United States Department of State

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INFORMATION MEMO FOR CHARGE d'AFFAIRES ERIC KNEEDLER, KENYA

FROM: S/GAC – Acting U.S. Global AIDS Coordinator, Principal Deputy Assistant Secretary, Dr. Angeli Achrekar, DrPH, MPH

THROUGH: Michael Ruffner, Chair, and Christalyn Steers-McCrum, PEPFAR Program Manager

SUBJECT: Fiscal Year (FY) 2023 PEPFAR Planned Allocation and Strategic Direction

Dear Chargé Kneedler,

First and foremost, I sincerely hope that you and your team are safe and healthy. I am extremely grateful for your leadership of the PEPFAR program and additional COVID-19 response efforts during this difficult year.

While countries around the world continue to manage the effects of the COVID-19 pandemic, and the U.S. government acts on its commitment of support, it is encouraging to see vaccines making their way around the globe. The COVID response – and continued use of the PEPFAR platform to support testing and vaccine delivery and uptake at point of care settings -- are essential to our ability to provide ongoing care and life saving support for people living with HIV. The PEPFAR program has faced many challenges as a program during this period. Nevertheless, the PEPFAR family and partners have carried the mission forward while enduring significant personal impacts of COVID-19. Despite these challenges, what remains true is the strength and resilience of PEPFAR in partnership with countries and communities – through our teams, and our programs in the midst of dueling pandemics.

Tremendous effort has been made by PEPFAR over the year to protect and accelerate the HIV gains, while leveraging the platform to respond to COVID-19 as well.

PEPFAR Country/Regional Operational Plan (COP/ROP 2022) (for implementation in FY2023) represents a pivotal year in PEPFAR, as several countries are reaching or approaching the agreed upon UNAIDS 95/95/95 benchmarks for attaining epidemic control. As countries approach these benchmarks, while pivoting from "scaling to close gaps" to "sustaining" epidemic control, we must ensure HIV program and population equity, address outstanding barriers that threaten to derail progress made in reducing new HIV infections and associated mortality, and tailor our programs to serve all populations.

This year it is particularly important to plan COP/ROP22 together with the country government, civil society, and multilateral partners. Across PEPFAR, the focus on equity requires vigilant attention to program data demonstrating results and gaps. A focus on equity also means a focus on population groups where our efforts to date have not closed gaps, and specific planning, resource allocation, and program tailoring are needed – depending on what the data reveal for each country – focusing on: children, adolescent girls and young women, and key populations.

While implementation continues, or in many cases, has started to scale up, most PEPFAR countries are on a path to achieving program coverage goals. With that in mind, PEPFAR programs should focus on four key themes as we approach COP/ROP 22 planning and implementation:

1. Achieve and sustain epidemic control using evidence-based, equitable, people-centered HIV prevention and treatment services.
2. Support resilient and capacitated country health systems, communities, enabling environments, and local partners to build enduring capabilities.
3. Strengthen cooperation and coordination for greater impact, burden sharing, and sustainability.
4. Employ an equity lens with a persistent focus on reducing persistent inequalities experienced by children, key populations, and adolescent girls and young women.

I want to applaud the PEPFAR team for:

1. Achieving the 95% viral load suppression mark. Not only has this threshold been crossed nationally, but over half of all PEPFAR-supported counties are at or over 95% and the others are close behind.
2. Full implementation of voluntary medical male circumcision (VMMC) and expansion of DREAMS. Even during these difficult times, the VMMC program has resumed at full capacity and our DREAMS program has expanded to include more adolescent girls and young women (AGYW) and improved its graduation rate.
3. Optimizing DTG and the expansion of multi-month dispensing (MMD). In particular, I was pleased to see the gap between males and females on TLD has closed and that more and more patients are being enrolled in MMD.
4. Improvements in safe and ethical index testing. This issue was front and center for us over the past year, and I am grateful for the hard work of the team to analyze each site, implement reform measures where necessary, and to track progress to ensure improvement happens.

Together with the Government of Kenya and civil society leadership we have made tremendous progress on the HIV response. Kenya should be proud of the progress made over the past 18 years of PEPFAR implementation and we are deeply grateful for the ongoing and deep coordination with the Global Fund and UNAIDS. Kenya has been especially successful and is one of a number of countries to have achieved the UNAID 90-90-90 goals and effective control of the HIV epidemic. We now must work to sustain the HIV impact and begin the long-term, gradual transformation of the program including the merging, management, and oversight of HIV services in more intentional alignment and integration with domestic systems. COP 22 will represent the first step in this journey.

Despite the achievement of the UNAIDS high level goals, our work is not done. In COP 22 guidance, changes in program direction will vary depending on where countries are in reaching epidemic control and the continued COVID-19 mitigations efforts each program is facing.

Specifically, more focus and attention should be given to the following key challenges in PEPFAR Kenya as we move towards sustaining impact:

1. Co-financing. As we shift to a sustaining impact approach, it is more important than ever that the Government of Kenya increase its HIV/AIDS funding and follow-through on its financing commitments.
2. Supply chain improvements. The stockouts of commodities Kenya experienced last year is unacceptable. Each and every factor that led to it should be analyzed thoroughly and addressed.
3. Unique IDs (UIDs). Unique IDs have been a minimum program requirement (MPR) for four COP cycles yet little progress has been made. The lack of a unique ID places an additional cost

burden on the program that can be avoided. For example, as we look at supply chain quantification and evolving our programmatic strategy to sustaining impact, ensuring our data are accurate must be even more of a priority.

