United States Department of State

Washington, D.C. 20520

January 16, 2019

INFORMATION MEMO FOR AMBASSADOR KYLE MCCARTER, KENYA

FROM: S/GAC – Ambassador Deborah L. Birx, MD

SUBJECT: FY 2019 PEPFAR Planned Allocation and Strategic Direction

We are grateful to you, Ambassador McCarter, and your Deputy Chief of Mission, for your engagement in planning, review and implementation with the community and Government to enhance PEPFAR program impact. We are grateful for your attention to core policy adoption and holding partners to account and performance for improved outcomes and greater impact. Finally we are grateful to your incredible PEPFAR staff in country, working together across agencies to ensure the most effective and efficient use of taxpayer dollars given the bilateral PEPFAR investment of $6,019,573,344 from FY 2004 – 2018.

Kenya has made enormous strides in the fight against HIV and has completed or is nearing completion of many PEPFAR program goals. We continue to wait for the Kenya Population-based HIV Impact Assessment (KENPHIA) data to formally construct COP 2019, but there are indications that the country is getting close to the UNAIDS 90-90-90 goals. We believe that Kenya may be close to achieving viral load suppression and declines in incidence, given the level of investment we have made, however, until we have the KENPHIA survey data we cannot really define the final budget moving forward. Additionally, we are achieving many of our systems and programmatic goals as evidenced by the well-functioning lab system, viral load coverage, and the success of Tuberculosis preventive therapy (TPT). COP 2018 is the opportunity to close any remaining gaps identified from the KENPHIA survey data and COP 2019 should reorient away from a scale up response to a sustaining the gains response. There are still remaining treatment gaps and circumcision goals that must be addressed in COP 2018 execution and the team will need to focus on fidelity of index testing with new strategies for reaching men and improving prevention strategies for reaching 10 – 17 year old adolescent girls and young women (AGYW) through the orphans and vulnerable children (OVC) and Determine, Resilient, Empowered, AIDS-Free, Mentored, and Safe (DREAMS) programs. In reorienting the program, the team will need to address the number of clinics that receive support but have modest caseloads and the number of implementing partners (IPs) that overspend and underperform. More importantly, COP 2019 will be an opportunity to right size and realign the program, including the number of clinic workers funded by PEPFAR to ensure that personnel and our investments overall are in those areas where unmet needs and gaps remain.

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) total planning level for Kenya for the 2019 Country Operational Plan (COP 2019) is **$350,000,000**, inclusive of all new funding

accounts and applied pipeline. Adjustments to the budget could occur after KENPHIA survey results are released. We remain concerned about the lack of transparency in the KENPHIA survey data as there are other PHIA surveys that began after Kenya's, were larger in scope, and we already have full data available for planning and budgeting.

If you have questions about the priorities and guidance laid out in this letter, please contact your Chair and Program Manager. My office is continually grateful for your team's work on the PEPFAR program, helping us to move towards an AIDS-free generation by supporting the HIV response in Kenya.

APPENDICES:

1. **COP 2019 PLANNING LEVEL**
2. **COP 2019 BUDGETARY REQUIREMENTS & GUIDANCE**
3. **PAST PERFORMANCE**
4. **COP 2019 DIRECTIVES**

APPENDIX 1: COP 2019 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the FY 2018 Q4 POART and performance information, the total COP 2019 planning level is estimated to be comprised as follows:

Table 1. COP 2019 Budget

Kenya TOTAL COP 2019 PLANNING LEVEL: $350,000,000			
Total Base Budget for COP 2019 Implementation			**$ 350,000,000**
Total COP 19 New Funding	$	228,861,239	
of which, VMMC	*$*	*11,951,271*	
of which, DREAMS	*$*	*29,242,670*	
Total Applied Pipeline	$	121,138,761	
Total Faith Based Organization (FBO) Initiative Funding (FY 18 Funds)			**$ 16,000,000**

**Funding for the VMMC program must be at least the amount noted here; however, this total can come from both new and applied pipeline funds.*
***Applied pipeline by agency is provided in below chart*

Table 2. Applied Pipeline

OU COP 2019 Applied Pipeline By Agency	
Total Applied Pipeline	**$ 121,138,761**
DOD	$ 2,537,098
HHS/CDC	$ 16,325,854
State/SGAC	$ 35,480,000
USAID	$ 66,795,810

***Based on agency reported available pipeline from EOFY*

All planning levels are subject to further adjustment, **based upon appropriations**, further analysis determining the availability of excessive pipeline, and other developments during the course of COP 2018 implementation and the COP 2019 review process. The total spend in the implementation of COP 2019 (FY 2020) may not exceed the total COP 2019 planning level of $350,000,000.

