United States Department of State

Washington, D.C. 20520

January 14, 2020

INFORMATION MEMO FOR AMBASSADOR MCCARTER, Kenya

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

SUBJECT: FY 2020 PEPFAR Planned Country Allocation and Strategic Direction

Dear Ambassador McCarter:

First, I wanted to personally thank you and Deputy Chief of Mission for your dedication to PEPFAR and working every day to achieve the most possible with the United States taxpayers' dollars. The ability to translate these resources into effective and impactful programming has and continues to be core to our collective progress. Your PEPFAR team in country is extraordinary and we are fortunate to witness their passion and compassion. We are very excited about your progress in:

- Community viral load suppression near 73%
- Over 90% viral load suppression of the caseload
- 93% achievement of the testing positive indicator
- Continued excellence in TB and TB/HIV

Together with the Government of Kenya and civil society leadership we have made tremendous progress together. Kenya should be proud of the progress made over the past 16 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

We did want to highlight both overarching issues we see across PEPFAR and a few specific to Kenya. Full details will follow in a more comprehensive letter from your S/GAC Chair and PPM.

Throughout the PEPFAR family of supported countries and communities, five gaps are shared across the globe holding us collectively back from achieving Sustainable Development Goal 3 related to controlling the HIV AIDS epidemic:

1. Continued new HIV infections in adolescents and young women
2. Supporting key populations with prevention and treatment services
3. Ensuring men are diagnosed and treated early (testing positive and new on treatment (linkage surrogate))
4. Ensuring 15-35-year-old asymptomatic clients are maintained on treatment and virally suppressed (net new on treatment and treatment current growth, (retention surrogate))

5. Ensuing all children are diagnosed and are on the best treatment regimens and virally suppressed

In Kenya, there are a number of continued gaps including:

- Low rates of DREAMS programming completion,
- Persistent challenges in linking all new positives to treatment, and
- Modest treatment cohort growth showing continued retention challenges

In a recent Office of Inspector General audit around PEPFAR coordination there were four draft preliminary recommendations based on their discussions with PEPFAR staff in the field from four countries, three of their recommendations are relevant to this Country Operational Plan planning cycle related to target setting, tool development, and timelines. Although we just received the draft report a few days ago we did not want to wait another COP cycle to make substantive changes related to the recommendations. The first was around targets and target-setting and the need for a clear and transparent understanding and dialogue in establishing targets. PEPFAR targets are not PEPFAR's, but flow directly from the UNAIDS Fast Track Strategy of 2016. Since 2016, both the PEPFAR strategy and targets were directly derive from the global communities of UNAIDS, WHO, and specifically Heads of State in their commitment to SDG 3 and are aligned to support the country's specific ambition towards those goals.

The global community in 2015 through their Heads of State committed to achieving SDG 3.3 by 2030 which for HIV is ending the HIV/AIDS epidemic as a public health threat. This was followed by a United Nations High Level Meeting on HIV/AIDS in June 2016, whereby these Heads of State committed to the 90/90/90 Fast Track Strategy. Essential to the strategy was 73% community viral load suppression (VLS) by 2020 and 86% community VLS by 2030 combined with increased prevention interventions and zero stigma and discrimination to ensure all ages, genders and risk groups have access to life saving prevention and treatment services. Also, in 2016, 22 PEPFAR-supported high HIV burden countries committed to the three Frees of Start Free, Stay Free, AIDS Free with 2020 targets of a decrease in new infections in children to 20,000, 85% of pregnant women on ART, AGYW new infections to < 100,000, 90% of children on ART and 25 million VMMCs. Since 2016 PEPFAR and the GF resources have been focused on achieving these global goals that have been translated to each country by UNAIDS and subsequently supported financially and technically by the PEPFAR family. Since 2016, PEPFAR has utilized these global commitment targets as PEPFAR targets with the commensurate increased funding to countries in 2016, 2017, and 2018 to achieve the goals set out by the Heads of State. Many countries have made tremendous progress towards these targets and others need to accelerate. Kenya is on track to achieve the 2020 and 2030 goals.