A fuller set of details, including funding earmarks and specific program direction are included in the accompanying COP/ROP 22 PEPFAR Planned Allocation and Strategic Direction Summary.

Consistent with the approach from years past, PEPFAR teams will once again be responsible for setting their own targets across PEPFAR program areas (with the treatment current target no less than the result that was to be achieved in COP 2021) in consultation with stakeholders. Teams should bear in mind that PEPFAR targets are not PEPFAR's but flow directly from the partner country government's commitment to the UNAIDS and SDG 3 goals.

The PEPFAR COP/ROP 22 notional budget for Kenya is **$345,000,000** inclusive of all new funding accounts and applied pipeline. All earmarks and program directives provided below must be met. Additionally, this level assumes that the DoD AFRICOS program will be funded in COP22 at $400,000. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team, in collaboration with the Government of Kenya and civil society of Kenya, believes is critical for the country's progress towards controlling the pandemic and maintaining control.

Finally, in alignment with efforts by the U.S. government to support diversity, equity, inclusion, and accessibility as well as to advance equity for underserved communities and prevent and combat discrimination or exploitation on the basis of race, religion, gender identity or sexual orientation, PEPFAR will work to ensure that these principles are upheld, promoted, and advanced in all PEPFAR programs and in how we do business.

Please note that within the next few days our PEPFAR Chairs and PEPFAR Program Managers (PPMs), working closely with our CAST teams, will review this planning letter and details contained, herein, with your wider PEPFAR country team. Stakeholder engagement is essential for a productive and impactful planning process, and civil society engagement will continue to be an integral part of this planning process. Included in this planning letter is an outline of the expectations for engaging key stakeholders and civil society, as we continue to finalize our approach to hosting a virtual COP/ROP22 planning and approval process.

Once again, thank you for your continued leadership and engagement during the COP/ROP22 process.

Sincerely,

Angeli Achrekar

Attachment: **COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction Summary.**

CC: **S/GAC – Mike Ruffner, Christalyn Steers-McCrum, Dan Koros**

Overview: COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly monitoring POARTs, as well as Headquarters Country Accountability and Support Teams (CAST) input, a thorough program review of your country over time has been conducted. This includes the end of year results of the Country Operational Plan (COP) 2020 and current COP 2021 implementation as we plan for COP 2022. We have noted the following key successes and challenges:

Successes

1. Viral Load Suppression (VLS)
VLS has continued to improve across counties, sexes, and all ages except under one-year-olds. Not only has nearly every group improved, but Kenya officially hit 95% overall VLS mark. Females are at 95% VLS, with males very close behind at 94% VLS, and ages 25 and older over at 95% VLS with under 25 averaging closer to 90% VLS. Nine more counties crossed the 95% VLS threshold this year, putting over half of the PEPFAR-supported counties at or above 95%. All but one county (Samburu at 89%) are above 90%. This across the board improvement coupled with reaching 95% VLS marks a major success for PEPFAR Kenya.

2. VMMC and DREAMS
Despite significant program stoppages or delays, both Kenya's VMMC and DREAMS programs are back on track. We are pleased to see that not only is VMMC at full performance this year, but the rate of VMMC follow-ups steadily improved over last year which was targeted for improvement in last year's planning level letter. We are pleased to see how DREAMS has expanded and improved since the COVID delays, adding more AGYW than last year all while graduating at a better rate.

3. DTG Optimization and MMD
Another major accomplishment over the last year has been achieving DTG optimization at 95% among adults newly started on ART and introducing pDTG according to COP expectations. Importantly, the gender gap has closed among adults with 84% of males and 85% of females on TLD. Additionally, 3-5MMD shows continued improvement for all ages throughout FY21.

4. Safe and Ethical Index Testing
We would also like to applaud the team for the intense focus on safe and ethical index testing accountability. We were glad to see reform measures rolled out where appropriate and to see improvements in nearly every category during the follow-up assessments. Ensuring index testing is done safely and ethically remains a top priority, and implementation should continuously be assessed through-out COP22.

Given your country's status of achieved or are near achieving epidemic control, the following priority strategic and integrated changes are recommended:

1. Co-financing
PEPFAR Kenya has one of the largest programs and budgets, but falls in the bottom third when it comes to host country government co-financing. Now that PEPFAR Kenya's focus is shifting to sustaining its HIV impact, the co-financing commitments and follow-through need to be a priority. In particular, there have been challenges ensuring commitments to commodities. To date, through a robust pipeline of funding PEPFAR has covered shortfalls. The pipeline of funds is now exhausted, and in COP22, PEPFAR's commitment to commodities will not exceed the quantities initially programmed for COP22, and funds for commodity gaps must come from a non-PEPFAR source. Co-financing is not limited to health commodities; there is room for increased investments across the program. The funding level

assumes that according to the Minimum Program Requirements (MPRs) that the Government of Kenya will annually take on responsibility for elements of the HIV response and follow through on execution of those commitments. The funding level does not include funds for unnecessary additions to the MPRs like requiring a viral load test for children to transition to pDTG or for newly-initiated clients to make use of differentiated service delivery services.