Central Funding

Kenya is also receiving $16,000,000 in Central Funds as a part of the FBO Initiative. These FY 2018 funds are being notified to you via this letter; however, note that these funds are being released immediately, ahead of the release of the bilateral COP 2019 funds. Central Funds for the FBO Initiative should be used as soon as possible after receipt, during the current implementation cycle of COP 2018/FY 2019. Part of the funds are to restore cuts made specifically and uniquely to FBOs during the COP 2018 cycle and need to be immediately

restored and continued at the increased level within COP 2019 planning. Part of the funds are for new activities as noted in Appendix 4, which provides further guidance on use of these funds and the budget breakdown by agencies and in some instances implementing partners. Each country team should specify the purpose and use of these funds (based on the data and analysis from the recent FBO TDYs) as part of the Strategic Direction Summary (SDS)**.**

APPENDIX 2: COP 2019 BUDGETARY REQUIREMENTS

Table 3. COP 2019 Earmarks

Kenya COP 2019 EARMARK REQUIREMENTS	
Care and Treatment (C&T)	$ 137,316,743
% of base funds allocated to C&T	*60%*
HKID	$ 16,020,287
Gender Based Violence (GBV)	$ 5,760,464
Water	$ 300,000

Care and Treatment: If there is no adjustment to the COP 2019 new funding level due to an adjustment in applied pipeline, Kenya's minimum requirement for the care and treatment earmark is reflected in the chart above. Your care and treatment requirement is calculated as the sum of total new FY 2019 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS budget codes, 30% of the total funding programmed to the MTCT budget code, 80% of the total funding programmed to the HLAB budget code, and 30% of the total funding programmed to the HVCT budget code. This minimum care and treatment earmark has been derived based upon a requirement that your country programs a minimum of 60% of all **new FY 2019 Base Funds** to care and treatment of people living with HIV

HKID Requirement: Kenya's COP 2019 minimum requirement for the HKID budget code is reflected in the chart above. Your COP 2019 HKID requirement is derived based upon the approved COP 2018 HKID level. The COP 2019 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.

Gender Based Violence (GBV): Kenya's COP 2019 minimum requirement for the GBV earmark is reflected in the chart above. Your GBV earmark requirement is calculated as the total **new FY 2019** funding programmed to the GBV cross-cutting code. Your COP 2019 earmark is derived by using the final COP 2018 GBV earmark allocation as a baseline. The COP 2019 planned level of new FY 2019 funds for GBV can be above this amount; however, it cannot fall below it.

Water: Kenya's COP 2019 minimum requirement for the water earmark is reflected in the chart above. Your water earmark requirement is calculated as the total **new FY 2019 funding** programmed to the water cross-cutting code. Your COP 2019 earmark is derived by using the final COP 2018 water earmark allocation as a baseline. The COP 2019 planned level of new FY 2019 funds for water can be above this amount; however, it cannot fall below it.

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. PEPFAR has set a 70% goal **by agency** by the end of FY20, and must meet 40% by FY19. 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 Kenya agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY20 as appropriate through their COP 2019 submission.

COP 2019 Applied Pipeline

All agencies in Kenya should hold a 3 month pipeline at the end of COP 2019 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending COP 2018 implementation (end of FY 2019) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP 2019, decreasing the new funding amount to stay within the planning level.

The Applied Pipeline amount of $121,138,761 given by S/GAC as a part of the COP 2019 planning level has been calculated to reflect the projected excessive pipeline as of the beginning of the COP 2019 implementation cycle (FY 2020), and is the minimum amount that Kenya must apply as pipeline in the COP 2019 submission. The distribution of new base funds and Applied Pipeline was calculated to ensure 3 months of pipeline remains with mechanisms, based upon the financial data submitted for the FY 2018 Q4 Obligation and Outlay and FY 2018 End of Fiscal Year (EOFY) reports. Expired funds, funds on expired mechanisms and projected FY 2019 outlays as submitted in the EOFY report were all taken into consideration to inform the projected excessive pipeline and the required COP 2019 applied pipeline amount.

Unliquidated obligations on closed mechanisms identified in the FY 2018 EOFY report should be de-obligated in a timely manner. This will continue to be monitored throughout FY 2019 (COP 2018 implementation) and into COP 2019.

