



UNCLASSIFIED

January 13, 2021

INFORMATION MEMO FOR AMBASSADOR MALONEY, ESWATINI

FROM: S/GAC Chair, Julia Martin and PEPFAR Program Manager, Stephanie Weber

THROUGH: Ambassador Deborah L. Birx, MD

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

Dear Ambassador Maloney,

I sincerely hope that this note finds you and your team well, safe, and healthy. As you arrive in country, 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. 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 sub-national areas for viral load coverage and suppression. We saw differential progress in this area independent of the impact of COVID-19. Focus on and deep analytics of clients 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 is essential. 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 county 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. Careful analysis of expenditures at mechanism and program areas level, along with a focus on continuing to build relationships and co-planning with your partner government, the Global Fund, UN organizations and other donors will enable optimal use of resources. 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; these unused 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 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 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:

- Achieving national level 95-95-95 HIV coverage with a well implemented back to care strategy that has closed gaps in outstanding treatment and viral load suppression in certain key age bands.
- Scaling recency testing during a prolonged COVID lockdown period by innovating in virtual training and testing site preparedness and initiation. The commitment to utilize recency as part of strategy to sustain epidemic control is clear.
- Preventative TB therapy (TPT) has expanded with a doubling in uptake over the past two years and trends in TPT completion rates increasing to 92%.

Together with the Government of the Kingdom of Eswatini and civil society leadership we have made tremendous progress together. Eswatini 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- to 35-year-old asymptomatic clients are maintained on treatment and virally suppressed [net new on treatment and treatment current growth, (retention surrogate)]
5. Ensuring all children are diagnosed, on the best treatment regimens, and virally suppressed

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

- The approach to HIV case finding has not yet yielded consistent results. While acknowledging that COVID negatively impacted the program's ability to conduct some forms of index testing and results for newly found positives were markedly under the targets set, it is not clear that the team has identified optimal approaches for testing for young women and men outside of OPD settings.
- Recency testing results show that significant new infections remain among adolescent girls and young women, and with the negative impact of COVID on the DREAMS program, alternative approaches must be deployed to reach this highly vulnerable population.
- Commodity insecurity due to the country's economic crisis has made the transition to TLD and MMD beyond three months difficult with 'start and stop' implementation. These strategies need to be completed in the current fiscal year as they are core to client retention.

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

Consistent with the approach from last year, PEPFAR teams will 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 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. Eswatini has achieved the 2020 goals at a national level 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 Eswatini is **\$71,500,000** 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 Kingdom of Eswatini and civil society of Eswatini, 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 partners 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 COP 21 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 of the Kingdom of Eswatini to enhance PEPFAR's program impact.

Sincerely,

Deborah Birx

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

CC: **S/GAC – Julia Martin, Stephanie Weber, Cheryl Amoroso**

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. Achieving a national level 95-95-95 HIV coverage with a well implemented back to care strategy that has closed gaps in outstanding treatment and viral load suppression in certain key age bands. High proxy retention and patient gains for most age/sex bands have been realized with a 49% reduction in AIDS-related deaths since 2010.
2. Scaling recency testing during a prolonged COVID lockdown period by innovating in virtual training and testing site preparedness and initiation.
3. Preventative TB therapy (TPT) has expanded with a doubling in uptake over the past two years and trends in TPT completion rates increasing to 92%.
4. COVID-19 mitigation measures including community ART distribution offered to and preferred by many patients has been a successful strategy in retaining clients on treatment.
5. PEPFAR/Eswatini has sustained 100% ART coverage among pregnant women and has sustained high rates of EID coverage and low rates infant positivity (< 2% at 12m).

Challenges:

1. The approach to HIV case finding has not yet yielded consistent results. While acknowledging that COVID negatively impacted the program's ability to conduct some forms of index testing and the results for newly found positives were markedly under the targets set, it is not clear that the team has identified optimal approaches for testing for young women and men outside of the OPD setting.
2. Recency testing results have shown that significant new infections remain among adolescent girls and young women, and with the negative impact of COVID on the DREAMS program, alternative approaches must be deployed to reach this highly vulnerable population.
3. Commodity insecurity due to the country's economic crisis has made the transition to TLD and MMD beyond three months difficult with 'start and stop' implementation. These strategies need to be completed in the current fiscal year as they are core to client retention. Additionally, while the economic landscape in Eswatini is bleak and serious, the GKOE must be held to maintaining some form of significant financial commitment to HIV and ensuring that the Global Fund dollars are used to support essential program delivery, including prevention.
4. While Eswatini has high rates of viral load coverage, the results among certain pediatric age bands are less than 50%. A clear understanding of the issues related to low coverage must be identified and solutions implemented. Consider the challenges with reporting particularly when reporting between facilities should be considered and granular patient level data analysis completed through the client management information and lab systems.

5. Prevention services have been seriously affected by COVID lockdowns. PrEP, DREAMS, VMMC and indigenous community program interventions have struggled to implement core services. Adaptations should be considered to regain some of the losses in these program areas.

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

1. Focus on prevention. Given the number of recent infections among AGYW and young men, it is essential that young women at high risk be identified – what are their risk behaviors – and link them to DREAMS program services and address the risk behaviors in a comprehensive way. Restarting VMMC at scale is essential both in preventing infections among young men as well as AGYW.
2. Ensure adequate resources for client-level data reporting systems and utilize the systems to inform programming to improve VL monitoring (coverage by specimen collection method) among children and adolescents.
3. Increase viral load coverage to > 90% across pediatric and adolescent fine age and sex bands. Conduct a deep analysis of CLHIV, line listing cases by facility for a better understanding of those that are not accessing viral load testing and the barriers to access. It is expected that Eswatini show a marked increase of DBS specimen collection among CLHIV in COP21. Continue to utilize the OVC program to provide CLHIV with additional support. Link HIV positive pregnant women and all positive EID cases with the OVC program.
4. Evolve the testing strategy to focus on young men and young women. Identify testing points and strategies outside of OPD potentially using sexually transmitted infection clinics as an anchor.

SECTION 1: COP 2021 PLANNING LEVEL

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

Table 1: All COP 2021 Funding by Appropriation Year

	Bilateral		Central	Total
	FY21	Unspecified	FY21	TOTAL
Total New Funding	\$ 63,681,573	\$ -	\$ 500,000	\$ 64,181,573
GHP-State	\$ 63,194,073		\$ -	\$ 63,194,073
GHP-USAID	\$ -		\$ 500,000	\$ 500,000
GAP	\$ 487,500		\$ -	\$ 487,500
Total Applied Pipeline	\$ -	\$ 7,318,427	\$ -	\$ 7,318,427
DOD		\$ 648,802		\$ 648,802
HHS/CDC		\$ 2,778,120		\$ 2,778,120
PC		\$ 2,046,223		\$ 2,046,223
USAID		\$ 637,500		\$ 637,500
State/AF		\$ 1,207,782		\$ 1,207,782
TOTAL FUNDING	\$ 63,681,573	\$ 7,318,427	\$ 500,000	\$ 71,500,000

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

Eswatini should plan for the full Care and Treatment (C&T) level of \$35,000,000 and the full Orphans and Vulnerable Children (OVC) level of \$16,700,000 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 21 Earmarks by Appropriation Year*

	Appropriation Year			
	FY21	FY20	FY19	TOTAL
C&T	\$ 35,000,000	\$ -	\$ -	\$ 35,000,000
OVC	\$ 16,700,000	\$ -	\$ -	\$ 16,700,000
GBV	\$ 1,100,000	\$ -	\$ -	\$ 1,100,000
Water	\$ 150,000	\$ -	\$ -	\$ 150,000

**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 21 Initiative Controls

	Bilateral	Central	TOTAL
Total Funding	\$ 71,000,000	\$ 500,000	\$ 71,500,000
Core Program	\$ 53,280,416	\$ -	\$ 53,280,416
Cervical Cancer	\$ 1,500,000	\$ -	\$ 1,500,000
Community-Led Monitoring	\$ -	\$ -	\$ -
Condoms (GHP-USAID Central Funding)	\$ -	\$ 500,000	\$ 500,000
DREAMS	\$ 14,219,584	\$ -	\$ 14,219,584
HBCU Tx	\$ -	\$ -	\$ -
One-time Conditional Funding	\$ -	\$ -	\$ -
Surveillance and Public Health Response	\$ -	\$ -	\$ -
VMMC	\$ 2,000,000	\$ -	\$ 2,000,000