2. Supply Chain

This year, PEPFAR Kenya was hit hard by complex supply chain issues leading to major stockouts of necessary pieces of EID tests, VLC tests, and TPT. This hurt many of our patients, and so plans must be in place that as soon as commodities arrive in country, these patients are followed up with to be given what they requested. These "mop up" plans should be prioritized and completed as quickly as possible. In addition, while many factors outside of our control fed into the stockouts, mitigation measures must be in place. This includes partnering with the Government of Kenya and Global Fund to ensure that barriers to the entry of commodities are removed. The COP22 funding level does not include funds to pay for unnecessary barriers. For instance, U.S.-donated commodities should continue to be allowed to enter Kenya tax-free and approvals for commodities to enter the country should continue to be granted swiftly so that commodities are not diverted or wasted. In addition, partnership with the Government of Kenya and Global Fund should also address barriers to the distribution of commodities, like issues preventing timely absorption of commodity funds and the lack of reporting tools and inadequate data quality.

3. Unique Identifiers

The requirement for a unique identifier has been a Minimum Program Requirement for four COP cycles and the lack of progress places an unacceptable burden on the PEPFAR program. As PEPFAR Kenya re-evaluates its strategic approach to revolve around sustainability and reaching the last mile, ensuring our data is clear is necessary, of which a key component is a UID. For instance, given some of the data issues encountered, it is plausible that PEPFAR Kenya has high rates of patient transfers and retests at facilities. The lack of a unique ID creates confusion over the true state of program performance. The funding level assumes that according to the MPR a unique ID is in place and the cost to the program is not borne by PEPFAR.

Additional Programmatic Challenges

1. Program Strategy Shifts

Now that Kenya overall is at epidemic control, the program approach should be examined to; 1) center the strategy around sustainability in every aspect of the program and 2) tailor the strategy to reach the last mile at the county-level and for all populations. This requires analyses on the program structure, features, and rationale county by county. For instance, how should PEPFAR Kenya's testing strategy evolve to reach and sustain 95-95-95? How will the testing strategy look different by county? This is to underscore the importance of the county-level ART Gap Assessment the Kenya CAST and ISMEs are working on right now, and the findings are expected to inform the COP22 strategy.

2. Retention/continuity of treatment

While the transition to TLD and MMD are essentially completed, data suggest that people still are not staying on treatment at the level we would expect. For example, only 40% of our total HTS_TST_POS turn into NET_NEW (which is an improvement from 37.6% in COP19), and in Nairobi county, only 22% of the 14.5k TX_NEW turned into TX_NET_NEW. If we had been able to keep only 80% of those clients in Nairobi, our country-wide TX_NET_NEW would be 24% higher than it was (48.7k), and we'd be that much closer to 95-95-95. In addition, nearly 40% of the clients who could have been added to our treatment cohort in Q4 experienced an IIT or refused/stopped treatment (looking at the waterfall analysis). IIT >3 mo is the largest contributor to the volume of IITs, but IIT <3 mo is at 9.7%, which is much higher

than the 2% benchmark. IIT >3 mo are especially high in adults older than 40, and IIT <3 mo are especially high in adolescents aged 15-19 and in Kakamega, Kitui, Machakos, Mombasa, Narok, Nandi, Taita, and Taveta counties. These issues are on top of Kenya's low IIT reporting completeness with only 54% of TX_CURR sites reporting IITs and Kenya's high amounts of patient transfers.

In COP22, please ensure IP staff are trained on IIT reporting and required data management practices are being implemented at the site level, including data cleaning for mechanisms with IIT overreporting and improving how transfer clients are captured. Please also focus on rearticulating U=U and other messaging to ensure it is client-centric, responsive to clients' emotions, and is not opaquely scientific; increasing community follow-up for IIT and the use of SMS; standardizing the return to care package; and increasing treatment literacy for PLHIV leveraging consumer marketing expertise (e.g. MenStar), especially for those populations (by age/sex) where the data shows the least viral suppression and most treatment interruption.

3. Right-sizing non-service delivery
With PEPFAR Kenya's focus shifting to sustaining HIV impact, in partnership with the Government of Kenya, the team must prioritize right-sizing non-service delivery. For every dollar spent at a site, PEFPAR Kenya spends up to a dollar and a half on above site according to expenditure reporting data. PEPFAR Kenya should review non-service delivery spending to identify duplicative activities that can be consolidated or centralized. Staff and material spending at site should be reviewed with a preference for maintaining current levels.

SECTION 1: COP/ROP 2022 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2021 (EOFY) tool, and performance data, the total COP/ROP 2022 planning level is comprised as follows:
Note – all pipeline numbers were provided and confirmed by your agency.

TABLE 1: All COP 2022 Funding by Appropriation Year

	Bilateral				Central				Total
	FY22	FY21	FY20	Unspecified	FY22	FY21	FY20	Unspecified	TOTAL
Total New Funding	**$ 334,448,676**	**$ -**	**$ 3,797,287**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 338,245,963**
GHP-State	$ 298,628,676	$ -	$ 3,797,287		$ -	$ -	$ -		$ 302,425,963
GHP-USAID	$ 32,500,000				$ -				$ 32,500,000
GAP	$ 3,320,000				$ -				$ 3,320,000
Total Applied Pipeline	**$ -**	**$ -**	**$ -**	**$ 6,754,037**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 6,754,037**
DOD				$ 1,200,656				$ -	$ 1,200,656
HHS/CDC				$ 5,181,945				$ -	$ 5,181,945
PC				$ 114,942				$ -	$ 114,942
State/AF				$ 256,494				$ -	$ 256,494
TOTAL FUNDING	**$ 334,448,676**	**$ -**	**$ 3,797,287**	**$ 6,754,037**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 345,000,000**