APPENDIX 3: PAST PERFORMANCE TRENDS

Table 4. COP 2017/ FY 2018 Outlays versus Approved Budget

Row Labels	Sum of Approved COP 2017 Planning Level	Sum of Total FY 2018 Outlays	Sum of Over/Under Outlays
Kenya			
DOD	$ 19,027,526	$ 16,537,535	$ (2,489,991)
HHS	$ 208,401,458	$ 206,039,974	$ (2,361,484)
PC	$ 1,273,192	$ 339,432	$ (933,760)
State	$ 11,386,565	$ (28,003,378)	$ (39,389,943)
USAID	$ 317,251,705	$ 198,810,164	$ (118,441,541)
Grand Total	**$ 557,340,446**	**$ 393,723,727**	**$ (163,616,719)**

Kenya's total FY 2018 outlay level of $393,723,727 is under your approved spend level of $557,340,446 (COP 2017 budget). Within this total, all agencies outlaid below their approved level.

Table 5. IP FY18 Outlays

***** *This table was based off the FY18 EOFY submissions, but edited to reflect OPU's as of January 15th, 2019. Agencies outlaid to the following Implementing Mechanisms 125% or more in excess of their COP17 approved planning level.*

Mech ID	Prime Partner	Funding Agency	COP17/FY18 Budget (New funding + Pipeline + Central)	Actual FY18 Outlays ($)	Over/Under FY18 Outlays (Actual $ - Total COP17 Budget $)
9108	American International Health Alliance Twinning Center	HHS/HRSA	$ 2,684,401	$ 3,465,335	129%
11406	U.S. Department of State	State/AF	$ 50,711	$ 115,286	227%
13882	Children of God Relief Institute	USAID	$ 1,443,097	$ 2,240,314	155%
14022	African Medical and Research Foundation	USAID	$ 1,857,180	$ 3,698,596	199%
16679	International Business & Technical Consultants Inc.	USAID	$ 350,000	$ 1,032,141	295%
17707	PLAN International	USAID	$ 8,573,362	$ 11,575,659	135%
17709	IntraHealth International, Inc	USAID	$ 4,020,000	$6,893,685	171%
17944	FHI 360	USAID	$ 3,931,219	$5,162,797	131%
17948	African Society for Laboratory Medicine	HHS/CDC	$ 100,000	$180,012	180%
18216	University of Maryland Baltimore	HHS/CDC	$ 600,000	$801,786	134%

Table 6. COP 2017/ FY 2018 Results versus Targets*

** Financial and target performance data not a one-to-one match as program classification expenditures encompass more than those towards indicator/target presented.*

Agency	Indicator	FY18 Target	FY18 Result	% Achievement	Program Classification	FY18 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	7,940,798	7,728,851	97%	HTS	$28,775,502	72%
	HTS_TST_POS	183,749	94,409	51%			
	TX_NEW	174,953	74,070	42%	C&T	$71,348,862	64%
	TX_CURR	779,945	628,817	81%			
	VMMC_CIRC	197,990	191,111	97%	PREV: CIRC	$10,435,283	61%
	OVC_SERV	81,356	104,294	128%	SE for OVC	$2,498,663	98%
					Above Site Programs	$24,749,539	0%
					Program Management	$33,981,533	0%
DOD	HTS_TST	456,768	564,050	123%			
	HTS_TST_POS	9,074	8,732	96%	HTS	$1,601,777	100%
	TX_NEW	8,505	6,435	76%			
	TX_CURR	55,279	49,863	90%	C&T	$6,969,906	100%
	VMMC_CIRC	26,489	25,718	97%	PREV: CIRC	$1,298,559	100%
	OVC_SERV	33,173	30,516	92%	SE for OVC	N/A	N/A
					Above Site Programs	$1,120,453	0%
					Program Management	$1,508,271	0%
HHS/HRSA	HTS_TST	N/A	N/A	N/A	HTS	N/A	N/A
	HTS_TST_POS	N/A	N/A	N/A			
	TX_NEW	N/A	N/A	N/A	C&T	$360,047	0%
	TX_CURR	N/A	N/A	N/A			
	VMMC_CIRC	N/A	N/A	N/A	PREV: CIRC	N/A	N/A
	OVC_SERV	16,773	23,087	138%	SE for OVC	$665,444	100%
					Above Site Programs	$663,154	0%
					Program Management	$1,267,813	0%
PC	HTS_TST	N/A	N/A	N/A	HTS	N/A	N/A
	HTS_TST_POS	N/A	N/A	N/A			
	TX_NEW	N/A	N/A	N/A	C&T	N/A	N/A
	TX_CURR	N/A	N/A	N/A			
	VMMC_CIRC	N/A	N/A	N/A	PREV: CIRC	N/A	N/A
	OVC_SERV	N/A	N/A	N/A	SE for OVC	N/A	N/A
					Above Site Programs	N/A	N/A
					Program Management	$1,143	

