United States Department of State

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INFORMATION MEMO FOR AMBASSADOR MICHAEL A. HAMMER, DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

FROM: Interim S/GAC Chair, Michael Ruffner, S/GAC Chair, Hilary Wolf, and PPM, Michelle Selim

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

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

Dear Ambassador Hammer,

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, we have seen our PEPFAR country teams and programs prove 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 clients returning to care ensure that we are addressing the critical persistent and new structural barriers. Focus on areas of recent treatment interruption help us 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, country programs should 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 has been crucial, 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 to understand 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 viral load coverage in FY2020
- Scaling up and maintaining treatment program
- Successful transition of 3+ multi-month dispensing of ARVs for adults and children

Together with the Government of the Democratic Republic of the Congo and civil society leadership, we have made tremendous progress together. DRC 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 five 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 DRC:

- Weak early infant diagnosis (EID) testing and coverage
- Low OVC coverage of CLHIV
- Weak pediatric case finding

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. Your OU 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 Operational Plan (COP 2021) notional budget for DRC is **$95,525,000** 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 the Democratic Republic of the Congo and civil society of the Democratic Republic of the Congo, 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: **Interim S/GAC Chair, Michael Ruffner; S/GAC Chair, Hilary Wolf; PPM, Michelle Selim; and PEPFAR Country Coordinator, Shirley Dady**

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 viral load coverage (VLC) from 67% in 2019 to 84% in 2020
2- Exceeded treatment targets for TX_NEW (104% achievement), TX_CURR (105% achievement); scaling up and maintaining treatment program
3- 3+ MMD transition success (roughly 80% coverage) for adults and children
4- High PMTCT_STAT (99%) and PMTCT_ART coverage (99.5%)
5- Successful introduction and scale up of HTS_SELF in the COVID-19 pandemic

Challenges:

1- Weak early infant diagnosis (EID) 2 month coverage (51%) and 12 month coverage (72%)
2- Pediatric cascade needs strengthening – low HTS_TST, low TX_CURR, low VLC across age bands – illustrating need for improved case finding and reducing ITT
3- Low PrEP uptake for KPs based on KP prevention continuum
4- Remaining gaps in VLS - overall VLS at 90% indicating an adherence issue (additionally low VLS in specific SNUs/age/sex especially children and PBFW)
5- High portion of PMTCT final outcome of unknown HIV status (12.6%)

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

1- Improve 2 month EID coverage and EID testing through POC testing
2- Strengthen pediatric cascade through OVC integration with CLHIV and TX_CURR (particularly <1 age band) and PBFW
3- Transition OVC for CLHIV portfolio to clinical or OVC partners in a consistent manner across country program
4- Expand and improve index testing fidelity for children (low contact elicitation <1) and adults
5- Better linkage of HIV-negative KPs on PrEP and expand KP case finding
6- Address adherence challenges to reach 95% VLS
7- Scale to 100% VLC in COP21
8- Scale up 6+ MMD for adults and children
9- Optimize pediatric ARVs through transition to 10mg DTG-based regimens
10- Continue to work with GDRC to reduce customs barriers for commodity importation
11- Prior to COP21, all sites should be assessed for safe and ethical index testing and any gaps should be addressed particularly in adverse event monitoring and reporting
12- Expand self-testing
13- Improve TB screening coverage and TPT completion

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	**$ 92,312,688**	**$ -**	**$ -**	**$ -**	**$ 525,000**	**$ -**	**$ -**	**$ -**	**$ 92,837,688**
GHP-State	$ 91,487,688	$ -	$ -		$ -	$ -	$ -		**$ 91,487,688**
GHP-USAID	$ -				$ 525,000				**$ 525,000**
GAP	$ 825,000				$ -				**$ 825,000**
Total Applied Pipeline	**$ -**	**$ -**	**$ -**	**$ 2,687,312**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 2,687,312**
DOD				$ -				$ -	**$ -**
HHS/CDC				$ -				$ -	**$ -**
HHS/HRSA				$ -				$ -	**$ -**
PC				$ -				$ -	**$ -**
USAID				$ 1,756,626				$ -	**$ 1,756,626**
USAID/WCF				$ -				$ -	**$ -**
State				$ -				$ -	**$ -**
State/AF				$ 930,686				$ -	**$ 930,686**
State/EAP				$ -				$ -	**$ -**
State/EUR				$ -				$ -	**$ -**
State/PRM				$ -				$ -	**$ -**
State/SCA				$ -				$ -	**$ -**
State/SGAC				$ -				$ -	**$ -**
State/WHA				$ -				$ -	**$ -**
TOTAL FUNDING	**$ 92,312,688**	**$ -**	**$ -**	**$ 2,687,312**	**$ 525,000**	**$ -**	**$ -**	**$ -**	**$ 95,525,000**