SECTION 2: COP 2022 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Countries should plan for the full Care and Treatment (C&T) level of $215,000,000 and the full Orphans and Vulnerable Children (OVC) level of $50,875,900 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

TABLE 2: COP 2022 Earmarks by Appropriation Year*

	Appropriation Year			
	FY22	FY21	FY20	TOTAL
C&T	$ 215,000,000	$ -	$ -	$ 215,000,000
OVC	$ 50,875,900	$ -	$ -	$ 50,875,900
GBV	$ 6,494,600	$ -	$ -	$ 6,494,600
Water	$ 550,000	$ -	$ -	$ 550,000
*Only GHP-State and GHP-USAID will count towards the earmarks (Care and Treatment, OVC, GBV, and Water).				
**Only GHP-State will count towards the GBV and Water earmarks				

TABLE 3: COP 2022 Initiative Controls: Each dollar planned in COP can belong to only one initiative. Most COP funding will be budgeted as Core Program. In general, initiatives other than Core Program are used to track activities/programs that cannot be tracked by the combination of program area and beneficiary alone. See Appendix 1 for more detailed information on initiatives.

	Bilateral	Central	TOTAL
Total Funding	**$ 345,000,000**	**$ -**	**$ 345,000,000**
Core Program	$ 282,718,503	$ -	$ 282,718,503
Cervical Cancer	$ 3,000,000	$ -	$ 3,000,000
DREAMS	$ 40,047,491	$ -	$ 40,047,491
OVC (Non-DREAMS)	$ 14,984,006	$ -	$ 14,984,006
VMMC	$ 4,250,000	$ -	$ 4,250,000

TABLE 4: Programmatic Controls: Programmatic controls are used to track programmatic directives that can be tracked by a combination of program area and/or beneficiary. Programmatic controls may overlap with Initiatives, for example PrEP for Adolescent Girls and Young Women may count towards both the DREAMS Initiative and the PrEP (AGYW) programmatic control. See Appendix 1 for more detailed information on programmatic controls.

	Bilateral	Central	TOTAL
Total Funding	**$ 5,681,000**	**$ -**	**$ 5,681,000**
PrEP (AGYW)	$ 1,877,200	$ -	$ 1,877,200
PrEP (KPs)	$ 3,803,800	$ -	$ 3,803,800

TABLE 5: State ICASS Funding

	Appropriation Year
	FY22
ICASS	$ 372,305

See Appendix 1 for detailed budgetary requirements and other budgetary considerations.

SECTION 3: PAST PERFORMANCE – COP/ROP 2020 Review

TABLE 6. COP/ROP OU Level FY21 Program Results (COP20) against FY22 Targets (COP21)

Indicator	FY21 result (COP20)	FY22 target (COP21)
TX Current <15	**64,320**	**77,929**
TX Current 15+	**1,180,812**	**1,275,246**
VMMC 15+	**55,640**	**55,023**
DREAMS (AGYW PREV)	**375,965**	**321,241**
Cervical Cancer Screening	**273,476**	**304,779**
TB Preventive Therapy	**40,427**	**76,327**

TABLE 7. COP/ROP 2020 | FY 2021 Agency-level Outlays versus Approved Budget

OU/Agency	Sum of Approved COP/ROP 2020 Planning Level	Sum of Total FY 2021 Outlays	Sum of Over/Under Outlays
OU	**$374,608,847**	**$342,938,999**	**$31,669,849**
DOD	$17,934,762	$15,376,181	$2,558,581
HHS/CDC	$147,418,158	$143,948,796	$3,469,362
PC	$190,000	$15,222	$174,778
State	$3,433,774	$1,336,890	$2,096,884
USAID	$204,882,153	$182,261,909	$22,620,244
USAID/WCF	$750,000	$0	$750,000

TABLE 8. COP/ROP 2020 | FY 2021 Results & Expenditures

Agency	Indicator	FY21 Target	FY21 Result	% Achievement	Program Classification	FY21 Expenditure	% Service Delivery
HHS/CDC	**HTS_TST**	2,274,162	**2,242,037**	98.6%	HTS Program Area	$10,216,390	69%
	HTS_TST_POS	80,674	**67,632**	83.8%			
	TX_NEW	77,337	**60,133**	77.8%	C&T Program Area	$61,441,810	66%
	TX_CURR	815,312	**767,009**	94.1%			
	VMMC_CIRC	21,928	**25,351**	115.6%	VMMC Sub-Program Area	$1,749,560	55%
	OVC_SERV	107,906	**154,269**	143%	OVC Beneficiary	$790,702	98%
DOD	**HTS_TST**	428,901	**288,458**	67.3%	HTS Program Area	$813,176	82%
	HTS_TST_POS	13,711	**6,204**	45.3%			
	TX_NEW	13,017	**5,400**	41.5%	C&T Program Area	$5,815,292	77%
	TX_CURR	72,336	**60,923**	84.2%			
	VMMC_CIRC	18,101	**14,654**	80.9%	VMMC Sub-Program Area	$1,145,446	93%
	OVC_SERV	26,608	**27,096**	101.8%	OVC Beneficiary	$692,026	72%
USAID	**HTS_TST**	2,131,415	**1,962,789**	92.1%	HTS Program Area	$12,011,339	81%
	HTS_TST_POS	75,689	**47,907**	63.3%			

TX_NEW	72,148	**44,323**	61.4%	C&T Program Area	$124,045,059	94%
TX_CURR	461,979	**417,200**	90.3%			
VMMC_CIRC	14,872	**15,648**	105.2%	VMMC Sub-Program Area	$656,513	64%
OVC_SERV	576,957	**605,526**	105%	OVC Beneficiary	$14,045,497	90%
				Above Site Programs	$19,553,531	
				Program Management	$48,421,743	

SECTION 4: COP/ROP 2022 DIRECTIVES

The following section has specific directives for COP 2022 based on program performance noted above. Please review each section carefully including the minimum program requirements.

