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INFORMATION MEMO FOR AMBASSADOR MCCARTER, Kenya

FROM: S/GAC Chair, Mike Ruffner and PPM, Christalyn Steers-McCrum

THROUGH: Ambassador Deborah L. Birx, MD

SUBJECT: Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction

Dear Ambassador McCarter,

I sincerely hope that this note finds you and your team well, safe, and healthy. We are grateful for your leadership protecting staff through this difficult time.

This year has brought unprecedented challenges with the COVID-19 pandemic impacting the entire global community. Despite obstacles faced, what has remained unwavering is the tireless commitment and incredible resiliency of our PEPFAR program, partners, and team across the over 50 countries in which we work. This includes rapid program adaptations, emerging innovations, and client-centered solutions to ensure continuity of HIV services. As the threat of COVID-19 has impacted PEPFAR countries, PEPFAR country teams and programs have proven to be focused and resilient in the face of dual pandemics of HIV and COVID-19.

PEPFAR implementation over the past year has shown tremendous effort to maintain clients on treatment, initiating and accelerating client centered service delivery adaptations, while doing what was possible in HIV prevention programs deeply affected by COVID-19 shutdowns. The following themes have emerged across all of PEPFAR-supported countries; As the economic impact of COVID continues to be seen at both national and community levels, it is more important than ever to use granular data and expand what is working in specific SNUs for viral load coverage and suppression. We saw differential progress in this area independent of the impact of COVID19. Focus groups and deep analytics of client returning to care to ensure we are addressing the critical persistent and new structural barriers. Focus on areas of recent treatment interruption to understand how COVID may have created or exacerbated barriers to access and treatment continuity. Across all countries we see persistent gaps in pediatric diagnosis, treatment and viral suppression. Particular attention should be paid to the pediatric cascade and identifying challenges by district and country for clear and actionable plans. In addition, leverage OVC, DREAMS and other resources for clear accountability to work with mothers and improve early infant diagnosis by two months of age and strengthen resiliency among at-risk women and girls. Community-led monitoring must raise visibility and appropriate response to the needs of populations already vulnerable before COVID. The assessment of needs, and strategies to reinforce OVC caregivers and HIV-affected families in crisis should contribute to budget and activity planning for care and treatment, DREAMS, OVC and wraparound resources. Furthermore, analyzing expenditures at mechanism and

program areas level, along with the work teams have done, to build relationships and co-planning with your partner government, the Global Fund, UN organizations and other donors. These relationships and planning efforts are critical to supply chain stability for key commodities as well as understanding COVID relief and other potential funding available in country to ensure most effective and efficient use of PEPFAR's contributions to the national HIV response in COP21.

We understand that specific programs will have carryover and others may not and these funds will be critical to ensure stabilization and expansion of critical prevention programming.

The COVID pandemic also laid bare the depth and breadth of inequities still across the globe and clear evidence that when constrained, Ministries of Health and governments make choices that differentially impact specific programming areas and specific populations. The pandemic revealed vulnerabilities in our non-public sector community efforts that we knew were present, and are now fully exposed, as these specific activities were the first to be dropped. Communities of women and children, and key populations including men who have sex with men, transgender individuals, sex workers, people who inject drugs, and people in prisons and other closed settings are not being adequately and sustainably supported by public-sector mechanisms. We have lost ground in all of our prevention services for all populations and for our most vulnerable and marginalized populations and must make every effort to recover.

Despite the disruptions caused by the COVID-19 pandemic, a number of countries have shown a level of resiliency were achieving epidemic control of HIV, and others are on the brink of epidemic control. With continued implementation, most PEPFAR countries are on a path to achieving program coverage goals. With that in mind, PEPFAR programs should focus on four key themes as we approach Country Operational Plan 2021 planning and implementation: advancing client-centered services; engaging with communities; implementing resilient and adaptive approaches; and supporting capacities for sustainable epidemic control.

We commend you and your team for your attention to the adoption and implementation of the public health policies that have the greatest impact on HIV, particularly as these very policies are critical to ensuring sustained HIV services during COVID-19. Also, we appreciate your role in supporting PEPFAR teams through this challenging period, and continuing to hold implementing partners accountable for their performance.

We are grateful to your incredible PEPFAR team in country, working together across agencies to ensure the most effective and efficient use of U.S. taxpayer dollars. We know there are strengths and weaknesses across the board and across the implementing agencies; and we look forward to working together to support those strengths and address those challenges.

We are very excited about your progress in:

- Improving the rate of viral load suppression relative to COP19.
- Increasing linkage to treatment in COP20, and the steady improvement since COP18.
- Greatly improving the DREAMs primary package completion rate.

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 18 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

As you will see in COP guidance this year, there are no substantial changes in program direction. While assessing possible deficits in programming arising from COVID-19 our fundamental challenges continue and we again highlight 5 overarching issues we see across PEPFAR.

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

Moreover, we note the following specific key challenges in PEPFAR Kenya:

- While linkage to treatment has increased, the number of people remaining on treatment is only slightly better than keeping pace with the rate of new infections, delaying the achievement of epidemic control.
- Viral load coverage dropped below 90% and lost 8 percentage points compared to COP19.
- Retention is poor across the board, but females ages 5-24 and males 25 and older in particular experience interruptions in treatment (IIT) at high rates.