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

Countries should plan for the full Care and Treatment (C&T) level of $60,000,000 and the full Orphans and Vulnerable Children (OVC) level of $5,700,000 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	$ 60,000,000	$ -	$ -	**$ 60,000,000**
OVC	$ 5,700,000	$ -	$ -	**$ 5,700,000**
GBV	$ 450,000	$ -	$ -	**$ 450,000**
Water	$ 100,000	$ -	$ -	**$ 100,000**

**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	**$ 95,000,000**	**$ 525,000**	**$ 95,525,000**
Core Program	$ 95,000,000	$ -	**$ 95,000,000**
Cervical Cancer	$ -	$ -	**$ -**
Community-Led Monitoring	$ -	$ -	**$ -**
Condoms (GHP-USAID Central Funding)	$ -	$ 525,000	**$ 525,000**
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	$250,799	$-	$-	

SECTION 3: PAST PERFORMANCE – COP/ROP 2019 Review

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

Indicator	FY20 result (COP19)	FY21 target (COP20)
TX Current <15	11,662	21,654
TX Current >15	155,423	180,482
VMMC >15	N/A	N/A
DREAMS (AGYW PREV)	N/A	N/A
Cervical Cancer Screening	N/A	N/A
TB Preventive Therapy	32,141	163,160

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

Agency	Sum of Approved COP/ROP 2019 Planning Level	Sum of Total FY 2020 Outlays	Sum of Over/Under Outlays
DOD	3,484,712	2,075,348	1,409,364
HHS/CDC	23,653,992	22,120,920	1,533,072
State	1,245,624	254,825	990,799
USAID	49,619,123	45,240,979	4,378,144
Grand Total	**78,003,451**	**69,692,072**	**8,311,379**

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

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

Mechanism ID	Partner Name	Funding Agency	Total Planning Level	Total Outlays	Outlay Delta Check
70065	Global Health Systems Solutions	HHS/CDC	$500,000	$670,340	($170,340)

Table 8. COP 2019 | FY 2020 Results & Expenditures

Agency	Indicator	FY20 Target	FY20 Result	% Achievement	Program Classification	FY20 Expenditure	% Service Delivery
HHS/ CDC	HTS_TST	460,143	**456,707**	99.3%	HTS Program Area	$1,019,550	89%
	HTS_TST_POS	24,959	**22,822**	91.4%			
	TX_NEW	23,884	**22,527**	94.3%	C&T Program Area	$6,741,235	70%
	TX_CURR	75,435	**78,500**	104.1%			
	OVC_SERV	21,855	**22,435**	103%	OVC Major Beneficiary	$2,094,747	85%
DOD	HTS_TST	50,057	**44,444**	88.8%	HTS Program Area	$52,665	100%
	HTS_TST_POS	2,952	**3,457**	117.1%			
	TX_NEW	2,959	**3,416**	115.4%	C&T Program Area	$1,414,274	90%
	TX_CURR	9,224	**9,620**	104.3%			
	OVC_SERV	2,467	**3,075**	124.6%	OVC Major Beneficiary	$304,799	71%
USAID	HTS_TST	440,473	**414,575**	94.1%	HTS Program Area	$3,116,574	72%
	HTS_TST_POS	24,913	**27,852**	111.8%			
	TX_NEW	23,610	**26,504**	112.3%	C&T Program Area	$32,117,579	90%
	TX_CURR	74,435	**78,965**	106.1%			
	OVC_SERV	20,196	**21,795**	107.9%	OVC Major Beneficiary	$1,806,309	91%
					Above Site Programs	$2,334,221	
					Program Management	$11,397,952	

COP 2019 | FY 2020 Analysis of Performance

Overall:
PEPFAR DRC has performed well during COP 2019 implementation even in the context of the COVID-19 pandemic. Impressive progress were accomplished across the cascade, surpassing targets in many areas. In COP 2019, the priorities including (1) improving VLC and EID coverage, (2) better case finding for hard-to-reach populations, (3) addressing retention issues, (4) strengthening the pediatric cascade, and (5) working with the GDRC to addressing the commodities customs clearance. We saw significant improvement in many of these objectives, particularly improved VLC (84%), higher HTS_TST achievement (96.3%), and reduced processing time for customs clearance. In addition, PEPFAR DRC made strides to introduce HIV self-testing and scale 3+ MMD as part of their COVID-19 mitigation strategy to protect the gains made in HIV response.

Moving into COP21, the focus will be to strengthen a few relative weaknesses in the program, including EID, the pediatric cascade, OVC program, PrEP scale-up, and the fidelity and scale of index testing.

