablers including stigma and discrimination.
- Provision of layered age appropriate core package of services that include school and community based HIV prevention, diagnosis and treatment of sexually transmitted infections, gender-based violence prevention and response, PrEP, condom promotion and provision, contraceptives, menstrual health management, community mobilization and norms change, social protection, parenting and caregiver programs targeting AGYW.

Expected Outcomes:

- >90% of vulnerable AGYW reached with a defined package of services in HIV high burden counties
- Increased coverage of primary prevention of HIV and sexual violence among 9-14 year olds working closely with FBO initiative and other local structures and systems.

3. Increased Access to Quality Health and Social Services for OVC and their Families

The implementer will provide approaches that demonstrate effective Case Management Approach (CMA) that are child-focused and family-centered. CMA in the context of OVC programs, is the process of identifying vulnerable children and families; assessing their needs and resources; working together to establish specific, realistic objectives and goals and planning actions to achieve objectives and goals; implementing plans through completing specific actions and receiving services that ensure children are healthy, schooled, safe and stable; monitoring both the completion of actions (including the receipt of services in a timely, context-sensitive, individualized, and family-centered manner) and progress toward achievement of objectives/goals (e.g., child protection and well-being, including HIV prevention, treatment, and adherence). Case management involves significant collaboration with the client unit—generally a family or household, including a child or children and their caregiver(s)—and utilizes problem-solving. Increased temperatures and extreme climate-related events due to climate change such as floods may increase the prevalence of heat-related or water-borne diseases, or otherwise negatively impact the health of administrators and participants during travel to or participation, or may damage or impede access routes for CMs or CHVs to access OVC HHs.

Implementer will demonstrate strategies to achieve collaboration and strategic interactions with diverse actors to improve the well-being of OVC and their families more sustainably.

3.1 Increased Targeted Services for HIV Exposed, Infected and affected OVC
The main entry point into a household is a child living with HIV (CLHIV), exposed, or at high risk for contracting HIV (e.g., pregnant teenager, child-headed, in exploitative labor, in transactional relationship or not in school). From this entry point, other children in the household are assessed to determine if a care plan is needed and to inform a referral system that links enrollees to appropriate services. Implementer will be required to demonstrate increased proportion of enrolled CLHIV, exposed children and children of People Living with HIV (PLHIV) by prioritizing their identification and enrollment via HIV clinical entry points. Implementers should demonstrate integrated and efficient approaches to accessing comprehensive services. Implementer will demonstrate approaches and emerging evidence-based strategies that promote systematic coordination, bi-directional referral pathways, and integration with care and treatment centers to ensure all CLHIV and adolescents enrolled in the OVC program are retained on treatment, and virally suppressed, and adequately prepared to transition to adult care.

Enrollees of the program should have access to the full range of age-appropriate health services including immunization, food and nutrition support, growth monitoring, early childhood development, maternal and child health services, deworming, TB, malaria, sexual and reproductive health. The implementer will demonstrate strategies that leverage on existing Pediatric, PMTCT, and MCH interventions to reach children <5 years and track sick and malnourished children. Increased intensity, duration and/or frequency of extreme climate-related events such as flooding, storms, and drought may impact the ability of the project to provide nutrition interventions and may result in food insecurity, increasing the susceptibility of vulnerable populations to disease. The implementer's strategies will consider adaptive and mitigation measures to ensure that food and nutrition support is sustainable.

The implementer will support OVC accessing both primary and secondary education, by addressing barriers to enrollment, attendance and progression particularly for adolescent girls. The implementer will explore evidence –based interventions that prevent HIV and sexual violence among different age cohorts 9-14 years and 15-17 years respectively. Focus will be on preventing risk before it occurs as well as reducing risk or consequences of exposure to risks among these age groups. As part of rights-based and gender transformative programming, the program should track improvements in the prevention and response to gender based violence and exploitation. The implementer will demonstrate effective interventions to address specific activities in the National violence against children survey (VACS - 2018), Response Plan, working closely with the Department of Children's Services and other stakeholders to disseminate and use the findings contextualized to target counties.

Expected Outcomes:

- Integrated case management that ensures access to comprehensive services
- Increased proportion of enrolled CLHIV, exposed children and children of PLHIV (80%), and those at risk
- Eligibility screening for HIV testing, 100% CLHIV link to treatment,
- Improved adherence, retention, and VL suppression among enrolled CLHIV
- Increased coordination with Pediatrics and PMTCT program for enrollment/tracking of HIV+ adolescents and HIV exposed infants.
- Behavior change among 9-14 years and 15-17 years (evidence-based)
- Increased number of enrolled children attending and progressing in school
- Market-driven livelihood activities e.g., vocational and entrepreneurial skills training for most at risk vulnerable and out of school adolescents
- Increased number of enrolled children with legal documents (birth certificates)
- Improved linkages to DREAMS services for adolescent and young pregnant girls such as safe spaces.
- Improved coordination, integration and collaboration with the public, private sectors including with formal and informal children protection and welfare structures for the well-being of children

