



United States Department of State

Washington, D.C. 20520

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January 13th, 2021

INFORMATION MEMO FOR CHARGÉ D'AFFAIRES YOUNG, ZAMBIA

FROM: S/GAC Chair, Mamadi Yilla and PPM Neha Safaya

THROUGH: Ambassador Deborah L. Birx, MD

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

Dear Chargé d'affaires Young,

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.

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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:

- Modeling resilience in PEPFAR programming as a necessity to get to epidemic control
- Demonstrating that, with an unrelenting focus on standards, you can provide quality care for HIV clients using multi-month dispensing of TLD and retaining 90% of clients on care and treatment
- Committing to the hard work of providing PrEP to the most vulnerable with high uptake and effective use, and pursuing saturation of VMMC

Together with the Government of Zambia (GRZ) and civil society leadership we have made tremendous progress together. Zambia 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. Ensuring all children are diagnosed and are on the best treatment regimens and virally suppressed

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

- Stubborn gaps in treatment coverage of pediatrics, men 20-24 and men over 50
- Inadequate Viral Load coverage including in pregnant and breastfeeding women (PBFW)
- Slow scale-up of Recency testing as a surveillance tool of future outbreaks now that Zambia has attained epidemic control nationally

A fuller set of details, including funding earmarks and specific program direction are included in the accompanying COP/ROP 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. Zambia has achieved the 2020 goals and is on track to achieve 2030 goals early which means sustaining the amazing gains will need to be our constant focus.

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/ROP 2021) notional budget for Zambia is **\$401,600,000**, 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 Zambia and civil society of Zambia, 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 and PPM, Mamadi Yilla and Neha Safaya, PEPFAR Country Coordinator, Daphyne Williams

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:

1. **Zambia was resilient and despite a pandemic, achieved epidemic control nationally in COP 19:** We commend the team for meeting critical prevention and treatment goals in COP 19. Between FY2018 Q1 and FY20 Q4, 304,000 additional Zambians have been added and retained on treatment, with 1,115,959 people now on treatment with PEPFAR support nationally.
2. **Demonstrating quality care for HIV clients, using multi-month dispensing of TLD and retaining 90% of clients on care and treatment.** Working with MOH to advance MMD policies over the past 3 years, the pandemic made MMD a necessity and there was an accelerated scale up of MMD of ART, reaching 90% of treatment clients. Of those clients, 56.08% were on 6MMD and 32.22% on 3MMD.
3. **Provision of PrEP and VMMC:** Successful demand creation campaigns including PrEP surges at DREAMS centers and offering 6MMD and single station PrEP provision led to remarkable achievements by Zambia of PrEP rollout across PEPFAR programs globally. In COP19, technical directives to stop performing VMMC in males under 15 were given, and as of COP19 Q4, the program has been successful in fully pivoting and successfully targeting only those 15 years and older. The program's results for VMMC exceeded the target of 399,387, despite service disruptions.

Challenges:

1. **Stubborn gaps in treatment coverage of pediatrics, men 20-24 and men over 50:** Along the clinical cascade, coverage for children is falling short. Children living with HIV (CLHIV) remain left behind, with only 76% on treatment, with the largest gaps geographically to be found in Copperbelt, Central and Southern Provinces. Retention in CLHIV also continues to trail behind adults with lost to follow up (LTFU) being the highest among those under the age of 5. An improvement of viral load coverage and suppression is also needed, but the strategy of putting CLHIV on DTG-based regimens has shown positive results and will need to be scaled up to improve results across the cascade.
2. **Inadequate Viral Load coverage including in pregnant and breastfeeding women:** Since COP18 Q2, there has been persistently low viral load coverage and suppression among pregnant and breastfeeding women. The team plans to conduct a DQA in facilities.
3. **Recency testing, as a surveillance tool of future outbreaks, must be scaled up:** Now that Zambia has attained epidemic control, this activity must be prioritized for monitoring the public health response.