Case Finding
- HTS_TST_POS was high, exceeding targets (102.5% achievement overall) with 54,131 PLHIV identified. Some partners had lower achievement of testing targets noted below.
- Index testing is the largest contributor to testing yield at 23.1% however this should be closer to 35%. Fidelity and scale of index testing needs to be addressed further.
- Pediatric case finding needs improvement especially given the low EID coverage. There were 4,119 new CLHIV identified, however this was only 80% achievement against the target.

Care and Treatment
- Linkage remains strong in DRC (97% overall) with few geographic variations
- Exceeded treatment targets for TX_NEW (104%), TX_CURR (105%), TX_NET_NEW (119%) however there was low target achievement for pediatric treatment: TX_NEW (67%), TX_CURR (88%)
- PEPFAR DRC made significant progress toward continuity of treatment (100% retention proxy). Kinshasa and Haut Katanga have seen declines in the number of patients experiencing an interruption in treatment (ITT). Lualaba experienced an increase in lost patients in FY20Q4.
- PEPFAR DRC improved their VLC from 67% in 2019 to 84% in 2020. Additional work is needed to reach 100% VLC in COP21 especially among children and young men.
- VLS increased to 90% overall, however there are gaps among pregnant and breastfeeding women (80%) and pediatric VLS (85%) which require additional support to improve adherence and granular site level management.
- TPT coverage needs to increase (currently 89% in FY2020) and the TB screening coverage of ART patients is low at 84%

OVC
- PEPFAR DRC exceeded their OVC_SERV targets with 47,305 OVC were served in FY2020 (106% achievement)
- PEPFAR DRC needs to continue refining the OVC program to ensure integration with clinical program including higher coverage of CLHIV <15. Overall proxy coverage at 42% with lower coverage in Haut Katanga and Lualaba.

- OVC should achieve targets particularly addressing underachievement in the youngest age groups, expand and intensify case management in collaboration with PEPFAR supported clinical sites

Key Populations

- PrEP needs to be expanded significantly among HIV-negative KPs
- VLS of FSW needs to improved (currently at 90% in FY2020)

PMTCT

- EID is disappointingly low with only 51%of HIV-exposed infants (HEI) tested at 2 months of age, and 72% at 12 months. POC testing needs to be expanded and PEPFAR DRC needs to make a concerted effort to improve EID especially in Kinshasa and Haut Katanga.
- HEI 12-month linkage is at 94% (lower coverage in Kinshasa) and should be closer to 100%
- Progress is also needed to bring the percent of HEI with a known status at 18 months down to 0% (currently at 16.6% or 409 infants without a known HIV status in FY2020).

Partner and Financial Performance

- Overall, all current partners in DRC are performing well and have met most of their targets except in the programmatic areas of index testing and viral load suppression.
- Of note, HPP, a new CDC-funded partner, struggled in FY20. However, this partner was extensively involved as a COVID-19 treatment center which likely accounted for the low achievement across several programmatic areas. Close observation will be requested for HPP to ensure performance improvement in the next year.
- Several partners had low achievement across testing goals.
    - FHI (a USAID partner) had only 51% achievement for HTS_TST and 76% achievement for HTS_TST_POS, while still expending 84% of their HTS program budget. Additionally their index testing program is severely lacking with only 30% achievement. This may warrant additional follow-up and close observation.
    - PATH (a USAID partner) also came up short for their HTS_TST achievement at 85% while over expending on their HTS budget.
    - HPP (a CDC local partner) had 47% achievement for HTS_INDEX, 83% HTS_TST achievement and 63% HTS_TST_POS while over expending on their HTS budget.
    - EGPAF (a USAID partner) accounts for a large portion of index testing in DRC and has low yield. This warrants closer observation and potential intervention to ensure index testing is carried as prescribed with fidelity.
    - ICAP (a CDC partner) did not achieve their index testing goals at 72%.
    - Khethimpilo (a USAID local partner) had low index testing results with 68% achievement.
- Viral load coverage and suppression (TX_PVLS D) was also an area of concern for several partners:
    - ICAP (a CDC partner) had 86% achievement and 82% VLC
    - Khethimpilo (a USAID local partner) - 63% achievement and 73% VLC
    - HPP (a CDC local partner) had 69% achievement and 82% VLC
    - EGPAF (a DoD partner) had 62% achievement and 72% VLC
- Most partner expenditure was consistent with respective budgets with a few exceptions due to COVID-19 impacts.