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

Table 4: State ICASS Funding

	Appropriation Year			
	FY21	FY20	FY19	Unspecified
ICASS	\$ 187,296	\$ -	\$ -	

SECTION 3: PAST PERFORMANCE – COP 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	9,039	9,813 (national)
TX Current >15	197,267	192,309 (national)
VMMC >15	5,084	7,351
DREAMS (AGYW PREV)	30,012	N/A
Cervical Cancer Screening	31,422	43,024
TB Preventive Therapy	43,733	51,183

Table 6. COP 2019 | FY 2020 Agency-level Outlays versus Approved Budget (This table includes only bilateral funding, not central funding)

Agency	Sum of Approved COP 2019 Planning Level	Sum of Total FY 2020 Outlays	Sum of Over/Under Outlays
DOD	\$2,368,076	\$1,581,871	\$786,205
HHS/CDC	\$31,717,803	\$27,644,263	\$4,073,540
PC	\$1,240,900	\$789,277	\$451,623
State	\$1,162,307	\$448,748	\$713,559
USAID	\$43,140,142	\$41,073,589	\$2,066,553
Grand Total	\$79,629,228	\$71,537,748	\$8,091,480

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 COP19 approved level.

Mechanism ID	Partner Name	Funding Agency	Total Planning Level	Total Outlays	Outlay Delta Check
17465	JSI Research And Training Institute, INC.	USAID	\$250,000	\$1,931,012	(\$1,681,012)
18601	Johns Hopkins University, The	USAID	\$2,780,388	\$3,610,914	(\$830,526)
18250	World Health Organization	USAID	\$95,800	\$212,083	(\$116,283)
104137		DOD	\$209,374	\$234,851	(\$25,477)

Table 8. COP 2019 | FY 2020 Results & Expenditures

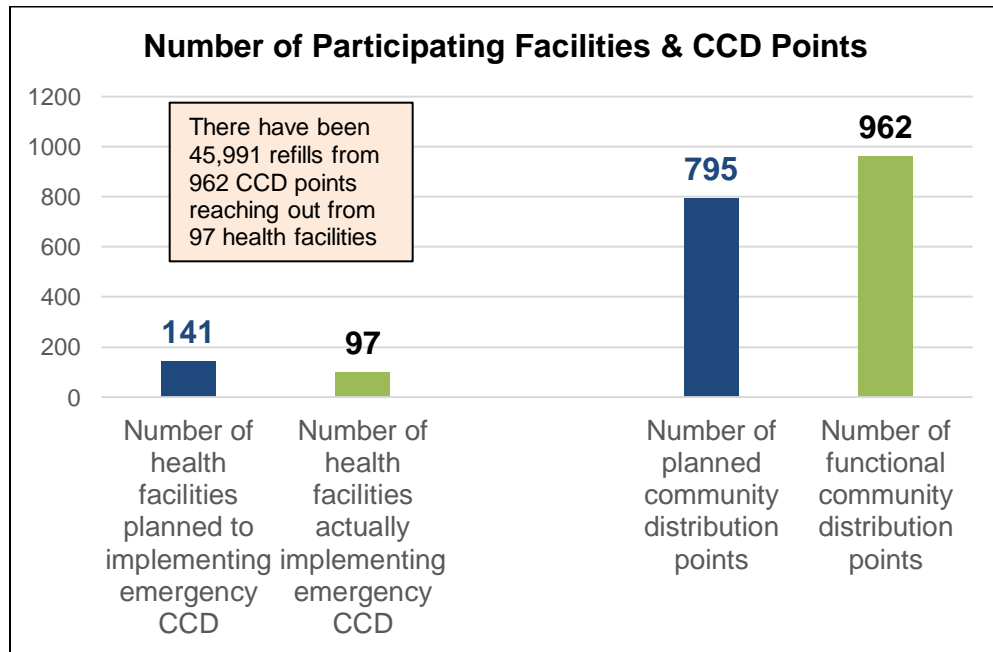
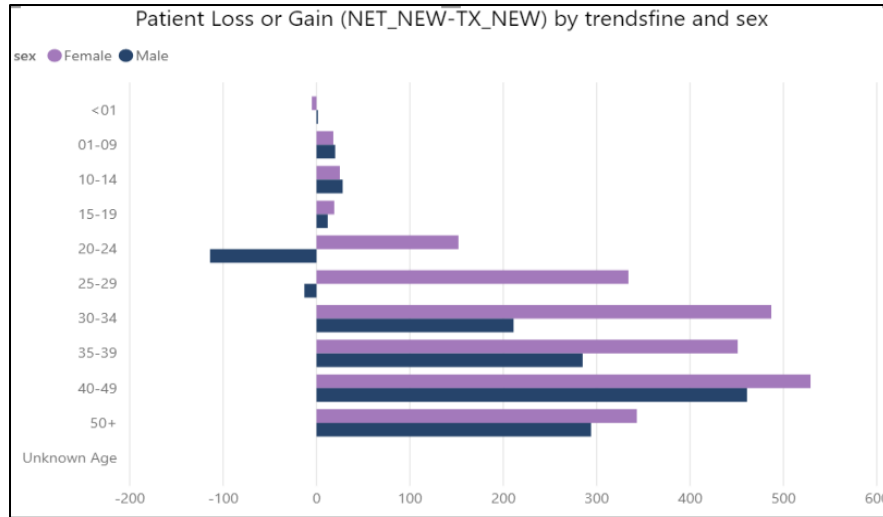
Agency	Indicator	FY20 Target	FY20 Result	% Achievement	Program Classification	FY20 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	143,736	156,904	109%	HTS	\$5,156,723	72%
	HTS_TST_POS	18,301	10,156	55%	HTS		
	TX_NEW	13,739	8,521	62%	C&T	\$8,532,574	31%
	TX_CURR	115,864	124,707	108%	C&T		
	VMMC_CURR	19,517	4,626	24%	VMMC		
DOD	HTS_TST	3,980	3,100	78%	HTS	\$173,560	52%
	HTS_TST_POS	620	407	66%	HTS		
	TX_NEW	534	343	64%	C&T	\$1,133,595	51%
	TX_CURR	3,092	3,011	97%	C&T		
	VMMC_CURR	400	581	145%	VMMC	\$50,754	100%
USAID	HTS_TST	99,437	135,494	136%	HTS	\$1,495,672	100%
	HTS_TST_POS	9,545	7,039	74%	HTS		
	TX_NEW	10,508	6,986	66%	C&T	\$12,951,430	74%
	TX_CURR	80,869	80,951	100%	C&T		
	VMMC_CURR	10,072	3,990	40%	VMMC	\$1,758,463	100%
	OVC_SERV	66,037	93,725	142%	OVC Beneficiary	\$5,016,771	99%
PC	OVC_SERV		558		OVC Beneficiary	\$8,781	87%
					Above Site Programs	\$5,088,837	
					Program Management	\$13,848,909	

COP 19 | FY 20 Analysis of Performance

Treatment Coverage and Continuity

Successes

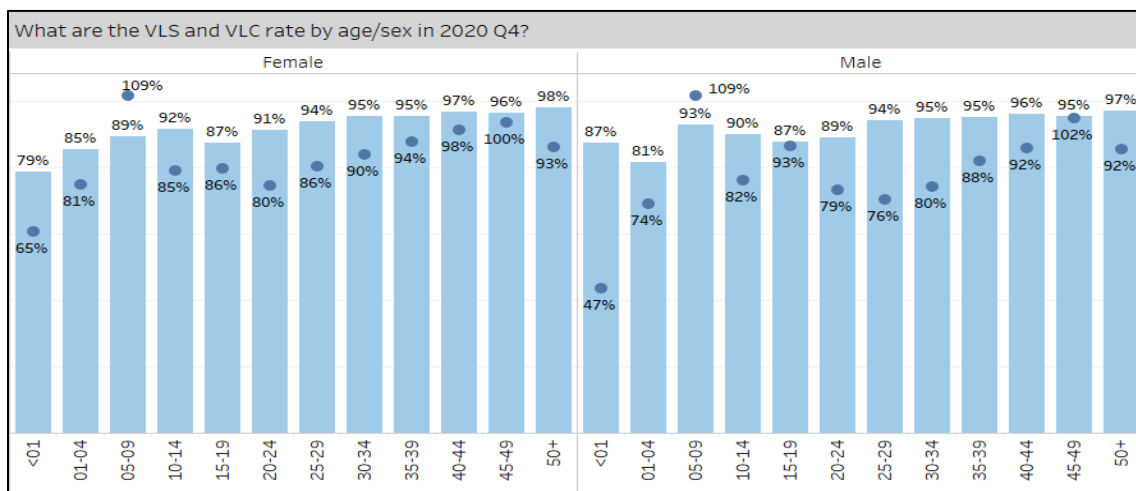
PEPFAR Eswatini has developed and implemented a comprehensive approach to understanding client movement and transfers within the country and a back to care approach that has yielded results shown through the attainment of the FY20 TX_CURR target. Nationally, the country has achieved the 95-95-95 targets. In addition, the implementation of specific COVID-19 mitigation measures including community commodity distribution, offered to and preferred by many patients, supported high proxy retention and patient gains for most age/sex bands.



