SDS Addendum for COP2023 Y2/FY25

Strategic Shifts and Key Agreements

For the second year of the Country Operational Plan (COP) 23, PEPFAR Kenya will continue to work in close collaboration with the Government of Kenya, development partners, civil society and other stakeholders to build a sustainable HIV response. The shifts identified for Year 2 of COP23 fall into two categories: 1. Efforts to provide the country with the foundation for HIV response alignment and ultimately for the Kenya to increase its proportional financial contribution to sustaining the response; and 2. Efforts to address lingering programmatic gaps toward the countries achievement of ending HIV as a public health threat. Over the course of 2023, the Government of Kenya planned for and began to operationalize its transition to Universal Health Coverage through greater focus on Primary Health Care. PEPFAR, GOK, and other relevant stakeholders also reviewed results in FY23 achievements and have identified course corrections to specifically reach the populations where a significant gap has remained. Through these efforts, the PEPFAR Kenya team is confident that it can achieve the goal of ending HIV as a public health threat by 2027.

PMTCT

In Kenya, eight counties contribute 50% of the country's HIV pediatric infections. In COP23 Y2, PEPFAR Kenya will geographically refocus to the eight counties (Siaya, Migori, Kisumu, Homa Bay, Nairobi, Kakamega, Bungoma and Nakuru) to address the high vertical transmissions. PrEP, Post ANC1 testing, and HEI screening will be scaled and Post ANC1 positives will be characterized to determine barriers. Also, Viral load coverage and monitoring of unsuppressed PBFW, and case management for high-risk negatives will be prioritized. Through county led technical assistance, joint data reviews and reporting, a support package to non-PEPAR sites in these counties will be defined and provided to address emerging gaps.

Most MCH registers are cross sectional and unlinked. The current low MNCH EMR coverage across the country limit longitudinal MIP tracking. To address these gaps, the 8 priority counties will fully roll out MNCH-EMR in all PEPFAR supported ANC sites with a phased roll out to the remaining 32 counties. Subsequently, machine learning will be utilized to provide insights and targeted program interventions.

In COP23 Y2, country structures to support eMTCT such as taskforce meetings, MCH in-charges meetings and joint activities will be bolstered. Shifts this year include:

- Allocation of a budget line for taskforce coordination through PEPFAR IPs and other NGOs domiciled in the respective counties for better synergy and coordination
- Partner Mapping across all SNUs that is CHMT led
- Development of top line PMTCT related indicator tracker with schedule for progress monitoring of both PEPFAR and Non PEPFAR sites
- Revamping EMTCT taskforces with clear TORs, roles and responsibilities
- Regular interagency and agency progress reviews of the focused counties

The RH/HIV minimum package in non-PEPFAR sites including private facilities and GoK, must be brought to compliance with comprehensive PMTCT services and reporting. PEPFAR Kenya will support the MoH to release a guidance circular on comprehensive EMTCT service provision in all ANC sites in the country that are public and private to ensure all PBFW accessing health facilities receive comprehensive MNCH services.

To strengthen community PMTCT service integration, PEPFAR Kenya will build the capacity of all Community Health Promoters (CHPs) on EMTCT and support bidirectional referrals for new cases and tracking of interruptions in treatment.

Pediatrics

Kenya continues to identify HIV infected older children due to missed opportunities for prevention of mother to child transmission of HIV and timely HIV case identification. In FY23, viral load testing coverage gap was at 17% and viral load suppression gap at 7%. Although >95% of children on 1st line ART are on a DTG based regimen, transition for those on second line LPV/r based regimen is yet to be operationalized. In FY 23, the proportion of children diagnosed with TB was below target at 11.4% probably due to gaps in TB screening and diagnostic work up for those with presumptive TB. TPT completion was also suboptimal at 88%.

PEPFAR Kenya will focus on treatment optimization by introducing TAF for children >25kg, and pALD for children >20kg. Changes to policy are required in COP23 Y2 to transition children on 2nd line PI to DTG and for pediatric ALD as a fixed dose combination. Operationalization of the pediatric DSD guidelines rollout will also be accomplished.

To support increased case finding, PEPFAR Kenya will continue to utilize index testing, address missed opportunities for testing in OPD, MCH, and IPD, and expand to linkage to OVC HTS clinical interphase.

For TB, TB screening will be integrated in all service delivery points. The clinical algorithm for diagnosis of TB in children will be rolled out, and the pediatric toolkit finalized and disseminated.

Finally, data use will be key to the shifts in COP23 Y2. CLHIV estimates will be reviewed for precision as well as the EMR interface. The MCH platform will be digitized, while pharmacy reporting tools will be reviewed and updated.

AGYW

In COP23 Y2, AGYW continue to experience the Triple Threat of teenage pregnancies, GBV, and persistence of high new HIV infections. PEPFAR will support expanded stakeholder engagement to review the national and county triple threats data, and interventions/ activities through the existing National and County TWG platforms. A multistakeholder TWG will be created to end the triple threat.

The DREAMS CORE package is resource intensive and may not be sustainable in its current state. In COP23, PEPFAR Kenya will shift to focus on innovation – to review and scale up efficient and sustainable models.

Gaps remain in the implementation framework for adolescents, including lack of implementation, and M&E framework and communication strategy. PEPFAR Kenya will support creating an enabling environment to implement DREAMS NextGen and work with NASCOP and stakeholders to:

- Review the DREAMS CORE package to identify interventions that can be mainstreamed.

