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January 13th, 2021

INFORMATION MEMO FOR CHARGÉ D'AFFAIRES VERNELLE FITZPATRICK

FROM: **S/GAC Chair, Angeli Achrekar and PPM, Sally Blatz**

THROUGH: **Ambassador Deborah L. Birx, MD**

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

Dear Chargé d'affaires FitzPatrick,

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

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

PEPFAR implementation over the past year has shown tremendous effort to maintain clients on treatment, initiating and accelerating client centered service delivery adaptations, while doing what was possible in HIV prevention programs deeply affected by COVID-19 shutdowns. The following themes have emerged across all of PEPFAR-supported countries; As the economic impact of COVID continues to be seen at both national and community levels, it is more important than ever to use granular data and expand what is working in specific SNUs for viral load coverage and suppression. We saw differential progress in this area independent of the impact of COVID19. Focus groups and deep analytics of client returning to care to ensure we are addressing the critical persistent and new structural barriers. Focus on areas of recent treatment interruption to understand how COVID may have created or exacerbated barriers to access and treatment continuity. Across all countries we see persistent gaps in pediatric diagnosis, treatment and viral suppression. Particular attention should be paid to the pediatric cascade and identifying challenges by district and country for clear and actionable plans. In addition, leverage OVC, DREAMS and other resources for clear accountability to work with mothers and improve early infant diagnosis by two months of age and strengthen resiliency among at-risk women and girls. Community-led monitoring must raise visibility and appropriate response to the needs of populations already vulnerable before COVID. The assessment of needs, and strategies to reinforce OVC caregivers and HIV-affected families in crisis should contribute to budget and activity planning for care and treatment, DREAMS, OVC and wraparound resources. Furthermore, analyzing expenditures at mechanism and program areas level, along with the work teams have done, to build relationships and co-planning with your partner government, the Global Fund, UN organizations and other donors. These relationships and planning efforts are critical to supply chain stability for key commodities as well as understanding COVID relief and other potential funding available in country to ensure most effective and efficient use of PEPFAR's contributions to the national HIV response in COP21.

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

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

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

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

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

We are very excited about your progress in:

- Improved testing yields due to the widespread implementation of the effective screening tool and improved index case testing; as well as strong clinical program linkage rates and increased viral load coverage and suppression
- Strong achievements in the prevention portfolio targets, including in key populations testing and prevention, and continued strong achievement in prevention among orphans and vulnerable children.
- Mostly successful implementation of user fee elimination.

Together with the Government of Cameroon and civil society leadership we have made tremendous progress together. Cameroon should be proud of the progress made over the past 18 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

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

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

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

- Persistent supply chain issues and national and site-level stock outs of rapid test kits, ARVs, INH, and viral load reagents have driven poor program results. National stock outs are the result of the government not meeting its Global Fund counterpart financing commitments, while site-level stock outs reflect the need for a strengthened and better coordinated supply chain at the regional and site level.
- Retention and loss to follow up issues continue to be a problem across the board, and especially among younger age cohorts. Viral load coverage and suppression, though improving, are still not at desired levels
- Pediatric performance is weak across the cascade on pediatric case finding, multi-moth dispensing, TB screening, prevention and completion, ART retention, and viral load suppression.

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. Cameroon has not achieved the 2020 goals and is not 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 Cameroon is **$85,500,000** 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 Cameroon and civil society of Cameroon, 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 – S/GAC – Angeli Achrekar, Sally Blatz, Amber Kimbro**

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. Improved testing yields due to the widespread implementation of the screening tool and improved index case testing over the last six quarters, including high contribution of ICT to positivity and efficient and targeted PITC testing. Strong linkage rates across most clinical partners and increased viral load coverage and suppression compared to last year in spite of viral load reagent stock challenges.

2. Key population and OVC partners continue to show strong achievements in the prevention portfolio; key population index testing results are strong and prevention target achievement for both OVC and Key Populations continue to be strong

3. Community-led monitoring of user fee elimination policy continues to show steady progress of successful implementation.