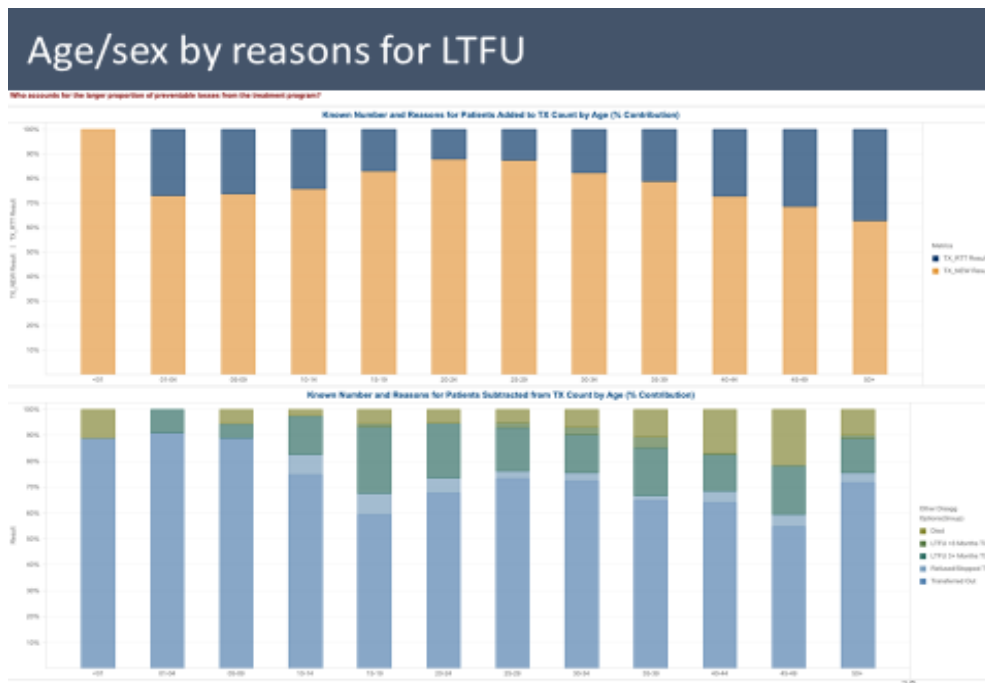
Challenges and Recommendations:

While treatment coverage is high, gaps remain in certain age bands which must be closed to sustain epidemic control. TX_NEW targets were not achieved (59%) by any partner in any region owing largely to COVID restrictions on movement of people. The most significant drop of 42% between Q2 and Q3 and then another 16% from Q3 to Q4. While viral load suppression is high, but there are persistent gaps in coverage – particularly among clients <15 years and males 20-34 years and by region with Shiselweni and the Military sites seeing the lowest coverage rates. Problems with incomplete TLD transition, pauses on 6-month MMD, insufficient reagents in some locations, and lack of petrol and lab technicians to run samples have all contributed to lower than expected coverage. With the issues known, longer term strategies to optimize operating high through-put platforms and consistent reagent supply will be essential along with completing the TLD transition, and using the completed LIS/CMIS interoperability to track clients not accessing viral load testing.

VL Suppression (2020 Q4)	VL Coverage (2020 Q4)
95%	91%



While back to care approaches have been successful, a focus on ensuring that persons are retained in treatment and do not drop out of treatment must be central to the strategy to sustain epidemic control. Enhanced data reporting to understand patient-level gains and losses and cause of death will be important in this effort. Overall, the majority of ‘loss’ is due to inter-facility and regional transfers, difficulties in retaining adolescent and young adult clients in the under 3-month period is notable with the same problem for >35-year-old clients in over 3 month retention. Continued implementation and adaptation of community commodity distribution in a client-centered approach attuned to changing national circumstances including COVID will be important. [Note: In graphic below, top graph shows proportion of return to care (blue) by age band; bottom graph breaks down the reasons for loss to follow-up with transfers dominating followed by under and over 3-month loss.]



Advanced HIV Disease

Successes

Eswatini has seen a 49% reduction in AIDS-related deaths since 2010. This achievement is owed to high treatment coverage as well as a focus on quality including:

- Improving the capacity of health care workers (HCW) in provision of quality Advanced HIV Disease (AHD) management;
- Systematic HCW trainings and follow-up with standard operating procedures in advance disease management with supportive supervision/mentorship;
- Improved screening for AHD and CD4 testing in 15 project sites; and
- Uptake of Xpert Ultra (32 labs, 84% of Xpert tests from Oct 2019-Sept 2020) and TB Lam (16 high volume facilities); and
- A successful CrAG screening roll out and reporting at 16 sites and procurement of fluconazole for cryptococcal meningitis.

Challenges and Recommendation:

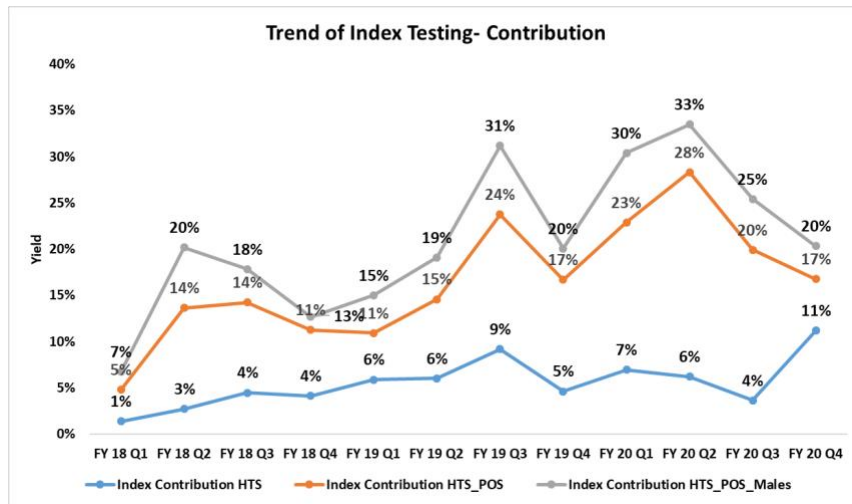
Analysis of patient level data shows increased mortality in persons over 40 years. Understanding how to reduce late HIV presentation for testing and treatment (predominately males) will be important as well as systematic tracking and documentation of AHD in clients failing ART or returning to care after treatment interruption. Understanding the reasons for late presentation for treatment and the profile of clients must be used to inform testing approaches. COP21 should continue to work on improvement of patient referral systems for lumbar punctures) and decentralization of CrAG screening and treatment beyond current project sites.

