United States Department of State

Washington, D.C. 20520

UNCLASSIFIED January 14, 2020

INFORMATION MEMO FOR AMBASSADOR JOHNSON, Namibia

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

SUBJECT: FY 2020 PEPFAR Planned Country Allocation and Strategic Direction

Dear Ambassador Johnson:

First, I wanted to personally thank you and Deputy Chief of Mission Lord 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. You have taught us how to rapidly expand to a changing epidemic, how to innovate in testing and linkage to care, how to transform policy to real site level impact. 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:

- Over the past year, Namibia has maintained high levels of treatment coverage and community viral load suppression through rapid implementation of WHO guidelines and patient-centered services. Through these actions, they will be one of the first nations to achieve the UNAIDS 95-95-95 goals, almost a decade ahead of schedule.
- Namibia successfully launched case-based surveillance through recency testing, which will allow for targeted interventions to interrupt active transmission. These programs are on track to scale nationally in FY 2020.
- DREAMS reached full-scale implementation in FY 2019, with high proportions of AGYW receiving the full package of services within their first year of participation.

Together with the Government of Namibia and civil society leadership we have made tremendous progress together. Namibia 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 Namibia. 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

Moreover, we note PEPFAR Namibia's key challenges:

- While community index testing partners continued to efficiently identify PLHIV, not all districts have community-based programs and facilities have struggled to reproduce community partner results. Effective index testing in all districts will be critical to fully realize the potential of case-based surveillance and respond to active areas of transmission.
- With such high treatment coverage, precision in data and monitoring of individual patients throughout the health sector will be critical and necessitates national electronic patient management systems that utilize unique identifiers.
- PEPFAR and, to a lesser extent, Global Fund, continue to support a significant number of human resources for health. Rationalizing the workforce needed to maintain epidemic control and building capacity within government institutions to manage those needs, will be critical going forward.

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 derived 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. Namibia is on track to achieve the 2020 and 2030 goals early and sustaining the amazing gains will need to be our constant focus.

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 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 **$84,176,000** 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) $44,450,000
    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 $32,600,000
        ii. ARV drugs and treatment commodities (everything except RTKs) $650,000
        iii. TB preventive treatment $3,200,000
        iv. Cervical cancer $500,000
        v. For earmark purposes 50% of M/O costs $7,500,000
        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. $23,200,000
    a. HKID or $4,700,000 dollars for continued historical OVC services
    b. DREAMS funding of $20,000,000 of which 85% is for vulnerable girls under 20 $17,000,000
    c. 10% of M/O or $1,500,000
3. Continued VMMC funding based on your percent of VMMC in the appropriate age band of >15 years old
    a. Total VMMC $3,500,000
    b. VMMC qualifies for ambition requests
4. Dramatic expansion of DREAMS programming $20,000,00 as noted above
5. Continued expansion of Key Populations prevention and expansion of PrEP depending on country submitted targets
    a. Key Population (non-treatment includes RTKs) $1,600,000
    b. PrEP total: $2,200,000 dollars (includes RTKs)
6. RTK and service support to ANC HIV testing $226,000
7. Remaining 40% M/O based on COP19 $6,000,000

Total COP2020 notional budget of **$84,176,000** (comprised of **$72,953,980** new and **11,222,020** pipeline).

Overall, across the PEPFAR portfolio, we have dramatically increased DREAMS funding to 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 currently covered and saturated 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 ANC should be consistent with any targets above FY2020 treatment current and be submitted with any ambition funding. Targets should reflect continued and sustained OVC, cervical cancer, and KP programming. For DREAMS, PrEP, and Preventive TB, targets should be increased 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 Namibia and civil society of Namibia believes is critical for the country's progress towards controlling the pandemic and maintaining control.

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 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.

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 3.3 goal.

Together we can.