Minimum Program Requirements (MPR)
All PEPFAR programs – bilateral and regional– must ensure the following minimum program requirements are in place. Adherence to these policies and practices is essential to the success of all PEPFAR programs at the national, subnational, and service delivery levels (e.g. facility, school, community). Evidence demonstrates that lack of any one of these policies/practices significantly undermines HIV impact and results in inefficient and ineffective programs.

All PEPFAR programs are expected to meet all of the requirements below, and the COP22 Planning Meeting will include a review of the status of each requirement, including assessment of implementation (including barriers) at the point of client services. To the extent that any requirement(s) have not been met by the time of the COP22 Planning Meeting, the PEPFAR OU team will need to present a detailed description of existing barriers and the remediation plans proposed that will allow them to meet the requirement(s) prior to the beginning of FY2023. The list will be included in the Strategic Direction Summary (SDS), as well.

Failure to meet any of these requirements by the beginning of FY2023 may affect the OU budget. The minimum requirements for continued PEPFAR support include the table below.

TABLE 9. COP/ROP 2022 (FY 2023) Minimum Program Requirements

Care and Treatment
1. Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups. Status: Completed.
2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens. Status: Completed.
3. Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.

	Status: Completed, but strategies should continuously be evaluated to identify areas of improvement.
4.	All eligible PLHIV, including children and adolescents, should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. Status: Completed, but stockouts affected implementation.
5.	Completion of Diagnostic Network Optimization (DNO) activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks. Status: Complete, but barriers remain. While Kenya has established DNO, DNO benefits from an annual review to account for changes in technology and improved capacity. Currently, there is sufficient testing capacity as long as reagents remain available. Barriers: However, due to the stockouts of reagents in COP20, the turnaround times were significantly prolonged. In addition, a mismatch between testing reagents and sample collection devices during the procurement process creates a secondary gap. Sometimes reagents are available, but collection devices are not and vice versa.
	Case Finding
6.	Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV. Status: In-process. Procedures continue to be reviewed and reassessed to ensure compliance.
	Prevention and OVC
7.	Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices) Status: Completed.
8.	Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV. Status: Completed.
	Policy & Public Health Systems Support
9.	In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups. Status: Completed.

10. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention. Status: Completed.
11. OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy. Status: Completed.
12. Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other partner country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention. Status: In process. U=U messaging was recently approved at the national-level and is now being rolled out county by count. Barriers: 1) U=U sensitization at the county level for all sub populations and all stakeholders. 2) Additional trainings and recruitment of champions needed.
13. Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses. Status: Completed.
14. Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended. Status: In-process. This remains an area of concern and should be prioritized this year. Barriers: Sub-optimal public financial management, private sector engagement, and use of available sector resources pose challenges.
15. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. Status: Completed.
16. Scale-up of case surveillance and unique identifiers for patients across all sites. Status: In-process. Final MOH framework to be disseminated and prototype (including registry, communications layer, and user interface) to be piloted this FY22. Barriers: Disputes between Ministry of Interior and civil society over legality of UPI system coupled with the delayed publication of Data Protection regulations have significantly slowed progress over the years.

In addition to meeting the minimum requirements outlined above, it is expected that Kenya will consider all the following technical directives and priorities. A full list of COP/ROP 2022 Technical Priorities and Considerations are listed in COP guidance and can be referenced in Section 6.

Table 10. COP/ROP 2022 (FY 2023) Technical Directives

Kenya–Specific Directives
HIV Clinical Services
1. Mother-baby pair tracking: With 15.7% of HIV-exposed infants (HEI) in the program having an unknown follow up determination for FY21, the tracking and retention of mother-infant pairs needs improvement. Better cohort monitoring can reduce the number of infants with an unknown final status and any missed opportunities in registering infants to the birth cohort. This can be done through partnership with mentor mothers and community health workers, as well as through more frequent use of the OVC platform. Ultimately, however, we recommend an HEI audit to better understand the gaps and identify specific ways to improve mother-baby pair tracking and retention. An audit could help answer questions around when and where babies are being identified, whether separate registers are being used for tracking, and whether any babies with HIV are coming from outside the PMTCT program. If mother-baby tracking and retention is lower for younger cohorts, we recommend age-appropriate services (e.g. mentor mothers, adolescent-friendly health care workers for AGYW, etc.).
2. Closing the sex gap: Even though males have a higher yield than females, identification rates, linkage, retention, and viral load coverage are all lower for males and show only small gains over years past. Index testing remains one of the most effective ways to identify new men living with HIV, and safe and ethical index testing services should be universally offered. PEPFAR Kenya should continue reviewing programming to leverage MenStar's consumer marketing approach and human-centered design principles to ensure services are people-centered and meet men's needs, to identify new or scale up successful differentiated service delivery (DSD) and decentralized drug distribution (DDD) approaches, and to expand peer to peer male coach programs.
3. Pediatrics: Low HTS_TST_POS achievement for under 15-year-olds and 15-19 year-olds has resulted in the under identification of children and adolescents living with HIV (C/ALHIV). To close the treatment gap for C/ALHIV the team must intensify their case finding efforts for this population through an optimal mix of testing modalities, including scaling family index testing and preventing undertesting in outpatient settings. In addition, interventions should address IIT for C/ALHIV and should continue to scale pDTG for all young CLHIV regardless of viral load. Viral load suppression for under five-year-olds should continue to rapidly improve once on pDTG.
HIV Prevention Services
1. OVC: Kenya should conduct a review of OVC graduation rates looking at factors such as HIV status and length of time since enrollment, to assess whether IPs are moving children and families toward graduation while also remaining focused on attaining key benchmarks as the ultimate program goal. Additionally, USAID Kenya should produce an analytic report of "exited without graduation" (OVC_SERV) rates to determine primary causes of loss to follow up and to outline remedial measures to prevent children and families from exiting without graduation.
2. PrEP for KP and AGYW: In COP 2022, PrEP should continue to be scaled up with a focus on ensuring policy and programmatic access to PrEP for higher incidence populations. Populations prioritized for PrEP should be tailored to the OU's epidemic context with a focus on Key Populations (including sex workers, men who have sex with men, transgender people, people in prisons and other closed settings, people who inject drugs), adolescent girls and young women including pregnant and breastfeeding AGYW, and other identified higher-incidence populations.
Other Government Policy, Systems, or Programming Changes Needed