HIV Case Finding

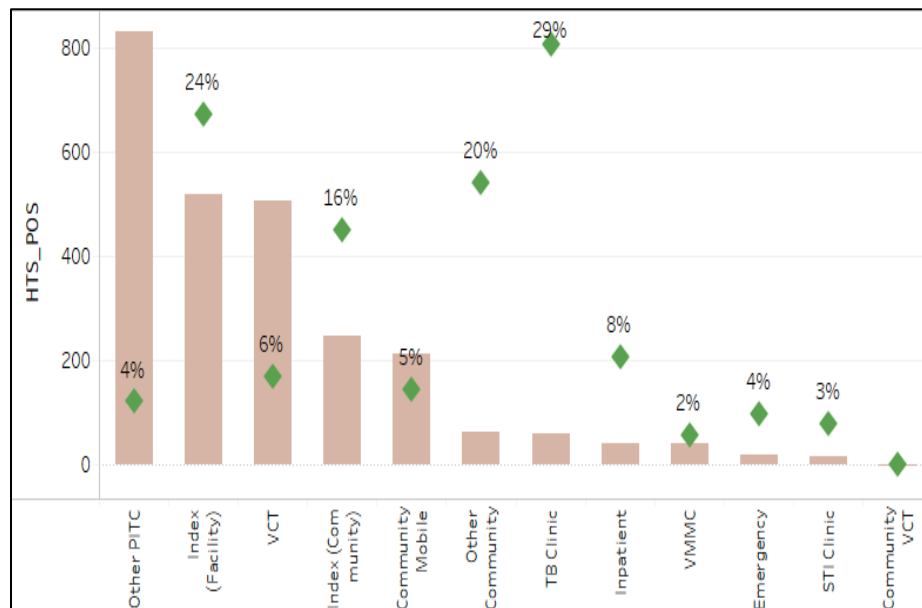
Successes

Index testing continued in FY20 with initial positive gains in Q1/Q2 on both the contribution of index testing in tests performed and positives found; however, these gains were reversed with the COVID

restrictions with the exception that progress was made in reaching males, particularly in facilities, through index testing with an overall FY20 yield of 24%.

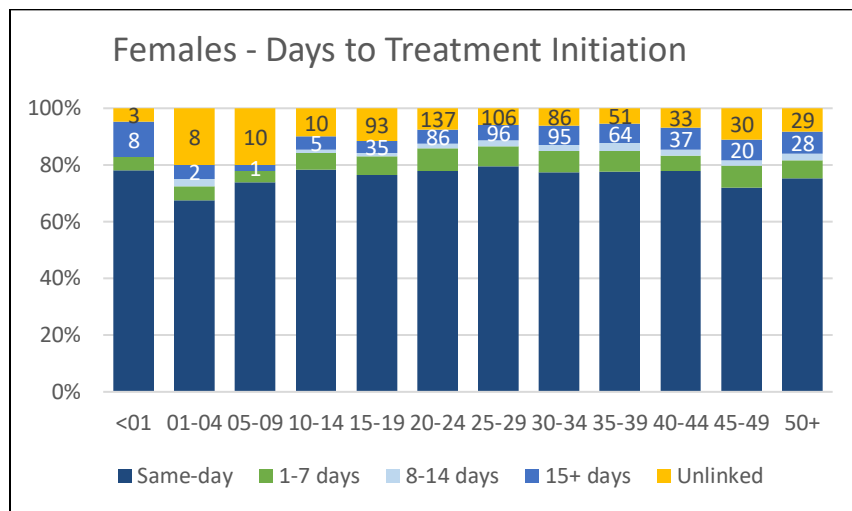
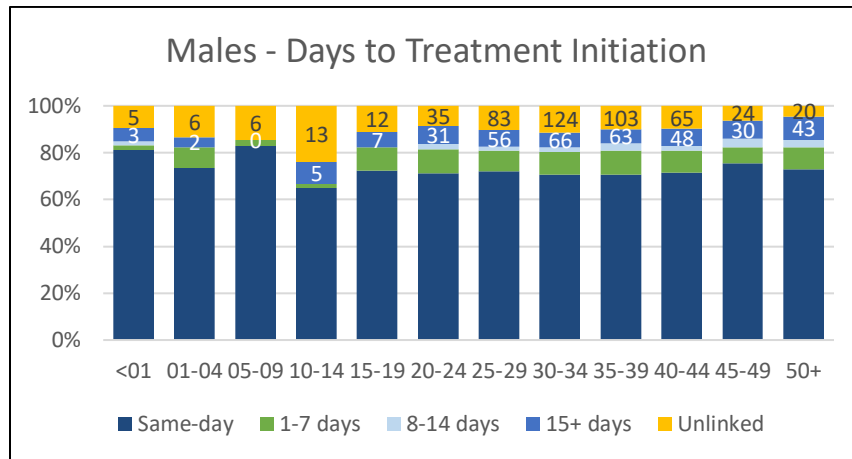


FY20 Q1-Q4: Case Finding by Modality (Males 20-34)



The Linkage Case Management (LCM) approach has been scaled up nationally and has shown consistent results with only a slight dip due to COVID challenges. LCM model is now being implemented country-wide with the MOH leading the effort. Expert clients are working as linkage coordinators and providing support for six months. Treatment enrolment data suggests positive results of the LCM intervention.

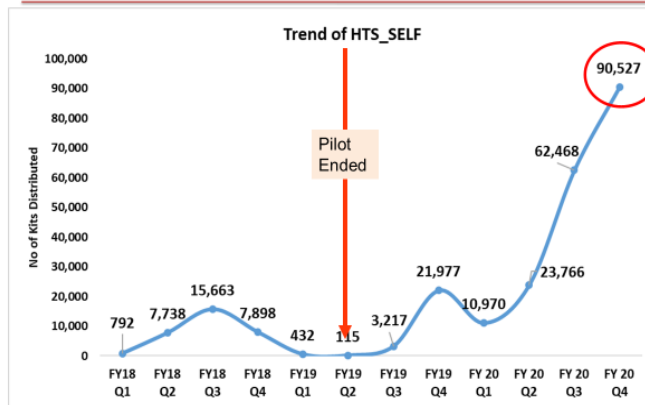
However, strategies should be adapted to address the issue that males 30-39 and females 20-29 represent the largest volume of those who take longer to link (15+ days) and have potential failure to link.



HIVST has been scaled dramatically, being used as a COVID-19 adaptation strategy to case finding. Self-testing has been deployed through the Faith and Community Initiative and routine case finding with >80% through the directly assisted approach and 85% of kits distributed in 15-39 year old males and females. However, it should be noted that under FCI, the HIV positive yield for persons not on ART is well under 1% with the exception of one region indicating that kit distribution is not effectively identifying those persons most at risk for HIV infection. Engagement of the private sector in HIVST distribution, including assisting the MOH with developing an MOU with retailers should be explored.



HTS_SELF Trend



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Challenges and Recommendations

While COVID restrictions reduced non-facility-based testing and follow-up with index cases, the majority of partners continued to implement testing largely in facilities but with limited impact with partners not achieving targets for positives identified. It is essential that approaches be implemented that do not rely on OPD testing under the current approach given the level of inefficiency in identifying HIV positive persons. Yields have been below 3.6% for the past three quarters of FY20. The program must identify means of optimizing PITC and identify strategies to increase the testing efficiency for this modality. Strategies should include: systematically reviewing site level data; conducting validation exercises for the risk screening tool; mentoring/supervision on the consistent use of the adult risk screening tool; using the risk screening tool with females ages 15-39 (instead of universal testing); and resolving the issue of national practice to report HIV testing by entry point only, even when the reason for testing would indicate a different reason for testing (e.g., TB, STI).