Over the past 4 years, PEPFAR resources were allocated based on need, performance, and specifically on the country's and communities' desire to achieve the SDG, Fast Track Strategy, and Three Free goals and country specific targets. Based on the OIG recommendation, S/GAC will take a different approach this year to target-setting. Our collective hope is that together we use this moment of reflection on progress and challenges along with the realization that the end of 2020 is only 11 months away to address these overarching challenges this year through COP 2019 implementation and use COP 2020 to maintain our progress, address any ongoing

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challenges and finally fund ambition for greater impact. Thus, S/GAC will not assign targets to countries but only provide notional budget levels. After the PEPFAR country team submits their targets the notional budget will then be adjusted to the presented level of ambition. Additional funding is available as ambition funding for treatment and VMMC.

The PEPFAR Country/Regional Operational Plan (COP/ROP 2020) notional budget is $375,000,000 inclusive of all new funding accounts and applied pipeline and reflects the following:

1. Sustaining the gains in treatment services based on your projected COP 2019 treatment result (FY2020 treatment current funded in COP19) $276,500,000
    a. The care and treatment budget is determined by all of your FY18 C/T expenditure services and commodities (no RTK commodities), including all aspects of the health system inclusive of human resources, laboratory and systems, commodities (exclusive of RTKs), an upward adjustment from FY19 treatment current to the FY2020 treatment current fully burdened cost of treatment services and commodities, and 100% of partner program management costs and data needs
    b. This Budget is broken down by
        i. Care and Treatment services including partner program management costs, FY2020 upward adjustment, EMR and data with surveillance, recency $161,000,000
        ii. ARV drugs and treatment commodities (everything except RTKs) $84,000,000
        iii. TB preventive treatment $7,200,000
        iv. Cervical cancer $2,000,000
        v. For earmark purposes 50% of M/O costs $22,300,000
        vi. Care and Treatment qualifies for ambition funds if addresses gap #3-5
2. Continued orphans and vulnerable children funding to include DREAMS vulnerable girls less than 20-year-old. $58,460,000
    a. HKID or $20,000,000 dollars for continued historical OVC services
    b. DREAMS funding of $40,000,000 of which 85% is for vulnerable girls under 20 $34,000,000
    c. 10% of M/O or $4,600,000
3. Continued VMMC funding based on your percent of VMMC in the appropriate age band of >15 years old
    a. Total VMMC $2,600,000
    b. VMMC qualifies for ambition requests
4. Dramatic expansion of DREAMS programming $40,000,000 as noted above, of which $34,000,000 is for vulnerable girls under 20 and the remainder of $6,000,000 is for other DREAMS programming.
5. Continued expansion of Key Populations prevention and expansion of PrEP depending on country submitted targets $10,000,000
6. RTK and service support to ANC HIV testing $3,600,000
7. Remaining 40% M/O based on COP19 $17,840,000

Total COP2020 notional budget of $375,000,000 (comprised of $324,078,956 new and $50,921,044 pipeline).

Overall, across the PEPFAR portfolio, we have dramatically increased DREAMS funding to address prevent new infections in adolescent girls and young women. For the first time we find across all districts implementing DREAMS, declines in new diagnoses of HIV in young women. These funds should be used to expand to the highest burden districts not current covered and saturate in urban areas.

Teams will develop their own targets across PEPFAR program areas described above, with the treatment current target no less than the result that was to be achieved in COP 2019. Testing support outside of KP, PrEP and ANC should be consistent with any targets above FY2020 treatment current and be submitted with any ambition funding. Targets reflecting continued and sustained OVC programming and KP programming. For DREAMS, PrEP, cervical cancer and Preventive TB, increased targets consistent with the level of increased budgets.

Again, the team has received a notional budget as noted above and a final budget approval will be contingent on the team's desired targets. As always funding is associated with a performance target that will be achieved with those resources. 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 controlling.

Additionally, country teams and specifically agencies independently can request additive ambition funds in the OU FAST to be submitted, based on their stated increased ambition in Treatment and VMMC, with commensurate increased partner level targets. This funding is available to agency partners with the highest performance with evidence that they are addressing the one of the critical gaps outlined above. Budget requests must be consistent with the cost of expanded targets and address one of the gaps in programming #3-5 above. These requests should be discussed with the S/GAC chair and PPM during the January strategy retreat and tentatively approved and be submitted with the DataPack and FAST tool. The final budget and associated country level targets will be discussed and approved during the Johannesburg meeting.

We are hoping this new approach to target-setting and budget will establish an open dialogue on target-setting and empower teams to work with all stakeholders to plan a strategic and impactful COP. The expectation is for country teams and agencies to propose to S/GAC the targets they believe are achievable and feasible and hold their partner's accountable to that achievement. In addition, this new approach to target-setting gives high performing partners and agencies with additional aspirations the opportunity to do more to achieve even greater impact with additional ambition resources.