COP 2017/ FY 2018 Performance

Overall

- PEPFAR Kenya program did not meet their official (OT) or adjusted (AT) COP 2017 targets for TX_NEW [Results: 145,122; OT: 274,874; Ach: 52.8% vs AT: 189,455; Ach: 76.6%] and TX_CURR [Results: 1,084,100; OT: 1,318,903; Ach: 82.1% vs AT: 1,156,760; Ach: 93.7%]
- Increase in testing was ineffective as yield dropped from 1.46% in FY17 to 1.39% in FY18. Additionally, the increase in HTS_TST was not in the modalities like index case testing, where we expected to see an increase. Index case testing dropped from 392,035 in FY17 to 341,276 in FY18.
    - Over 3,800 testing sites reported in DATIM in FY18, with 877 sites identifying 1 – 5 positives and 176 sites reporting testing but no results.
- Linkage remain stalled at 78% for women and 76% for men with retention at 31% for women and 17% for men in FY18.
- Achieved VMMC targets overall, however, target achievement was not reached in the targeted age bands (20 – 49 year old males).
- Above site – progress has been made to build and strengthen the systems needed to monitor and support epidemic control.
    - Lab systems are now complete with full viral load coverage and short turnaround times.
- DREAMS/OVC – underperformance within the 10 – 17 year old age bands in FY18.
    - Significant progress made in providing testing services, however, there remains a gap in the provision of prevention services for those identified as negative.
- HRH – based on the HRH_CURR data reported, PEPFAR supports one health care worker cadre for every 49 patients [TX_CURR / HRH_CURR – 1,084,100/22089=49] and provides a significant amount of the pre-service trainings.
- The PEPFAR Kenya program, minus commodities, is 47% Service Delivery and 53% Non-Service Delivery.
- Despite being given directions to decrease spending commensurate with adjusted targets, COP 2017 expenditures are higher than previous COP spending when adjusted for lower commodity spending (see chart below):

	Total Expenditures	Commodities	Total Expenditure less Commodities
COP 16 (EA Data Nav)	461,409,859	101,060,632	360,349,227
COP 17 (ER)	436,755,079	61,834,217	374,920,862
Difference	**-24,654,780**	**-39,226,415**	**14,571,635**

    - Agencies outlaid less funds to implementing partner but from the IP expenditure reporting there was an increase in IP spending.
    - The following IPs in the table below reported expenditures greater than 100% of their approved COP 2017 bilateral funding.
        - IPs highlighted in yellow reported expenditures greater than $6 million and those in red underperformed against their MER targets, where applicable (see

second table below). For the above site IP, they far exceeded their annual benchmark and overspent (e.g. HRH Kenya).

KENYA				
Period		COP17		
Program		Total		
IM Number	Implementing Mechanism	Expenditure	Budget (new + pipeline)	Exp/Bud %
18203	EGPAF Timiza	$19,579,001	$ 18,162,015	108%
18505	CHS Shinda	$15,794,989	$ 15,251,051	104%
18206	KCCB KARP	$12,587,150	$ 11,141,713	113%
18506	UCSF Clinical Kisumu	$11,697,214	$ 10,584,812	111%
18491	South Rift Valley (Named November 2017)	$10,083,536	$ 9,834,349	103%
18283	OVC Follow On Rift and Central	$9,055,763	$ 8,791,992	103%
18511	CHAK CHAP Uzima	$8,458,735	$ 8,009,304	106%
17709	HRH Kenya	$6,532,803	$ 4,020,000	163%
18214	Health Information Systems Innovations	$5,085,119	$ 4,495,000	113%
17944	Linkages	$4,599,018	$ 3,931,219	117%
18490	Kisumu West (Named November 2017)	$4,263,135	$ 3,535,161	121%
18507	CHS Tegemeza Plus	$4,133,711	$ 4,014,012	103%
9108	AIHA	$3,406,643	$ 2,684,401	127%
17954	Implementation of Sustainable Laboratory Quality Systems	$3,387,780	$ 3,175,208	107%
17958	Afyainfo National Mechanism Follow on (HIGDA)	$3,327,260	$ 2,850,000	117%
14009	Kenya Nutrition and HIV Program Plus	$3,216,219	$ 2,952,941	109%
14022	APHIAplus Imarisha	$3,147,121	$ 1,857,180	169%
18509	AMREF Nairobi Kitui	$2,605,231	$ 2,468,513	106%
13882	Integrated Program for both HIV infected and affected children and their households	$2,459,853	$ 1,443,097	170%
17947	Implementation of Sustainable Laboratory Quality Systems	$2,320,286	$ 2,267,392	102%
17959	Sustaining National HMIS Kenya	$1,708,021	$ 1,500,000	114%
18285	Coordinating Comprehensive Care for Children	$1,687,654	$ 1,600,000	105%
7139	HP Plus	$1,273,849	$ 1,200,000	106%
9110	APHL	$1,208,302	$ 776,667	156%
17711	Implementation and expansion of blood safety	$940,325	$ 850,000	111%
16670	HIV Fellowship Program	$922,421	$ 850,000	109%
17964	Measure Evaluation IV	$843,567	$ 200,000	422%
18216	UMB PACE Kamilisha	$812,902	$ 600,000	135%
18260	International AIDS Education and Training Center (I-TECH)	$675,766	$ 650,000	104%
18517	UOW Training	$506,484	$ 450,000	113%
18261	Quality Improvement Capacity for Impact Project (QICIP)	$368,382	$ 300,000	123%
17948	Laboratory Networking	$128,141	$ 100,000	128%
11406	Community Grants Program	$103,776	$ 50,711	205%