A fuller set of details, including funding earmarks and specific program direction are included in the accompanying COP 21 PEPFAR Planned Allocation and Strategic Direction Summary

Consistent with the approach from last year, PEPFAR teams will once again be responsible for setting their targets in consultation with stakeholders. Teams should bear in mind that PEPFAR targets are not PEPFAR's but flow directly from the partner country government's commitment to the UNAIDS and SDG 3 goals. Since 2016 PEPFAR and the Global Fund 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 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 has achieved the 2020 goals of community viral suppression but is not on track to achieve 2030 goals early which means continued vigilance in implementing full and complete HIV services down to the facility level.

S/GAC will not assign targets to countries, but only provide notional budget levels sufficient to achieve the full SDG goal and sustain gains made. **Teams will develop their own targets across PEPFAR program areas, with the treatment current target no less than the result that was to be achieved in COP 2020.** After the PEPFAR country team submits their COP 21 targets, the notional budget will then be adjusted to the presented level of ambition.

The PEPFAR Country/Regional Operational Plan (COP 2021) notional budget
for Kenya is **$365,000,000** inclusive of all new funding accounts and applied pipeline. All earmarks and program direction provided below must be met. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team, in collaboration with the Government of Kenya and civil society of Kenya, believes is critical for the country's progress towards controlling the pandemic and maintaining control.

We are hoping this 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.

PEPFAR, with partner governments, multilateral partners, and communities, continues to move rapidly toward control of the HIV pandemic and plan for sustainability of programs. Achieving epidemic control for HIV will be a remarkable accomplishment, saving millions of lives, significantly lowering the burden of HIV/AIDS in countries and communities, reducing the future costs required to sustain the HIV response, and building sustainable public health systems capacity in host countries.

Please note that within the next few days our PEPFAR Chairs and PEPFAR Program Managers (PPMs), working closely with our CAST teams, will plan to review this planning letter and details contained, herein, with your wider PEPFAR country team. Where PEPFAR successfully navigated disruption due to COVID-19 during 2020, it was a result of strong teams, local partners, communities, dedicated health and community workers, leveraging longstanding capacities and platforms established by PEPFAR. Our teams, partners, and communities worked together to adapt and further innovate program implementation and models of service delivery so that the adverse impacts of a dual pandemic threat on essential HIV services were mitigated. Stakeholder engagement is essential for a productive and impactful planning process. Included in this planning letter is an outline of the expectations for engaging key stakeholders and civil society, as we continue to finalize our approach to hosting a virtual 2021 COP planning and approval process.

I am so grateful to you and your entire team for your leadership and engagement in the planning, review and implementation of the President's Emergency Plan for AIDS Relief (PEPFAR) program, along with the community and Government to enhance PEPFAR's program impact.

Sincerely,

Deborah Birx

Attachment: **Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction Summary.**

CC: **S/GAC – Chair Mike Ruffner, PPM Christalyn Steers-McCrum, and PEPFAR Country Coordinator, Tamu Daniel**

Overview: Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly POARTs, the agency self-assessments and from Headquarters Country Accountability and Support Teams (CAST), a thorough program review of your country over time has been conducted. This includes the end of year results of the Country Operational Plan (COP) 2019 and current COP 2020 implementation as we plan for COP 2021. We have noted the following key successes and challenges:

Successes:

- Viral load suppression improved from 92% in COP19 to 94% at the end of COP20.
- While linkage remains below 90%, it increased from 81% in COP19 to 86% at the end of COP20.
- AGYW primary package completion nearly doubled in FY20 compared to FY19, with a completion rate of 85% against targets.

Challenges:

- TX_NET_NEW cohort growth is only a little better than the number of new infections, and far below where it should be. Not only did TX_NET_NEW (53,184) exceed the number of new infections (42,000) by only 27%, but TX_NEW_NEW should have more than doubled new infections (237%) as TX_NEW (122,017) was much larger than TX_NET_NEW.
- VLC dropped by 8 percentage points from last COP, and it has steadily decreased quarter by quarter with the most ground (3 percentage points) lost between the last quarter in COP18 and the first quarter in COP19 and between the first and second quarters of COP19. In addition, some populations and geographic areas are even further behind. For instance, males lag behind females by five percentage points at 85%.
- 42% of added patients in Q3 and Q4 either became LTFU, stopped treatment, or experienced an unattributed loss. Many of these were experienced by females 5-24 and males 25 and older.

Given Kenya's status of nearing achieving epidemic control, the following priority strategic and integrated changes are recommended:

- A) Conduct an analysis to determine why there is a large disparity between TX_NEW and TX_NET_NEW and develop a remediation plan. B) Continue advocating for 6MMD for all populations in all locations.
- A) Expand VLC in high volume facilities and counties with VLC <90% and about 1000 TX_CURR ART. Continue optimization for facilities with TX_CURR <100. B) To address the general downward trend and the Q4 testing gap of 139,682, optimize sample collection opportunities through SMS, continue to roll-out DBS for all facilities with TX_CURR <500, and use community cadre reminders for VL monitoring prior to clients' next ART refill dates. C) Leverage the continued ARV optimization efforts to ensure VL monitoring post-TLD transition occurs.
- A) Conduct an analysis of the TX_ML indicator to understand what kinds of patients are facing interruptions in treatment and where geographically to develop better targeted interventions. B) Improve patient follow up, tracking, and adherence counseling with a focus on lagging populations and geographic areas as appropriate. C) For females (as well as other patients) ages 5-25, consider expanding family-centered models of care. Family members can be booked for joint appointments, files are kept together, family counseling can be provided with treatment buddies within the same household, and MMD schedules and pick-ups are synchronized. Reference COP21 guidance for additional family-centered strategies. D) For

males ages 25 and older, the implementation of 6MMD should be pursued. For additional strategies, please reference the FY2020 Analysis of Performance section in this letter and COP21 guidance. E) Emphasized focus should be placed on three SNUs with particularly high interruptions in treatment and low returns to treatment: Bungoma, Kakamega, and Machakos. F) In general, all retention efforts should be aided by increasing differentiated service delivery and improving multi month dispensing. Other client friendly innovations need to continue and be expanded, especially new ARV distribution points listed in the technical directives section.

SECTION 1: COP 2021 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2020 (EOFY) tool, and performance data, the total COP 2021 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency. Due to increased costs in FY 2020, including those due to COVID, and correspondingly lower applied pipeline going into COP21, COP envelopes have been decreased in some OUs so that S/GAC has funds reserved to address program gaps identified by PHIAs that have yet to be completed and to address other potential future requirements as the impacts of COVID on the program are better known. These funds will be allocated to OUs at a later date as appropriate.

TABLE 1: All COP 2021 Funding by Appropriation Year

	Bilateral				Central				Total
	FY21	FY20	FY19	Unspecified	FY21	FY20	FY19	Unspecified	TOTAL
Total New Funding	**$344,517,410**	**$-**	**$-**	**$-**	**$-**	**$-**	**$-**	**$-**	**$344,517,410**
GHP-State	$306,197,410	$-	$-		$-	$-	$-		$306,197,410
GHP-USAID	$35,000,000				$-				$35,000,000
GAP	$3,320,000				$-				$3,320,000
Total Applied Pipeline	**$-**	**$-**	**$-**	**$20,482,590**	**$-**	**$-**	**$-**	**$-**	**$20,482,590**
DOD				$1,308,779				$-	$1,308,779
HHS/CDC				$6,405,183				$-	$6,405,183
HHS/HRSA				$-				$-	$-
PC				$7,464				$-	$7,464
USAID				$9,765,031				$-	$9,765,031
USAID/WCF				$-				$-	$-
State				$-				$-	$-
State/AF				$2,996,133				$-	$2,996,133
State/EAP				$-				$-	$-
State/EUR				$-				$-	$-
State/PRM				$-				$-	$-
State/SCA				$-				$-	$-
State/SGAC				$-				$-	$-
State/WHA				$-				$-	$-
TOTAL FUNDING	**$344,517,410**	**$-**	**$-**	**$20,482,590**	**$-**	**$-**	**$-**	**$-**	**$365,000,000**

SECTION 2: COP 2021 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Countries should plan for the full Care and Treatment (C&T) level of $215,000,000 and the full Orphans and Vulnerable Children (OVC) level of $50,000,000 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 2021 Earmarks by Appropriation Year*

	Appropriation Year			
	FY21	FY20	FY19	TOTAL
C&T	$215,000,000	$-	$-	$215,000,000
OVC	$50,000,000	$-	$-	$50,000,000
GBV	$5,700,000	$-	$-	$5,700,000
Water	$550,000	$-	$-	$550,000

**Only GHP-State and GHP-USAID will count towards the Care and Treatment and OVC earmarks. **Only GHP-State will count towards the GBV and Water earmarks.*

TABLE 3: COP 2021 Initiative Controls

	Bilateral	Central	TOTAL
Total Funding	$365,000,000	$-	$365,000,000
Core Program	$317,702,509	$-	$317,702,509
Cervical Cancer	$3,000,000	$-	$3,000,000
Community-Led Monitoring	$-	$-	$-
Condoms (GHP-USAID Central Funding)	$-	$-	$-
DREAMS	$40,047,491	$-	$40,047,491
HBCU Tx	$-	$-	$-
One-time Conditional Funding	$-	$-	$-
Surveillance and Public Health Response	$-	$-	$-
VMMC	$4,250,000	$-	$4,250,000

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

TABLE 4: State ICASS Funding

	Appropriation Year			
	FY21	FY20	FY19	Unspecified
ICASS	$259,584	$-	$-	

SECTION 3: PAST PERFORMANCE – COP 2019 Review

Table 5. COP Kenya Level FY20 Program Results (COP19) against FY21 Targets (COP20)

Indicator	FY20 result (COP19)	FY21 target (COP20)
TX Current <15	**68,607**	**87,802**
TX Current >15	**1,127,827**	**1,261,825**
VMMC >15	**57,907**	**54,901**
DREAMS (AGYW PREV)	**257,358**	**-**
Cervical Cancer Screening	**7,564**	**292,715**
TB Preventive Therapy	**90,529**	**133,179**

Table 6. COP 2019 | FY 2020 Agency-level Outlays versus Approved Budget*

Agency	Sum of Approved COP/ROP 2019 Planning Level	Sum of Total FY 2020 Outlays	Sum of Over/Under Outlays
DOD	15,723,196	13,487,342	2,235,854
HHS/CDC	151,842,116	142,482,193	9,359,923
State	2,903,661	1,458,135	1,445,526
USAID	204,462,028	193,884,396	10,577,632
Grand Total	**374,931,001**	**351,312,066**	**23,618,935**

*This tables includes only bilateral figures at present.