1. Human Resources for Health (HRH): The team should review the allocation and density of HRH staff at the county and site level regularly in partnership with the Government of Kenya to ensure implementation of consistent HRH strategy and policy. Kenya employs significantly more HRH than comparable PEPFAR programs and long-term sustainability should be discussed with the GOK and counties. The team should share detailed HRH data with government partners to enable productive discussions.
2. Structural barriers for KPs: COP/ROP 22 plans should prioritize and take specific steps to address the structural barriers that impede scale up of KP-led and KP-competent differentiated HIV services, as well as the lack of robust data to guide key populations programming. To strengthen strategic information to guide KP responses, plans may include efforts to strengthen individual level data systems and analyses and address gaps in subnational data. Addressing structural barriers should entail improving the enabling environment for HIV service delivery; mitigating harmful policy and social norms that fuel stigma, discrimination and violence faced by key populations; strengthening the capacity of key populations organizations; and strengthening the KP competency of HIV service providers. PEPFAR teams should ensure they are coordinating strategically with relevant State and U.S. government units (e.g. DRL), partner government, multilateral, and other donor funding streams and institutions. As part of the new COP 22 MPR, PEPFAR teams will be expected to describe and present their approach to improving KP data and addressing barriers to accelerated KP-centered HIV services during COP/ROP 22 planning meetings.
3. Sustainability: The two lowest scoring elements in this 2021 Sustainability Index and Dashboard (SID) were Civil Society Engagement and Private Sector Engagement elements. These two elements have also decreased over time. Three out of the four Strategic Information elements have consistently scored low. These are all critical elements for sustained systems to deliver HIV programs. Please conduct an analysis to determine if the current portfolio of activities is appropriate and ensure sufficient COP22 investments in these two elements and the Strategic Information domain to result in increases in the 2023 SID scores.

COP/ROP 2022 Active Engagement with Community and Civil Society (see section 2.5.3 of COP Guidance)

The full participation of community stakeholders and civil society in every stage of PEPFAR programming, planning, and monitoring, as appropriate and consistent with applicable law, regulations and policy, from advocacy to service delivery, is critical to the success and sustainability of PEPFAR and the global effort to combat HIV. Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional, and international civil society and community stakeholders, multilateral partners and the partner country government.

Civil society organizations are essential and to be invited to participate in the virtual COP22 strategic retreats, planning meetings, as well as approval meetings. In particular, engagement with local CSOs at the country-level is required and should begin early and continue during the entirety of the COP planning, monitoring, and implementation process.

This engagement of civil society, including faith-based organizations/faith communities, specifically includes the sharing of FY 2021 Q4 and FY 2021 Annual Program Results (APR), analyses, and the convening of an in-country planning retreat with local stakeholders, no later than the week of February 7, 2022, in order to introduce and discuss all COP/ROP 2022 tools, guidance, results and targets as well as

the proposed trajectory and strategy for COP/ROP 2022. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund, with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In March 2022, PEPFAR will convene virtual meetings where outstanding decisions will be discussed and finalized. In addition to partner country representatives, the meetings will also include representatives from local and international civil society and community organizations, faith-based organizations/faith communities, private sector, and multilateral partners. Specific guidance for the 2022 virtual meeting delegations will be provided separately.

Engagement with all stakeholders is required beyond the meetings and throughout COP/ROP 2022 development, finalization, and implementation. As in COP/ROP 2021, the draft Strategic Direction Summary (SDS) is required to be shared with both CSO and FBO stakeholders for their input and comments at least 7 days prior to submission to S/GAC. Please refer to the COP/ROP 2022 Guidance for a full list of requirements and engagement timelines. In addition, a more detailed timeline for sharing key data visualizations and other information with stakeholders is forthcoming.