- Develop an AYP communication strategy
- Develop an M&E framework
- Co-develop contextual interventions for AYP to include norms change and economic strengthening activities.

VMMC

To achieve the desired flatline targets of 55,000 VMMCs within the funding envelope for COP23 Y2, the PEPFAR Kenya will focus on shifts aimed at increasing program efficiency. In Kenya, the VMMC program reach of 55,000 men across 10 counties is inadequate for bridging access gaps for HTS and other services for men. PEPFAR Kenya will shift liberalize HIV-testing for VMMC clients to bridge their HTS access gaps and increase linkage to HIV prevention and treatment services. MOH staff capacity to provide VMMC as an integrated service will also be strengthened.

Demand creation, and mobile and outreach VMMC service delivery models are at a high cost in Kenya. In COP23 Y2, PEPFAR Kenya will shift away from dedicated VMMC mobilizers to utilizing social media and integrating demand creation for VMMC with other programs through community health promotors where feasible. Outreach and mobile VMMC will be limited to male-dominated workplaces with high demand while re-focusing service provision to health facilities.

To increase domestic resource inflows into VMMC for long term sustainability, PEPFAR will support the MOH in advocating for changing VMMC classification as a cosmetic surgery to essential minor surgery supported under the social health insurance fund (SHIF).

Finally, monitoring of PrEP integration into VMMC will be strengthened by introducing metrics for monitoring PrEP integration into VMMC services.

HIV Testing Services

COP23 Y2 shifts and recommendations for HTS are aimed towards addressing population specific and geographic equity gaps. Despite success over the last two decades in improving awareness of HIV status in the country, males and children still lag. According to the 2023 national HIV estimates, only 86% of the pediatrics and 93% of males know their HIV status, with the male AYPs having lower rates of awareness at 86% compared to 94% of males aged 25 years and above.

To close the gaps in COP 23, for all age-groups, there will be a shift to using the Community Health promoters (CHPs) across the established Primary care networks (PCNs) to increase identification of testing needs and linkage to HTS for pediatrics, as well as messaging and distribution of HIVST among the AYPs and males. In addition, optimized facility-based testing will be sustained for all the populations and age-groups.

We will ensure timely testing and address missed opportunities for uptake of index testing among children where eighteen thousand children listed as contacts of index clients were not tested in FY 23. This will be specifically done through testing the children at home and in the community as opposed to waiting for them to be brought to the facility. To ensure children encountered within the health facilities are not missed, eligibility screening and testing at all SDPs (especially the OPD, IPD and MNCH) will be strengthened through regular review of client flow and patient processes at facility level with an aim of continuous learning and adapting to address the gaps.

For the AYP, SNS as a promising modality for case-finding and entry to prevention services, will be scaled up to ALL supported sites from the current coverage of about 80%. This will be done as part of the larger efforts in aligning the HTS approach from HTS for case-finding only to HTS for treatment and prevention, nationally. In addition, the PEPFAR Kenya team will participate in the MoH led multi-sectoral engagement to develop a one-AYP response, particularly for the AGYW.

Male engagement for HTS will be improved through use of community based male champions for HIV messaging and HIVST distribution. In addition, community-based testing will be strengthened to close the gaps in reaching males listed as contacts of index clients as well as scaling up provision of SNS at all supported sites.

The PEPFAR Kenya team will continue to leverage on technology to improve HTS uptake. We aim to ramp up digitization of HTS through scaling up uptake of eHTS from the current 80% to 100% of the treatment EMR sites. We will continue to employ machine

learning, as part of digitization, to increase precision of case finding and prevention by increasing the proportion of clients screened in sites with eHTS using machine learning from the current rate of 73% to 100%.

Adult Care

In COP23 Y2, the success of the advanced HIV disease (AHD) program is dependent on all stakeholders including the GoK prioritizing and honoring the commodity procurement commitments. The HIV program in Kenya will adopt the use of the newer, more efficacious and less nephrotoxic liposomal amphotericin B for treatment of cryptococcal meningitis. Coordination of the AHD program will be through the newly formed national AHD subcommittee which has membership from NASCOP, the regional TWG representatives, NHRL, PEPFAR, GF, CHAI, EGPAF, WHO and civil society representatives.

To improve the treatment uptake and control of non-communicable diseases, the HIV program will start integrating the HIV services into mainstream health services and leverage on the public Health care and social health insurance schemes to improve access to NCD medication for PLHIV with these comorbidities by encouraging our clients to register as well as apply for the indigent scheme for those eligible. We shall work with the MOH to integrate the lay workers into public health care.

Optimization of treatment will be done by introducing TAFLD for clients with renal dysfunction as per WHO guidance. We shall work with NASCOP to put in place the policy for transitioning those on second line protease inhibitor-based regimen to DTG in line with WHO and current literature.

The HIV program will work with the department of reproductive health to improve the HPV vaccination coverage among the girls living with HIV by identifying vaccination champions among the adolescent peers as well as working with the OVC and DREAMS programs for referrals. We shall also integrate mental health screening in all service delivery points.

HIV/TB

Tuberculosis remains the leading cause of morbidity and mortality among PLHIV. Progress has been made to reduce the burden of TB among PLHIV; however, many cases remain undetected, resulting in unacceptably high TB mortality. This is a result of the use of TB screening tools with low sensitivity, and less than ideal access to TB diagnostics tools as well as suboptimal treatment of both TB and HIV. PEPFAR Kenya intends to invest in WHO recommended dCXR with computer aided

detection (CAD) artificial intelligence to improve sensitivity of TB screening and diagnosis while increasing access to molecular TB diagnostic tools and LF-LAM for those with advanced HIV disease.