Challenges:

1. Persistent supply chain issues and stock outs (nationally and at the site level) of rapid test kits (mostly Q1 and Q2 stockouts), adults and pediatric ARVs (1st and 2nd line), and viral load reagents (mostly Q1 and Q2 stockouts), and IPT (Q1 through Q3) have driven poor program results. The national stock outs are the result of the government not meeting its Global Fund counterpart financing commitments. Significant recurring issues in coordination and distribution between the sites/clinical partners and regional warehouses continue that must be resolved.

2. Retention and loss to follow up issues continue to be a problem across the board, especially with younger cohorts. It is important to note Q1 gains resulted from moving into new sites, not from improvement in services and there were substantial losses from Q2-Q4. Viral load coverage and suppression, though improving modestly compared to last year are still only 55% and 88% respectively, both below the target of 90%.

3. Pediatric performance, though showing modest gains in testing vs last year, is weak across the cascade as compared with adults, especially pediatric index and ITC yields, pediatric multi-moth dispensing coverage, retention and loss, TB screening, prevention and completion and viral load suppression.

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

1. Supply Chain coordination and optimization must be a central priority for COP21. Coordination issues between the sites/clinical partners and regional warehouses must be improved. Detailed directives are provided below.

2. Improvement in both viral load suppression and viral load coverage is encouraging, but progress needs to be made to achieve 90% coverage nationally, and in the suppression of pediatrics.

3. Pediatric gaps must be addressed and prioritized through coordination between the OVC program and the clinical program.

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 PHIAs that have yet to be completed and to address other potential future requirements as the impacts of COVID on the program are better known. These funds will be allocated to OUs at a later date as appropriate.

TABLE 1: All COP 2021 Funding by Appropriation Year

	Bilateral				Central				Total
	FY21	FY20	FY19	Unspecified	FY21	FY20	FY19	Unspecified	TOTAL
Total New Funding	**$82,020,142**	**$-**	**$-**	**$-**	**$500,000**	**$-**	**$-**	**$-**	**$82,520,142**
GHP-State	$81,445,023	$-	$-		$-	$-	$-		**$81,445,023**
GHP-USAID	$-				$500,000				**$500,000**
GAP	$575,119				$-				**$575,119**
Total Applied Pipeline	**$-**	**$-**	**$-**	**$2,979,858**	**$-**	**$-**	**$-**	**$-**	**$2,979,858**
DOD				$85,473				$-	**$85,473**
HHS/CDC				$-				$-	**$-**
HHS/HRSA				$-				$-	**$-**
PC				$1,204,919				$-	**$1,204,919**
USAID				$1,523,169				$-	**$1,523,169**
USAID/WCF				$-				$-	**$-**
State				$-				$-	**$-**
State/AF				$166,297				$-	**$166,297**
State/EAP				$-				$-	**$-**
State/EUR				$-				$-	**$-**
State/PRM				$-				$-	**$-**
State/SCA				$-				$-	**$-**
State/SGAC				$-				$-	**$-**
State/WHA				$-				$-	**$-**
TOTAL FUNDING	**$82,020,142**	**$-**	**$-**	**$2,979,858**	**$500,000**	**$-**	**$-**	**$-**	**$85,500,000**

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

Countries should plan for the full Care and Treatment (C&T) level of $20,000,000 and the full Orphans and Vulnerable Children (OVC) level of $1,800,000 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	$20,000,000	$-	$-	**$20,000,000**
OVC	$1,800,000	$-	$-	**$1,800,000**
GBV	$250,000	$-	$-	**$250,000**
Water	$164,115	$-	$-	**$164,115**