Implementing Partners that over expended – Clinical Cascade Performance against Targets:

Indicator	COP 2017 / FY 2018 Implementing Mech	Targets	Results FY	% Achievement FY
HTS_TST_POS				
	South Rift Valley (Named November 2017)	5,244	6,851	130.6%
	CHAK CHAP Uzima	7,841	4,656	59.4%
	EGPAF Timiza	30,427	10,782	35.4%
	UCSF Clinical Kisumu	20,007	6,709	33.5%
	CHS Shinda	35,623	9,557	26.8%
	Kenya Conference of Catholic Bishops (KCCB) / KCCB KARP	11,265	6,774	60.1%
TX_CURR				
	South Rift Valley (Named November 2017)	39,361	36,605	93.0%
	CHAK CHAP Uzima	58,280	48,749	83.6%
	EGPAF Timiza	98,472	72,889	74.0%
	UCSF Clinical Kisumu	67,583	46,867	69.3%
	CHS Shinda	103,477	69,302	67.0%
	Kenya Conference of Catholic Bishops (KCCB) / KCCB KARP	90,578	78,446	86.6%
TX_NEW				
	South Rift Valley (Named November 2017)	4,880	5,039	103.3%
	CHAK CHAP Uzima	10,272	4,079	39.7%
	UCSF Clinical Kisumu	15,896	5,776	36.3%
	EGPAF Timiza	28,435	9,096	32.0%
	CHS Shinda	32,382	8,320	25.7%
	Kenya Conference of Catholic Bishops (KCCB) / KCCB KARP	19,262	6,192	32.1%
TX_PVLS				
	South Rift Valley (Named November 2017)	72,861	60,465	83.0%
	CHAK CHAP Uzima	110,328	82,788	75.0%
	EGPAF Timiza	185,695	133,299	71.8%
	UCSF Clinical Kisumu	127,707	90,076	70.5%
	CHS Shinda	189,976	116,680	61.4%
	Kenya Conference of Catholic Bishops (KCCB) / KCCB KARP	171,529	137,665	80.3%

APPENDIX 4: COP 2019 DIRECTIVES

Table 7. COP 2019 (FY 2020) Targets

Indicator	Pediatric (<15) Treatment Target	Adult Women (15+) Treatment Target	Adult Men (15+) Treatment Target	Treatment Target Total[a]
COP 18 (FY 19 Targets)				
TX_NEW (New on Treatment)	6,617	96,416	79,629	182,662
TX_CURR (Current on Treatment)	93,695	801,512	378,458	1,273,665
TB_PREV	N/A	N/A	N/A	153,076
VMMC_CIRC	N/A	N/A	N/A	301,850
COP 19 (FY 20 Targets)				
TX_NEW (New on Treatment)	16,906	39,594	126,017	182,517
TX_CURR (Current on Treatment)	105,916	791,878	485,552	1,383,346
TB_PREV	N/A	N/A	N/A	138,951
VMMC_CIRC				200,000
COP 19 (FY 20 Targets)				
Treatment Coverage	90%	90%	90%	90%

[a]Targets should be further allocated by age and sex based on disaggregated PLHIV estimates and unmet need for ART.

These targets were developed based on the following assumptions:

- TX_NEW: Targets for TX_NEW assume that 95% of TX_CURR patients are retained from year to year, and that 90% of the TX_NEW target will be retained and thus contribute to the required TX_NET_NEW to achieve the TX_CURR target. Kenya should consider has they move to Epidemic Control how they can exceed these minimum requirements.
- TX_CURR: TX_CURR targets were generated to move Kenya to 95-95-95 at the country-level based on preliminary PLHIV estimates and ART coverage estimates. In order to achieve this target, the team needs accurate reporting and minimization of loss and mortality.
- TB_PREV: Targets for TB_PREV were calculated using an estimated number of patients expected to be on ART at the start of COP 2019 who would screen negative for TB symptoms, the proportion likely to be ineligible for clinical reasons, the estimated number who would have already received TPT by the start of COP 2019 and projected enrollment and completion rates.
- VMMC_CIRC: Targets for VMMC were developed based on current coverage, past performance, and available funding for prevention activities.