Community-led Monitoring (CLM)

In addition to prescribed and routine engagement during PEPFAR's annual business cycle, including around COP/ROP planning and quarterly POART processes, all PEPFAR programs are required to develop, support, and fund community-led monitoring (CLM) in close collaboration with independent, local civil society organizations and host country governments. Community-led monitoring in COP22 should build on prior activities in COP21 and be designed to help PEPFAR programs and health institutions pinpoint persistent problems, challenges, barriers, and enablers to effective client outcomes at the site level. In addition to being data-driven and action-oriented, CLM should continue to ensure indicators are defined by communities and health service users, and data should be additive and not a duplicate collection of routine data already available to PEPFAR through MER or SIMS. New in COP22, PEPFAR-supported community-led monitoring programs must include an explicit focus on key populations. CLM should be utilized to advance equity and to support improvement in programs, especially for populations who have not yet fully experienced the benefits of HIV epidemic control. For example, OUs with pediatric care and treatment programs should consider utilizing CLM to track and ensure accountability for child, adolescent, and family-centered care.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment: Each OU's COP/ROP 2022 minimum requirement for the care and treatment earmark is reflected in Table 2. If there is no adjustment to the COP/ROP 2022 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The Care and Treatment earmark will be calculated as the sum of the following:

- 100% Care and Treatment (C&T) Program Areas
- 50% Testing (HTS) Program Areas
- 100% Above Site Program: Laboratory System Strengthening
- 70% Pregnant and Breastfeeding Women Beneficiary Group
- Proportional % Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the C&T earmark)

Orphans and Vulnerable Children (OVC): Each OU's COP/ROP 2022 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The OVC earmark will be calculated as the sum of the following:

- 85% (DREAMS initiative funding — commodities planned under DREAMS initiative — Any HTS interventions planned under DREAMS initiative — Any C&T intervention planned under DREAMS initiative)
- 100% (OVC Beneficiary group funding — commodities planned under any intervention with OVC beneficiaries — Any HTS planned under interventions with OVC beneficiaries
- Proportional Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the OVC earmark)

Abstinence, Be Faithful/Youth (AB/Y) Reporting Requirement: If AB/Y-programmed activities do not reach a 50 percent threshold of all sexual prevention funding, as calculated by the formula below, in any country with a generalized epidemic, S/GAC is required to report to the appropriate Congressional committees on the justification for the decision. Generalized epidemic countries which do not meet the 50 percent threshold must provide a brief written justification in FACTS Info, explaining the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors.

Abstinence, Be Faithful/Youth (AB/Y) programming, formerly captured in the HVAB budget code, will now be captured by using a combination of prevention program areas and beneficiaries, which are identified in the formula below. The numerator captures those interventions that are Abstinence, Be Faithful/Youth (AB/Y) programming, and the denominator approximates all sexual prevention activities. The proportion of Abstinence, Be Faithful/Youth (AB/Y) programming as a proportion of all sexual prevention activities is calculated by dividing the numerator by the denominator:

Numerator

Prevention: primary prevention of HIV and sexual violence

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, and boys)

+

Prevention: community mobilization, behavior, and norms change

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, boys, adults, not disaggregated)

Denominator

Prevention: primary prevention of HIV and sexual violence (all populations)
+
Prevention: **community mobilization, behavior, and norms change** (all populations)
+
50 % Prevention: **Not disaggregated** (all populations)

Gender Based Violence (GBV): Each OU's COP/ROP 2021 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2022** funding programmed to the GBV cross-cutting code. Your COP/ROP 2022 earmark is derived by using the final COP/ROP 2021 GBV earmark allocation as a baseline. The COP/ROP 2022 planned level of new FY 2022 funds for GBV can be above this amount; however, it cannot fall below it.

Water: Each OU's COP/ROP 2021 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2022 funding** programmed to the water cross-cutting code. Your COP/ROP 2021 earmark is derived by using the final COP/ROP 2021 water earmark allocation as a baseline. The COP/ROP 2022 planned level of new FY 2022 funds for water can be above this amount; however, it cannot fall below it.

Initiative Controls: Table 3 shows initiative controls where S/GAC has directed funding for a set of activities that cannot be accounted for through program areas and/or beneficiaries alone. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned.

The four initiative controls below (**Cervical Cancer**, **DREAMS**, **OVC (non-DREAMS)**, and **VMMC**) have been assigned to the appropriate OUs. For OUs where these controls are designated in the PLL, the amounts reflect the minimum required. These initiative controls can be exceeded without a control change, but a control change request would be required before a lower level for these activities can be planned.

Cervical Cancer - This initiative provides funding for all activities related to cervical cancer screening and diagnosis and treatment of precancerous cervical lesions for women living with HIV as outlined in the COP Guidance.

DREAMS - The DREAMS initiative should capture all funding specifically allocated as DREAMS in the OU's planning level and must be used for the goal of HIV and sexual violence prevention among adolescent girls and young women (AGYW) ages 10-24 years (unless otherwise approved) in approved DREAMS SNUs in accordance with the DREAMS and COP Guidance. The DREAMS initiative can also include prevention interventions in DREAMS geographic areas for girls and boys aged 10-14 which may be cost shared with the OVC (non-DREAMS) initiative as noted in the COP guidance.

OVC (non-DREAMS) - OVC (non-DREAMS) is a new initiative in COP/ROP 2022. OUs should use the initiative to budget for OVC (non-DREAMS) programming, including all OVC comprehensive activities as outlined in the COP Guidance. The OVC (non-DREAMS) initiative should include ASP, SE, and PREV costs (except PrEP and VMMC) linked to any OVC beneficiary (including sub-beneficiaries such as OVC caregivers). As the initiative is new for COP/ROP 2022, OUs should pay particular attention to funds programmed under OVC (non-DREAMS) to ensure that the current cohort of children enrolled in the comprehensive program receive continuity of care for FY 2023. The OVC (non-DREAMS) initiative can also include prevention interventions for girls and boys aged 10-14 which may be cost-shared with the DREAMS initiative as noted in the COP guidance. The OVC (non-DREAMS) initiative cannot be met with any HTS, C&T, PM or commodities costs.