**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	**$85,000,000**	**$500,000**	**$85,500,000**
Core Program	$85,000,000	$-	**$85,000,000**
Cervical Cancer	$-	$-	**$-**
Community-Led Monitoring	$-	$-	**$-**
Condoms (GHP-USAID Central Funding)	$-	$500,000	**$500,000**
DREAMS	$-	$-	**$-**
HBCU Tx	$-	$-	**$-**
One-time Conditional Funding	$-	$-	**$-**
Surveillance and Public Health Response	$-	$-	**$-**
VMMC	$-	$-	**$-**

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

TABLE 4: State ICASS Funding

	Appropriation Year			
	FY21	FY20	FY19	Unspecified
ICASS	$139,389	$-	$-	

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	**11,120**	**21,521**
TX Current >15	**300,395**	**430,846**
VMMC >15	**N/A**	**N/A**
DREAMS (AGYW PREV)	**N/A**	**N/A**
Cervical Cancer Screening	**N//A**	**N/A**
TB Preventive Therapy	**9,652**	**368,389**

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

OU/Agency	Sum of Approved COP/ROP 2019 Planning Level	Sum of Total FY 2020 Outlays	Sum of Over/Under Outlays
OU			
DOD	$1,828,773	$1,614,994	$213,779
HHS/CDC	$64,775,237	$59,052,340	$5,722,897
PC	$1,254,291	$599,840	$654,451
State	$700,000	$378,511	$321,489
USAID	$28,624,486	$25,089,346	$3,535,140
Grand Total	**$97,182,787**	**$86,735,031**	**$10,447,756**

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

The following IMs outlayed at least 110 percent of their COP/ROP19 approved level.

No IMs outlayed more than 110 percent of their budget in COP19 in Cameroon.

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	1,926,750	1,164,169	60%	HTS	$6,378,003	92%
	HTS_TST_POS	125,000	49,064	39%			
	TX_NEW	125,842	46,539	37%	C&T	$37,775,015	76%
	TX_CURR	372,679	303,490	81%			
	VMMC_CIRC	N/A	N/A		VMMC	N/A	N/A
	OVC_SERV	N/A	N/A		OVC Beneficiary	$0	N/A
DOD	HTS_TST	32,607	23,892	73%	HTS	$243,245	88%
	HTS_TST_POS	2,190	1,556	71%			
	TX_NEW	2,093	1,536	73%	C&T	$967,319	86%
	TX_CURR	8,913	8,034	90%			
	VMMC_CIRC	N/A	N/A		VMMC	N/A	N/A
	OVC_SERV	N/A	N/A		OVC Beneficiary	$0	N/A
USAID	HTS_TST	55,212	51,220	93%	HTS	$770,556	72%
	HTS_TST_POS	6,501	7,920	122%			
	TX_NEW	N/A	N/A		C&T	$14,709,308	95%
	TX_CURR	N/A	N/A				
	VMMC_CIRC	N/A	N/A		VMMC	N/A	N/A
	OVC_SERV	54,317	62,158	114%	OVC Beneficiary	$4,225,857	66%
				Above Site Programs		$2,363,955	
				Program Management		$15,478,565	

COP/ROP 2019 | FY 2020 Analysis of Performance

Cameroon's COP19 represented the first year of a two-year strategy to scale up PEPFAR's presence across Cameroon in order to achieve epidemic control by the end of COP20. While COP19's targets were aggressive, the program fell far short of the treatment targets for COP19, putting the COP20 goal of epidemic control at great risk. The program was plagued by supply chain challenges during COP19, including stock tensions and stock outs of key HIV commodities, driven by the government not meeting its counterpart financing commitments to the Global Fund, as well as by distribution and coordination challenges between clinical sites and regional warehouses, which impeded the program's ability to deliver services to patients and meet its targets for testing, treatment, TB and viral load coverage.