To optimize TB treatment outcomes, we will support the implementation of TB and TPT DSD models nationally beyond the Nairobi pilot sites. In addition, the country will support the phase-in of shorter treatment regimens for drug susceptible and drug resistant tuberculosis while closing the gaps in uptake of TB preventive treatment. To enhance sustainability PEPFAR Kenya will work with the country team to develop an MOH led TB acceleration plan that builds on other health sustainability structures including the PHC and UHC agenda.

Key and Priority Population Services

COP23 Y2 will focus on reaching KPs who have been unreached including, young KP <24yrs, "camouflaged" KPs, KPs utilizing virtual platforms and will continue to assess for other sub populations. COP23 shifts include adjustments to service delivery models to meet emerging needs of new KP sub populations, addressing self-stigma, and utilization of differentiated service delivery approach.

PEPFAR Kenya will implement the following Innovative Service Delivery Models in COP23 Y2:

- Social media/digital platforms messaging and reach e.g., PrEP uptake on Tik tok and other social media platforms using peer champion. This approach will be piloted in the 3 populous cities of Mombasa, Nairobi & Kisumu.
- Link online pharmacy models and pilot the use of "My Dawa" platform to provide prevention products.
- Intensify PrEP delivery at the community using existing outreach models.
- Engage peer educators to reach camouflaged KPs through non-conventional venues e.g., massage parlor, upscale clubs, home-based services.

Differentiated services will be delivered by

- Extending clinic working hours to meet the needs of KPs especially in the context of integration e.g. late evening, early morning, dedicated days for young KPs.

Self-stigma among KP will be addressed by:

- Reviewing M&E tools for use of terminology acceptable for different KP sub-groups e.g., use of the terminology “sex work” may not be acceptable for young women engaging in transactional sex.
- Scale up training of service providers on KP friendly services across all departments and entry points in integrated DICEs and new sites.

Additionally, in COP23 Y2 the program will focus on the roll out of the new guidelines, policies, and surveys.

- Development of the M&E framework for KP
- Engage MOH to fast track completion and dissemination of transgender (TG) guidelines, and vulnerable populations (VP) guidelines
- Review and update the current KP guidelines (2014)
    - Revise HIV testing requirements to match World Health Organization (WHO) guidance
    - Use of HIV self-testing to monitor PrEP continuation.
    - Include new program strategies e.g. ED-PrEP, U=U, SNS etc. in the guidelines
- The results from the integrated biological and behavioral survey (IBBS) expected to be released this year will be used to inform programming and make any needed program adjustments.

Commodities

There is inconsistent availability of the variety of commodities required for HIV services in Kenya. PEPFAR commodity investments and shifts in COP23 Y2 are targeted to priority commodities according to WHO guidelines and aligned to program strategies. In COP23 Y2, PEPFAR Kenya will continue to provide support for enhanced data analytics in national forecasting, supply planning, and procurement monitoring; end-to-end data visibility; county-level supply chain management support; and supply chain audits.

HRH

PEPFAR Kenya will collaborate with GOK and other stakeholders to develop an HRH policy that will guide HRH development and management, addressing PHC needs that include HIV services at various levels of service delivery.

Staffing structure and workforce alignment will be priority in COP23 Y2. The PEPFAR-supported clinical workforce not aligned to GoK service structure and renumeration will be examined through an inter-agency analysis of all PEPFAR-supported clinical staff, identifying those outside of public service scope and their remuneration packages. To plan and budget staff more effectively, we will engage with GoK and WHO in the planning and implementation of the nation-wide Workload Indicators for Staffing Needs (WISN) exercise.

PEPFAR-supported community and lay workforce are currently not aligned to GoK's Community Health Promoters (CHPs) cadre specified under PHC Act 2023. To address this, PEPFAR Kenya will:

- Examine all PEPFAR-supported community and lay cadres, including their qualifications, functions and remuneration packages.
- Participate in the ongoing CHP curriculum review to ensure inclusion of HIV services at community and facility levels within Primary Care Networks (PCN).
- Support GOK develop SOPs for CHP registry to enhance data quality and use for decision making.

Health workers providing services in PEPFAR-supported clinics/ departments need enhanced knowledge and skills to effectively provide quality HIV services and to integrate into the workforce. In COP23 Y2, in collaboration with GoK and other stakeholders, PEPFAR Kenya will conduct a training needs assessment among staff working in non-PEPFAR supported clinics and departments and develop approaches to train and mentor them to ensure parity with staff at PEPFAR-supported clinics. Secondarily, this will contribute towards service integration and sustainability. We will work with GOK, FBO, and private sectors to assess the supervisory and TA capacity regarding HIV services and identify approaches to build their capacity.