Deborah Birx

United States Department of State

Washington, D.C. 20520

UNCLASSIFIED January 16, 2020

COP 2020 Planning Level Letter | PART 2

INFORMATION MEMO FOR AMBASSADOR LISA JOHNSON, NAMIBIA

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 and challenges:

Successes:

- Namibia has maintained high levels of treatment coverage and community viral load suppression through rapid implementation of WHO guidelines and patient-centered services, and is on track to be one of the first nations to achieve the UNAIDS 95-95-95 goals.
- Namibia successfully launched programs to identify those recently infected with HIV and target interventions to interrupt active transmission. These programs are on track to scale nationally in FY 2020.
- DREAMS reached full-scale implementation in FY 2019, with high proportions of AGYW receiving the full package of services within their first year of participation.
- Realignment of portfolios is largely complete with minimum interruption of services.

Opportunities and Challenges:

- Community index testing partners continued to efficiently identify PLHIV, particularly men; however, not all districts have community-based programs and facilities have struggled to reproduce community partner results. Effective contact tracing in all districts will be critical to respond to active areas of transmission.
- With such high treatment coverage, data quality and the ability to follow individual patients throughout the health sector is critical to monitor maintenance of epidemic control and necessitates a national patient management system utilizing unique patient identifiers.
- Namibia has made significant progress to address system barriers to expand cervical cancer

services for WLHIV. Now that these barriers have been addressed, there is opportunity to rapidly scale service delivery and ensure all eligible WLHIV are screened for cervical cancer every two years.

- PEPFAR and, to a lesser extent, Global Fund, continue to support a significant number of human resources for health. Rationalizing the workforce needed to maintain epidemic control, and building capacity within government institutions to manage those needs, will be critical going forward.

SECTION 1: COP/ROP 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/ROP 2020 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency.

TABLE 1 : All COP 2020 Funding by Fiscal Year

OU Total	Bilateral				Central	TOTAL
	FY20	FY19	FY17	Unspecified	Unspecified	TOTAL
Total New Funding	**$ 72,953,980**	**$ -**	**$ -**			**$ 72,953,980**
GHP- State	$ 71,466,480	$ -	$ -			**$ 71,466,480**
GHP- USAID	$ -	$ -	$ -			**$ -**
GAP	$ 1,487,500	$ -	$ -			**$ 1,487,500**
Total Applied Pipeline				**$ 10,713,614**	**$ 508,406**	**$ 11,222,020**
DOD				$ -	$ -	**$ -**
HHS/CDC				$ -	$ -	**$ -**
HHS/HRSA				$ -	$ -	**$ -**
PC				$ 637,847	$ -	**$ 637,847**
State				$ -	$ -	**$ -**
USAID				$ 10,075,767	$ 508,406	**$ 10,584,173**
TOTAL FUNDING	**$ 72,953,980**	**$ -**	**$ -**	**$ 10,713,614**	**$ 508,406**	**$ 84,176,000**

***Based on agency reported available pipeline from EOFY 2019.*

SECTION 2: COP 2020 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Countries should plan for the full Care and Treatment (C&T) level of $44,450,000 and the full Orphans and Vulnerable Children (OVC) level of $23,200,000 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 by Fiscal Year *

Earmarks	COP 2020 Planning Level			
	FY20	FY19	FY17	Total
C&T	$ 30,000,000	$ -	$ -	**$ 30,000,000**
OVC	$ 20,000,000	$ -	$ -	**$ 20,000,000**
GBV	$ 110,000	$ -	$ -	**$ 110,000**
Water	$ 50,000	$ -	$ -	**$ 50,000**

** 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.*

Table 3. Total COP 20 Initiative Funding

	COP 20 Total
Total Funding	**$ 28,700,000**
VMMC	$ 3,500,000
Cervical Cancer	$ 500,000
DREAMS	$ 20,000,000
HBCU Tx	$ -
COP 19 Performance	$ -
HKID Requirement	$ 4,700,000

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

SECTION 3: PAST PERFORMANCE – COP 2018 Review

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

Indicator	FY19 result (COP18)	FY20 target (COP19)
TX Current <15	**9,688**	**10,283**
TX Current >15	**173,545**	**219,517**
VMMC >15	**22,966**	**50,203**
DREAMS (AGYW PREV)	**13,462**	**N/A**
Cervical Cancer Screening	**4,949**	**41,781**
TB Preventive Therapy	**19,864**	**82,126**