Table 7. COP 2019 | FY 2020 Results & Expenditures

Agency	Indicator	FY20 Target	FY20 Result	% Achievement	Program Classification	FY20 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	2,704,620	2,934,337	108%	HTS Program Area	$12,392,387	73%
	HTS_TST_POS	85,056	77,994	92%			
	TX_NEW	80,838	66,300	82%	C&T Program Area	$56,913,372	70%
	TX_CURR	801,797	729,559	91%			
	VMMC_CIRC	139,697	68,178	49%	VMMC Sub-Program Area	$5,524,429	73%
	OVC_SERV	27,952	78,562	107%	OVC Beneficiary	$1,609,581	86%
DOD	HTS_TST	245,630	318,569	130%			
	HTS_TST_POS	6,216	6,850	110%	HTS Program Area	$1,051,700	64%
	TX_NEW	5,996	5,774	96%	C&T Program Area	$4,965,190	65%
	TX_CURR	68,546	59,128	86%			
	VMMC_CIRC	16,232	14,610	90%	VMMC Sub-Program Area	$687,742	64%
	OVC_SERV	26,257	35,100	134%	OVC Beneficiary	$897,562	68%
USAID	HTS_TST	2,181,607	2,179,468	~100%			
	HTS_TST_POS	64,030	56,742	89%	HTS Program Area	$9,822,802	91%
	TX_NEW	60,446	50,040	83%	C&T Program Area	$102,658,485	94%
	TX_CURR	462,728	407,769	88%			
	VMMC_CIRC	44,071	38,793	88%	VMMC Sub-Program Area	$1,158,960	100%
	OVC_SERV	574,604	613,869	107%	OVC Beneficiary	$18,170,622	57%
					Above Site Programs	$16,382,004	
					Program Management	$49,777,714	

COP2019 | FY 2020 Analysis of Performance

The Kenya program had many successes in FY20 beyond the excellent performance on VLS, the steady improvement in linkage, and the considerable improvement in the DREAMS primary package completion rate. Transition to counties and local partners continued, and staff at the facility level were maintained and partner level staff were decreased. The OVC program successfully completed a difficult restructuring of the program.

Importantly, in response to last COP's directives, the Kenya program significantly increased testing efficiency. They reduced testing by nearly 50% in FY20Q4 over FY19Q4 while also increasing yield from 2.28% to 2.58% in the same time span. While this is not enough to make up for the lost ground in COP18, it marks an important programmatic improvement that should continue into COP21.

While this progress is commended, additional challenges remain beyond the disparity between TX_NEW and TX_NEW_NEW, VLC, and retention discussed earlier in this letter. In particular, improvements are also needed on EID, for males across the clinical cascade, on index testing, and on VMMC. The reimagining and reengineering of the KP program is still ongoing and must be scaled up with MSM in particular.

Males are falling behind on the whole clinical cascade, particularly in testing, linkage, and viral load coverage.

- A) Kenya should continue implementing client-centered interventions that target men for increased testing and retention. Kenya should optimize community distribution channels targeted at men and leverage the client-centric elements of MenStar to scale-up the number of men accessing HIV services. Reference MenStar resources on SharePoint (https://pepfar.sharepoint.com/sites/MenStar), including the MenStar Strategy, Operational Guidance, and Compendium, for recommended strategies and interventions.
- B) Consider increasing resources in COP21 for client-centric and targeted treatment literacy messaging, leveraging consumer marketing expertise. Developing a more client-centered, consumer marketing approach to social behavior change is recommended, especially one that focuses on highlighting the benefits of staying on or returning to treatment.
- C) In order to increase the number of men returning to treatment, we recommend the use of a peer to peer support program/escorted linkage for men (ideally by another man). Clients should have access to responsive support structures and peer networks throughout the entire journey to help them reach and maintain viral suppression. Data suggest that 95% of men return to care with the support of a man living with HIV serving as a coach or linkage facilitator. In addition, peer navigation programs can be strengthened by specific training on empathy and effective, compassionate engagement of the issues that men commonly face (e.g., fear, specific logistic challenges, disclosure, etc.). Kenya should invest resources in COP21 in a male peer to peer/coach program.

Proxy EID 2-month coverage is only at 75.3%, and there has been no improvement since last COP in coverage or in PMTCT_HEI_POS linkage. Data analysis shows that retention of mother child pairs is lagging and should be the focus of a renewed county by county effort to identify root causes of retention issues.

- Integrate EID into the OVC program by enhancing collaboration between OVC and PMTCT partners to ensure that women living with HIV and their infants (pre and post pregnancy), particularly adolescent mothers at high risk of poor retention in the PMTCT cascade, are offered OVC program enrollment, supported with timely uptake of EID services, and cared for over time. Establish MOUs prior to COP21 implementation between OVC and clinical partners to define roles and collaboration to support mother-infant pairs to access EID services and wrap-

around OVC supportive services. Support should be provided, at a minimum, through infant and young children's final outcome test.
- Review HEI data and perform a root cause analysis to identify gaps and improve coverage for EID under 2 months by county. Continue improving coverage among 2-12 month EID.
- If root cause analysis shows that lack of EID coverage is a hindrance, establish new POC machines.
- Continue ART optimization to ensure PBFW have access to TLD and that children are also on optimized regimens.