Given your country's status of achieved or are near achieving epidemic control, the following priority strategic and integrated changes are recommended:

1. This COP letter provides U.S. government support to the Zambian national response via our bilateral PEPFAR program and through the Global Fund as one comprehensive plan. Therefore, PEPFAR must hold joint consultations with GRZ and the Global Fund early to address any threats to the supply of commodities for client needs.
2. Rapidly complete the ZAMPHIA, as the results will inform how close we are to saturation and steady state. It will also provide a lens into outstanding programmatic gaps and/or systemic challenges to be addressed.
3. Implement a focused strategy to increase case finding, treatment retention and viral load suppression among pediatrics and men. Specifically, build on prior momentum by scaling up MMD, DTG-based regimens/ART optimization, and index testing of biological children for CLHIV to close any gaps across age groups and geographical locations and interrupting transmission in these priority groups.
4. Retention efforts must succeed in COP 20 to ready the national response supported by PEPFAR to focus on surveying epidemic control in COP 21.
5. Expand the concept of family-centered and family care models used in COP 19 and 20 to deliver patient-centered care, leveraging our OVC, VMMC, DREAMS programs as access points into the family for improved outcomes.
6. Attention to continuing transmission amongst young men 20-24 and men under 50 using peer-led community strategies and deploying the approaches offered via MenStar.

SECTION 1: COP/ROP 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/ROP 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 PHIA's 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	\$ 358,141,536	\$ -	\$ -	\$ -	\$ 1,600,000	\$ -	\$ -	\$ -	\$ 359,741,536
GHP-State	\$ 330,729,005	\$ -	\$ -		\$ -	\$ -	\$ -		\$ 330,729,005
GHP-USAID	\$ 25,000,000				\$ 1,600,000				\$ 26,600,000
GAP	\$ 2,412,531				\$ -				\$ 2,412,531
Total Applied Pipelin	\$ -	\$ -	\$ -	\$ 41,858,464	\$ -	\$ -	\$ -	\$ -	\$ 41,858,464
DOD				\$ 3,072,375				\$ -	\$ 3,072,375
HHS/CDC				\$ 5,373,626				\$ -	\$ 5,373,626
HHS/HRSA				\$ -				\$ -	\$ -
PC				\$ 7,614,691				\$ -	\$ 7,614,691
USAID				\$ 19,059,999				\$ -	\$ 19,059,999
USAID/WCF				\$ 901,519				\$ -	\$ 901,519
State				\$ -				\$ -	\$ -
State/AF				\$ 5,836,254				\$ -	\$ 5,836,254
TOTAL FUNDING	\$ 358,141,536	\$ -	\$ -	\$ 41,858,464	\$ 1,600,000	\$ -	\$ -	\$ -	\$ 401,600,000

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

Zambia should plan for the full Care and Treatment (C&T) level of **\$248,000,000** and the full Orphans and Vulnerable Children (OVC) level of **\$40,000,000** 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	\$ 248,000,000	\$ -	\$ -	\$ 248,000,000
OVC	\$ 40,000,000	\$ -	\$ -	\$ 40,000,000
GBV	\$ 3,100,000	\$ -	\$ -	\$ 3,100,000
Water	\$ 614,000	\$ -	\$ -	\$ 614,000

*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	\$ 400,000,000	\$ 1,600,000	\$ 401,600,000
Core Program	\$ 353,843,277	\$ -	\$ 353,843,277
Cervical Cancer	\$ 5,000,000	\$ -	\$ 5,000,000
Community-Led Monitoring	\$ -	\$ -	\$ -
Condoms (GHP-USAID Central Funding)	\$ -	\$ 1,600,000	\$ 1,600,000
DREAMS	\$ 30,156,723	\$ -	\$ 30,156,723
HBCU Tx	\$ -	\$ -	\$ -
One-time Conditional Funding	\$ -	\$ -	\$ -
Surveillance and Public Health Response	\$ -	\$ -	\$ -
VMMC	\$ 11,000,000	\$ -	\$ 11,000,000

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

TABLE 4: State ICASS Funding

	Appropriation Year			
	FY21	FY20	FY19	Unspecified
ICASS	\$ -	\$ -	\$ -	

SECTION 3: PAST PERFORMANCE – COP/ROP 2019 Review

Table 5. COP/ROP OU Level FY20 Program Results (COP19) against FY21 Targets (COP20)*

Indicator	FY20 result (COP19)	FY21 target (COP20)
TX Current <15	46,545	53,493
TX Current >15	1,069,414	1,109,769
VMMC >15	435,483	375,608
DREAMS (AGYW PREV)	390,139	N/A
Cervical Cancer Screening	165,315	258,351
TB Preventive Therapy	289,359	502,062