Bearing in mind the supply chain challenges and impacts of COVID-19, the performance across the cascade was mixed; there were some very bright spots, and some areas where improvement is needed. On testing, COP19 saw formal approval of, and subsequent wide-spread implementation of, the testing screening tool. This resulted in improved yields for OtherPITC testing. Additionally, index testing was scaled up effectively and continued to constitute a larger and larger proportion of positives, with Metabiota (DOD) and the Cameroon Baptist Convention Health Board (HHS/CDC) approaching 30% of positives coming from index testing. The team implemented some innovative testing approaches, including anonymous contact notification, online and satellite site outreach, and self-testing. While we applaud these efforts, we also note that target achievement of new positives identified (HTS_TST_POS) was at 44% for the year. This result impacted the new patients that were added to treatment, which also fell very short of the target, with 38% achievement for the year. Continued training and mentoring of clinical staff on index testing, the continued use of the screening tool, and an improved commodities situation for RTKs should all improve the testing outcomes in COP21.

Linkage to treatment results were strong at HHS/CDC and DOD clinical partners, though the national linkage data suggests that there is a disconnect between patients who are found to be positive at Key Population Drop-in Centers (DICs) who are then initiated on treatment at a clinical site. The "handshake model" must improve such that KP clients can be identified as positive at KP sites, and then initiated on treatment at clinical sites without any additional testing. Additionally, key populations sites should not be initiating patients on treatment unless those facilities have treatment targets (TX_NEW and TX_CURR), in agreement with the government and the PEPFAR team. In the general population, linkage rates vary by partner/Zone and by age. While linkage was strong in the military, and in Zones 1 and 2 at clinical partners, linkage lagged below 90% in Zones 3 and far below 90% in Zone 4. Additionally, linkage rates for young adult men were very low, the lowest for men 15-19 at 58% in Q4 of FY20. Patient retention, specifically loss to follow up (LTFU) among all age groups, but especially among younger adult age groups (15–34-year-olds), continues to be a major problem in Cameroon. We believe that this retention problem is at least in part driven by the fact that only a minority of patients are taking TLD for treatment, and also because not enough of the patient population is enrolled in Multi-Month Dispensation (MMD), especially 6-month MMD. TLD and 6-month MMD must be dramatically scaled up in COP21. Additional client centered services, especially Decentralized Drug Distribution (DDD) should be rapidly scaled in Zones 2-4 where they currently are not being widely used. Overall, the treatment target for COP19 of 381,592-perhaps the most important target for measuring progress toward epidemic control-was not achieved, with only 311,524 patients on treatment at the close of the year. Supply chain improvements and scale up of client centered services like MMD, DDD and the adoption of TLD will be key to improving this result for COP21, as will the adoption of MenStar approaches for addressing linkage and retention issues among young adult men.

Viral load coverage continued to improve in COP19, even in spite of the program now serving a much larger population than in COP18, however, the overall viral load coverage for the year was still far below the desired level of 90%, coming in at 55% for the year in COP19. While this is far too low and must

improve, we were encouraged to see that all five clinical partners showed consistent increases in viral load coverage during Q2-Q4 of COP19. Viral load suppression however, though showing modest improvements as compared to last year, continues to be below 90%, at 88% for the year, which does represent an improvement over the PHIA result from 2017, which was 80%, but is still below the epidemic control target of 90%. We believe this will also be helped by continued scale up of TLD and MMD and a renewed focus on client-centered services.

The TB program in Cameroon struggled in COP19, due largely to the unavailability of INH. TB screening was stagnant overall, reaching only 84% of ART patients by the end of COP19, roughly the same level it has been at for the past 3 years. Pediatric screening rates were lower. TB_PREV results reached only 6% of the target for the year, again, due to INH shortages, however for those who were initiated on TPT, completion rates were quite low, at 61% for adults in Q4 of FY20 and 49% for pediatrics. As supply chain issues are resolved team should rapidly increase coverage of TPT, TB screening rates should increase, and completion rates for TPT must increase. The program should consider shorter regimens-not INH- to improve completion rates.