In the next 48 hours, more detailed descriptions of OU's programmatic successes and challenges will be conveyed to your wider PEPFAR team by the S/GAC Chair and PPM in a phone call, after which the detailed planning level letter will be immediately released.

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Again, thank you for your work and we are looking forward to working with you to achieve your Fast Track Strategy and ultimately the SDG 3 goal.

Together we can.

Deborah Birx

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United States Department of State

Washington, D.C. 20520

UNCLASSIFIED January 16, 2020

COP 2020 Planning Level Letter | PART 2

INFORMATION MEMO FOR AMBASSADOR KYLE McCARTER, KENYA

SUBJECT: Fiscal Year (FY) 2020 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly POARTS and from Headquarters Country Accountability and Support Teams, we have thoroughly reviewed progress of the program in your country over time and specifically the end of year results of the Country Operational Plan (COP) 2018 and current COP 2019 implementation as we plan for COP 2020. We have noted the following key successes:

- Excellent viral load coverage and viral suppression rates over 90%
- Case finding more in line with targets and continued maturation of index testing
- High levels of ART coverage and viral suppression in high burden counties

We are particularly pleased that the team has embraced the change going into COP 19 to focus on counties and differentiating our efforts based on disease burden.

Despite these strengths, there are still some areas of concern:

- Weak DREAMS programming with low completion rates
- Ongoing challenges in linkage to treatment and retention while acknowledging some results from Q4 efforts
- Pockets of weakness in certain counties in certain program areas (e.g. low viral suppression in Pregnant and Breastfeeding women in 10 counties)

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SECTION 1: COP 2020 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2019 (EOFY) tool, and performance data, the total COP 2020 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency.

Table 1. COP 2020 Total Budget including Applied Pipeline

OU Total	Bilateral				Central	TOTAL
	FY20	FY19	FY17	Unspecified	Unspecified	TOTAL
Total New Funding	$324,078,956	$ -	$ -			$324,078,956
GHP-State	$285,758,956	$ -	$ -			$285,758,956
GHP-USAID	$ 35,000,000	$ -	$ -			$ 35,000,000
GAP	$ 3,320,000	$ -	$ -			$ 3,320,000
Total Applied Pipeline				$ 49,498,804	$ 1,422,240	$ 50,921,044
DOD				$ 1,487,840	$ -	$ 1,487,840
HHS/CDC				$ 20,697,789	$ -	$ 20,697,789
HHS/HRSA				$ -	$ -	$ -
PC				$ -	$ -	$ -
State				$ -	$ -	$ -
USAID				$ 27,313,175	$ 1,422,240	$ 28,735,415
TOTAL FUNDING	$324,078,956	$ -	$ -	$ 49,498,804	$ 1,422,240	$375,000,000

**Based on agency reported available pipeline from EOFY.

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SECTION 2: COP 2020 BUDGETARY REQUIREMENTS

Countries should plan for the full Care and Treatment (C&T) level of $276,500,000 and the full Orphans and Vulnerable Children (OVC) level of $58,460,000 from Part 1 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 2020 Earmarks

Earmarks	COP 2020 Planning Level			
	FY20	FY19	FY17	Total
C&T	$ 200,000,000	$ -	$ -	$ 200,000,000
OVC	$ 40,000,000	$ -	$ -	$ 40,000,000
GBV	$ 5,760,464	$ -	$ -	$ 5,760,464
Water	$ 300,000	$ -	$ -	$ 300,000

** Countries should be programming to levels outlined in Part 1 of the COP 2020 Planning Level Letter. These earmark controls above represent the **minimum** amounts that must be programmed in the given appropriation year.*

For countries with GHP-State and GHP-USAID funds the C&T and OVC earmark requirements can be met with FY20 funding from any combination of the two accounts.