Index testing is still not optimized. Ensuring safe and ethical index testing is implemented with fidelity at every site is key to success. The OU needs to ensure that all testing counselors comply with PEPFAR program standards. Index testing procedures that are respectful of the client are more effective in identifying new PLHIV. For those PLHIV that are identified, the treatment cohort is not rising in concert with the PLHIV. Part of that is due to retention challenges for AGYW and men, but also it may be due to other factors including transfers that show up as new PLHIV but are not new to the program. The country team needs to resolve the unique identifier problem or roll out more health information exchanges.

Kenya did not report any notifiable adverse events in COP19, but had the highest rate of non-follow-up of VMMCs of all OUs (16.25% in COP19 vs 11.24% in COP18). Adverse events are often diagnosed during follow up, so review the program to ensure that follow up is occurring with fidelity.

Partner and Financial Performance

While many partners nominally achieved their TX_NEW targets, because of prior performance and retention challenges, most partners are not supporting the caseload expected by the end of COP19. Moreover, with weaknesses in viral load coverage, it is unclear how many virally suppressed patients are supported by the partner, although of those patients with documented viral load, 94% are suppressed. Going forward partners will be judged on whether the cohort of virally suppressed individuals have kept pace with the number of PLHIV to be added per year. Overall only six partners achieved more than 95% of their TX_CURR target. Given that most partners start off the year with well over 90% of their TX_CURR already in their caseload, 95% is a minimum threshold of performance.

Overall only 37% of PLHIV identified translated into a new patient counted in TX_CURR. With the lack of unique identifiers or health data exchanges it is hard to know whether PLHIV are new to the system or have transferred from other facilities. The country team is reminded that a fully functioning unique identifier system is a minimum program requirement for the third COP cycle.

SECTION 4: COP 2021 DIRECTIVES

The following section has specific directives for COP 2021 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.

Minimum Program Requirements (MPR)
All PEPFAR programs – bilateral and regional– were expected to have the following minimum program requirements in place by the beginning of COP20 implementation (FY2021). Adherence to these policies and practices is essential to the success of all PEPFAR programs at the national, subnational, and service delivery levels (e.g. facility, school, community). Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs.

All PEPFAR programs are expected to meet all of the requirements below, and the COP21 Planning Meeting will include a review of the status of each requirement, including assessment of implementation (including barriers) at the point of client services. To the extent that any requirement(s) have not been met by the time of the COP21 Planning Meeting, the PEPFAR OU team will need to present a detailed description of existing barriers and the remediation plans proposed that will allow them to meet the requirement(s) prior to the beginning of FY2021. The list will be included in the Strategic Direction Summary (SDS), as well.

Failure to meet any of these requirements by the beginning of FY2022 may affect the OU budget. The minimum requirements for continued PEPFAR support include the following table.

Table 8. COP 2021 (FY 2022) Minimum Program Requirements

Minimum Program Requirement	Status and issues hindering Implementation
Care and Treatment	
1. Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Complete.
2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	Continue offering TLD to women of child bearing years and continue optimization of pediatric regimens.
3. Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	Continued improvement needed in MMD and DDD.
4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by the end of COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	Complete.
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.	Complete, except EID, especially for under 2 month.
Testing	

1. Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	Prior to COP21 , all sites should be evaluated for Safe and Ethical Index Testing.
Prevention and OVC	
1. 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)	PrEP policy is complete, but program execution needs to be improved.
2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV	Complete.
Policy & Systems	
1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention.	Complete.
2. 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.	Ongoing execution of CQI.
3. 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	PEPFAR, Networks of People Living with HIV (NEPHAK), and GOK/NASCOP are developing a roadmap to implementation of U=U. GOK is incorporating U=U under Adherence for the sub populations across Treatment and Prevention programs in the ongoing revision of National Treatment Guidelines (first draft due in January 2021). Adaptation and customization of U=U messaging

reduce stigma and encourage HIV treatment and prevention.	for sub populations such as AYP, PMTCT, and KP will be done. GOK/NASCOP is incorporating U=U into all treatment literacy materials, for use in all treatment and prevention settings.
4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Good progress noted.
5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	While public sector contributions to HIV/AIDS increased from 18.8% in Kenya Fiscal Year (KFY) 2012/13 to 22.1% in KFY 2015/16, donors remain the predominant source of HIV financing at 62.3%. Kenya's contribution as part of its Global Fund (GF) counterpart-financing requirement was $22 million in 2017/18, $25 million in 2018/19, and is expected to increase by $25.4 million in 2019/20 according to a presentation to the National Assembly. This is further expected to increase to $31 million by 2020/21. While donors finance the majority of the HIV response, the percent is down from 86.4% in 2018/19 to 75% 2019/20. 2021/22 budget is pending. The country must provide evidence that the amount of the budget executed increased.
6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Complete.
7. Scale-up of case surveillance and unique identifiers for patients across all sites.	Standard not met.