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
Namibia			
DOD	N/A	N/A	N/A
HHS/CDC	37,056,539	35,880,403	1,176,136
HHS/HRSA	200,000	203,109	(3,109)
PC	1,393,000	845,943	547,057
State	461,742	172,256	289,486
State/AF	234, 258	100,000	134,258
State/SGAC	N/A	N/A	N/A
USAID	32,257,648	26,990,890	5,266,758
Grand Total	**71,368,929**	**64,192,601**	**7,410,586**

**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

Operating Unit	Mechanism ID	Mechanism Name	Partner Name	Funding Agency	Last Active COP	Active, Closing, Closed, Inactive	Approved COP 18 Planning Level	Total Outlays During FY 19	Outlay Delta Check
Namibia	16771	Namibia Mechanism for Public Health Assistance, Capacity, and Technical Support (NAM-PHACTS)	Regents of the University of California, San Francisco, The	HHS/CDC	2019 COP	Active	$ 404,028	462,043	(58,015)
Namibia	18040	WHO	World Health Organization	HHS/CDC	2019 COP	Closing	50000	58,772	(8,772)
Namibia	18035	Namibia Mechanism for Public Health Assistance, Capacity, and Technical Support	UNIVERSITY OF WASHINGTON	HHS/CDC	2019 COP	Active	$ 8,469,605	9,963,290	(1,493,685)
Namibia	16756	Improving the Quality of Namibia's Essential Health Services and Systems (IQ-NEHSS)	Ministry of Health and Social Services, Namibia	HHS/CDC	2018 COP	Closed	3067788	3,958,962	(891,174)
Namibia	18039	UNICEF	Unicef	HHS/CDC	2019 COP	Active	$ 50,000	182,049	(132,049)
Namibia	14390	Cooperative Agreement	University of Namibia	HHS/CDC	2018 COP	Closed	0	55,157	(55,157)
Namibia	17834	DGHA HQ TA Cooperative Agreement – UCSF	University of California at San Francisco	HHS/CDC	2015 COP	Closed	0	213,336	(213,336)
Namibia	18358	EGPAF	Elizabeth Glaser Pediatric AIDS Foundation	HHS/CDC	2018 COP	Closed	0	91,285	(91,285)
Namibia	18362	Association of Public Health laboratories (APHL)	Association of Public Health Laboratories	HHS/CDC	2018 COP	Closed	0	30,995	(30,995)
Namibia	18611	Clinical and Laboratory Standards Institute	Clinical and Laboratory Standards Institute	HHS/CDC	2018 COP	Inactive	$ -	99,773	(99,773)
Namibia	18360	Quality Improvement and Capacity for Impact Project (QICIP)	Regents of the University of California, San Francisco, The	HHS/HRSA	2019 COP	Closing	200000	203,109	(3,109)
Namibia	18126	AIDSFree	JSI Research And Training Institute, INC.	USAID	2019 COP	Active	$ 3,350,150	3,817,718	(467,568)
Namibia	17529	Maternal and Child Survival Program	JHPIEGO	USAID	2018 COP	Closed	0	69,982	(69,982)
Namibia	MA0051		United Nations Children's Fund	USAID		Closed	0	37,886	(37,886)
Namibia	18404	Project SOAR	Population Council, Inc., The	USAID	2019 COP	Active	$ -	400,814	(400,814)

**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	258,927	**347,535**	134.2%	HTS Program Area	$2,865,332	76%
	HTS_TST_POS	16,396	**12,142**	74.1%			
	TX_NEW	18,207	**9,997**	54.9%	C&T program Area	$12,506,334	49%
	TX_CURR	157,212	**145,134**	92.3%			
	VMMC_CIRC	23,247	**17,059**	73.3%	VMMC Subprogram of PREV	$3,271,452	91%
	OVC_SERV				OVC Major Beneficiary		N/A
HRSA	HTS_TST		**1,203**		HTS Program Area		N/A
	HTS_TST_POS		**129**				
	TX_NEW				C&T program Area	$156,327	0%
	TX_CURR						