Table 3. Total COP 2020 Initiative Funding

	COP 20 Total
Total Funding	$ 69,600,000
VMMC	$ 2,600,000
Cervical Cancer	$ 2,000,000
DREAMS	$ 40,000,000
HBCU Tx	$ -
COP 19 Performance	$ 5,000,000
HKID Requirement	$ 20,000,000

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

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SECTION 3: PAST PERFORMANCE – COP 2018 Review

Table 4. COP Kenya Level FY19 Program Results (COP18) and FY20 Targets (COP19)

Indicator	FY19 result (COP18)	FY20 target (COP19)
TX Current Adults	1,069,405	1,241,665
TX Current Children	73,889	91,406
VMMC among males 15 years or older	70,555	126,096
DREAMS	120,193	n/a
Cervical Cancer	n/a	n/a
TB Preventive Therapy	95,995	1,151,642
TB Treatment of HIV Positive (TX TB)	1,118,965	1,411,004
PrEP_New	34,110	37,947

Table 5. COP 2018 | FY 2019 Agency-level Outlays versus Approved Budget

OU/Agency	Sum of Approved COP 2018 Planning Level	Sum of Total FY 2019 Outlays	Sum of Over/Under Outlays
Kenya			
DOD	$15,963,728	$17,520,490	($1,556,762)
HHS/CDC	$177,649,684	$180,578,841	($2,928,797)
HHS/HRSA	$2,088,269	$2,246,738	($158,469)
State	$1,976,237	$249,068	$1,727,169
State/AF	$144,000	$0	$144,000
State/SGAC	$45,480,000	$0	$45,480,000
USAID	$261,095,394	$320,499,899	($59,404,505)
Grand Total	$504,397,312	$521,095,036	($16,697,724)

**Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.*

Table 6. COP 2018 | FY 2019 Implementing Partner-level Outlays versus Approved Budget

Mech ID	Prime Partner	Funding Agency	COP18/FY19 Budget (New funding + Pipeline + Central)	Actual FY19 Outlays ($)	Over/Under FY19 Outlays (Actual $ - Total COP18 Budget $)
9110	Association of Public Health Laboratories, Inc. (THE)	HHS/CDC	637,707	780,606	(142,899)
13346	World Health Organization	HHS/CDC	350,000	435,999	(85,999)
16670	University of Nairobi	HHS/CDC	539,775	724,018	(184,243)

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18517	UNIVERSITY OF WASHINGTON	HHS/CDC	250,000	344,897	(94,897)
18223	UNIVERSITY OF MARYLAND	HHS/CDC	2,823,335	4,786,024	(1,962,689)
16684	Elizabeth Glaser Pediatric AIDS Foundation	HHS/CDC	522,485	976,300	(453,815)
18215	COPTIC ORTHODOX CHURCH	HHS/CDC	1,977,262	4,218,123	(2,240,861)
13919	Clinical and Laboratory Standards Institute	HHS/CDC	337,339	768,581	(431,242)
18496	JHPIEGO CORPORATION	USAID	7,551,081	10,152,157	(2,601,076)
13701	KENYA MEDICAL SUPPLIES AUTHOR ITY	USAID	110,861,698	149,310,346	(38,448,648)
17719	Pathfinder International	USAID	8,110,320	11,593,940	(3,483,620)
17718	Interchurch Medical Assistance, Inc.	USAID	6,509,000	9,426,314	(2,917,314)
16705	United nations office on drugs and crime	USAID	1,092,805	1,594,651	(501,846)
17958	Palladium Group	USAID	1,900,000	2,787,512	(887,512)
14022	African Medical and Research Foundation	USAID	1,661,297	2,688,520	(1,027,223)
14012	MOI TEACHING AND REFERRAL HOSPITAL	USAID	12,888,105	22,652,210	(9,764,105)
13868	POPULATION SERVICES KENYA	USAID	2,394,436	5,459,666	(3,065,230)
18499	Palladium Group	USAID	850,000	2,422,000	(1,572,000)
14009	FHI 360	USAID	1,717,542	6,297,048	(4,579,506)

**Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.*

Table 7. COP 2018 | FY 2019 Results & Expenditures

Agency	Indicator	FY19 Target	FY19 Result	% Achievement	Program Classification	FY19 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	5,598,769	4,621,252	121.2%	HTS Program Area	$21,517,019	75%
	HTS_TST_POS	92,242	103,494	89.1%			
	TX_NEW	73,575	100,866	72.9%	C&T Program Area	$65,925,482	68%
	TX_CURR	660,186	729,107	90.5%			