**All targets are sourced from the Zambia COP20 Approval Memo*

Table 6. COP/ROP 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	\$ 11,968,321	\$ 9,895,075	\$ 2,073,246
HHS/CDC	\$ 143,002,272	\$ 128,976,416	\$ 14,025,856
HHS/HRSA	\$ 2,500,000	\$1,997,334	\$ 502,666
PC	\$ 5,320,621	\$ 3,031,496	\$ 2,289,125
State	\$ 1,918,183	\$ 1,481,424	\$ 436,759
USAID	\$ 256,345,109	\$ 214,112,827	\$ 42,232,282
Grand Total	\$ 421,054,506	\$ 359,494,572	\$ 61,559,934

**All figures are sourced from the Zambia EOFY Tool and outlays reported in this letter represent a snapshot in time.*

**These figures include only bilateral figures at present*

Table 7. COP/ROP 2019 | FY 2020 Implementing Partner-level Significant Over-Outlays versus Approved Budget*

Mechanism ID	Partner Name	Funding Agency	Total Planning Level	Total Outlays	Outlay Delta Check
14339	DEPARTMENT OF STATE	State	\$93,804	\$118,849	(\$25,045)

**This table was based off the FY20 EOFY submissions. Agencies outlaid to the following Implementing Mechanisms 110% or more in excess of their COP19 approved planning level. Outlays reported in this letter represent a snapshot in time.*

** These figures include only bilateral figures at present*

Table 8. COP/ROP 2019 | FY 2020 Results & Expenditures*

Agency	Indicator	FY20 Target	FY20 Result	% Achievement	Program Classification	FY20 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	722,326	1,734,311	240%	HTS Program Area	\$7,807,987	94%
	HTS_TST_POS	45,760	120,638	264%			
	TX_NEW	44,370	107,129	241%	C&T Program Area	\$58,015,891	84%
	TX_CURR	604,391	627,215	104%			
	VMMC_CIRC	189,813	240,857	127%	VMMC Sub-Program Area	\$6,704,066	72%
	OVC_SERV	2,807	2,108	75%	OVC Beneficiary	\$138,280	100%
DOD	HTS_TST	83,706	86,198	103%	HTS Program Area	\$1,248,782	48%
	HTS_TST_POS	7,004	7,019	100%			
	TX_NEW	6,675	5,192	78%	C&T Program Area	\$2,649,182	52%
	TX_CURR	45,968	41,575	90%			
	VMMC_CIRC	18,043	25,640	142%	VMMC Sub-Program Area	\$716,388	72%
	OVC_SERV	12,743	7,746	61%	OVC Beneficiary	\$752,750	27%
USAID	HTS_TST	650,154	1,088,306	167%	HTS Program Area	\$10,166,863	88%
	HTS_TST_POS	33,514	84,800	253%			
	TX_NEW	32,133	75,309	234%	C&T Program Area	\$143,853,223	85%
	TX_CURR	464,418	478,442	103%			
	VMMC_CIRC	191,531	227,824	119%	VMMC Sub-Program Area	\$4,790,251	75%
	OVC_SERV	344,677	411,283	119%	OVC Beneficiary	\$4,796,660	71%
	Above Site Programs						\$26,137,705
Program Management						\$50,167,468	

*Financial and target performance data are not a one-to-one correlation as program classification and expenditures encompass more than the indicator/target presented.

COP/ROP 2019 | FY 2020 Analysis of Performance

Overall - PEPFAR Zambia made consistent and steady progress toward epidemic control during COP 2019. Despite the ongoing COVID-19 pandemic, the program adapted and provided continuity of care. Multi-month dispensing was rapidly scaled up and expanded for larger cohorts of clients, all treatment targets were achieved, and innovative and expanded community platforms delivered results. Zambia outperformed despite many pandemic-induced challenges including delays in commodities shipments, and delays in transition to TLD. We look forward to the continued passion and progress the team brings to the program and the clients they serve.

Test positive and new on treatment are the “gateway” metric on clinical partner performance so those indicators provide a proxy view of the quality of services the partner offers. We acknowledge that the specific PHDs plays a critical role in the outcomes province by province, and district by district.