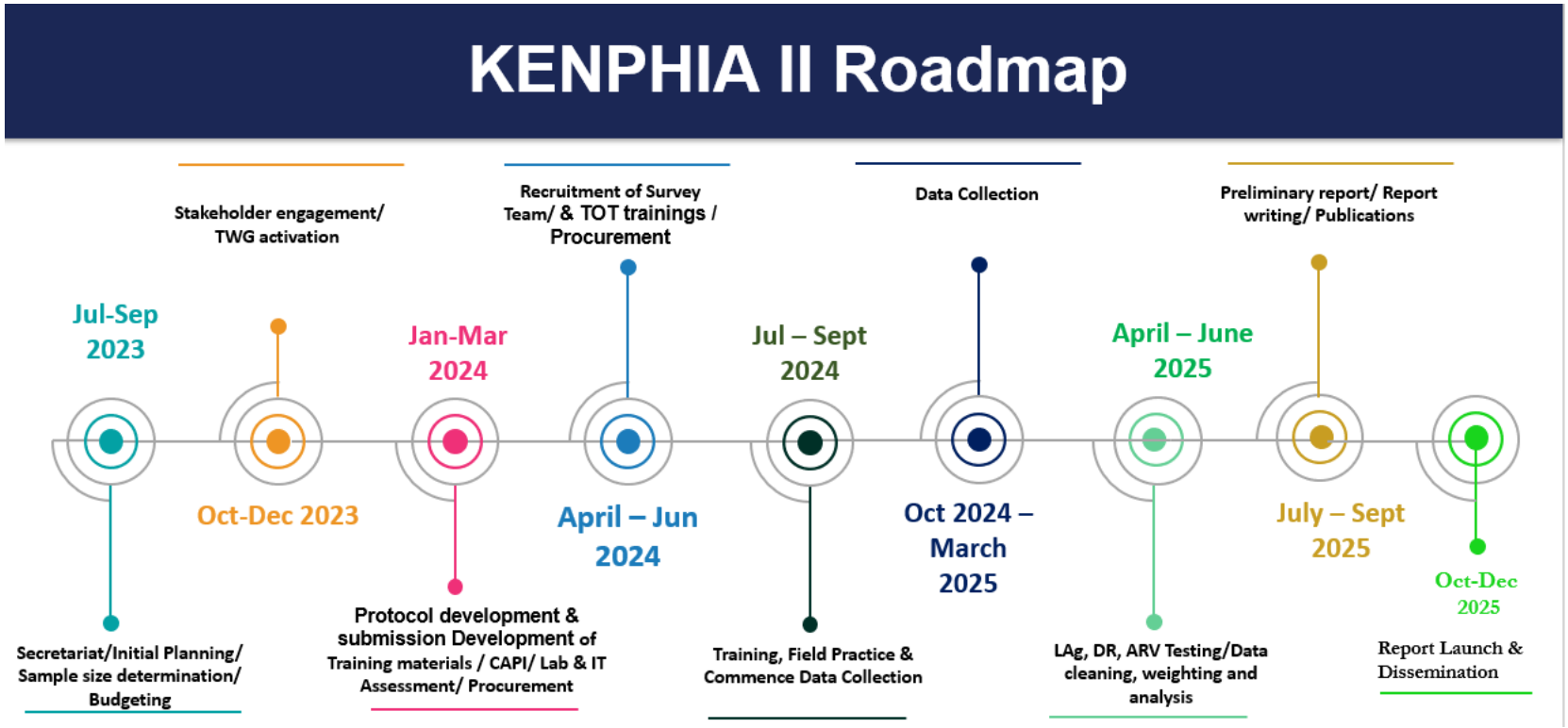
Recent HIV Infection Surveillance

Recent HIV infection surveillance in Kenya will shift from a programmatic approach of looking at recent infections among those newly diagnosed with HIV, to estimating incidence among antenatal clinic attendees i.e. proportion recent among at risk antenatal

clinic attendees. This surveillance system will be implemented in all 47 counties in Kenya in all or a systematic sample of antenatal clinics. Limiting antigen avidity (LAg) avidity assay will be used in this model, combined with viral load testing among those classified as LAg recent to determine true recent infection status. National and county level incidence among antenatal clinic attendees will be used to track the epidemic and respond based on county-specific epidemic control and 95-95-95 achievement status.

KENPHIA

In COP23 Y2, PEPFAR Kenya will shift in approach to recent HIV infection surveillance to a model that allows estimation of HIV incidence in antenatal clinic attendees. The roadmap below outlines the activities and milestones over the next year with a plan of preliminary results expected by FY25/Q4.



Updated Target Tables

Target Table 1 ART Targets by Prioritization for Epidemic Control

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Prioritization Area	**Total PLHIV (FY23)**	**New Infections (FY24)**	**Expected Current on ART (FY23)**	**Current on ART Target (FY24)** ***TX_CURR***	**Newly Initiated Target (FY24)** ***TX_NEW***	**ART Coverage (FY24)**	**ART Coverage (FY25)**
Attained	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	**Not applicable**
Scale-Up Saturation	766,448	9,845	752,864	773,443	33,045	101%	**101%**
Scale-Up Aggressive	433,087	5,480	411,006	420,131	16,096	97%	**98%**
Sustained	165,530	2,002	147,979	153,641	8,049	93%	**99%**
Central Support	14,034	210	Not applicable	Not applicable	Not applicable	0%	**Not applicable**
Total	**1,379,099**	**17,537**	**1,314,962**	**1,350,358**	**57,277**	**98%**	**100%**