Subject to COP Development

	VMMC_CIRC	185,145	196,612	94.2%	VMMC Subprogram of PREV	$8,169,623	75%
	OVC_SERV	72,833	102,142	71.3%	OVCMajor Beneficiary	$1,258,433	67%
DOD	HTS_TST	405,302	260,658	155.5%	HTS Program Area	$773,108	69%
	HTS_TST_POS	7,856	4,889	160.7%			
	TX_NEW	5,652	4,842	116.7%	C&T Program Area	$4,294,407	53%
	TX_CURR	50,862	56,987	89.3%			
	VMMC_CIRC	25,798	26,495	97.4%	VMMC Subprogram of PREV	$632,265	71%
	OVC_SERV	32,039	25,376	117.0%	OVCMajor Beneficiary	$1,016,768	40%
USAID	HTS_TST	4,213,244	3,299,620	127.7%	HTS Program Area	$22,734,931	85%
	HTS_TST_POS	76,096	79,933	95.2%			
	TX_NEW	63,134	77,140	81.8%	C&T Program Area	$165,184,195	88%
	TX_CURR	432,246	487,527	88.7%			
	VMMC_CIRC	70,095	76,944	91.1%	VMMC Subprogram of PREV	$1,589,568	57%
	OVC_SERV	509,672	645,392	79.0%	OVCMajor Beneficiary	$19,970,814	78%
	Above Site Programs					$36,802,474	
	Program Management					$76,810,038	

COP 2018 | FY 2019 Analysis of Performance

COP 2019 represents a significant shift in strategy and programming. As such, reviewing COP 2018 performance must be taken in context and in particular partner performance is less important than in other countries given the geographic shifts being implemented in Kenya. We remain concerned that KENPHIA results have not been publicly released, but data shared with

Subject to COP

the interagency and incorporated into SPECTRUM show great progress against the disease and close to 73% community viral load suppression. With 100% Viral load coverage and increasing viral suppression rates, Kenya is a shining example for the PEPFAR program. With over 90% viral suppression in the caseload, it is clear the base program for those who remain on treatment is strong.

Because the first 90 levels have not achieved the UNAIDS benchmark, this means that there are still gaps among certain populations notably the young and within key populations. Index testing is improving but still needs to mature, while general facility based testing continues at high unproductive rates. Overall though, continued growth in the number of positives found meant that over 90% of the testing positive goal was achieved. We expect these rates to be sustained through COP 19. While finding positives was strong in COP 18, there is a persistent modest problem in linking patients to treatment with roughly 80% linkage to treatment over the course of several years.

With a renewed focus on return to care through the LEAPING and surging efforts, retention challenges improved. However, the best result occurred in Q4 and we will need several quarters of continued success to determine if the retention solutions are robust. Overall, the patient treatment cohort only increased by 30% of the positives found in COP 18 with linkage and retention challenges blamed for the low result.

Progress on 2 month EID has stalled at 80% and more worrisome we are still missing 10% of babies by 12 months. Coupled with modest EID rates, there are weak counties in the viral suppression of pregnant and breastfeeding women thus counties with low EID rates, weak viral load coverage and weak viral suppression rates should be prioritized for additional assistance. As noted above, viral suppression rates are high but with dolutegravir adoption 95% VLS should be the goal. Pediatric viral suppression rates continue to be low with poor suppression in infants and around 80% suppression for children. OVC programs need to be focused on caring for HIV positive children.

Circumcision targets were met largely by achievement in the 10-14 age band. However, according to KENPHIA results there are a number of high burden counties with saturation rates below 80% in the upper age bands indicating demand creation and targeting needs to be improved.

Funding is available for COP 20 to expand DREAMS programming. However, according to data available in Panorama, there are significant problems in current DREAMS programming. In most DREAMS counties, primary package completion is below 50% and length of time in the program does not improve completion rates. The team must address the problems before expanding to new geographies. Going forward, since adolescent and young adult groups have lower rates of knowledge of status and more significant retention issues, it is essential to improve prevention programs including VMMC and DREAMS programming.

Commodity spending continues to be highly variable. The volatility makes planning extremely difficult and going forward PEPFAR will have to make firm commitments on commodity spending.

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We applaud the team for embracing the shift to county led responses as well as the differentiated approach to county ART coverage. S/GAC will closely monitor the programmatic shifts taking place in Care and Treatment and Key Population programming.

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SECTION 4: COP 2020 DIRECTIVES

The following section has specific directives for COP 2020 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives. The COP 2020 directives include targets for Treatment Current and TB Preventive Therapy. Targets for VMMC, DREAMS, cervical cancer and PrEP should be set based on FY19 performance. Funds for these programs have been allocated based on FY19 performance (see Table 4).