3.2 Increased Economic Stability of Households to Care and Protect OVC

Resilient families are much better positioned for graduation from assistance and able to provide for their children more sustainably. The implementer will include household economic strengthening activities with proven effectiveness and efficiency within the range of Kenyan household contexts. Well defined benchmarks and outcomes are essential. These activities should address the unique needs of the target households, with clear timeframes and measurable criteria for graduating beneficiaries from program support. Implementer to demonstrate how OVC caregivers and adolescents will be supported to be more resilient to financial shocks, improved livelihoods as well as referrals and enrollment in GOK social protection programs. Strengthening families will allow them to reclaim their roles as primary caregivers. Implementers will be expected to work directly with local partners to help families implement effective and evidence-based HES interventions to expand assets, improve household welfare and prevent future risk exposure, including interventions that strengthen the linkages to clinical/facility-based and other socio-economic services.

Graduation and Transition

In line with the geographical PEPFAR Pivot Strategy, OVC activities must clearly demonstrate approaches to preparing children and families who have attained a certain level of resilience and no longer require support for eventual graduation from the program. Similarly, clear exit and/or transition strategies to other providers are needed for children and families who still need mitigation services. The Implementer will implement low risk rural, peri-urban and urban sensitive household economic strengthening (savings and loans, financial literacy, micro-credit, Income Generating Activities (IGAs) and livelihood interventions to ensure phased graduation and full graduation of beneficiaries and HHs' within 2-3 years of the project implementation.

Implementers are expected from the on-set to employ graduation benchmarks, exit and/or transition strategies and approaches that are contextualized and responsive to levels of household vulnerability. The implementer is expected to propose interventions that show a clear process of transition that demonstrates implementer's capability to sustain the benefits of the program in order to avoid undue harm and ensure affected families are involved in the whole process and are not abruptly cut off from assistance. Similarly, specific transition strategies to other providers are needed for children and families who are not stable.

Expected Outcomes:

- Increased uptake of evidence-based household economic strengthening initiatives/models (savings and loans groups, income generating activities), in targeted households.
- Increased percent graduation from the PEPFAR program support each year.
- Increased graduation of beneficiaries and HHs' informed by case plans within 2-3 years of the project implementation.
- Increased knowledge and skills of parents and caregivers on parenting practices/childcare and effective communication, especially with adolescents
- Proportion of eligible households benefiting from the broader social safety net and protection programs
- Number of eligible households enrolled on social protection programs, including the Cash Transfers (CT) and National Health Insurance Fund (NHIF).
- Increased public awareness on the needs of OVC needs and available resources.

3.3 Strengthened Capacity of Local Systems and Structures to Support OVC Services

The Journey to Self-Reliance (J2SR) requires governmental systems and structures that are open and accountable with capacity to lead and oversee the country's development agenda. This result is dedicated to strengthening the capacity of the local organizations, systems and structures to effectively lead implementation of GOK policies and strategies, use data, better coordinate, leverage resources, oversee child welfare and social protection services and provide supportive supervision to volunteer networks engaged in case management, including households enrolled in social protection/safety net programs.

Capacity building encompasses individual and organizational skills and knowledge, as well as strengthening institutions and systems to perform core functions effectively and efficiently. Programs that focus on strengthening local capacities and relationships are more likely to have sustained results. Implementer should demonstrate strategies that support local community-based entities to reinforce the role of community health workers, community case/child volunteers and child welfare and social protection personnel. Implementers are expected to demonstrate how they will work through and engage with existing government systems and community structures for effective service delivery. This shall include linkages to social protection programs and partnerships with the private sector as appropriate to improve outcomes for OVC as shown in: http://www.pepfar.gov/documents/organization/195702.pdf.

Data for decision making is critical to informing the design, implementation and progress tracking of OVC programs. Collaborative efforts in building or reinforcing information systems and infrastructure to avail high-quality data for various decision-making processes are important. Implementers will ensure adequate capacity to collect, analyze, interpret, manage and use data, as well as to embed quality

improvement throughout the continuum of case management. Such activities are to be done with leadership from GOK to ensure maximum use of their data systems such as the Child Protection Information Management System (CPIMS) and Single Registry. The implementer will outline effective strategies to data management and use by county structures including Area Advisory Councils and county teams to inform annual target setting, budgeting and supporting appropriate interventions.