	VMMC_CIRC				VMMC Subprogram of PREV		N/A
	OVC_SERV				OVC Major Beneficiary		N/A
PC	OVC_SERV	3,859	**636**	16.5%	OVC Major Beneficiary	$19,735	100%
USAID	HTS_TST	149,590	**148,109**	99%	HTS Program Area	$1,975,024	90%
	HTS_TST_POS	9,758	**3,885**	39.8%			
	TX_NEW	8,669	**3,637**	42%	C&T program Area	$6,598,024	38%
	TX_CURR	61,733	**38,192**	61.9%			
	VMMC_CIRC	31,032	**23,406**	75.4%	VMMC Subprogram of PREV	$3,108,413	70%
	OVC_SERV	33,248	**31,219**	93.9%	OVC Major Beneficiary	$1,121,731	91%
					Above Site Programs	$6,194,591	
					Program Management	$12,166,484	

COP 2018 | FY 2019 Analysis of Performance

During FY 2019, PEPFAR continued to support Namibia across the clinical cascade as they move closer to achieving epidemic control. This included a combination of direct service delivery and technical assistance to support all three 90s; provision of human resources for health; launch and/or expansion of services to prevent new infections among AGYW and young men; initiation of cervical cancer screening and treatment for WLHIV; and strengthening of supply chain and information systems to ensure long term sustainability of the response.

Case Finding

- Overall: PEPFAR Namibia supported 488,963 HIV tests in FY 2019 and identified 15,894 new PLHIV, 120% and 61% of targets, respectively. Testing yield for FY 2019 was 3.25%, a decline from 4.34% in FY 2018 and 5.04% in FY 2017. The number of positives identified also decreased from FY 2018, consistent with the reduced treatment gap as Namibia approaches epidemic control.
- Index Testing: Index testing contributed to 18% of the total positives identified in FY 2019. Community-based index testing programs remained strong and identified twice as many positives as facility index testing programs while maintaining high yields and coverage in most districts. DAPP and Project Hope also found a greater proportion of men through use of index testing than other modalities. Several districts with only facility-based index testing partners (Walvis Bay, Swakopmund, Otjiwarongo, Okahao, Okahandja, Luderitz, Gobabis) struggled to successfully implement effective index testing. PEPFAR Namibia should focus assistance to these regions per the COP 2019 plan during FY 2020, particularly as case-based surveillance expands nationally. Proxy indicators for children born to HIV positive mothers indicate that not all are being tested for

HIV. PEPFAR Namibia should ensure all children with an HIV+ biological parent are tested for HIV during FY 2020. Consider distribution of self-tests to parents receiving HIV clinical services.

- Provider Initiated Testing and Counseling: The largest volume of new positives, 50%, were identified through PITC. PITC yields declined from 3.1% in Q4 FY 2018 to 2.7% in Q4 FY 2019. University of Washington showed slightly higher performance, maintaining yields at 3.1% in FY 2019. Given treatment coverage and declining yields, PEPFAR needs to focus PITC and deploy use of symptom and risk-based screening tools during FY 2020.
- Early Infant Diagnosis: At Q4 FY 2019, EID at 2 months was 70% and reached 84% at 12 months, with significant variability between districts. PEPFAR Namibia should continue to refine EID programs to improve EID coverage at 2-months during FY 2020, including through use of community-based support services and enhanced data systems.