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements in place no later than the beginning of COP 2019 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.

For COP 2020, the failure to meet any of these requirements will result in reductions to the Kenya budget. (See Section 2.2. of COP Guidance)

Table 8. COP 2020 (FY 2021) Minimum Program Requirements

	Minimum Program Requirement	Status	Outstanding Issues Hindering Implementation
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	Policy Enacted	

[1] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

Subject to COP Development and Approval

	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 weighing ≥20kg, and removal of all nevirapine-based regimens.[2]	Policy Enacted	Team should ensure that pediatric regimens are optimized and should plan for adoption of DTG for children when the product is available in generic form which could occur during COP 20
	3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	Policy enacted	Low DSD and MMD adoption rates hinder programmatic success. Viral suppression policies may hinder DSD uptake
	4. All eligible PLHIV, including children, should have been offered TB preventive treatment (TPT) by end of COP20; cotrimoxazole, where indicated,	Policy enacted	

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[2] Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019
[3] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

	must be fully integrated into the HIV clinical care package at no cost to the patient.[4]		
	5. Completion of Diagnostic Network Optimization 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.	Completed	
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	Policy enacted	Remaining Scale and fidelity issues

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[4] Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

	parent must be tested for HIV.[5]		
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)[6]	Policy enacted	Scale up of PREP services strong but gaps remain
	8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and Alignment of OVC packages of services and enrollment to provide comprehensive	Policy enacted	Some strengthening of OVC packages is needed

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[5] Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 https://www.who.int/hiv/pub/self-testing/hiv-self-testing- guidelines/en/

[6] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en).

	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) 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 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.		
Policy & Public Health Systems Support	9. 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	Policy enacted	The SID references informal user fees that should be eliminated.

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	treatment and prevention.[7]		
	10. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	CQI practices are in place	Team should consider interagency consistency of forms and approaches for CQI
	11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host 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	Kenya has adopted U=U	

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[7] The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005
[8] Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

	treatment and prevention.		
	12. Clear evidence of agency progress toward local, indigenous partner prime funding.	Kenya is progressing on local partners	New County agreements should be used to support local partner requirement
	13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	Current lack of evidence of host government assuming greater responsibility of HIV services, low execution rates especially of commodities	GOK and counties need to come to COP meetings with clear commitments of responsibility for HIV response
	14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	On track	
	15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Unique identifiers is policy	Long timeline on adoption of huduma number needs to be addressed.

COP 2020 (FY 2021) Technical Directives

In addition to meeting the minimum requirements outlined above for COP 2020, we expect the program to accelerate the transition and increase the number of counties which will become primary implementing partners. If COP 19 targets are achieved, most counties will move to the evolve category and should move to a full public health case base surveillance approach.
Index testing should be at scale and fidelity and fully matured as the primary method of finding positives. For younger age bands, adolescents and young adults, index testing should expand to include sexual network testing.

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Per the funding letter part 1, test kit purchases are restricted to PMTCT and KP programs. The government should develop a plan to create testing cadres and PEPFAR hired testing personnel should be redeployed to other programming weaknesses including retention and KP programs.

Weaknesses in retention should be addressed and should include new patient friendly drug distribution options. Adherence and retention issues for pediatric patients should be addressed and OVC programming should align with HIV positive children.

For circumcision, budget levels are set based on expenditures and historical rates of circumcisions in upper age bands. Ambition funds are available if the team wants to increase the numbers of upper age band circumcisions. For counties that have achieved saturation VMMC program should end.

DREAMS completion rates are unacceptably low and need to be addressed before DREAMS expansion can occur.

During COP 19, Kenya was asked to rationalize and name lead county IP's in care and treatment. In COP 20, the team should rationalize and name lead prevention IP's for each county.

Given the volatility in commodity purchases, the PEPFAR team should work with the Global Fund and the Government of Kenya to have a stable agreement on share of purchases, with the Government of Kenya committing to a larger share of commodities over time. In addition to commodities, given that a number of lab system investments have been successfully completed, the team should create a transition plan for regional laboratories.

As Kenya continues to evolve, the team should work to increase private sector options for care and treatment and supply chain including:

- Expand the provision of differentiated care and medicine pick up points via the private sector that offer additional options and convenience for clients, declutter the public health system, and tap into client willingness to pay and/or health insurance offerings covering HIV. Enabling activities for such efforts include accessing reduced pricing for medicines, capitated care delivery cost model, expanded insurance offerings, and attracting clients to use such services.
- Reduce the cost of last mile distribution for HIV commodities through KEMSA by optimizing third party logistics arrangements, in partnership with the Global Fund.
- Utilize private sector capacity to oversee the vendor-managed inventory model for laboratory commodities.