It is finally critical to note that across the cascade, pediatrics (<15-year-olds) underperformed adults to an alarming degree. Testing yields for pediatrics, on average, were half of those for adults in COP19, with even greater discrepancies on OtherPITC yields and index yields. Pediatric MMD coverage was far below that of adults, and perhaps most alarming, pediatric viral load suppression was only 64%, compared to 88% for adults. As noted above, pediatric completion rates for TPT were far below those of adults. Pediatric outcomes must be improved in COP21.The OVC program must lead the way to address the shortcomings that are currently happening in the services and outcomes for pediatrics in testing, treatment, TB, and viral load coverage and suppression.

Expenditures for clinical partners in COP19 were not proportionate to the results that were returned. While COP19 clinical expenditures increased by 134%, treatment current results increased by only 56% and treatment new results increased by only 61%. This indicates that increased funding has not resulted in commensurate increases in performance. This effect was especially strong at CDC clinical partners, with the Cameroon Baptist Convention Health Board dramatically outspending other clinical partners, and EGPAF also displaying high expenditures per result. Efficiencies must be gained in COP21.

In the prevention program, key population and OVC partners continue to show strong achievements, especially strong target achievement of prevention targets (OVC_SERV and _KP PREV). COP 19 experienced weak PP_PREV results for AGYW due to Peace Corps withdrawal, however priority population work with clients of sex workers was successful. Though PrEP roll out was limited in COP19, PrEP uptake has been progressing in recent months and APR target achievement for PREP_NEW was strong. PREP_CURR showed underperformance due to smaller than anticipated existing PREP treatment population in new sites. PrEP adherence must be a focus in COP21, and the policy limiting PrEP access to those ages 21 and over must be removed so PrEP can be accessed by all populations with elevated risk of HIV, including AGYW.

Finally, PMTCT and EID program activities, even in the midst of COVID-19, sustained relatively high coverage of HIV testing (91%) and ART to pregnant women (94%). While these are positive results, there is urgent need to increase EID testing coverage by 2 months of age, which is currently at 59% as well as linkage to treatment. To achieve optimal outcomes for HIV exposed infants, identifying HIV-positive cases and linking them to optimal treatment are essential.

SECTION 4: COP/ROP 2021 DIRECTIVES

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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 and issues hindering Implementation
Care and Treatment	
1. Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Linkage rates declined overall in COP19, driven in part by challenges in the KP handshake model (which may be resolved with data quality improvement) and challenges in Zone 3 and 4 and with young adult men. Coordination and data reporting practices between KP and clinical partners in the handshake model must be improved during COP21. If the KP partner initiates patients on treatment, they must receive TX_CURR and TX_NEW targets. Improvements to immediate test and start must be implemented at clinical partners in Zones 3 and 4 and specific strategies, like MenStar, must be employed to address the particularly weak linkage numbers among young adult men, especially ages 15-34.
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	All policy barriers to transitioning children, adolescents and women of childbearing potential to TLD must be

regimens for children who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	removed, and TLD transition must rapidly scale up in COP21 such that TLD is offered as the first line treatment for all PLHIV. Any remaining NVP-based regimens for children must be completely eliminated now.
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.	Six-month dispensation must be scaled rapidly and policy requiring undetectable viral loads in order to be eligible for MMD must also be removed. 6 month and 3-month dispensation must be rapidly scaled up at all clinical and military sites. DDD must also be scaled up in Zones 2-4 where it is currently extremely limited.
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.	TB_PREV target achievement was perhaps the weakest result in all of COP19 in Cameroon, at 6% achievement for the year. Though this was largely due to INH stock not being available at sites, this nevertheless represents a failure of the program to meet this minimum program requirement. In addition, for those patients who were initiated on TPT, completion rates were quite low, at 61% for adults in Q4 of FY20 and 49% for pediatrics. TPT must scale rapidly in COP21, completion rates must improve and TB screening rates (at 84% of PLHIV) must also improve, especially in the South and Littoral.
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.	PEPFAR-led Diagnostic Network Optimization exercises must be prioritized and accelerated in COP21, with a priority placed on network optimization of laboratory-based approaches for Viral Load and EID. Opportunities may exist for TB as well as other coinfections, and the PEPFAR team should engage with all relevant stakeholders to explore these, while ensuring the optimization around VL/EID is taking place. The PEPFAR team should plan to report progress on this work during COP21 POARTs, including progress on assessing the current network structure, laboratory capacity, and testing coverage and efficiency by laboratory catchment area.
Testing	

1. Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	Continue to scale index testing, especially in Zones 2-4 to increase proportion of positives coming from index testing at all partners. Continue to prioritize training of HCW and innovative approaches like anonymous contacting and KP self-testing. Continue to emphasize confidentiality and safety in the implementation of index testing.
Prevention and OVC	
1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)	While the limited COP19 PrEP roll out showed positive progress, we look to COP20 to ensure that PrEP is reaching all populations at elevated risk of HIV. Current MoH policy limiting PrEP eligibility to those 21 and over should be revised so that PrEP is made available to all desired populations, including AGYW.
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	OVC_SERV results have been positive, however, the OVC program in COP19 did not effectively wraparound the clinical program to deliver strong PLHIV results across the cascade. COP21 must be about refocusing the OVC program to improve testing, treatment, MMD, TB, and viral load suppression outcomes for pediatrics.
Policy & Systems	
1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention.	User fee elimination, which went into effect in COP19, has been mostly successful, however some work remains to achieve complete elimination of both formal and informal user fees at all sites for all HIV and related services. Community-led monitoring of this implementation should continue.
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.	Site-level CQI practices have been active in COP18 and COP19 must continue to Prep ensure proper data reporting, and patient tracking. CQI approaches must also be implemented in commodities data reporting, ordering and fulfillment practices and coordination between clinical partners and the SC partner.
3. Evidence of treatment and viral load literacy activities	These activities should expand in COP21.

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.	U=U messaging has been rolled out but must continue to be emphasized by KP, OVC and clinical partners.
4. Clear evidence of agency progress toward local, indigenous partner direct funding.	USAID, DOD and CDC Cameroon must all dramatically improve in the transition to local partners. All three agencies are very far from 70% target at the agency level and must demonstrate progress in COP21. USAID's transition to local partners for KP and OVC services must be complete by COP21.
5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	The Government of Cameroon showed a strong commitment in eliminating user fees, however, they have not met their counterpart financing at Global Fund, which has resulted in wide-spread stockouts and interruption of HIV services to patients. PEPFAR looks to the Government of Cameroon to be a financial partner in the HIV epidemic response and to commit to meeting all of their financial commitments in COP21.
6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Monitoring that began in COP18 should continue to scale with systems to monitor morbidity and mortality prioritized.
7. Scale-up of case surveillance and unique identifiers for patients across all sites.	Health information systems are not currently in place in to enable case- based surveillance or implement unique identifiers for the general treatment population.

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

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

OU –Specific Directives
HIV Testing Treatment
1. The Supply Chain in Cameroon must be optimized through improved planning, coordination, communication, logistics, information management, data sharing and quantification among all partners. This improvement will affect testing and treatment outcomes nationally. Specific directives are outlined below.
2. MMD, DDD and TLD must rapidly scale up in COP21. All policy barriers to their successful implementation must be resolved. This will be the main solution for retention and viral load suppression problems, but specific approaches for younger cohorts, and specifically men, must be engaged as well. We recommend utilizing MenStar approaches to address linkage and retention challenges among young adult men.
3. Index testing and viral load coverage must continue to increase with viral load coverage achieving 90% in COP21. Viral load suppression must also show improvement and target 90% suppression in COP21.
4. Weak pediatric testing yields, retention, TB screening and completion, MMD enrollment and viral load suppression must be addressed, and should be the focus of OVC activities in COP21.
HIV Prevention
1. PrEP must be scaled up and made available to all population with elevated risk of HIV. Policy barriers to PrEP scale up for any vulnerable population, including adolescent girls and young women must, be removed.
Other Government Policy or Programming Changes Needed
1. The Government of Cameroon must be a reliable partner and meet all of its co-financing requirements to ensure the constant availability of HIV commodities at sites. PEPFAR looks to the government to assist in the improvement of the Supply Chain in Cameroon, as detailed in the guidance below. 2. The Government of Cameroon must continue to make progress on implementing policies for informal and formal user fee elimination across all sites.