COP 2019 Minimum Requirements

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements no later than the beginning of COP19 implementation

(FY 2020). Adherence to these policies and practices are essential to the success of all PEPFAR programs at the national, subnational, community, and service delivery levels. Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs. Failure to meet any of these requirements by FY 2020 will result in reductions to the Kenya budget.

Table 8. Minimum Requirements

Minimum Requirements (COP 2019 Guidance)	**Kenya Specific Guidance for COP 2019 (and where applicable to COP 2018)**
1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups.	
2. Adoption and implementation of differentiated service delivery models, including six month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents.	Increase the number of patients classified as stable and enrolled in differentiated service delivery models of care.
3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine based regimens.	Ensure the TLD policy includes an option for informed consent for HIV positive women of child-bearing age.
4. Scale up of Index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established.	Ensure Index testing is the primary testing modality (at least 30% of overall testing should be ICT). Reduce stigma and intimate partner violence to ensure more HIV positive women are able to disclose their sexual partners
5. TB preventive treatment (TPT) for all PLHIVs must be scaled-up as an integral and routine part of the HIV clinical care package.	Ensure capacity within the GoK to mop up the remaining cohort of PLHIV eligible for TPT, ensuring improved documentation, reporting, and strengthening of pharmacovigilance.
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	All COP 2019 treatment IP work plans need to reflect fidelity to achieve >95% linkage rate of identified positive clients. Treatment IP work plans should include a plan for same day initiation for newly identified clients or a return to care plan for identified known positives.
7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as	

ANC and TB services, affecting access to HIV testing and treatment and prevention.	
8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups.	Ensure follow through on the lab optimization tool completed during COP 2018. Build capacity within the GoK to take on the ongoing monitoring
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Establish an active public health surveillance system capable of identifying new outbreaks as they develop and accurately track quality of care and subpopulation morbidity and mortality indicators. Ensure the morbidity and mortality indicators are included in the national reporting database.
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management.	Improve DREAMS programs and services provided to 10 – 17 year old age bands, with an emphasis in the high burden areas. Ensure prevention services are offered to adolescent girls and boys identified as negative in the high burden counties.
11. Evidence of resource commitments by host governments with year after year increases.	Develop a responsibility matrix with the GoK for the HIV/AIDS program and encourage accountability.
12. Clear evidence of agency progress toward local, indigenous partner prime funding.	Identify opportunities to move towards local, indigenous prime partners.
13. Scale up of unique identifier for patients across all sites.	Collaborate with the GoK to develop a policy that requires the use of unique identifiers.

In addition to meeting the minimum requirements outlined above, it is expected that Kenya will ensure appropriate progress towards viral load management and improved use of efficient testing strategies.

Table 9. Other Requirements

Additional Requirements (COP 2019 Guidance)	**Kenya Specific Guidance for COP 2019 (and where applicable to COP 2018)**
Viral load management: Country policy updated.	Ensure the national viral load policy is compliant with the global standard (WHO guidance)
Screen better and test smarter: Stop over-testing.	Policy adoption of optimized testing that targets patients who are at risk of HIV, including focus on index testing.

COP 2019 Technical Priorities

Program to Sustain Epidemic Control

As Kenya gets closer to epidemic control, there needs to be a shift towards a more sustainable HIV/AIDS program with increase investments and responsibilities for the Government of Kenya (GoK) and other donors.

- **National and Regional** – Establish an active public health surveillance system capable of identifying new outbreaks, tracking quality of care and subpopulation morbidity and mortality indicators, to maintain current levels of disease control and clinical management with an emphasis on:
  - HIV Case-based Surveillance System, including recency testing; and
  - Quality Management Process
- **Facility** – Prioritize PEPFAR investments in areas with the highest disease burden and unmet need based on the KENPHIA, with an emphasis on:
  - Active Index Case Testing and passive risk and symptom based facility testing
    - PrEP for all high-incidence populations
    - Self-testing
  - HIV surveillance and recency testing for newly diagnosed. Recency testing must be at scale in COP 2018 among all new HIV positives individuals.
  - Same day ART initiation
  - Viral Suppression
  - Transition all PEPFAR supported testing and treatments sites with cumulatively less than ten identified positives and clients on treatment to the GoK.
- **Community** – Refine PEPFAR investments in areas with the highest disease burden and unmet need based on the KENPHIA, with an emphasis on:
  - OVC Program targeted to high burden areas only
  - Key and Priority Populations prevention program in high burden areas only