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To stop over testing the GOK should:

- Update HTS algorithm to be consistent with updated WHO HTS guidelines that recommend an algorithm requiring three consecutive reactive tests to make an HIV diagnosis, given HTS positivity of < 5%.
- Update HTS guidelines to recommend more strategic HIV testing based on assessment of elevated HIV risk including re-testing no more than annually for sexually active individuals and people who have ongoing HIV-related risks. More frequent retesting (eg, every 3–6 months) should be limited individuals taking pre-exposure prophylaxis (PrEP), those from a key population group presenting with an STI, and other individuals with specific risks.

COP 2020 Technical Priorities

Client and Family Centered Treatment Services
COP 2020 planning must specifically and thoroughly address the challenge of interrupted antiretroviral treatment and client loss, especially among young adults. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous ART for a population that is often young and asymptomatic— and for whom HIV treatment is easily interrupted by drug side effects, inconvenience, lack of time, poor customer service, stigma and discrimination, or life circumstances. Maintaining long-term viral suppression necessitates planning and implementing services that are convenient and fit the lives of the clients and make it easy for patients on ART to continue treatment. PEPFAR requires development and full implementation of key client-centered policies and practices at the site- level, including optimized treatment (Dolutegravir-based therapy) and multi-month dispensing, convenient ARV pick-up arrangements, and community and client participation in design and evaluation of services. OUs must ensure 100% “known HIV status” for biological children of TX_CURR clients (15+), including chart review and retrospective elicitation of eligible biological children.

Community-led Monitoring
In COP 20, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through State Department Ambassador’s small grants in close collaboration with independent, local civil society organizations and host country governments. Collaboration with community groups, civil society organizations and patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level.

Pre-Exposure Prophylaxis (PrEP)
Groups to be prioritized for PrEP include those testing negative in index testing but remaining at increased risk of HIV acquisition by virtue of unprotected exposure to a PLHIV with unsuppressed viral load, key populations including sex workers, men who have sex with men, transgender persons, people who use drugs, adolescent girls and young women, including pregnant and breastfeeding women, in areas with high HIV incidence or with high risk partners, and other identified serodiscordant couples. (Groups will be tailored to country context).

Subject to COP Development and Approval

TB Preventive Treatment (TPT)
TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP20; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

DREAMS
DREAMS funding is allocated within your COP 2020 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 2020 Guidance. In addition to ensuring that all DREAMS beneficiaries complete the core package of relevant services, priorities for COP20 DREAMS implementation include: systematically identifying and engaging AGYW that are most vulnerable to HIV acquisition, improving the package of economic strengthening services offered to AGYW (including exploring potential job opportunities through PEPFAR), and accelerating PrEP uptake for AGYW.

OVC
To support the Minimum Program Requirement described above, in COP 20 clinical sites and OVC implementing partners should jointly develop formal relationships, such as a memoranda of understanding (MOU), outlining the roles and responsibilities of each member of the multi-disciplinary care team and addressing key issues such as bi-directional referral protocols, case conferencing, shared confidentiality, and joint case identification. PEPFAR-supported treatment clinicians should play a key role in training OVC community case workers to build their knowledge in areas such as adherence, retention, and disclosure.

VMMC
Funds have been provided to conduct VMMC for males 15 years or older. The team is reminded of the revised guidance which allows surgical VMMC under the age of 15 only by the dorsal slit method and only for those who have attained Tanner stage 3 or higher of development and are able to provide full informed consent for the procedure. While Shang ring may be considered for those below age 15 regardless of Tanner stage, the same informed consent issues apply. All VMMC providers must adhere to the requirements for reporting of Notifiable Adverse Events.

Cervical Cancer Screening and Treatment:
Funding for cervical cancer screening and treatment of pre-invasive lesions. The target for screening must be equal to half of the TX_CURR for women age 25-49. All teams performing cervical cancer screening must adhere to the PEPFAR screening guidance. Basic treatment should be available for pre-cancerous lesions at the site of screening except under exceptional circumstances. All sites performing screening should establish clear referral mechanisms for patients needing treatment not available on site such as LEEP or evaluation for potential invasive cancer. Patient referral between sites should be facilitated and outcomes of the referral tracked to assure appropriate treatment and to allow reporting of results.