Target Table 2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

Target Table 2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts								
SNU	**Target Populations**	**Population Size Estimate (SNUs) 2024**	**Current Coverage 15-64 yrs. (FY23)**	**Current Coverage 15-29 yrs. (FY23)**	**VMMC_CIRC (in FY24)**	**Expected Coverage (in FY24)**	**VMMC_CIRC (in FY25)**	**Expected Coverage (in FY25)**
Turkana	15-64 yrs	283,243	78%	82%	13,200	**81.6%**	13,200	**81.6%**
Kisumu	15-64 yrs	353,757	64%	125%	12500	**66.1%**	12500	**66.1%**
Siaya	15-64 yrs	270,300	66%	117%	8250	**67.5%**	8250	**67.5%**
Homa Bay	15-64 yrs	299,615	70%	94%	8200	**71.2%**	8200	**71.2%**
Migori	15-64 yrs	303,392	69%	102%	6000	**69.2%**	6000	**69.2%**
Nandi	15-64 yrs	276,159	92%	Not applicable	3000	**90.9%**	3000	**90.9%**
Nairobi	15-64 yrs	1,575,300	86%	Not applicable	3000	**83.7%**	3000	**83.7%**
Militar	15-64 yrs	Not	Not	Not	**850**	Not	**850**	Not

y		applicable	applicable	applicable		applicable		applicable
	Total/ Average	Not applicable	Not applicable	Not applicable	**55,000**	Not applicable	**55,000**	Not applicable

Target Table 3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Table 3 Target Populations for Prevention Interventions to Facilitate Epidemic Control				
Target Populations	**Population Size Estimate* (SNUs)**	**Disease Burden***	**FY24 Target**	**FY25 Target**
PP_PREV	Not applicable	Not applicable	521,693	521,693
AGYW_PREV	Not applicable	Not applicable	321,241	321,241
KP_PREV	Not applicable	Not applicable	344,792	344,792

Target Table 4 Targets for OVC and Linkages to HIV Services

SNU	Target # of Active OVC. OVC_SERV	Target # of Active OVC. OVC_SERV DREAMS	Target # of Active OVC. OVC_SERV Preventive	Target # of Active OVC. OVC_SERV Comprehensive	Target # of Active beneficiaries receiving support from PEPFAR OVC programs whose HIV status in known in program
Bungoma County	7,818	-	1,316	6,502	6,384
Busia County	13,322	-	2,176	11,146	10,942
Homa Bay County	68,071	24,593	6,358	37,120	36,432
Kajiado County	4,218	-	594	3,624	3,558
Kakamega County	12,051	-	1,822	10,229	10,010
Kericho County	6,766	-	952	5,814	5,708
Kiambu County	32,347	20,151	1,712	10,484	10,288
Kilifi County	19,590	-	2,760	16,830	16,524
Kisii County	9,626	-	1,354	8,272	8,122
Kisumu County	61,490	16,494	6,101	38,895	38,147
Kitui County	2,856	-	402	2,454	2,410
Machakos County	4,268	-	600	3,668	3,600
Makueni County	3,318	-	468	2,850	2,798
Meru County	3,922	-	552	3,370	3,310
Migori County	48,786	33,073	2,202	13,511	13,257

Mombasa County	27,497	20,798	940	5,759	5,651
Muranga County	2,846	-	400	2,446	2,402
Nairobi County	111,117	49,289	8,691	53,137	52,147
Nakuru County	16,352	-	2,302	14,050	13,794
Nyamira County	1,338	-	190	1,148	1,128
Siaya County	30,301	13,788	2,333	14,180	13,884
Trans-Nzoia County	4,714	-	662	4,052	3,978
Turkana County	5,524	-	778	4,746	4,660
Uasin Gishu County	6,660	-	938	5,722	5,618
Vihiga County	2,230	-	314	1,916	1,882

Updated Budget Tables

Table B.1.1 COP 22, COP 23/FY 24, COP 23/FY 25 Budget by Intervention

Intervention	COP 22	COP 23/FY 24	COP 23/FY 25
	345,000,000	347,775,122	322,000,000
ASP: Health Management Information Systems (HMIS)-NSD; Military	-	40,000	37,420
ASP: Health Management Information Systems (HMIS)-NSD; Non-Targeted Populations	-	4,225,521	4,413,739
ASP: Health Management Information Systems (HMIS)-NSD; OVC	-	356,888	346,082
ASP: HMIS, surveillance, & research-NSD; Key Populations	1,500,000		
ASP: HMIS, surveillance, & research-NSD; Non-Targeted Populations	10,045,252	-	-
ASP: Human resources for health-NSD; Non-Targeted Populations	1,118,703	1,169,098	1,343,049
ASP: Laboratory systems strengthening-NSD; Non-Targeted Populations	3,451,498	2,427,224	2,182,685
ASP: Laws, regulations & policy environment-NSD; Non-Targeted Populations	-	622,639	817,611
ASP: Management of disease control programs-NSD; AGYW	40,247		
ASP: Management of disease control programs-NSD; Children	-	5,839	5,231
ASP: Management of disease control programs-NSD; Key Populations	86,525	334,800	261,689
ASP: Management of disease control programs-NSD; Non-Targeted Populations	2,321,099	2,186,501	2,248,608
ASP: Management of disease control programs-NSD; Pregnant & Breastfeeding Women	186,033	177,246	113,804
ASP: Not Disaggregated-NSD; Non-Targeted Populations	827,118		
ASP: Procurement & supply chain management-NSD; Non-Targeted Populations	904,333	1,345,000	1,997,869
ASP: Public financial management strengthening-NSD; Non-Targeted Populations	357,729	865,622	1,161,664
ASP: Surveys, Surveillance, Research, and Evaluation (SRE)-NSD; Key Populations	-	1,600,000	-
ASP: Surveys, Surveillance, Research, and Evaluation (SRE)-NSD; Non-Targeted Populations	-	11,651,908	10,880,926
C&T: HIV Clinical Services-NSD; Children	48,687	455,296	394,128
C&T: HIV Clinical Services-NSD; Key Populations	-	30,324	27,169
C&T: HIV Clinical Services-NSD; Non-Targeted Populations	4,678,066	19,579,941	16,183,856
C&T: HIV Clinical Services-NSD; Pregnant & Breastfeeding Women	55,732	1,329,769	927,225
C&T: HIV Clinical Services-SD; Children	387,610	2,442,281	2,126,485
C&T: HIV Clinical Services-SD; Key Populations	1,400,627	7,195,955	7,005,333
C&T: HIV Clinical Services-SD; Non-Targeted Populations	21,227,928	51,776,727	39,777,436
C&T: HIV Clinical Services-SD; Pregnant & Breastfeeding Women	893,527	7,307,355	6,193,592
C&T: HIV Drugs-NSD; Non-Targeted Populations	-	245,642	189,031
C&T: HIV Drugs-SD; Children	1,112,210	1,239,315	2,979,541
C&T: HIV Drugs-SD; Non-Targeted Populations	26,701,187	33,854,664	28,107,129
C&T: HIV Drugs-SD; Pregnant & Breastfeeding Women	-		
C&T: HIV Laboratory Services-NSD; Children	-	32,913	29,485