In addition to meeting the minimum requirements outlined above, it is expected that Kenya will consider all the following technical directives and priorities:

Table 9. COP 2021 (FY 2022) Technical Directives

OU –Specific Directives
HIV Treatment
Safe and Ethical Index Testing: Assess all sites and all counselors according to PEPFAR Safe and Ethical Index Testing standards as soon as possible, and implement remediation plans as appropriate. Resume index testing for all populations safely and ethically. Increase involvement of KP CSOs in the Safe and Ethical Index Testing assessment and monitoring processes. Audit patients to ensure they feel the index testing procedure was performed in a respectful, efficient manner.
Advanced Disease: In FY20Q4, infant mortality (patient died/TX_CURR) was 1.28%, which is much higher than mortality among older children and adults. Improved screening and management of advanced HIV disease is needed for both newly diagnosed children as well as children already on ART. Quantification for commodities for advanced disease, such as CD4, urine-LAM, and prophylactic medications, should include children and adolescents, and pediatric formulations of cotrimoxazole and TPT should be procured. Ensure that infants living with HIV have access to advanced HIV disease interventions to reduce mortality, as indicated by WHO's Technical Brief on the Package of Care for Children and Adolescents with Advanced HIV Disease: stop AIDS (available at https://www.who.int/publications/i/item/9789240008045).

HIV Prevention
Orphans and Vulnerable Children: Overall, Kenya performed well across OVC indicators and age bands, but improvements are still needed. A) EID should be integrated into the OVC program. The OVC program shouldn't just focus on status, but also on the tracking and tracing of PBFW and linking them to the OVC program. B) For the past two years, Kenya has reported unacceptably high numbers of children exiting the program without graduation. In FY19, 206,863 children and in FY20, 92,678 children were exited without graduation. These losses point to weak partner management and a lack of robust case management. The team must conduct an analysis to understand why these losses happened and put mitigation measures in place to ensure these large losses do not reoccur. These efforts should be documented, and the report made available for review. C) Given the strong performance on GEND_GBV for DREAMS age bands, but low performance in general, focus efforts on decreasing GBV for all non-DREAMS age bands while maintaining high DREAMS performance.
Cervical Cancer: Provide a detailed description of cervical cancer implementation status and scale-up plans for screening and treatment in the COP 2021 SDS. Plans should detail strategies to screen around 50% of women living with HIV between the ages of 25 and 49, scale up screening services, and improve access to treatment services, prioritizing same day screen and treat services in ART sites and clear referral and linkage support where same day treatment is not feasible.
Tuberculosis: A) Support improvement of quality of TB symptoms screening to improve yield (only at 2.2% positive for TB symptoms). B) Conduct evaluation of laboratory transport and access to GeneXpert in counties with low performance. C) Conduct an evaluation of TPT program in counties with low TPT completion rate (<85%) to identify and address challenges.
Other Government Policy or Program-wide Programming Changes Needed
• Continue to advocate for six-month MMD as a national policy. Regions of focus could include military, Kericho, Kwale, and Turkana. • Issue the Community-Led Monitoring Notice of Funding Opportunity as soon as possible. • Develop and report on standard, program wide county capacity metrics. By the end of Q1 COP 21, all counties in conjunction with the COG, county management, and civil society should be evaluated for the functional and financial barriers to local responsibility. Develop individual county plans to address the barriers to local responsibility • Activity Based Costing follow on work should be funded in COP 21.

Additional Directives

Supply Chain

Implement Decentralized Drug Distribution (DDD). Presently, most patients are on facility-based fast-track model, but other options such as community-based approach (e.g. Community-based ART refill groups) and tapping into current private sector initiatives of utilizing community pharmacies for drug pickups from the current 3 pilot counties should be used. Initial findings from the pilot in the 3 counties shows that 98% of pharmacies surveyed show an interest in dispensing ARVs and 93% need staff training to do so. Set clear targets for the implementation of the DDD model through the private sector initiatives.

Key Populations

Yield is lower for KPs than for the general population, suggesting further analysis is needed to understand the epidemic for KPs. In addition, KPs face low linkage and low VLC. Strengthen relationship with KP CSOs, especially on issues of improving mobilization and retention of MSMs and TG populations and on

Safe and Ethical Index Testing. The OU should provide evidence that funding is available to local groups and that services are being delivered by members of the community.

COP 2021 Technical Priorities

Client Centered Treatment Services

COP21 planning must ensure treatment continuity for all current and new clients. To do this, programs must specifically and thoroughly address the challenge of interrupted antiretroviral treatment, especially after initiating ARVs and through young adulthood. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous adherence to ART for an adult population that is 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 free, fit the lives of the clients, and empower clients to on ART to stay the course. PEPFAR requires development and full implementation of key client-centered policies and practices at the site-level, including client education on the benefits of lifelong treatment, optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient and safe ARV access arrangements, and community and client participation in design and evaluation of services.

Pediatric- and Adolescent-Centered Services

In COP21, PEPFAR programs are required to demonstrate improvement in pediatric case finding, including safe and ethical index testing, to close HIV treatment gaps across age and sex bands. Programs must move forward with the introduction and broad use of pediatric DTG formulations in FY21 (COP20), with full implementation expected to occur during the first quarters of FY22 (COP21). Programs need to further advance pediatric- and adolescent-specific continuity of treatment programming, including age-appropriate differentiated models of care and leveraging bidirectional synergies with clinical and OVC implementing partners. OUs must develop a comprehensive plan to achieve ≥ 90% viral load coverage and viral load suppression across all age and sex bands. To further reduce morbidity and mortality, clinical programs should include an evidence-based advanced HIV disease package of care for children and adolescents.