PLHIV Stigma Index 2.0
PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised Stigma Index 2.0 or complement Global Fund or other donors financing

Subject to COP Development and Approval

implementation of the Stigma Index 2.0, if it has not already been implemented in the OU. This revised U.S. government compliant version can begin the process of baseline data collection for evaluating the future impact of interventions on reducing stigma and can inform future HIV program planning. If the revised Stigma Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 20, whether supported by PEPFAR or other resources.

COP 2020 Stakeholder Engagement (see section 2.5.3 of COP Guidance)

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/ROP 2020 remains a requirement for all PEPFAR programs, and as such the COP/ROP 2020 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2019 Q4 and FY 2019 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2020 in order to introduce and discuss all COP/ROP 2020 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2020. 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. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund New Funding requests with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2020, PEPFAR will convene in-person meetings in Johannesburg, South Africa, Bangkok, Thailand, and Atlanta, GA 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. Specific guidance for the 2020 meeting delegations have been provided elsewhere. Engagement with all stakeholders is required beyond the meetings and throughout the COP/ROP 2020 development and finalization process. As in COP/ROP 2019, 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/ROP 2020 Guidance for a full list of requirements and engagement timelines.

Subject to COP Development and Approval

APPENDIX 1: Detailed Budgetary Requirements

Table 11. COP 2020 New Funding Detailed Controls by Initiative

	COP 2020 Planning Level			
	FY20			COP 20 Total
	GHP-State	GHP-USAID	GAP	
Total New Funding	$285,758,956	$ 35,000,000	$ 3,320,000	$324,078,956
Core Program	$260,758,956	$ 35,000,000	$ 3,320,000	$299,078,956
COP19 Performance	$ 5,000,000			$ 5,000,000
HKID Requirement ++	$ 20,000,000			$ 20,000,000

++DREAMS countries with GHP-USAID funding can use FY20 GHP-USAID funding to meet their FY20 HKID Requirement. These countries include: Kenya; Nigeria; South Africa; Tanzania; Uganda; and Zambia

Care and Treatment: If there is no adjustment to the COP/ROP 2020 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment amount from Part 1 of the planning level letter across all funding sources. Additionally, due to Congressional earmarks, some of the care and treatment requirement must be programmed from specific funding sources, as indicated above in Table 2. Your care and treatment requirement for the purposes of Congressional earmarks is calculated as the sum of total new FY 2020 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS, HLAB budget codes, 80% of the total funding programmed to the MTCT budget code, and 50% of the total funding programmed to the HVCT budget code.

Orphans and Vulnerable Children (OVC): Countries must program to the full OVC amount from Part 1 of the planning across all funding sources. Your OVC requirement is made up of the HKID Requirement (see details below) and 85% of the DREAMS non-HKID programmed funds for all new FY 2020 funds. Additionally, due to Congressional earmarks, some of the OVC requirement must be programmed from specific funding sources, as indicated above in Table 2. The COP 2020 planned level of new funds for the OVC earmark can be above this amount; however, it cannot fall below it.

HKID Requirement: OU's COP/ROP 2020 minimum requirement for the HKID budget code is reflected in Table 3 and is a subset of the OVC earmark. Your COP/ROP 2020 HKID requirement is derived based upon the approved COP/ROP 2019 HKID level inclusive of OVC and prevention intervention for children under 19 budget codes. The COP/ROP 2020 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.

Gender Based Violence (GBV): OU's COP/ROP 2020 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total new

Subject to COP Development Approval

FY 2020 funding programmed to the GBV cross-cutting code. Your COP/ROP 2020 earmark is derived by using the final COP/ROP 2019 GBV earmark allocation as a baseline. The COP/ROP 2020 planned level of new FY 2020 funds for GBV can be above this amount; however, it cannot fall below it.

Water: OU's COP/ROP 2020 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total new FY 2020 funding programmed to the water cross-cutting code. Your COP/ROP 2020 earmark is derived by using the final COP/ROP 2019 water earmark allocation as a baseline. The COP/ROP 2020 planned level of new FY 2020 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 OU 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/ROP 2019 submission.

COP 2020 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

All agencies in Kenya should hold a 3 month pipeline at the end of COP 2020 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 2019 implementation (end of FY 2020) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP 2020, decreasing the new funding amount to stay within the planning level.

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