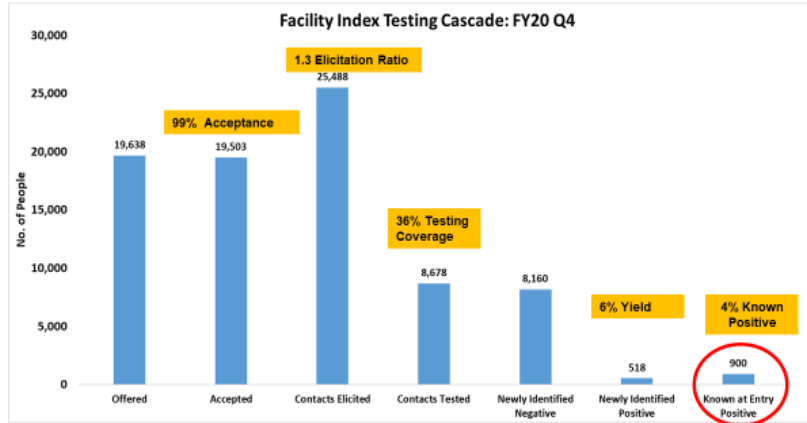
Partner	HTS							Positives							Yield					
	FY 20 Q1 Results	FY 20 Q2 Results	FY 20 Q3 Results	FY 20 Q4 Results	FY 20 Results	FY 20 Target	% of Target	FY 20 Q1 Results	FY 20 Q2 Results	FY 20 Q3 Results	FY 20 Q4 Results	FY 20 Results	FY 20 Target	% of Target	FY 20 Q1 Results	FY 20 Q2 Results	FY 20 Q3 Results	FY 20 Q4 Results	FY 20 Average	FY 20 Target
Dedup	-668	-527	-180	-163	-1,538	-1,618	95%	-18	-5	-23	-36	-82	-490	17%	3%	1%	13%	22%	5%	30%
PSI	3,142	6,352	838	1,750	12,082	34,966	35%	676	825	177	257	1,935	7,010	28%	22%	13%	21%	15%	16%	20%
EGPAF	23,503	30,927	22,639	33,859	110,928	76,963	144%	1,425	1,628	975	1,240	5,268	7,750	68%	6%	5%	4%	4%	5%	10%
FHI 360	628	1,010	479	2,434	4,551	5,695	80%	79	113	74	121	387	869	45%	13%	11%	15%	5%	9%	15%
ICAP-Manzini	19,641	20,471	13,624	14,469	68,205	55,669	123%	829	869	682	697	3,077	6,466	48%	4%	4%	5%	5%	5%	12%
TLC	2,711	3,840	1,780	3,645	11,976	8,695	138%	362	362	150	359	1,233	667	185%	13%	9%	8%	10%	10%	8%
JPEIGO	0	78	168	246	7,181	3%	0	0	2	2	189	1%	N/A	0%	N/A	1%	1%	1%	3%	
Triple R	2,392	2,722	75	2,864	8,053	8,084	100%	40	79	3	21	143	259	55%	2%	3%	4%	1%	2%	3%
URC_DoD	801	823	695	809	3,128	3,980	79%	130	133	69	85	417	620	67%	16%	16%	10%	11%	13%	16%
URC - Lubombo	13,464	13,632	9,506	10,008	46,610	31,153	150%	619	621	540	416	2,196	2,759	80%	5%	5%	6%	4%	5%	9%
Total	65,614	79,328	49,456	69,843	264,241	230,768	115%	4,142	4,625	2,647	3,162	14,576	26,099	56%	6%	6%	5%	5%	6%	11%

Index testing elicitation and testing coverage are poor in facilities. There should be a strong focus on making sure counselors are adhering to the index testing procedures including eliciting all sexual partners and eligible biologic children-- supportive supervision/mentoring can aid in ensuring adherence. Issues around testing coverage should be explored and expert clients/linkage coordinators should assist with

addressing this issue. In FY20 Q4 only 46% of those eligible were offered index testing. On the positive, acceptance rates of those offered were high.

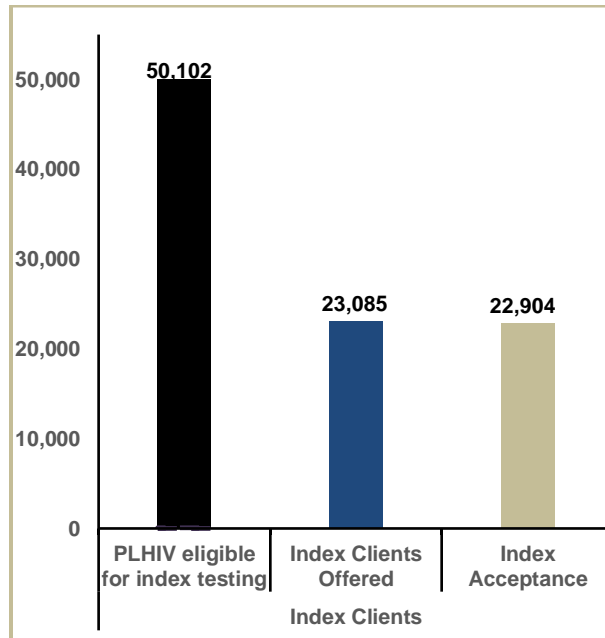


Facility Index Testing Cascade – Q4 Only



29

FY20 Q4 Index Cascade



Recency

Successes and Recommendations

A strong collaboration across PEPFAR, the MoH and partners allowed for the restart of recent infection surveillance activities safely during COVID-19 restrictions. Setting up a process for recertifying sites, training staff in a hybrid in-person and virtual setting, and providing continuous quality improvement (CQI) for sites implementing recency testing has enabled an increase of 24 – 81% site activation over the FY20 period. FY20 achievements include: 48% RTRI coverage overall; 89% viral load coverage among RTRI recent; and 5% RITA recent. Females 15-29 represent 66% of all recent infections and overall, more recent infections clustered in urban settings.

Early recency surveillance data should be used to direct testing efforts to facilities and geographic locations where AGWY and younger men are accessible. Maximize the DREAMS program venues and outreach to reach women.

PMTCT

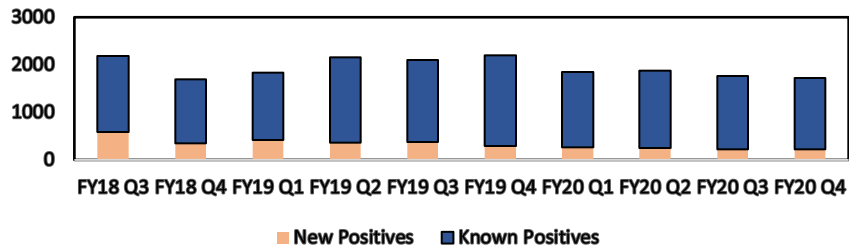
Successes:

Eswatini is to be commended on consistently linking nearly all infants living with HIV to ART (100% in Hhohho, Manzini and Shiselweni; > 90% in Lubombo).



Eswatini is also be commended on sustained 100% ART coverage among pregnant women, and for sustained high rates of EID coverage and low rates infant positivity (< 2% at 12m) even in the midst of COVID. Quarterly trends demonstrate an increase in the proportion of HIV positive pregnant women who are already aware of their HIV status at ANC1 (87%) in Q4 FY20, compared to 71% in Q1 FY18.

Quarterly Trends in PMTCT_STAT_POS



Challenges and Recommendations

Although decreasing every year, FY20 preliminary PMTCT_FO unknown is 20.2% (32.3% in FY19; 36.6% in FY18). Reduce PMTCT_FO unknown to < 5% across each clinical partner in COP21.

Given the importance of sustaining epidemic control, plateaued rates of vertical transmission, poor proxy rates of for viral load coverage for pregnant women (< 50%), and the inability to calculate coverage among breastfeeding women, the CMIS and LIS systems must be levered to provide the client-level granularity that is needed to understand issues and barriers to services. The expectation is to achieve >90% viral load coverage and suppression for pregnant women and breastfeeding women across all clinical partners in COP21.



Pediatrics

Successes:

Eswatini is to be commended on achieving high rates of viral suppression across many pediatric fine age bands (< 15y). With exception of <1 year, males and females across all age bands ranges 88-91% suppression. Viral load coverage rates range from 80-93%, also with the exception of the <1 year age band which is well below the target coverage rate.

Eswatini has successfully met FY20 TX_CURR target for children and young adolescents (< 15 years) with notable improvement in TX_NET_NEW (1.0% patient gain at FY20 Q4 vs. minus 16.9% patient loss at FY19 Q4). The pediatric treatment program has also successfully 3+MMD to ~90% of pediatric clients.