Community-led Monitoring

In COP 21, 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)

In COP 2021, PrEP should continue to be made widely available with a focus on getting PrEP, (including possible new PrEP options) to the people that need it. Groups to be prioritized for PrEP include HIV negative partners of index cases key populations including sex workers, men who have sex with men, transgender persons, people in prisons and other closed settings, people who inject drugs, adolescent girls and young women and, pregnant and breastfeeding women, in areas with high HIV incidence or with higher risk partners, and other identified serodifferent couples. Groups should be tailored to the OU's epidemic context.

TB/HIV

TB/HIV services must be integrated, including DSD and MMD models for both TB and TB preventive treatment (TPT). All PLHIV must be routinely screened for TB and have access to molecular diagnostic

testing and/or point of care tests such as LF-LAM. TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP21; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

Advanced HIV disease

The advanced disease package of care should be fully integrated into clinical care and includes diagnostics and therapeutics for tuberculosis and cryptoccal meningitis as well as cotrimoxazole. Countries should budget adequately for commodities including urinary LAM, CrAg, amphotericin B and flucytosine. Please see section 6.5.2 of the COP guidance.

DREAMS

DREAMS funding is allocated within your COP 2021 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 2021 Guidance. In addition to ensuring that all DREAMS beneficiaries complete the core package of relevant services, priorities for COP21 DREAMS implementation include systematically identifying and engaging AGYW that are most vulnerable to HIV acquisition; particularly pregnant AGYW and those who are mothers; improving the package of economic strengthening services offered to AGYW (including exploring potential job opportunities through PEPFAR); ensuring evidence-based curricula are implemented with quality and fidelity; enhancing mentoring selection, training, compensation and supportive supervision processes; and accelerating PrEP uptake for AGYW in DREAMS SNUs.

OVC

To support the Minimum Program Requirement described above, in COP 21 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, pediatric case finding, case conferencing, shared confidentiality, joint case identification, and data sharing. In high volume clinics within high burden SNUs, at least 90% of children (<age 19) in PEPFAR-supported treatment sites should be offered enrollment in OVC programs. OVC staff placed in clinics (e.g., as linkage coordinators, case managers, etc.) should have the capacity to assess child and family needs (including food and economic security) and to offer appropriate referrals. 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 for those 15 or older. While Shang ring may be considered for those below age 15 with headquarters approval, it should be limited to those age 13 or above who are able to understand the procedure and provide informed consent, along with parental consent as dictated by local laws. 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 and report into the cervical cancer MER indicators. 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.

Condoms and Lubricants

Condoms are key to a successful combination HIV prevention approach and are a cost-effective tool for preventing other sexually transmitted infections and unintended pregnancies. PEPFAR's goal is to ensure high levels of use, equitable access to, and sustained demand for condoms and lubricants among key and priority populations and low-income groups. In COP21, through the Condom Fund, GHP-USAID will provide $20.3 million in assistance to PEPFAR-supported countries to procure and deliver condoms and lubricants to address key condom supply and demand issues This funding is in addition to funds allocated for condom programming and additional condom/lubricant procurement in each country from COP21 country funding as determined during the COP planning process.

Coordination with other donors that provide commodities, including the Global Fund, is also critical and expected. The process for estimating your country's total condom and lubricant need is outlined in the COP21 guidance. Among other items, this justification should include an outline of how Kenya will support condom programming in FY22 with funds from your base COP21, the Condom Fund, the GF and/or other donors, and the host-country government. Please note that in FY22 there will also be limited funding available to cover unexpected or emergency condom and/or lubricant requests from PEPFAR-supported countries. Access to these funds will be provided on a first come, first served basis, and OUs will be required to provide a justification for why their special request is being made.

PLHIV Stigma Index 2.0

PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised PLHIV Stigma Index 2.0 utilizing the standard methodology, or complement Global Fund or other donors financing implementation of the PLHIV Stigma Index 2.0, if it has not already been implemented in the OU. If the revised PLHIV 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 21, whether supported by PEPFAR or other resources. Completion of the PLHIV Stigma Index 2.0 should be accompanied by a response and action plan discussed and agreed upon by all stakeholders that will address findings. Where the PLHIV Stigma Index 2.0 has already been conducted, COP 21 focus should be on concerted action to address findings.

Human Resources for Health (HRH) and Sustainability

Using data from the HRH Inventory completed in COP20 Q4, OUs are expected to complete a comprehensive HRH analysis to optimize staffing at the site- and above-site-levels. PEPFAR programs in countries that will be near to or reach 95/95/95 in the COP20 implementation cycle are required to develop and implement plans to sustain their progress and effectively retain clients in quality HIV treatment programs. Results from the Sustainability Index and Dashboard (SID) 2019 should inform the OUs on their progress and gaps related to the policies and technical areas for inclusion in the sustainability plans. Resource alignment data should be used to understand the HIV funding landscape--especially with a more granular understanding of PEPFAR and GFATM investments-- who is paying for what services in order to enhance strategic collaboration and coordination and avoid duplication during the program planning cycle.