Other technical and programmatic priorities for Kenya:

- **Partner Performance** – improve IP expenditure monitoring to reduce overspending. IP spending should be aligned with actual achievement. Each agency should include their plan for how they plan to monitor IP
- **Table 6** – review achievements and identify areas for sustainable transition to the GoK.
  - **HRH** – complete a right-sizing and rationalization exercise to determine the right mix of health care workers cadres in which PEPFAR should support (fully and partially).
  - **Lab** – with 100% viral load coverage and short turnaround time, lab systems investments should be moved to maintenance.
- Facilitate clear discussions (including measurable goals) between MOH and MOFs to ensure long-term sustained country investments in the key areas of sustaining control.

  - Complete an activity based costing (ABC) exercise in COP 2018 in cooperation with S/GAC to help inform transition and sustainability discussions.
- Develop a commodities procurement responsibility plan with the GoK and GF that clearly outlines who will purchase commodities (such as ARVs, RTKs, lab reagents, etc.)
- Transition HIV prevention and treatment services to local implementing partners in areas that have reached attainment.

Tuberculosis

PEPFAR OUs are expected to offer Tuberculosis Preventive Treatment (TPT) as a routine part of HIV care, which means that all care and treatment partners are expected to offer TPT and report on it. Programs are expected to fully scale TPT over the next two years, such that all PLHIV who are on treatment and are eligible for TPT have received a course by the end of COP 2020. Therefore, the TB_PREV targets included in this letter were set as described above under the target table. For COP 2019, the number of patients that are expected to complete a course of TPT in Kenya is 138,951, approximately half the total number of eligible PLHIV, per the mandate from S/GAC to fully scale TPT over the next two years. COP 2020 TB_PREV targets will cover the remaining 50% of the eligible PLHIV on ART, adjusted upward for those that will be newly enrolled in ART during the COP 2019 implementation period

DREAMS

Kenya is allocated $29,242,670 funding for DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) programming in COP 2019, of which, $3,736,502 of your COP 19 HVAB budget code needs to be part of your DREAMS programming. This funding is allocated within your COP 2019 planning level and must be used exclusively for the goal of HIV Prevention among adolescent girls and young women (AGYW) in DREAMS SNUs in accordance with all DREAMS and COP 2019 Guidance. All new funding allocated to AGYW prevention programming, including DREAMS, must be allocated to the AGYW Prevention cross-cutting budget code.

Kenya needs to meet targets for girls aged 10-17 through strong collaboration and planning across OVC and DREAMS. OVC specifically needs to focus on strengthening and expanding HIV and violence prevention programming for 9-14 year-olds through further coordination and co-planning with DREAMS. Team must work with implementing partners to decrease the number of DREAMS beneficiaries assigned per DREAMS mentors/peer leaders. During a recent SGAC monitoring visit, it was noted that mentors/peer leaders were responsible for managing cohorts of an average of 100-300+ DREAMS girls. This practice negatively impacts the retention of mentors/peer leaders and compromises the quality of services and support provided to DREAMS beneficiaries.

VMMC

Kenya is allocated $11,951,271 funding for VMMC. As with COP 2018, your total COP 2019 allocation to the CIRC budget code is included in your COP funding determined in this letter. VMMC funding must be used exclusively to support the implementation of VMMC programs in

males 10 years and older as pursuant with the CIRC budget code guidance, including the minimum package of clinical and prevention services which must be included at every VMMC delivery point, circumcisions supplies and commodities, communication and demand creation, training, and case finding and linkages for high-risk men.

Kenya's total VMMC target for COP 2019 is 200,000 and a minimum of 60,000 circumcisions should be done in men over age 14.

	COP19					
	Target	Total $	VMMC coverage 15-24	VMMC coverage 15-49	Minimum % 15+	Minimum VMMC in 15+
Kenya	200,000		91%	93%	30%	60,000

Cervical Cancer Screening and Treatment:

All PEPFAR OUs that are offering cervical cancer screening and treatment services should ensure that activities planned are in line with the PEPFAR clinical guidance (issued June 2018). A detailed description of implementation status and scale-up plans is requested within the Strategic Direction Summary for COP 2019. All funding allocated from your COP 2019 budget must be used exclusively to reduce morbidity and mortality of women on ART in Kenya.