OU/PSNU Levels

- Almost all partners across agencies were able to meet and exceed targets on TX_NEW and TX_CURR, while only spending around 90% of C&T budget as an OU.
- While targets were met for TX_NEW and TX_CURR, treatment coverage gaps remain for children under 1, ages 5-9, adolescent boys and girls, and men between the ages of 20-24.
- PEPFAR Zambia has achieved high VL suppression rates for almost all KP sub-populations, but still faces challenges with VL coverage, particularly with those who inject drugs (PWID).
- The DREAMS program has seen an increased rate of completion of primary packages, at 100% for most age bands but still struggles to reach young women between the ages of 20-24.

Partner and Financial Performance

DOD:

DOD partners have overall found 7,019 new positive clients, retained 41,575 on treatment, with most of these partners reaching their treatment targets.

- *Jhpiego and Family Health International*: Both partners are within reach of their HTS_TST_POS targets at 138% and 90% respectively.
- *Family Health International*: only achieved 78% of TX_NEW targets and did well with 90% of targets achieved for TX_CURR, while only expending 75% of their C&T budget.
- *Society for Family Health*: only achieved 17% of target for HTS_TST_POS, but it does not have budget allocated to HTS. This is likely due to their focus being a VMMC IP and a decrease in active-duty military clients due to COVID-19. As DOD’s VMMC partner, this IP executed 104% of their budget and achieved 142% of their targets.
- *PCI*: had a low overall CXCA_SCRN achievement, but with a focus on first time screenings 96% were screened for cervical cancer for the first time.

HHS/CDC:

CDC partners have excelled at finding and retaining clients. Overall they found 120,638 new positives, and of those, they newly enrolled 107,129 and retained 627,215 on treatment.

- *UTH*: achieved 229% of target for HTS_TST_POS while only expending 50% of their budget; they also excelled in index testing and HTS_Self modalities, with well over 100% achievement. This IP also only achieved 75% of their OVC_SERV targets while expending 178% of their OVC budget.

- *CRS*: continues to be a strong treatment partner, putting 16,366 new clients on treatment with an achievement of 349% and achieved 129% of their TX_CURR targets while expending 83% of their C&T budget. However, for their VMMC targets they only achieved 66% of their targets and only expended 83% of their budget. All other CDC VMMC partners achieved and exceeded their targets for VMMC.
- *WPHO*: achieved 287% of its target for getting new clients on treatment, achieved 107% of its target for TX_CURR and expended 83% of their C&T budget.
- All partners implementing PrEP exceeded PrEP_NEW and PrEP_CURR targets, except for *ZCheck*, which only achieved 43% of new targets and 39% of current targets.

All of CDC's treatment partners either overachieved on treatment targets or were very close to achieving them without over-expending in their respective budgetary categories. They should continue to utilize successful partners and increase targets for those that are consistently overachieving in their results. Using UTH for OVC, while overspending and underachieving targets, is not the best use of their funding. This guidance does not stop the critical partnership between UTH and other OVC service providers necessary for the pediatric treatment surge plan to succeed.

HRSA:

- Implemented a model for differentiated service delivery that dramatically decongested hospitals and decreased the waiting time for stable HIV clients to access services. Clients who used to have to wait hours to see a provider at the hospital, requiring time away from work or school, now have little to no waiting time.
- The capacity of data management teams has been improved, allowing hospital staff access to real-time HIV data, which enable them to quickly provide appropriate care to clients. Hospital management also uses these data to ensure that the hospital is nimble in responding to overall needs. Hospital staff and management were supported to reconfigure the flow of HIV services using the Kaizen model to enhance the efficiency with which patients are served.
- HRSA at S/GAC's request transitioned and scaled up the HBCU partnership from a HOP activity to an integrated COP activity in COP20 and must report on targets.

Peace Corps:

- Despite Volunteers being evacuated, Peace Corps has pivoted its work to ensure the agency continues to support epidemic control through innovative efforts. Staff in country remain engaged with the PEPFAR Inter-agency team's support efforts including:
 - Communication and coordination with interagency teams and their IP(s) to provide TA and support various trainings
 - TA and training for Counterparts assisted with activities previously started with volunteers in the communities such as GRS and Life Skills Training
 - As a result of the evacuations, budget execution was less than expected

USAID:

USAID partners have successfully found 84,800 new positives, and of those, they newly enrolled 75,309 retained 478,442 clients on treatment.