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 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.	• Policy has been adopted in 100% of PEPFAR sites and districts • Linkage proxy in FY2020: - 97% overall, 97% in Haut-Katanga, 97% in Kinshasa and 93% in Lualaba • Linkage proxy FY20: 96% in children, 98% in adult females; 96% in adult males
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.	• DRC achieved 96% of adults on TLD in FY2020 • Nevirapine removed • 100% of children on DTC-based regimen (>20kg) and TLD (>30kg)

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.	• DRC has implemented MMD and delivery models in 100% of PEPFAR sites and districts • DSD/ARV including PODI, CAG, Adherence clubs for men • DSD for disclosure and ARV in adolescents' groups (Ariel groups) • MMD available for children
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.	• This policy has been adopted for 100% of PEPFAR sites and Health Zones • Planned to cover 100% of needs in COP19 • 3HP adopted and forecasted for COP20 • TPT completion 89.2% in FY2020
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.	• Improvement is needed for the EID and VL coverage testing. • 51% of EID coverage at 2 months (proxy) • VL Coverage: 84%
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.	• Policy adoption in 100% of PEPFAR sites and Health Zones • Contact children are under 15 years, biological children • Screening by use of IPV screening tool • Continuing to scale up with fidelity and scale • Yield in adults:36.9% index, 27.3% index mod (FY2020) • Contribution to overall positives needs to increase: 23.12% (FY2020) • Self-testing will continue to expand in COP21

Prevention and OVC	
1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices*)*	• PrEP needs to be scaled up moving forward. Currently PrEP_CURR= 1,597 (71% target achievement) • Expansion to negative sexual partners in discordant couples
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 0-17 : 34,421 children received OVC services (73% of OVC beneficiaries are <18 year old children) • Primary prevention services provided to 9-14 years through validated models • There is need to innovate within the OVC program and ensure coordination between OVC and clinical partners • In COP21, OVC and clinical partners in the DRC must work together to ensure that 90% or more of children and adolescents on ART with PEPFAR support in OVC SNUs are offered the opportunity to enroll in the comprehensive OVC program.
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.	• Commitment at a political high level for universal coverage of healthcare strategy • 1st phase is adoption of national act for free services in ANC and MCH services
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.	• Systematically monitored during SIMS and Granular Management sites visits

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.	• Health care providers and health community workers/peer educators provide general counseling • DRC does not yet have a structured U=U messaging package endorsed by the Ministry of Health
4. Clear evidence of agency progress toward local, indigenous partner direct funding.	• 9.2% of OU budget= local partners
5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	• User fees eliminated for ANC services and infant care • Government committed to match $6,000,000 to GF as counterpart funding
6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	• 100% PEPFAR sites report on morbidity and mortality outcomes through DHIS • TX_ML quarterly reporting started in FY20 • Disaggregates available on reason of missing appointments • Further disaggregates for causes of death
7. Scale-up of case surveillance and unique identifiers for patients across all sites.	• Strategic vision discussed • Consultancy to provide a roadmap for Unique Identifier Code (UIC) in development • Consensus to start with PLHIV UIC to be embedded in the wider Health system UIC code and eventually in the national upcoming digital UIC

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

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

OU –Specific Directives
HIV Treatment
1. Improve 2 month EID coverage and EID testing through POC testing if necessary
2. Strengthen pediatric cascade through OVC integration with CLHIV and TX_CURR (particularly <1 age band) and PBFW
3. Scale to 100% VLC in COP21 and address adherence challenges to reach 95% VLS
4. Scale up 6+ MMD for adults and children
5. Optimize pediatric ARVs through introduction of 10mg pDTG-based regimens before end of COP20 and fully scale by the end of COP21
6. Improve TB screening coverage and TPT completion
7. Expand and improve index testing fidelity and case finding for children, adults, and KPs, ensure that all sites are compliant with safe and ethical program standards
8. Expand self-testing
9. Improve TB screening coverage and TPT completion
HIV Prevention
1. Better linkage of HIV-negative KPs on PrEP
Other Government Policy or Programming Changes Needed
1. Prior to COP21, all sites should be assessed for safe and ethical index testing and any gaps should be addressed particularly in adverse event monitoring and reporting
2. Continue to work with the GDRC to reduce customs barriers for commodity importation

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.

DRC will have access to $525,000 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 the DRC 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 DRC should 1) consistently and continuously use and analyze data at the individual patient level with aim of program improvement (e.g. use patient level data to understand retention differences across patient cohorts and create more tailored risk models and intervention). 2) Utilize available data interoperability solutions to harmonize and triangulate data across EMRs, commodities, pharmacy dispensation, laboratory data, HRH and other data.

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

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

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

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

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

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

This engagement, of both civil society, and of faith-based organizations/faith communities, specifically includes the sharing of FY 2020 Q4 and FY 2020 APR results and analyses and the convening of an in-

country planning retreat with local stakeholders during the last two weeks of January 2021 in order to introduce and discuss all COP/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 (C&T): OU'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): 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 2021 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

All agencies in the DRC 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.