VMMC - All services and equipment related to providing surgical and ShangRing VMMC for boys/men ages 15 and above, and ShangRing circumcision only for boys ages 13 and 14 years, should be budgeted using the VMMC initiative.

While the CLM initiative does not appear in PLL budget tables, as CLM remains a requirement in COP/ROP 2022 for all OUs, each OU is responsible for programming a portion of funds under the **Community-Led Monitoring** initiative.

Community-Led Monitoring - During COP/ROP 2020, PEPFAR invested in expansion of community-led monitoring, making it a requirement of all OUs, as a critical way to listen to community voices in assessment of program quality and design of client-centered services. Community-led monitoring remains a requirement in FY 2023.

In addition to the five initiatives above, S/GAC may also allocate funding to OUs under two additional initiative controls: **Condoms (GHP-USAID Central Funding)** and **One-Time Conditional Funding**. If the OU was designated to receive funding under either one or both these initiatives in COP/ROP 2022, Table 3 will reflect these amounts. Unless otherwise noted, country teams should meet these funding controls when programming in their FAST.

Condoms (GHP-USAID Central Funding) - This initiative control denotes the amount of GHP-USAID central funding the country team may use to procure male and female condoms, lubricants, and to ship these commodities to the OU. Any additional condoms and lubricants to be procured with PEPFAR funding should be budgeted in the FAST with bilateral funding.

USAID Southern Africa Regional Platform - This initiative is for the country's share of the costs to operate the USAID Southern Africa Regional Platform, which provides administrative and technical support for Angola, Botswana, Eswatini, Lesotho, and Namibia. These funds were previously planned as part of the bilateral COP funding, but are now budgeted and notified centrally, with country amounts included as central funding in the overall COP levels for Angola, Botswana, Eswatini, Lesotho, and Namibia. Only these 5 countries may use this initiative, and this initiative can only be used with central funding specifically provided as part of the PLL controls.

One-Time Conditional Funding - The release of any funding made available under this initiative is contingent upon the OU's ability to meet all requirements outlined in their final COP/ROP approval memo. OUs that fail to meet these minimum standards may be ineligible to receive these funds for programmatic implementation in FY 2023.

No control is set in the PLL for the **HBCU Tx** and **Surveillance and Public Health Response** initiatives, but OUs may include relevant funds under these initiatives instead of Core Program as appropriate.

All funding not attributed to one of the nine COP/ROP 2022 initiatives above should be attributed to the **Core Program** initiative.

For additional details on initiatives, see the PEPFAR Financial Classifications Reference Guide.

Programmatic Controls: Table 4 shows programmatic controls where S/GAC has directed funding for certain programmatic activities. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned. Since every dollar programmed in COP must belong to one initiative, programmatic controls will be a subset of one or more initiative controls, even if the standard Core Program initiative.

PrEP (AGYW) – The PrEP (AGYW) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for the Females – Adolescent Girls and Young Women sub-beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the number of AGYW on PrEP wherever possible. Countries with a PrEP (AGYW) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

PrEP (KPs) – The PrEP (KPs) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for all sub-beneficiaries under the KP beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the number of KPs on PrEP wherever possible. Countries with a PrEP (KPs) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

State ICASS: Table 5 shows the amount that the OU must program under State for ICASS Costs.

Funds Programmed under State/SGAC (S/GAC TBDs)

No funding may be programmed under State/SGAC without prior approval from S/GAC M&B. In general State/SGAC TBDs are only used in extraordinary and or unusual circumstances. To the degree that funding is approved, the rationale and any conditions attached to the funding will be documented by M&B. Any S/GAC TBDs approved during COP/ROP 2022 planning will require supplemental language in the OU's COP/ROP 2022 approval memo, clearly outlining the process for how these funds can be accessed. Any funds that have not been distributed to agencies before the end of FY 2023 may be subject to reprogramming in future planning cycles towards the same OU or another OU.

COP/ROP 2022 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

Whenever possible, all agencies within an OU should hold several months of pipeline at the end of COP/ROP 2022 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. If an agency/OU combination has a history of over-outlays, or in cases where an agency/OU COP envelope has increased in recent years, there may not be sufficient funding to maintain this buffer. With the exception of Dominican Republic, Ethiopia, Haiti, South Sudan, Zimbabwe, Asia Regional Program, and Western Hemisphere Regional Program, which should hold up to four months of pipeline, all other OUs are permitted to hold no more than three months of buffer pipeline.

Any agency that anticipates ending COP/ROP 2021 implementation (end of FY 2022) with a pipeline in excess of three or four months is required to apply this excessive pipeline to COP/ROP 2022, decreasing the new funding amount to stay within the planning level.

Transitioning HIV Services to Local Partners

To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. In COP19 Guidance, PEPFAR set a goal that 40% of partners must be local by the end of FY19, and 70% by the end of FY20.While considerable progress was made in this effort, the 70% mark was not achieved by all agencies in all OUs, and thus in FY22 and FY23, teams must continue to prioritize this so that the 70% goal can be realized. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY23 as appropriate through their COP/ROP 2022 submission.