C&T: HIV Laboratory Services-NSD; Pregnant & Breastfeeding Women	1,237		
C&T: HIV Laboratory Services-SD; Children	2,620,824	2,993,292	1,978,443
C&T: HIV Laboratory Services-SD; Military	-	40,000	37,420
C&T: HIV Laboratory Services-SD; Non-Targeted Populations	31,241,948	23,012,798	18,291,097
C&T: HIV/TB-NSD; Children	-	56,136	50,685
C&T: HIV/TB-NSD; Non-Targeted Populations	-	926,963	849,389
C&T: HIV/TB-SD; Children	-	360,732	323,190
C&T: HIV/TB-SD; Non-Targeted Populations	-	6,098,851	20,099,791
C&T: Not Disaggregated-NSD; Key Populations	216,139		
C&T: Not Disaggregated-NSD; Non-Targeted Populations	14,916,658	-	-
C&T: Not Disaggregated-NSD; Pregnant & Breastfeeding Women	838,778		
C&T: Not Disaggregated-SD; Key Populations	7,549,212		
C&T: Not Disaggregated-SD; Non-Targeted Populations	37,816,955	-	-
C&T: Not Disaggregated-SD; Pregnant & Breastfeeding Women	6,627,844		
HTS: Community-based testing-NSD; Key Populations	-	62,399	55,904
HTS: Community-based testing-NSD; Non-Targeted Populations	-	445,547	399,178
HTS: Community-based testing-SD; Key Populations	-	1,904,446	1,884,605
HTS: Community-based testing-SD; Non-Targeted Populations	313,988	2,119,030	1,899,865
HTS: Facility-based testing-NSD; Key Populations	49,999	93,598	83,856
HTS: Facility-based testing-NSD; Military	8,293	4,887	4,572
HTS: Facility-based testing-NSD; Non-Targeted Populations	71,482	1,667,009	1,917,883
HTS: Facility-based testing-NSD; Pregnant & Breastfeeding Women	25,355	62,990	62,338
HTS: Facility-based testing-SD; Key Populations	38,894	760,353	854,518
HTS: Facility-based testing-SD; Military	22,381	19,547	18,286
HTS: Facility-based testing-SD; Non-Targeted Populations	12,503,125	15,001,861	15,724,016
HTS: Facility-based testing-SD; Pregnant & Breastfeeding Women	814,737	792,902	747,750
HTS: Not Disaggregated-NSD; Key Populations	-		
HTS: Not Disaggregated-NSD; Non-Targeted Populations	1,835,612	-	-
HTS: Not Disaggregated-NSD; Pregnant & Breastfeeding Women	-		
HTS: Not Disaggregated-SD; Key Populations	3,028,653		
HTS: Not Disaggregated-SD; Non-Targeted Populations	7,633,050	-	-
HTS: Not Disaggregated-SD; Pregnant & Breastfeeding Women	10,647		
PM: IM Closeout costs-NSD; Non-Targeted Populations	404,000	386,780	-