***Expected Outcomes*:**

- Strengthened programmatic and financial capacities of local/indigenous organization to deliver quality and sustainable services

Strengthened Local Partners Capacity to Deliver Quality Health and Social Services

Local Prime Partner Capacity Development
USAID recognizes the role of local partners in designing and implementing innovative public health approaches within the geographic coverage area, which complement national and county health programs. This intermediate result expands and strengthens USAID's partnerships with local partners and advances effective and sustainable approaches consistent with the Journey to Self-Reliance. In the Non-U.S. Organization Pre-award Survey (NUPAS), the local prime partner together with USAID will identify specific technical and organizational capacity development needs of their organization, to be addressed through the proposed five year implementation period The local prime partner, based on the needs identified, will propose mentoring partnerships that will contribute to strengthening their technical and organizational capacity in order to support county health programs at scale

Illustrative Indicators

- Sustainability
  - Organization relies on a diversified resource base
  - There are secure resources (staff, tools, etc.) to carry out activities
- Financial Management
  - Organization has designed appropriate internal controls, and controls are operating effectively
  - Organization prepares, reviews, and updates donor agreement budgets consistently and accurately
- Human Resources
  - The organization has formal systems and processes for staff training and development
- Subgrant and sub-awardee Management
  - Organization has a well-developed and functional system to identify, operationalize, and evaluate adherence to various compliance requirements
  - Organization has a well-functioning monitoring and support system for achieving technical and programmatic targets and goals as stated in donor agreement, as well as procedures for compliant selection, start-up, monitoring, support, and close-out
- Strategic Information
  - There is capacity to process and tabulate raw data into information that can be used for decision making and reporting to donors

For guidance on planning and measuring sustainability, local partner implementers are encouraged to review the "Taking the Long View" Sustainability Manual, which can be found on the following site: https://www.mchip.net/sites/default/files/TLVManual.pdf.

Local partners capacity development for quality service delivery
USAID in line with the journey to self-reliance approach and PEPFAR's direction for the future of the program, do encourage working with the locally based (within host country) organizations. The intention is to support and develop local organizations with knowledge and skills adequate to deliver quality health services, in compliance with both local and international standards. The local organizations often

demonstrate a lack of adequate capacity for financial management, leadership and management, institutional policy, personnel with appropriate skills mix, as well as quality controls to provide quality services. The prime partner will be expected to do the following for the local partners they will be working with;

- assess local partners capacity to deliver quality health services
- plan and implement local partner capacity development based on the identified needs
- develop a local partner capacity development maturity matrix that will be used to graduate them out
- Mature local partners given more responsibilities and guidance to perform at a higher level in terms of resources, geographical coverage and targets as may apply.

Expected outcomes:

- all the local partners under the prime provided with training and mentorship based on their specific capacity weaknesses
- The maturation matrix applied to track progress towards maturity and graduate them out once they attain maturity levels.
- Proportion of supported local partners that have graduated out and attracting more resources to perform at a higher level.

VI. CROSS-CUTTING: Youth, Gender and Environment

a. Increased Reporting and Prevention of Sexual and Gender Based Violence (SGBV)

Sexual and gender-based violence meted on adolescents has been documented as one of the key drivers to HIVs. Early sexual debut is associated with SGBV among adolescents living with HIV (ALHIV). This objective will facilitate Gender Transformative approaches to adolescent HIV programming and improve integration of SGBV prevention and reporting. Under this objective, interventions that will lead to norms change, violence prevention and response will be emphasized.

Interventions will seek to prevent perpetration of sexual violence among ALHIV, protect ALHIV served by PEPFAR against sexual violence while being part of PEPFAR programs (child safeguarding policies), and facilitate disclosure, reporting and appropriate system responses to cases of sexual violence against ALHIV with a focus of holding perpetrators accountable.

b. Programmatic Linkages and Integration

Implementers will be expected to draw synergies from the different opportunities offered across USG platforms. Implementers will tap opportunities working with the education sector to foster integration thereby promoting country ministry of education efforts to support adolescent learners living with HIV. Additional areas of integration include SRH to support ALHIV access information and effective contraception in line with their reproductive health needs; DREAMS to empower AGYW and decrease their risk, strengthen their families, mobilize communities for change and decrease the risk of sexual partners of AGYW.

USAID seeks to improve standardization and efficiencies in service provision and accessing of comprehensive services by OVC and their families. Increased bi-directional referrals are needed between beneficiaries of GOK and USAID programs as well as among USAID mechanisms and other sectors. The exchanging of technical approaches and experiences should increase the range of child welfare and social protection stakeholders engaging in collaborating, learning and adapting (CLA). USAID seeks input on how to apply CLA given the varied operating environments of programming for OVC.

USAID also aims to enhance employment opportunities and the overall labor supply in nine focused geographic areas and sectors, through both wage employment and self-employment, for unemployed and

underemployed youth who have not completed secondary education. Both the child welfare and social protection sectors need improved transparency, accountability and citizen participation. USAID democracy and governance programs implement interventions that intensify service user participation to improve service quality and demand which consequently increases utilization. The Economic Development Office of USAID/KEA funds numerous activities focused on elevating poverty and building household resilience through viable pathways that are contextually responsive. Demonstrate strategies to leverage existing opportunities exist for collaborative learning on social capital, financial inclusion, livelihood diversification and women's empowerment and equality.