Results – Summary (2)

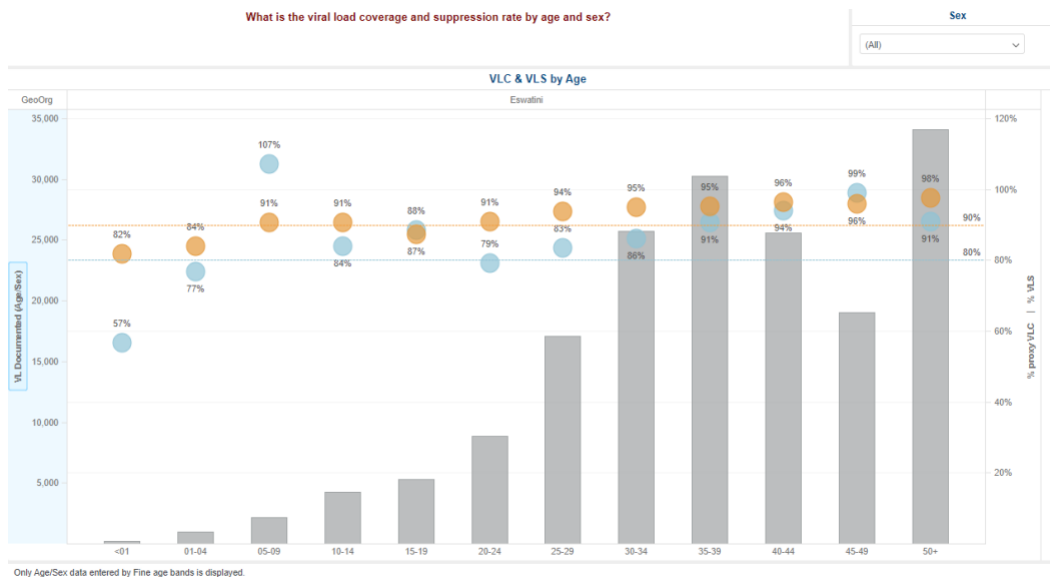
FY20 Q4 RESULTS SUMMARY									
Indicator	FY 20 Target	FY 20 Q1 Results	FY 20 Q2 Results	FY 20 Q3 Results	FY 20 Q4 Results	FY 20 Results	% of Target	Coverage	Yield
TX_CURR	184,848	173,341	178,366	181,059	187,429	187,429	101%		
TX_NET_NEW		2,592	5,025	2,693	6,370	16,680	N/A		
TX_CURR (<15 yrs)	8,645					8,540	99%		
TX_CURR (15 yrs +)	176,087					178,889	102%		

Challenges and Recommendations:

As is the case with pregnant and breast-feeding women, the poor proxy viral load coverage rates for certain pediatric age bands (< 50%) must leverage the CMIS and LIS investments to provide the client-level granularity that is needed to better understand barriers to care and/or data quality issues. Additionally, historically there has been less use of DBS for VL specimen collection among children; increased use of DBS should be explored. In COP21, results should reach >90% VL coverage across all pediatric and adolescent age bands.

As seen in >15-year age bands, there was sub-optimal performance of HTS_POS and TX_NEW FY20 targets for children <15 years. Significant decreases were observed during FY20 Q3 which improved slightly in Q4. Generally, during FY20, Eswatini achieved only 30% HTS_POS target <15yo and 55% TX_NEW target <15yo. The index testing modality contributed 22% of all positive children <15yo identified; ensure adequate resources to bolster safe and ethical index testing for pediatric contacts.

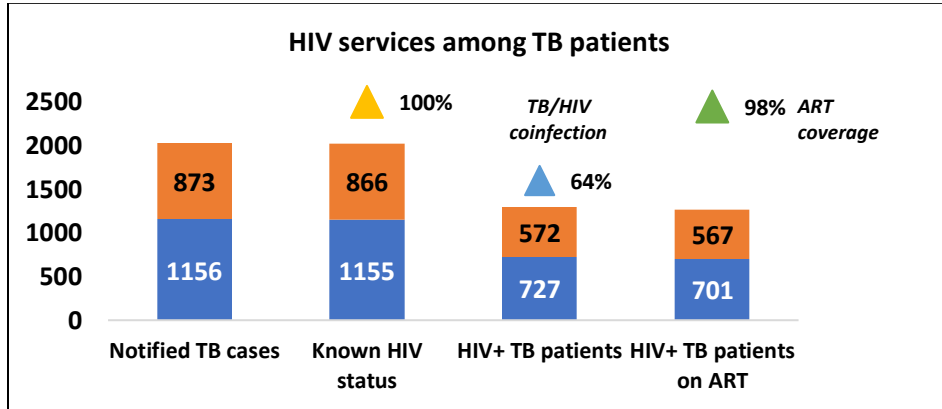
Lower VL suppression rates for <5 years and 15–19-year age bands are an ongoing concern. The Eswatini program is commended for spearheading pediatric ART optimization efforts by phasing out NNRT use and readiness to introduce pediatric DTG 10mg as soon as possible. However, there are ongoing structural systems that can be further strengthened to achieve > 90% VL suppression rates for all pediatric and adolescent age bands. In response to the lower suppression rates for < 5y and 15-19 age bands, the program should focus on quality with Enhanced Adherence Counselling (EAC) interventions, caregiver support with optimal ART administration, family-centered service delivery models, viremia clinics and enrollment in OVC services.



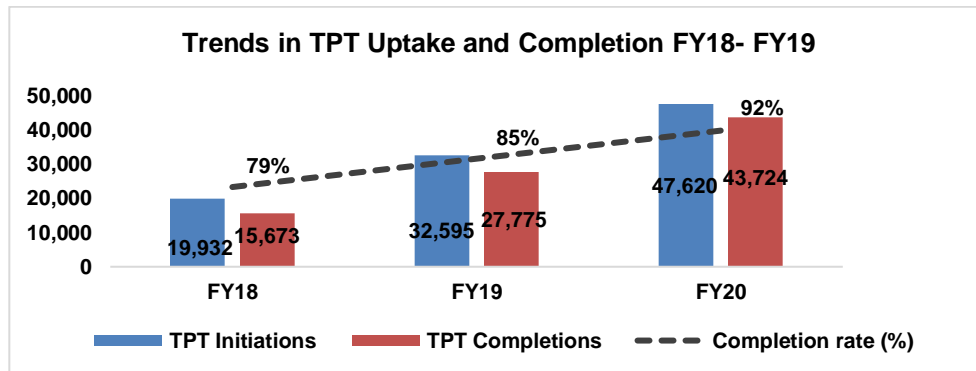
TB/HIV

Successes:

Eswatini has achieved high HIV testing and HIV treatment among TB patients with high TB specimen collection (100%) and referral (>95%) for quality rapid molecular testing among ART patients that screened positive for TB. Additionally, the implementation of the more sensitive TB diagnostic (Xpert MTB/RIF Ultra) has been rolled out across all 32 peripheral laboratories improving sensitivity of disease detection for clients.



The TPT program has maintained strong completion rates among HIV+ clients and grown its TPT initiation rate. Provider training and a MoH circular shifted policy and policy uptake.



Challenges and Recommendations:

TB screening among PLHIV yielded an average of 4% TB positive results versus 10-15% (optimal level based on epidemiology). Identification of means to improve the quality of screening provided through validating performance and training of screeners is needed. The quality of TB screening in children should also be reviewed especially in children newly initiated on ART and children with malnutrition.

While ART distribution has been expanded through DSD models, such models for TPT and TB treatment must be scaled up to keep pace. Commodity security for TPT and TB treatment is a risk to TPT scale-up and control of TB morbidity and mortality in Eswatini. Stock-outs in INH, pyridoxine and Xpert cartridges coupled with delays in receipt of 3HP have been FY20 challenges. Early warning of stock-outs and managing country-wide distribution of commodities to minimize risk of stock-outs will remain an important COP21 strategy.

OVC

Successes:

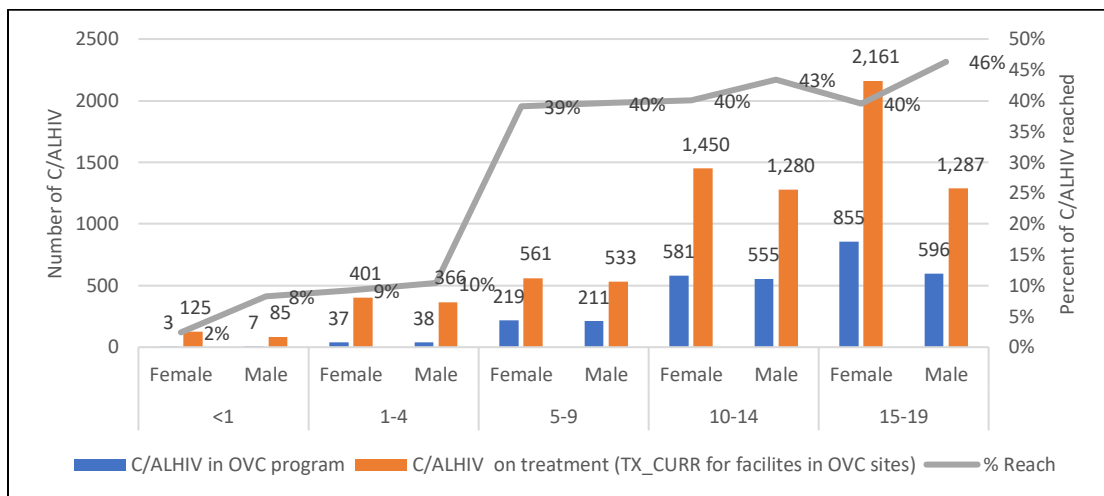
PEPFAR served 93,725 OVC beneficiaries (143% of annual target) with 64% (60,303) of those receiving services under the age of 18 and 36% (33,422) over 18. (Note: OVC over 18 years old include 7,115 adolescents aged 18-20 who are still in school and/or who continue to receive livelihood interventions. OVC caregivers over 20 include 26,892 adults.) Eswatini also met high achievements against all additional targets, including 97% known status proxy and 100% (2,110) of HIV+ OVC on ART.