Almost all testing partners exceeded their HTS_TST_POS targets, except for Eradicate TB, which only achieved 57%.

- *Discover-H*: achieved 341% of their TX_NEW target and 133% of their TX_CURR target while only executing 89% of their C&T budget.

- *SAFE and EQUIP*, achieved well over their TX_NEW and TX_CURR targets, while under executing their budgets.
- All OVC partners either nearly achieved or overachieved in OVC_SERV targets. *Development Aid from People to People* achieved 133% of their targets while only expending 43% of their OVC budget, while *Expanded Church Response Trust* also exceeded targets, they over-expended their budget at 252%.
- All VMMC partners exceeded their targets while all under spending their budgets.
- All PrEP partners exceeded PrEP_NEW and PrEP_CURR targets. EQUIP only expended 93% of its PrEP budget, while achieving 759% of new targets and 967% of current targets. On the over hand, SAFE expended 303% of its PrEP budget while achieving 204% of their new targets and 165% of their current targets.

USAID partners have performed well in treatment and superbly in key prevention interventions, but will still need to close the gap in the pediatric clinical cascade, improve transitions to local partners and continue to scale up DSD to cater to client needs (PrEP, 6MMD, etc.).

SECTION 4: COP/ROP 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 table on the following page.

Table 9. COP/ROP 2021 (FY 2022) Minimum Program Requirements

Minimum Program Requirement	Status for COP20 Implementation (and issues hindering implementation)
Care and Treatment	

<p>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.</p>	<ul style="list-style-type: none"> • The Test and Start strategy (with same-day initiation) is part of the Zambian HIV treatment guidelines. These are being fully implemented.
<p>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.</p>	<ul style="list-style-type: none"> • Rapid optimization of HIV treatment using TLD for HIV-infected patients is progressing well in Zambia. Zambia targets 95 percent of all eligible adults on HIV treatment to be on TLD in 2021. • This number should increase to 97.5 in 2022, and 100 percent in 2023.
<p>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.</p>	<ul style="list-style-type: none"> • Differentiated models for HIV service delivery is part of the national guidelines, including 6MMD for adults and 3MMD for children.
<p>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.</p>	<ul style="list-style-type: none"> • The target for TPT was set to ensure all eligible PLHIV will have completed a course of TPT in the last 3 years (from COP19 to COP21). This will be achieved building on the success of COP20. Children are being prioritized through the Pediatric Surge Campaign. • Co-trimoxazole is fully integrated into the clinical care package at no cost to the patient.
<p>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.</p>	<ul style="list-style-type: none"> • Overall, with technical support from FIND, CIDRZ LIFE, is supporting the Ministry of Health lab services unit to collect information on placement, instrument capacity, human resources, laboratory information systems including digital test requisition and results return, power, sample referral in order to ensure 100% access to viral load and early infant diagnosis within 2 weeks for all on treatment and all HIV exposed infants, respectively. • The optimization process will focus initially on POC instruments (GeneXpert and mPIMA) with initial outcomes reported to the MOH lab TWG for review on January 18. This will lead to optimization of GeneXpert utilization for Tb, VL, EID, HPV (if adopted for HPV) and COVID-19. • Subsequently, additional components of the integrated sample referral, testing and results return systems will be incorporated into the model and options for optimization will be assessed and presented to MOH for decision making, leading to generalized optimization of the laboratory system by the end of COP 20.