Addressing Gaps in Epidemic Control, including by Enhancing Engagement with Faith Communities

As one of the countries that participated in the FBO Mapping and Gap Analysis TDYs, or that posted a reduction between COP17 and COP18 of $10,568,580 in support for FBO partners. PEPFAR Kenya will receive $10,568,580 (part of $16,000,000) to restore funding in COP18 execution to the partners and in the amounts indicated below and these partners must receive full funding for all services provided in COP19 remembering that many FBO clinics are often not subsidized to the same extend as public sector clinics. The remaining amount - 50% should be invested in the primary prevention of sexual violence and HIV among children ages 9-14 year olds.

Specifically, to address the gaps in funding from the previous year:

- $1,723,255 should be programmed with Coptic Hospital (CDC)
- $ 1,966,481 should be programmed with Interchurch Medical Assistance (USAID)
- $932,792 should be programmed with Hope Worldwide (CDC)
- $379,566 should be programmed with Reformed Church of East Africa (USAID)
- $355,278 should be programmed with Christian Health Association of Kenya (CDC)
- $1,419,216 should be programmed with Kenya Catholic Conference of Bishops (CDC)
- $1,000,000 should be programmed with Children of God Relief Institute (USAID)

Additional priorities identified in the FBO Mapping and Gap analysis TDY that are specific for Kenya and that can be supported as part of these previous investments for named partners include evidence-based programs that layer sexuality education and norms change into the widespread Alternative Rites of Passage camp programs which provide VMMC for boys ages 9 to 14; and survivor support for victims of SGBV using components of the DREAMS/OVC package/programming (e.g. educational support; alternative family care, legal aid, norms change, and cognitive behavioral therapy)

You have also been selected as one of the countries to receive additional Central support through the FBO and Community Initiative in the amount of $ 8,223,412.

Of this total, USAID will receive $ 4,233,153 and CDC will receive $ 3,990,259. These funds are to be used to engage those who work in high burden areas (including informal settlements) with faith communities, such as local faith-based and traditional networks, local faith-based and traditional organizations, as well faith and traditional leaders.

The investments in primary prevention of sexual violence and HIV should include raising awareness among faith and traditional leadership about sexual violence and HIV risk faced by 9-14 year olds; using national-to-local infrastructures to train faith leaders in targeted implementation of evidence-based approaches within faith community infrastructures, including youth, parenting, and men's religious programing, with a focus on community mobilization, changing norms and parenting/caregiver programs (these programs include Families Matter, Parenting for Lifelong Health, Real Fathers, Coaching Boys Into Men, and SASA! Faith); and engaging in child safeguarding policy development and implementation through faith and traditional community structures.

The investments in primary prevention of sexual violence and HIV should include raising awareness among faith and traditional leadership about sexual violence and HIV risk faced by 9-14 year olds; training and targeted implementation of evidence-based approaches with a focus on community mobilization, changing norms and parenting/caregiver programs; and engaging in child safeguarding policy development and implementation through faith and traditional community structures, assuring inclusion of the contextualized process for accessing health, legal, and social protection referrals, assuring inclusion of the contextualized process for accessing health, legal, and social protection referrals.

Some Faith and Community partners support both HIV case-finding/linkage/retention and prevention of sexual violence and HIV risk among ages 9-14 years; in these cases, it may be possible to engage in comprehensive prevention and care by supporting both key FBO priorities.

Collaboration with the Global Partnership for Sustainable Development Data

PEPFAR-HQ, through a grant with the Global Partnership for Sustainable Development Data, is exploring an effort with the Government of Kenya to advance interoperability of data systems to support efforts to address HIV/AIDS and related health risks and challenges. We encourage PEPFAR-Nairobi's assistance in ensuring that this effort successfully engages the Government of

Kenya and other stakeholders, and produces optimal impact in building country ownership of efforts to achieve sustainable epidemic control.

COP 2019 Stakeholder Engagement

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 host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of COP 2019 remains a requirement for all PEPFAR programs, and as such the COP 2019 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2018 Q4 and FY 2018 APR results and analyses and the convening of an in-country planning retreat with local stakeholders no later than the week of January 28, 2019 in order to introduce and discuss all COP 2019 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP 2019. In February, initial COP tools will be submitted to S/GAC for review and feedback. S/GAC will provide feedback prior to the in-person meetings in March and April, and teams should reflect the feedback with their revised submissions. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team.

In March and April 2019, PEPFAR will convene in-person meetings in Johannesburg, South Africa, Bangkok, Thailand, and Washington, DC where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and multilateral partners. Engagement with all stakeholders is required beyond the meetings and throughout the COP 2019 development and finalization process. As in COP 2018, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP 2019 Guidance for a full list of requirements and engagement timelines (Section 2.5.3).