Care and Treatment

- Treatment Coverage: At the end of FY 2019, Namibia reported 171,498 PLHIV were on treatment in public facilities (166,418 in PEPFAR-supported facilities). With the addition of the estimated 18,500 patients receiving treatment in the private sector and current estimates for PLHIV of 200,000, Namibia has exceeded 90% treatment coverage. Efforts in FY 2020 should continue to focus on eliminating the remaining gaps for populations not yet at 90%, particularly men of all ages, pediatrics and key populations.
    - Specifically for men, this will require focused testing strategies, including index testing, and client centered services targeting healthy men. PEPFAR Namibia should leverage insights garnered through MenStar. Please see the newly released MenStar Guidance Document and Compendium for recommended strategies, interventions, and examples.
- New on Treatment: PEPFAR Namibia supported initiation of 13,598 new patients in FY 2019, a slight reduction from FY 2018, consistent with current levels of treatment coverage. The majority, 60%, of newly initiated clients were women.
- Current on Treatment: Although PEPFAR Namibia reported 13,598 new patients on treatment, TX_CURR declined by 13,426 from Q4 FY2018 to Q4 FY2019. This was largely due to data quality issues resulting from movement of patients between facilities and cleaning of records as new electronic patient management systems were deployed. Finalizing national scale up of QUANTUM, and associated site-level data-quality assessments, by the end of FY 2020 is critical to understanding treatment coverage levels as we approach UNAIDS 2020 goal deadline. USAID should work with it implementing partners to ensure complete roll-out of QUANTUM by September 30, 2020.
- Return to Care/LTFU: DAPP has demonstrated effective tracing of patients lost to follow up, confirming or re-engaging over 90% of patients to treatment. Effective

interventions deployed by DAPP should be scaled to all facilities in FY 2020 to ensure complete geographic coverage.

- Viral Load: Namibia continued to demonstrate high levels of viral load coverage and suppression, even with the challenges with the National Institute of Pathology (NIP) early in FY2019. By Q4, coverage had recovered to 90% for eligible clients with an overall VLS of 92%. VLS in Q4 was slightly lower than in previous quarters and PEPFAR Namibia should continue to monitor and intervene in response to any potential negative trends. Specific points:
    - There is significant variability in coverage and suppression at the district level. For example, Walvis Bay and Keetmanshoop reported less than 70%, and Keetmanshoop, Opuwo and Gobais reported 80% for coverage and suppression, respectively. PEPFAR Namibia should focus efforts in FY 2020 to improve outcomes in line with those achieved in the rest of the country.
    - Lower volume facilities reported increased variability in suppression rates with some reporting VLS as low as 50-60% during Q4 FY 2019.
    - VLS was lower in pediatric and adolescent populations (~80% in FY 2019 Q4). PEPFAR Namibia should continue to link CLHIV to OVC and adolescent support services.
- ART Optimization: Almost all adults were transitioned to TLE 400 in FY 2018 and early FY 2019. TLD transition was launched on time in October 2019. The number of adults and pediatric patients on NVP-based formulations was reduced by 50% in FY 2019, with all remaining patients scheduled to cease NVP in FY 2020.

OVC

- The OVC_SERV achievement for OVC beneficiaries under age 18 was 90% in Namibia for FY 2019 (99% USAID, 17% for Peace Corps). All agencies and implementing partners should work to improve the OVC_SERV achievement to 90% or higher in FY 2020.
- VLS among CLHIV linked to OVC programs was higher than pediatrics overall, with several districts (Oshakati, Eenhana, Windhoek and Engela) achieving over 90%. VLS among OVC in Omuthiya, Rundu, Andara and Nyangana was significantly lower and USAID and Peace Corps should work with OVC partners to improve outcomes in these districts during FY 2020 implementation.

DREAMS

- FY 2019 marks the first full year of implementation of DREAMS. During that period, 9,222 girls were enrolled in the program and over 50% completed the primary package. Girls age 10-14 were most likely to have completed the primary package.
- Layering: The Namibia team should focus on ensuring that each AGYW in DREAMS receives a layered package of services. Q4 AGYW_PREV data show that 18-50% of AGYW 10-24 in DREAMS have not completed the full primary package of services

(variation by age band). Improving economic strengthening activities and linkage to employment may be a way to improve engagement among the 15-19 and 20-24 year old age bands, and aligns with COP20 priorities.

- Partner realignment: The partner realignment should not disrupt services. This is something that should be closely monitored.

VMMC

- In FY 2019, PEPFAR Namibia performed 40,465 VMMCs. While this was only 75% of the annual target, it was an increase of 1,700 over FY 2018.
- Of the 40,465 clients receiving services, 17,499, or 43%, were under the age of 15. This is an increase from prior years and USAID should work with the new VMMC partner to ensure targeting of priority age bands during FY 2020 implementation. Note that men under the age of 15 will not be eligible for PEPFAR-funded VMMC procedures in FY 2021.