PM: IM Program Management-NSD; OVC	1,577,725	1,495,986	833,813
PM: USG Program Management-NSD; Non-Targeted Populations	28,079,868	31,299,099	29,710,437
PREV: Medication assisted treatment-NSD; Key Populations	427,062	322,803	405,070
PREV: Medication assisted treatment-SD; Key Populations	-		
PREV: Non-Biomedical HIV Prevention-NSD; AGYW	2,971,809	1,711,827	1,515,735
PREV: Non-Biomedical HIV Prevention-NSD; Key Populations	380,172	363,169	328,353
PREV: Non-Biomedical HIV Prevention-NSD; Military	217,104	-	-
PREV: Non-Biomedical HIV Prevention-NSD; Non-Targeted Populations	628,738	307,272	332,903
PREV: Non-Biomedical HIV Prevention-NSD; OVC	24,000	20,000	20,000
PREV: Non-Biomedical HIV Prevention-SD; AGYW	-	2,926,989	2,622,458
PREV: Non-Biomedical HIV Prevention-SD; Non-Targeted Populations	-	90,517	57,641
PREV: Non-Biomedical HIV Prevention-SD; OVC		-	727,053
PREV: Not Disaggregated-NSD; AGYW	1,841,178	1,822,662	2,113,033
PREV: Not Disaggregated-NSD; Children	-		
PREV: Not Disaggregated-NSD; Key Populations	396,996	1,714,516	1,084,255
PREV: Not Disaggregated-NSD; Military	-	39,669	37,111
PREV: Not Disaggregated-NSD; Non-Targeted Populations	530,945	387,421	814,453
PREV: Not Disaggregated-NSD; OVC	14,044	15,000	15,000
PREV: Not Disaggregated-SD; AGYW	6,163,723	4,433,334	4,301,140
PREV: Not Disaggregated-SD; Children	-		
PREV: Not Disaggregated-SD; Key Populations	6,100,572	6,475,410	4,775,228
PREV: Not Disaggregated-SD; Military	-	155,485	115,457
PREV: Not Disaggregated-SD; Non-Targeted Populations	407,098	14,264	38,992
PREV: PrEP-NSD; AGYW	26,099		
PREV: PrEP-NSD; Key Populations	807,297	932,695	867,042
PREV: PrEP-NSD; Military	-	1,496	1,400
PREV: PrEP-NSD; Non-Targeted Populations	501,296	266,067	417,627
PREV: PrEP-SD; AGYW	1,851,101	1,268,492	1,133,100
PREV: PrEP-SD; Key Populations	2,541,079	3,110,931	2,654,433
PREV: PrEP-SD; Military	-	2,245	2,100
PREV: PrEP-SD; Non-Targeted Populations	2,003,693	1,985,773	1,812,211
PREV: Violence Prevention and Response-SD; AGYW	-	36,848	33,012
PREV: VMMC-NSD; Military	-	17,165	16,058

PREV: VMMC-SD; Non-Targeted Populations	3,492,592	3,026,114	2,123,631
SE: Case Management-NSD; Non-Targeted Populations	-	12,429	-
SE: Case Management-NSD; OVC	-		
SE: Case Management-SD; AGYW	55,820	30,774	158,198
SE: Case Management-SD; Non-Targeted Populations	135,398		
SE: Case Management-SD; OVC	5,452,680	5,234,089	4,903,886
SE: Economic strengthening-NSD; OVC	-	420,000	420,000
SE: Economic strengthening-SD; AGYW	18,475,418	17,812,852	14,104,912
SE: Economic strengthening-SD; OVC	4,692,160	4,371,177	4,167,574
SE: Education assistance-SD; AGYW	4,735,951	5,381,051	4,665,117
SE: Education assistance-SD; OVC	3,990,939	4,212,655	2,845,059
SE: Food and Nutrition-SD; OVC	-	19,609	18,344
SE: Not Disaggregated-NSD; AGYW	276,857		
SE: Not Disaggregated-NSD; Non-Targeted Populations	92,300		
SE: Not Disaggregated-NSD; OVC	901,696	-	-
SE: Not Disaggregated-SD; AGYW	309,367		
SE: Not Disaggregated-SD; Non-Targeted Populations	-		
SE: Not Disaggregated-SD; OVC	847,976	-	-
SE: Psychosocial support-SD; Non-Targeted Populations	-		
SE: Psychosocial support-SD; OVC	-	133,160	121,048

Table B.1.2 COP22, COP 23/FY 24, COP 23/FY 25 Budget by Program Area

Program Area	COP 22	COP 23/FY 24	COP 23/FY 25
	345,000,000	347,775,122	322,000,000
ASP	20,838,537	27,008,286	25,810,377
C&T	160,560,161	160,500,110	146,826,469
HTS	26,356,216	22,934,569	23,652,771
PM	65,372,769	67,529,213	65,310,779
PREV	31,905,755	32,175,148	28,995,466
SE	39,966,562	37,627,796	31,404,138

Table B.1.3 COP22, COP 23/FY 24, COP 23/FY 25 Budget by Beneficiary

Targeted Beneficiary	COP 22	COP 23/FY 24	COP 23/FY 25
	345,000,000	347,775,122	322,000,000
AGYW	36,747,570	35,424,829	30,646,705
Children	4,169,331	7,585,804	7,887,188
Key Populations	24,523,227	24,901,399	20,287,455
Military	307,278	360,546	307,293
Non-Targeted Populations	252,297,484	253,553,718	240,408,791
OVC	17,501,220	16,278,564	14,417,859
Pregnant & Breastfeeding Women	9,453,890	9,670,262	8,044,709

Table B.1.4 COP 22, COP 23/FY 24, COP 23/FY 25 Budget by Initiative

Initiative Name	COP 22	COP 23/FY 24	COP 23/FY 25
	345,000,000	**347,775,122**	**322,000,000**
Cervical Cancer	3,000,000	3,676,948	3,661,636
Community-Led Monitoring	83,129	1,200,000	1,163,353
Core Program	282,635,374	273,791,414	258,627,755
DREAMS	40,047,491	38,846,066	33,207,874
General Population Survey	-	10,000,000	10,000,000
KP Survey	-	1,600,000	-
LIFT UP Equity Initiative	-	1,000,000	-
OVC (Non-DREAMS)	14,984,006	13,890,431	12,568,723
VMMC	4,250,000	3,770,263	2,770,659

USG Staffing Updates

Department of Defense

During COP23, year one, DOD completed the hiring process for one management and finance specialist position. For COP23 year two, we propose to repurpose the unfilled driver position to a LE Staff Sustainability Advisor position in order to adequately support sustainability and transition. This portfolio is critical to achieve and maintain program goals, including reaching and sustaining HIV epidemic control as budgets decline. Additionally, as the amount of government-to-government funding increases for DOD PEPFAR-supported counties, additional oversight will be needed to ensure government entities meet USG and PEPFAR funding and program requirements. The position will also play an important role in supporting interagency and Government of Kenya sustainability working groups, which DOD are currently challenged to support. Funding for this position will be availed from the repurposed driver position budgeted for in COP 23 and other minor shifts.