	<ul style="list-style-type: none"> • More specifically on the LIS component of Diagnostic Network Optimization, the effort is on-going. Currently, three electronic systems are deployed to achieve the following: a) E-labs to track samples from collection points up to the PCR labs and for results return (sample and results return visibility); b) DISA-Lab to receive/record samples at the PCR lab and track sample movement within the PCR lab; and c) SmartCare to link lab information to patient care information. Zambia is working on strengthening the interoperability of the three systems to improve synergies. The aim of all these interventions is to increase VL coverage and reduce results turnaround time to less than two weeks.
Testing	
<p>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.</p>	<ul style="list-style-type: none"> • Index testing and HIV self-testing have been scaled up. All children of PLHIV are offered HIV testing. • All IPs have started conducting the safe and ethical index testing site assessments. So far, the OU has conducted 943 site assessments, with 432 sites meeting the minimum standards. • IPs have continued reassessing sites which did not initially meet the minimum standards. • IPs have been trained in IPV screening and are ensuring that assessment procedures for IPV are followed.
Prevention and OVC	
<p>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)</p>	<ul style="list-style-type: none"> • PrEP is being offered as an HIV prevention method in about 900 PEPFAR supported sites. • Implementing partners are scaling up PrEP provision among at-risk PBFW. • Differentiated PrEP service delivery for at-risk AGYW and KP at community level on-going. • High rates of acceptability of PrEP among adult men.
<p>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</p>	<ul style="list-style-type: none"> • OVC IPs, in collaboration with DSD IPs in the interagency space, have drafted MOUs, SOPs and data collection tools for bidirectional linkages. The comprehensive OVC model, providing case management for C/ALHIV, is a cornerstone of the COP20 pediatric surge in Zambia. • OVC IPs to focus on testing all biological children <19 years of women on ART at facilities where there is OVC IP presence. • For primary prevention, the following activities have been in place: <ol style="list-style-type: none"> 1. FMP and Sinovuyo Parenting programs implemented in the DREAMS program 2. Coaching Boys into Men implementation is ongoing since June 2020

	<p>3. IMPower training not yet conducted due to COVID</p> <p>4. Justice for Children TOTs done, waiting for training to cascade down to the districts</p>
<p>Policy & Systems</p>	
<p>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.</p>	<ul style="list-style-type: none"> • Zambia does not have a formal user fees policy which would include a combination of any of the following: drug costs, supplies and medical material costs, entrance fees or consultation fees paid at each visit. However, select services extract a subsidy from patients: <ol style="list-style-type: none"> 1. Registration fee to facilitate/procure a registration card and/or a book for recording (one off) 2. Initial radiographs 3. Self-referral (patients who avoid navigating the primary health care system by self-referring themselves to a designated higher level of care) • These out-of-pocket costs can potentially reduce access to HIV care, especially among the indigent populations (though there is no formal evidence of this). • PEPFAR will monitoring this with CSO assistance.
<p>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.</p>	<ul style="list-style-type: none"> • Quality assurance is an integral part of HIV programming in Zambia and focuses on data and contents of the program such as: <ol style="list-style-type: none"> 1. Laboratory: where the hallmark is maintenance of minimum standards 2. Patient care: where the hallmarks are patients' clinical and surrogate outcomes 3. Program and CoAg management: QI projects are picked by provincial and districts mentors every quarter to improve key areas of need. • These are monitored in a structured manner using internal and external quality improvement and assessment.
<p>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 reduce stigma and encourage HIV treatment and prevention.</p>	<ul style="list-style-type: none"> • Viral load literacy is included in policy, implementation, and community levels. • U=U was officially launched publicly by the Zambian Republican President. • The Ministry of Health continues to promote awareness amongst service providers and the community on the need for all HIV-infected clients to achieve HIV viral suppression. • Civil society organizations and political and traditional leaders continue to engage stakeholders on viral load literacy. • Over the last year there has been improvement in: 6MMD, retention in treatment, and viral load coverage and viral suppression.

<p>4. Clear evidence of agency progress toward local, indigenous partner direct funding.</p>	<ul style="list-style-type: none"> • USAID is committed to increasing its funding to local indigenous partners. In October 2020, three new local partners were awarded prime agreements for OVC and related services. There are four procurements in progress at various stages that are targeted for local partners including HIV prevention, HIV treatment and supply chain. In addition, USAID is increasing its investments in G2G programming. • In COP20, CDC provided 67% of its funding to government and local indigenous partners and all provincial health offices in CDC-supported provinces provide the majority of direct service delivery.
<p>5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended</p>	<ul style="list-style-type: none"> • Although GRZ has been increasing its budgetary allocation for health (2019 ZMW8.0bn; 2020 ZMW9.3bn; 2021 ZMW9.6bn), the sector budget as a proportion of the national budget has been reducing (2019 9.3%; 2020 8.8%; 2021 8.1%). • With the rapid depreciation of the local currency in the last year, the dollar equivalence of the 2021 health budget is \$480m compared to \$672m in 2019 (-29%).
<p>6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.</p>	<ul style="list-style-type: none"> • Thirty-five facilities in 22 districts in Central, Copperbelt, Eastern, Lusaka, Southern and Western provinces have been connected to the mortality surveillance database. • Verbal autopsies on community deaths (brought-in-dead) are being conducted and data is currently being uploaded to the mortality surveillance database. Training on ICD-10 coding for facility deaths in same facilities planned for FY21.
<p>7. Scale-up of case surveillance and unique identifiers for patients across all sites.</p>	<ul style="list-style-type: none"> • Surveillance activities are underway, staff were hired and trained, and equipment procured in 18 districts in four provinces. Database and dashboards are developed, and data successfully being transmitted. Two additional provinces scheduled to be activated by June 2021. • Unique patient identification using fingerprint biometrics has been implemented in 145 facilities, with the target of reaching 250 facilities by September 2021.