Cervical Cancer

- 5,765 WLHIV were screened for cervical cancer in FY 2019, 14% of the annual target. 821 women screened positive for pre-cancerous lesions and 714, or 87%, were treated.
- PEPFAR Namibia addressed several structural and policy barriers limiting implementation in FY 2019 and should push partners to rapidly scale in FY 2020.

Key Populations

- PEPFAR Namibia exceeded case-identification targets for all KPs in FY 2019. The majority of KP tested and identified as HIV positive were sex workers. KP-testing yield was variable quarter on quarter and by population. In Q4 FY 2019, overall yield was 5%.
- Namibia achieved 87% of the self-testing target among KP through community-based HIVST programs. These programs contributed to nearly 70% of the new HIV-positive cases identified among KP.
- Index testing among key populations has shown impressive yields, reaching almost 50% in Q3 FY 2019; however, scale remains low. PEPFAR Namibia should temporarily halt index testing in KP until further technical guidance is provided. After the hold is resolved, PEPFAR Namibia should continue to support network-based approaches to identify HIV+ KP during FY 2020. PEPFAR Ethiopia has developed effective approaches to engage sex workers in social networking models that may be applicable in Namibia.
- VLS was 94% for all KP but varied by population, with MSM and other high-risk groups at 89% and 88%, respectively.
- PEPFAR Namibia completed an IBBS during FY 2019 implementation. Please present preliminary findings and how they are informing KP strategies going forward during the regional planning meeting in Johannesburg.

Above-Site

- Information Systems: PEPFAR Namibia supported roll out and expansion of several systems to improve information systems. This includes:
    - Successful piloting of the new electronic patient management system, QUANTUM, at 18% of sites. Expansion has been approved by MOHSS and PEPFAR Namibia should work with partners to ensure it is fully scaled by end of FY 2020.
    - Expansion of P-Tracker to 206 of 251 sites, covering 91% of ANC attendees and 95% of labor and delivery.
    - DHIS2 was rolled out to 100% of district health information offices with plans to expand into high volume sites in FY 2020.

- Supply Chain: PEPFAR Namibia has continued to provide technical assistance to national, district, and site level procurement systems, including forecasting and distribution. This year GRN approved exemptions to procurement guidelines to allow pooled procurement for HIV commodities.

- Human Resources for Health: PEPFAR Namibia supports over 1200 health workers (50% lay or community) and HRH investment accounts for 20% of the total budget. In partnership with the Government of Namibia and other donors, PEPFAR is working to finalize the HIV sustainability framework, which includes a phased transition for HRH with implementation beginning in COP 20.

Financial Performance

- All agencies outlaid within approved COP 2018 approved planning levels. USAID outlaid 80% of approved levels and S/GAC recommends a deeper dive to understand underlying cause (i.e. project delays, actual vs predicted costs, etc.).
- Four CDC implementing partners reported expenditures in excess of outlays and FY 2019 budget levels. Please provide additional rationale for each of the following:
    - MOHSS (16756 and 70228): $5,377,340 expenditure / $4,166,990 budget
    - Univ Wash (18035): $10,984,645 expenditure / $8,469,605 budget
    - UNICEF (18039): $302,770 expenditure / $50,000 budget
    - UCSF (16771): $611,976 expenditure / $404,028 budget

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.

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 Namibia budget. (See Section 2.2. of COP Guidance)

Table 9. 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]	Complete	None noted
	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]	TLD Transition Started in October, 2019 and will be completed by end of FY 2020. The number of patients still on NVP-based regimens continues to decline and are expected to be fully transitioned in FY 2020. MOH recently received authority to use pooled procurement to help address barriers associated with pricing and/or purchase volume, particularly for pediatric formulations.	Global availability of optimized pediatric formulations has slowed transition.