Cross-HIS Data interoperability - Use and Analysis

Improved data visibility, and analysis are essential for better understanding the HIV epidemic and reaching epidemic control.

PEPFAR Kenya should 1) consistently and continuously use and analyze data at the individual patient level with aim of program improvement (e.g. use patient level data to understand retention

differences across patient cohorts and create more tailored risk models and intervention). 2) utilize available data interoperability solutions to harmonize and triangulate data across EMRs, commodities, pharmacy dispensation, laboratory data, HRH and other data.

Systems Investments

PEPFAR teams are expected to align systems investments with key systems barriers to achieving epidemic control. System investments should also be aligned to achieving and maintaining minimum program requirements for COP including adoption and use of unique identifiers, building country capacity in disease surveillance and other core competencies to achieve and maintain epidemic control including country ability to perform continuous quality improvement. Systems investments that have achieved their goals should be candidates for countries to assume responsibility to achieve the minimum program requirement for increased responsibility and increased government expenditures.

Faith and Community Initiative (FCI)

Building upon PEPFAR's standing principle to ensure "every dollar is optimally focused for impact", OUs with continuing FCI investments should continue implementing best practices in accordance with FCI and COP21 Guidance. Priorities for COP21 FCI implementation for addressing gaps in reaching men and children include: coordination through an Inter-Faith Steering Committee to advance treatment literacy; and decentralized, continuing care through faith-engaged community posts, faith-engaged highly targeted HIV self-testing, and/or community adolescent treatment programs for youth living with HIV.

Innovative solutions and adaptive practices

There are extraordinary examples of innovation by our field teams and partners during COVID. These include adaptations and lessons learned that span across many of our technical and program areas as well as all countries we work in. Teams should look at ways to strengthen and improve our capacity to innovate, design, and create within the communities we serve. This includes systematically looking at the evidence base and how to learn from these examples as well as strengthen our methods to help scale proven strategies and interventions.

COP 2021 Active Engagement with Community and Civil Society (see section 2.5.3 of COP Guidance)

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

As in years past, civil society organizations are considered essential and invited to participate both in the virtual COP21 strategic planning meetings, as well as virtual approval meetings. .

This engagement, of both civil society, and of faith-based organizations/faith communities, specifically includes the sharing of FY 2020 Q4 and FY 2020 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2021 in order to introduce and discuss all COP 2021 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP 2021. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2021, PEPFAR will convene virtual meetings 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, faith-based organizations/faith communities, and multilateral partners. Specific guidance for the 2021 virtual meeting delegations will be provided separately.

Engagement with all stakeholders is required beyond the meetings and throughout COP 2021 development, finalization, and implementation. As in COP 2020, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with both CSO and FBO stakeholders for their input and comments at least 48 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP 2021 Guidance for a full list of requirements and engagement timelines.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment (C&T): OU's COP 2021 minimum requirement for the C&T earmark is reflected in Table 2. If there is no adjustment to the COP 2021 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment earmark amount across new FY 2021 GHP-State and GHP-USAID funding. The Care and Treatment earmark will be calculated as the sum of the following:

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

Orphans and Vulnerable Children (OVC): OU's COP 2021 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2021 GHP-State and GHP-USAID funding. The OVC earmark will be calculated as the sum of the following:

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

Abstinence, Be Faithful/Youth (AB/Y) Reporting Requirement: If AB/Y-programmed activities do not reach a 50 percent threshold of all sexual prevention funding, as calculated by the formula below, in any country with a generalized epidemic, S/GAC is required to report to the appropriate Congressional committees on the justification for the decision. In such cases, teams should provide brief justifications and explain the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors. The written justifications should be uploaded as 'Budgetary Requirements Justification' to the document library of FACTS Info.

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

Numerator

Prevention: primary prevention of HIV and sexual violence

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

+

Prevention: community mobilization, behavior, and norms change

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

Denominator

Prevention: primary prevention of HIV and sexual violence (all populations)

+

Prevention: **community mobilization, behavior, and norms change** (all populations)

+

50 % Prevention: **Not disaggregated** (all populations)

Gender Based Violence (GBV): OU's COP 2021 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2021** funding programmed to the GBV cross-cutting code. Your COP 2021 earmark is derived by using the final COP 2020 GBV earmark allocation as a baseline. The COP 2021 planned level of new FY 2021 funds for GBV can be above this amount; however, it cannot fall below it.

Water: OU's COP 2021 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2021 funding** programmed to the water cross-cutting code. Your COP 2021 earmark is derived by using the final COP 2019 water earmark allocation as a baseline. The COP 2021 planned level of new FY 2021 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 FY21, and must meet 40% by FY20. 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 FY21 as appropriate through their COP 2020 submission.

State ICASS: Table 3 shows the amount that the OU must program under State for ICASS Costs.

COP 2021 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 2021 implementation whenever possible in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. If an agency/OU combination has a history of over-outlays, or in cases where an agency/OU COP envelope has increased in recent years, there may not be sufficient funding to maintain a 3 month buffer. Any agency that anticipates ending COP 2020 implementation (end of FY 2021) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP 2021, decreasing the new funding amount to stay within the planning level.