The OVC program has built strong synergies with DREAMS, well integrated geographically and operationally, offering most vulnerable OVC girls the full DREAMS prevention package. 41% of OVC adolescent girls are enrolled in DREAMS. In FY21, the OVC program is expanding to four additional sites which will start implementing DREAMS.

The OVC program has also made progress on its work with PEPFAR clinical partners and supported health facilities, providing *Linkage Facilitators* to liaise with facilities and partner staff expert clients. The same success has been seen in the cross-work with programs for commercial female sex workers, enrolling children of sex workers with significant vulnerabilities into the OVC program.

Challenges and Recommendations:

The number of A/CLHIV enrolled in OVC services has remained relatively stagnant with an increase of 10% from FY19 to FY20. In FY20 Q4 14% of A/CLHIV met TX_CURR <20 and 23% of CLHIV met TX_CURR <15. In COP20, OVC and clinical implementing partners in Eswatini must continue to work together (finalizing formal MOUs and updating cohort analysis) to ensure that 90% or more of children and adolescents on ART with PEPFAR support in OVC districts are offered the opportunity to enroll in the comprehensive OVC program.



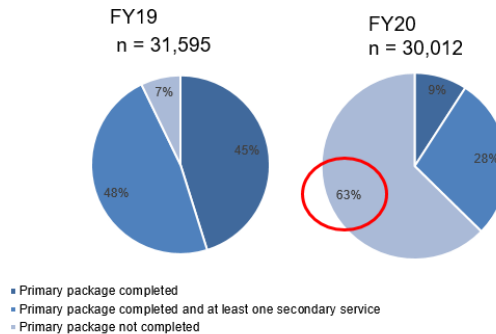
Increase access to HIV data from facilities for the OVC partners remains a barrier to the provision of quality care. Direct information from facilities on VL suppression and MMD data associated with A/CLHIV has not yet been shared with OVC partners. Clinical partners must support OVC partners on data sharing and advocate with MOH to enable monitoring of outcomes.

AGYW/DREAMS

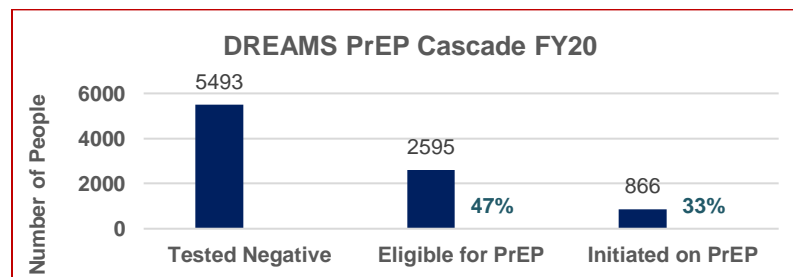
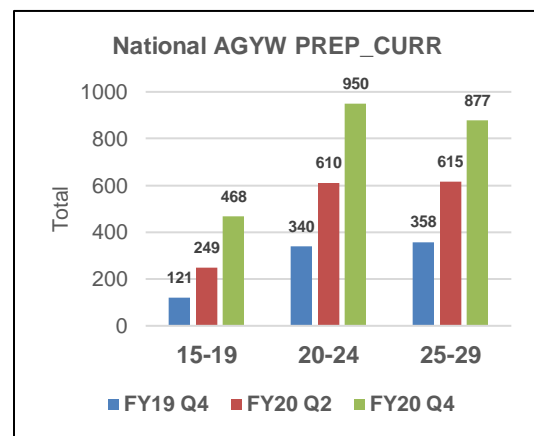
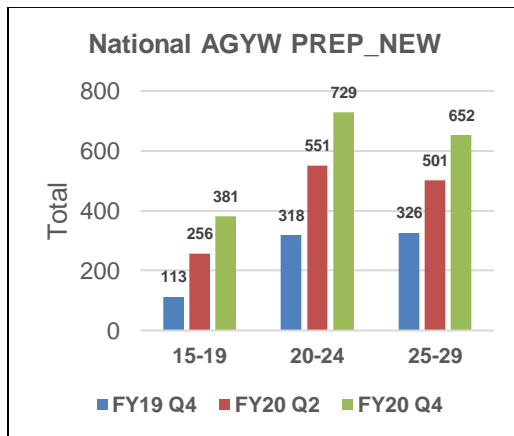
Successes, Challenges and Recommendations:

In FY20, DREAMS programming was severely affected by the COVID restrictions. With 86% completion of health and social referrals achieved, the limited ability to deliver services resulted in a very high incompleteness rate of the primary package (63%) versus incompleteness in FY19 (7%). In COP20 implementation and planning for COP21, these losses must be regained with intensified efforts to reach AGYW with services in virtual and small group means, particularly young women in the 20-29 age band most seriously affected by the COVID context.

Completion rate: comparison FY19/FY20



Whereas PrEP nationally showed continue scale up with innovations in how AGYW were contacted and provided with PrEP, there was low uptake of PrEP for AGYW in DREAMS districts, with the exception of Manzini; DREAMS programming must find solutions to offering AGYW PrEP that are at high risk for HIV infection within the COVID context of limitations on service delivery. Increasing knowledge about PrEP and access to should affect demand for PrEP by AGYW.



The GEND_GBV results were 42% (801 of 1,890) for DREAMS; recommend improving access and ensuring high quality post-violence care services.

PreP

Successes:

The Eswatini PrEP program is making gains in scale up of new PrEP initiations year over year, from 51% achievement in FY18, to 93% achievement in FY19, and 188% achievement in FY20. PrEP delivery overachieved in PrEP initiations among AGYW 15-24. Program delivery overachieve in PrEP initiations among KPs.

Challenges and Recommendations:

PEPFAR should work with the MoH to continue expansion and scale-up so that PrEP is offered at all facilities to maximize access taking those successful program delivery adaptations in the COVID context to new sites (e.g., decentralized drug distribution, virtual demand creation, telehealth). Given the ongoing level of transmission among pregnant and breastfeeding women, prioritize PrEP access for this vulnerable population.

Cervical Cancer:

Successes:

In spite of COVID restrictions, Eswatini has recorded exceptional linkage rates to treatment for positive cases in FY20, with 98% of screen-positive women treated in the most recent quarter (FY20 Q4). Additionally, the country program was successful in increasing the number of facilities implementing cervical cancer activities, which ultimately led to the achievement of 81.2% of the cervical cancer targets for the FY20 during the course of which partners and facilities successfully reduced the FY19 LEEP backlog. Overall, 1,035/1175 (88%) of patients who screened positive for a pre-invasive lesion were successfully linked and received further treatment.

Challenges and Recommendations:

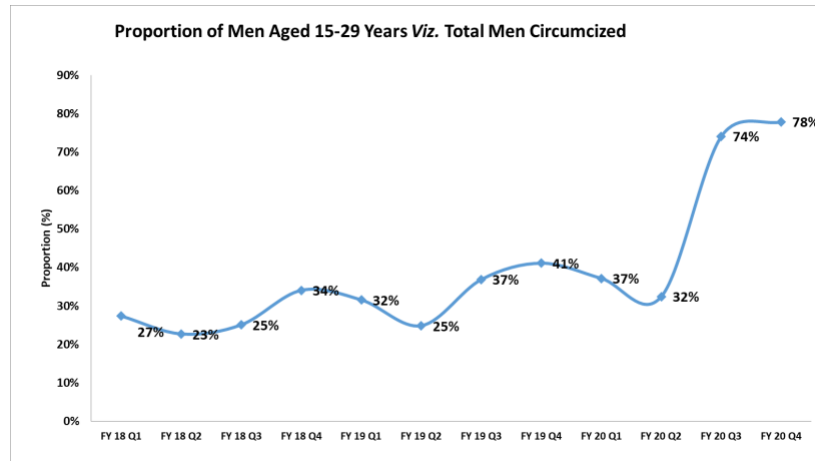
Program implementation lost some momentum due to COVID-19 with cervical cancer screening coverage of women living with HIV achievement of 81%. Finding strategies to continue to scale up services to ensure achievement of the screening target will be important in FY20 and COP21. Efforts should be strengthened to ensure that ART sites have the capacity to offer patients same day screen and treat services where feasible.