[1] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015
[2] Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

	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]	Community-based ART models continue to expand throughout the country. Stable patients are eligible for MMD with the vast majority receiving 3 or more months per visit. Dispensing of up to 12 months is available based on patient needs.	None noted
	4. All eligible PLHIV, including children, should have been offered TB preventive treatment (TPT) by end of COP20; cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	Namibia has provided TPT for several years with high coverage and completion rates. Technical assistance has helped improve reporting of TPT indicators.	None noted
	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	Viral load coverage remains high (90% in Q3 and Q4 FY 2019), even with complications with NIP earlier in the year. EID coverage was 70% and 85% at Q4 FY 2019 for two and twelve months, respectively.	None – PEPFAR Namibia team please provide additional data on turn-around-time for EID during the planning level meeting.

[3] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

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

	results delivered to caregiver within 4 weeks.		
Case Finding	6. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	Index and self-testing are included in the national guidelines. Community-based index testing continues to prove effective in finding new adult cases. Still several districts without efficient index testing services that are to be addressed during COP 2019 implementation. For every woman of reproductive age newly diagnosed with HIV, 0.7 children were tested.	No barriers but ratio of children tested suggests need to ensure all children of HIV+ biological parents are tested if they are of unknown status.
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]	PrEP is available for clients at elevated risk. Among KP, majority of PrEP uptake has been sex workers. PEPFAR Namibia exceeded PrEP targets for AGYW.	Recommend refined communication and demand generation for other at-risk populations, including MSM and PBFW.

[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).

	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 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.	OVC programs are consistent with all requirements. Almost all OVC are of known status and those positive linked to treatment services. OVC living with HIV have better outcomes, as measured by VLS, than those CLHIV not in OVC programs.	None noted
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	HIV and related services do not have formal or informal user fees.	None noted

	and 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]	MOH and PEFPAR IPs maintain CQI programs and practices to improve clinical quality.	None noted
	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 treatment and prevention.	PEPFAR Namibia has incorporated treatment and viral load literacy activities into COP19 and has worked closely with the MOH and other host country leadership offices to support these activities and relevant messaging. Additionally, the MOH fully supports U=U and has been working to sensitize the public on its importance.	None noted
	12. Clear evidence of agency progress toward local, indigenous partner prime funding.	The majority of PEPFAR Namibia programs are implemented through local partners, with increasing responsibilities and resources being transferred over time.	Given the increased scope, the new VMMC program was awarded to an international partner in COP 19 with the goal of eventual transition to local

[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

			partners expected during the next award cycle.
	13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	GRN continues to be the primary funder of HIV services in Namibia. During FY 2020, MOH's TA role is expanding to include additional sites previously covered by Intrahealth.	Economic challenges and the on-going drought will limit short-term increases in GRN investments.
	14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	PEPFAR Namibia started reporting on TX_ML in FY 2019 with additional efforts to improve morbidity and mortality reporting as part of COP 2019 implementation.	None noted
	15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Recency testing was launched in FY 2019 with plans to scale during FY 2020. COP 2019 includes resources to advance development of an UI during FY 2020 and will require ongoing efforts in FY 2021.	None noted

In addition to meeting the minimum requirements outlined above, it is expected that PEPFAR Namibia will:

Table 10. COP 2020 (FY 2021) Technical Directives

Namibia –Specific Directives
HIV Treatment 1. Continue to refine client-centered approaches to retain patients, particularly asymptomatic patients, on life-long treatment, including DSDM expansion, MMD, and services tailored to men. 2. Continue to support continuous quality improvement to bring all sites to 95% retention and VLS. Enhance CQI efforts to improve viral load outcomes for pediatric patients, including completion of transition to optimized pediatric regimens. Expand youth-based adherence support groups.

3. Support revision of National pediatric ART guidelines to include WHO-recommended dosing for dolutegravir for pediatric patients < 30 kgs. Consider procurement of pediatric DTG formulations as budget permits.
4. Support optimization of TPT regimens to include 3-HP. Consider procurement of 3-HP as budget permits.
5. Consider applying for ambition funding to address remaining gaps in treatment coverage.