Key Supply Chain Directives for COP21

1. PEPFAR clinical partners working at sites should provide monthly reports on stock levels and consumption rates of key HIV commodity items at sites, including testing, treatment, viral load, and TB commodities. This data should be disaggregated by age and posted to PEPFAR SharePoint each month and will be leveraged by the supply chain partner and other key stakeholders for planning purposes.
2. National annual quantification exercises with quarterly updates should take place, with participation from the Government of Cameroon, the Global Fund, and other key stakeholders. A central tenet of these exercises must be the sharing of data on both procurement and stock levels at the national and regional level.
3. Coordination between the USAID Supply Chain partner, and PEPFAR's clinical partners must continue to improve. Recently established weekly clinical/SC partner meetings, monthly meetings at the regional level between clinical IP and SC partner POCs, and quarterly interagency clinical/SC partner coordination meetings must all continue through COP21.

4. Additional TA support at the regional level should be supplied to larger regions by the Supply Chain partner to assist in order requisition and review as well as in the development of distribution plans and route optimization.
5. USAID Supply Chain partner will continue to provide LMD to sites in COP21, however transition to local partner must be complete in at least 5 regions by the end of COP21.
6. PEPFAR-led Diagnostic Network Optimization exercises must be prioritized and accelerated in COP21, with a priority placed on network optimization of laboratory-based approaches for Viral Load and EID. Opportunities may exist for TB as well as other coinfections, and the PEPFAR team should engage with all relevant stakeholders to explore these, while ensuring the optimization around VL/EID is taking place. The PEPFAR team should plan to report progress on this work during COP21 POARTs, including progress on assessing the current network structure, laboratory capacity, and testing coverage and efficiency by laboratory catchment area.

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 ≥ 90% viral load coverage and viral load suppression across all age and sex bands. To further reduce morbidity and mortality, clinical programs should include an evidence-based advanced HIV disease package of care for children and adolescents.

Community-led Monitoring
In COP 21, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through State Department Ambassador's small grants in close collaboration with independent, local civil society organizations and host country governments. Collaboration with community groups, civil society organizations and patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level.

Pre-Exposure Prophylaxis (PrEP)

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

TB/HIV

TB/HIV services must be integrated, including DSD and MMD models for both TB and TB preventive treatment (TPT). All PLHIV must be routinely screened for TB and have access to molecular diagnostic testing and/or point of care tests such as LF-LAM. TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP21; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

Advanced HIV disease

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

OVC

To support the Minimum Program Requirement described above, in COP 21 clinical sites and OVC implementing partners should jointly develop formal relationships, such as a memoranda of understanding (MOU), outlining the roles and responsibilities of each member of the multi-disciplinary care team and addressing key issues such as bi-directional referral protocols, pediatric case finding, case conferencing, shared confidentiality, joint case identification, and data sharing. In high volume clinics within high burden SNUs, at least 90% of children (<age 19) in PEPFAR-supported treatment sites should be offered enrollment in OVC programs. OVC staff placed in clinics (e.g., as linkage coordinators, case managers, etc.) should have the capacity to assess child and family needs (including food and economic security) and to offer appropriate referrals. PEPFAR-supported treatment clinicians should play a key role in training OVC community case workers to build their knowledge in areas such as adherence, retention, and disclosure.

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.

Cameroon will have access to $500,000 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 Cameroon 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 Cameroon 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.

<u>Innovative solutions and adaptive practices</u>
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

<u>Care and Treatment (C&T)</u>: OU's COP/ROP 2021 <u>minimum requirement</u> 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): OU'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): OU'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: OU'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 the OU 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 Cameroon 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.

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