Department of State / PEPFAR Coordination Office

Almost all vacant positions have now been filled, except for the DREAMS Coordinator position which be adjusted to encompass all special activities for the PEPFAR Coordination Office. The Bureau for Global Health Security and Diplomacy has announced multiple initiatives to address specific thematic areas and populations to which Kenya may participate. As the need for a specific DREAMS Coordinator has reduced with the maturity of the program, this role will maintain those responsibilities and coordinate the interagency preparation and oversight of any GHSD initiatives for Kenya. The funding for this position is within the current funding envelope for State.

Peace Corps

Peace Corps has made no changes to staffing positions from COP 23/Year 1.

The Centers for Disease Control and Prevention (CDC)

CDC's Division of Global HIV and Tuberculosis Kenya Field Office (CDC Kenya) reduced the cost of doing business, largely from savings due to exchange rate fluctuations. With these savings, CDC was able to redirect $200,000 from CODB to programmatic activities.

CDC Kenya's organizational and personnel management efforts continue to support and sustain a program that identifies new HIV and tuberculosis cases, utilizes different modalities to collect individual-level data electronically, and closes gaps in human resources for health. Additionally, the program has a robust history of funding local partners. In FY24, 97% of CDC funds are awarded to local partners, of which 5% is awarded directly at the county level. All cooperative agreements are both financial and technical support partnerships, and all receive fiscal oversight and technical support through interdisciplinary teams of CDC subject matter experts. G2G partnerships require enhanced oversight measures necessary given the inherent risks in the local context. Analysis of trends of fraud, waste, and abuse prevented, identified, and mitigated in G2G mechanisms suggests that long term success for sustained epidemic control will require more intensive oversight in the coming years rather than less.

CDC Kenya conducted an extensive review of existing staffing, current vacancies, and projected future needs, and concluded CDC will need to be responsive to declining budgets while simultaneously expand our human capacity in the country office to provide appropriate oversight. As such, CDC proposes to abolish two NSDD38 U.S. direct hire positions in Kisumu that have been vacant for more than a year. CDC also proposes to repurpose certain existing locally employed (LE) positions into LE staff leadership positions.

USAID

USAID has made no changes to staffing positions from COP 23/Year 1 and the cost of doing business remains flatlined. Almost all vacant positions have now been filled or are in the process of being filled.

In COP 22, USAID reviewed staffing requirements to provide adequate oversight of USAID programs and technical assistance, especially in managing local awards. Several positions that were not needed were removed in the previous COP. USAID's staffing approach includes frequent monitoring, reporting, and analyzing of results to make course adjustments and adapt program approaches.

Priority Areas for Sustainability Roadmap Development

The primary goal of the PEPFAR Kenya Sustainability Roadmap is to provide a measurable pathway to the transition of the national HIV response to primarily be funded through Kenyan resources. This transition will be achieved through redefining program approaches and integrating HIV service delivery into the broader GOK health service structure and increasing the GOK funding. In 2023, the Ministry of Health (MOH) rolled out a new plan for Universal Health Coverage that includes a shift of perspective toward Primary Health Care (PHC) and a revision of the social health insurance platform. The Ministry of Health, Kenya is preparing HIV, STI and Viral Hepatitis National Strategic Plan (NSP), this policy document will include the Sustainability Road map for the country. Through the NSP, Kenya will seek to transform HIV service delivery to integrate HIV services into the new PHC model providing HIV patients with the potential for more holistic care. This transformation should include better engagement with private sector providers, as well as increasing opportunities for local manufacture of HIV health products.

The NSP will address the wider health systems issues that support HIV service delivery e.g. human resource for health and transition mechanism to government funded HRH, integration of the EMRs operating in the CCCs are integrated into the MOH's HMIS system as it rolls out. The NSP/Sustainability Roadmap will also outline an affordable pathway with clear yearly benchmarks to move from the current PEPFAR level of support to a GOK-financed model through the new Social Health Insurance Fund. The NSP/Roadmap should also outline the financial support needed by the GOK for commodity procurement to provide the MOH with clear markers for planning and executing of budget so ensure commodity security in the future.

PEPFAR Resource Commitments to the Sustainability Roadmap Development Process

PEPFAR Kenya and the Ministry of Health is working collaboratively with multiple partners i.e. UNAIDS, Bill and Melinda Gates Foundation, WHO and Global Fund in the development process, costing and final validation of the NSP/Sustainability document. These stakeholders will provide financial and technical expertise to undertake program review, stakeholder meetings and staff needed to complete the NSP and Sustainability Roadmap. The Ministry of Health through NASCOP is steering the process and convenes all the stakeholders drawn from county, community representatives to participate in the process.