Case-Finding

1. Ensure testing strategy aligns with COP 2020 guidance. This includes elimination of PEPFAR support for provider-initiated, voluntary testing and counseling (outside KP programs) and other modalities outlined in COP guidance. Consider applying for ambition funds to address any remaining gaps in the cascade.
2. In alignment with the long-term sustainability of the HIV response, continue to transition clinical testing services to the Ministry of Health, starting with transition of contact tracing/index testing activities. S/GAC recommends using award end dates to phase transition, starting with Project Hope's activities to MoH at the end of FY 2020.
3. Ensure rapid assays for recent infection are scaled throughout Namibia. Continue to provide continuous quality improvement to ensure effective implementation and use of data to drive ongoing case-finding and prevention efforts.
4. Expand demand for and access to self-testing within key populations.
5. Continue support to patient management and community support models to ensure improved coverage of EID at 2 months.

HIV Prevention

1. DREAMS: PEPFAR Namibia is receiving an increase in new funding which should be used for the following:
    a. Significantly scale-up PrEP for AGYW in all DREAMS districts.
    b. To receive additional funds, Namibia must present a strategy and a timeline at the COP meeting for the following:
        i. Hire a dedicated DREAMS Coordinator (100% LOE)
        ii. Hire a DREAMS Ambassador for each district to support DREAMS coordination and oversight
        iii. Implement approved, evidence-based curricula in line with the current DREAMS Guidance
        iv. Ensure a fully operable layering database with unique IDs across IPs and SNUs
        v. Ensure a full geographic footprint in all districts

vi. Address challenges and ensure DREAMS implementation in all districts with fidelity (e.g. transportation support)

2. PrEP: Expand demand for, access to, and retention on PrEP within high-risk populations, particularly among KP, AGYW and PBFW.
3. VMMC: Refine programming to target VMMC to males 15 or older, consistent with COP guidance (exemptions noted). Continue to evolve geographic footprint as saturation is reached in men ages 15+. Note funds for VMMC were reduced to reflect percent of VMMC's in FY 2019 in the under 15 age band but Namibia can apply for ambition funds to support additional VMMC targets.
4. Cervical Cancer: Continue to scale services such that all eligible WLHIV receive cervical cancer screening services once every two years. Strengthen referral network to ensure 100% of WLHIV screened positive for pre-cancerous lesions receive treatment.

Key Populations

1. Revise KP strategy to reflect new data from IBBS. Please come prepared to present and discuss preliminary data analysis during the planning meetings in Johannesburg.
2. Expand use of successful social network testing approaches within KP. Recommend dialog with implementing partners in Ethiopia who have been particularly successful working with FSW to find their male partners and link them to treatment.
3. Increase demand and uptake of unassisted self-testing among KP groups. Particularly for MSM and TGW.

OVC

1. In COP20, OVC and clinical implementing partners in Namibia must work together to ensure that 90% or more of children and adolescents on ART with PEPFAR support in OVC SNUs are offered the opportunity to enroll in the comprehensive OVC program.

Health Systems

1. Health systems investments should be targeted to support retention of the treatment cohort.
2. Information systems: CQI to improve existing data systems, including QUANTUM, P-Tracker. Improve integration of data systems through HQ-supported mechanisms.

COP 2020 Technical Priorities

Client and Family Centered Treatment Services

COP20 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. Namibia 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).

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 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 2020 remains a requirement for all PEPFAR programs, and as such the COP 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 2020 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP 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 2020 development and finalization process. As in COP 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 2020 Guidance for a full list of requirements and engagement timelines.

APPENDIX 1: Detailed Budgetary Requirements

TABLE 11 : New Funding Detailed Initiative Controls

	COP 2020 Planning Level			
	FY20			COP 20 Total
	GHP-State	GHP-USAID	GAP	
Total New Funding	**$ 71,466,480**	**$ -**	**$ 1,487,500**	**$ 72,953,980**
Core Program	$ 66,766,480	$ -	$ 1,487,500	**$ 68,253,980**
COP 19 Performance	$ -			**$ -**
HKID Requirement ++	$ 4,700,000			**$ 4,700,000**

++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 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/ROP 2020 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

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