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

Table 10. COP/ROP 2021 (FY 2022) Technical Directives

OU –Specific Directives
1. Complete the ZAMPHIA.
2. Implement a focused strategy to increase case finding, treatment retention and viral load suppression among pediatrics, specifically building on prior momentum by scaling up MMD, DTG-based regimens/ART optimization, and index testing of biological children for CLHIV to close any gaps across age groups and geographical locations and interrupting transmission in these two priority groups.

3. Continue focusing on retention efforts to ready the national response supported by PEPFAR to focus on surveying epidemic control in COP 21.
4. Expand the concept of family-centered and family care models used in COP 19 and 20 to deliver patient-centered care, leveraging our OVC, VMMC, DREAMS programs as access points into the family for improved outcomes – see below.
5. Use real-time Recency surveillance data to define, develop, and implement a targeted public health investigation and response that includes review of HIV testing, care and treatment data to identify drivers of HIV transmission and make programmatic changes accordingly. Viral load is strongly recommended at all sites for Recency testing within an OU.
6. PEPFAR must respond to continuing transmission amongst young men 20-24 and men under 50 using peer-led community strategies, FCI and deploying the approaches offered via MenStar. The effectiveness and resilience of peer-led KP programming efforts through the KPIF community program that leveraged CSO-led online platforms, navigators and educators showed an effective approach to achieve improved KP cascades and should be utilized broadly to serve the outstanding hard to reach clients in need of services. As appropriate, redirect funding to support effective peer-led community monitoring service delivery where it is proving more effective than facility-based services to reach high-risk groups.
Other Government Policy or Programming Changes Needed
<ul style="list-style-type: none"> • PEPFAR and the Global Fund must continue their effective partnership and hold joint discussions with the new GRZ leadership in January 2021 to address any threats to the supply of all commodities for client needs. • With Zambia at epidemic control, it is appropriate that the team leverage accessibility to the “family” through programs offered via our OVC program, and use the VMMC and DREAMS platforms to meet client needs as laid out in the COM letter. These additional entry points to the family present a pathway to provide an integrated multi-sector support for the wellbeing of our clients.

COP/ROP 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 $\geq 90\%$ 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 cryptococcal 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 SNU's 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 SNU's.

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 SNU, 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.

Zambia will have access to **\$1,600,000** million from the Condom Fund in COP21/FY22, contingent upon adequate justification of need. 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 Zambia 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/ROP 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 Zambia 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/ROP 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/ROP 2021 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 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/ROP 2021 development, finalization, and implementation. As in COP/ROP 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/ROP 2021 Guidance for a full list of requirements and engagement timelines.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment: Zambia's COP/ROP 2021 minimum requirement for the C&T earmark is reflected in Table 2. If there is no adjustment to the COP/ROP 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): Zambia’s COP/ROP 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): Zambia's COP/ROP 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/ROP 2021 earmark is derived by using the final COP/ROP 2020 GBV earmark allocation as a baseline. The COP/ROP 2021 planned level of new FY 2021 funds for GBV can be above this amount; however, it cannot fall below it.

Water: Zambia's COP/ROP 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/ROP 2021 earmark is derived by using the final COP/ROP 2019 water earmark allocation as a baseline. The COP/ROP 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/ROP 2020 submission.

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

COP/ROP 2021 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

All agencies in Zambia should hold a **3 month pipeline** at the end of COP/ROP 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/ROP 2020 implementation (end of FY 2021)

with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP/ROP 2021, decreasing the new funding amount to stay within the planning level.