Approaches should be prioritized to improve capacity and referral network in place for patients who are unable to receive same day service for management of preinvasive lesions or for diagnosis and management of advanced cervical cancer.

VMMC

Successes:

After a MoH required slowing of services in Q3 due to COVID-19, the program took a phased approach to reopen services at some static sites during Q4. The proportion of circumcisions performed in <15-year-old clients decreased to <3.5% in Q3 and Q4 from a historical average of 60%. Men aged 15-29 correspondingly increased to a record high of 78% of VMMCs performed.



Challenges and Recommendations:

Recruiting clients age 15+ years is likely to remain a challenge; modify demand creation and service delivery activities to achieve success are planned, but COVID restrictions have not allowed for full implementation in FY20.

Lab: Viral Load and Early Infant Diagnosis

Successes:

Except for Lubumbo Hospital, the other three VL testing labs are meeting the escalating demand of patients eligible for VL tests quarter after quarter. As noted in the treatment section, high national VL suppression, including for youth has been achieved. Viral load coverage has also improved in Q4 despite Covid-19, including for pregnant women.

Challenges and Recommendations:

Advocate for permitting trained personnel other than laboratory staff to operate the near POC GeneXpert platforms and initiate POC testing for VL specifically for improving coverage of PBFW and <15 yo. This will enable expanded coverage for hard-to-reach populations. Given the importance of laboratory systems to the sustainability of the HIV response, continue efforts to support the development, approval, costing and implementation of the national laboratory strategic plan. In addition, continue efforts to ensure adequate numbers of qualified laboratory personnel to perform HIV testing, TB diagnosis, as well as routine and complex laboratory testing.

HMIS

Successes:

Central Medical Information System (CMIS) has been supported by PEPFAR through several phases of development. As of FY20, CMIS covers 75% of ART clients in 89% of ART delivery sites. The CMIS development has been a strong collaboration between PEPFAR, the Global Fund and the MoH each playing a funding and development role.

In addition to supporting a strong patient record system (CMIS), PEPFAR has focused on data quality and has completed both Phase 1 and 2 (PEPFAR-supported sites) of a data verification exercise in FY2; analysis is in progress. Data verification has been core to understanding client movement and loss and has informed the back to care strategy that has proven successful.

FY20 also saw the successful interoperability of the CMIS and LIS platforms in 30 health facilities with deployment planned for all facilities using CMIS. This will allow for enhanced understanding of gaps in

viral load coverage and improve lab result results reporting which is important for improving client quality of care.

Challenges and Recommendations:

Continue developing a case surveillance protocol and implement Case Surveillance to better identify re-testers and deduplicate and strengthen HIV surveillance in country with allocated PEPFAR funding.

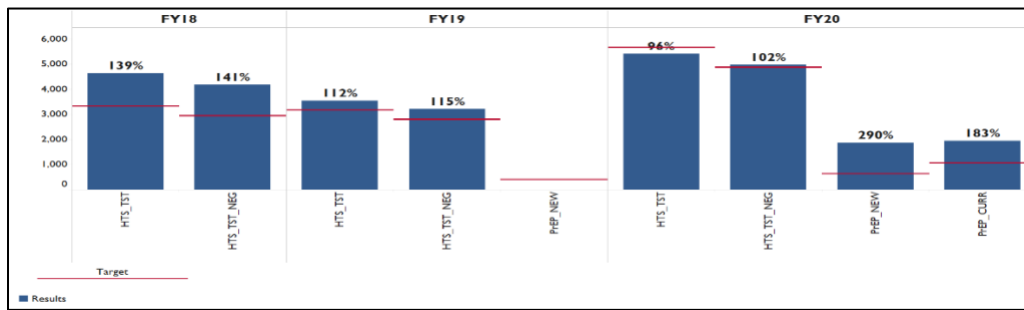
Strengthen data quality through using the results of the data verification to identify areas of improvement.

Continue migration of all PEPFAR supported sites to CMIS v2.5 to streamline data integration and improve the accuracy of record linkage and deduplication. Prioritization should be given to ART sites for deployment of CMIS.

Key Populations

Successes:

PrEP uptake among KP has been strong in FY20 with 38% of KP who tested negative initiating on PrEP compared to 0% in FY19. This has been accomplished in the context of significant COVID restrictions with the aid of ‘PrEP ambassadors.’



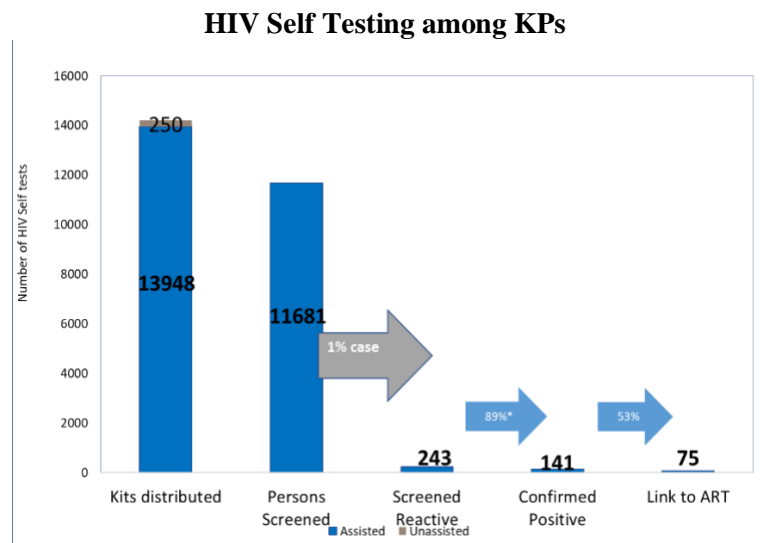
Case finding among KP has increased over the past two fiscal years identifying 452 new positives in FY20 across all partners as compared to 333 in FY19. While the proxy linkage rate using MER indicators show results as low as 53% in FY20, an interagency custom indicator used to document KP linkage to treatment shows a linkage rate close to 100% in both FY19 and FY20.

Challenges and Recommendations:

Index testing has improved with a high yield (27%) but the offer of index testing and acceptance rates remain low with significant missed opportunities. Support to health care and community workers on how to effectively offer testing should remain a focus.



HIV self-testing has been implemented through KP programs but with limited effect. The identification of HIV positive persons has been low with poor linkage (55%) to treatment for the small number that tested HIV positive. Improved training among partners who provide the ‘assisted self-testing’ must be a priority in order to improve the impact of this testing modality.



*The 89% confirmed positive is once 84 known positives were removed from the 243 screened reactive.

MOUs are needed between clinical and community partners to ensure KP who experience an interruption in treatment are relinked to ART with the help of peer navigators or case managers and KPs due for VL testing are notified. VL testing has decreased each quarter in FY20 and was as low as 2.5% illustrating a large gap in VL coverage for KP in Eswatini. Recommendation on improved coordination across partners could also improve coverage and reporting of VL testing among KP. Decentralized sample collection for VL testing through drop-in centers or at other community sites in addition to point-of-care VL testing are strategies requiring additional funding that would enhance client-centered care and improve viral load coverage among KP.

While case finding has improved from FY19 to FY20, social network testing should be further expanded to reach KP who may not identify as KP and have not recently tested or received HIV prevention or treatment services. In Q4, EPOA led to a positivity rate of 7% compared to 5% through community testing among all KP.

Commodities and Supply Chain

Successes:

Eswatini achieved an increase in TLD transition in adults from 74% in FY20 Q2 to 82% in FY20 Q4, and trends in MMD uptake for all durations 3+ months has improved from 53% in Q1 to 78% in Q4.

While 6MMD scale up was delayed due to stock challenges, the development and mentoring of facilities on ART decentralized drug distribution supply chain tools, such as commodity ordering and reporting tools was supported by Regional Logistics Officers to enable patient drug pick-up at over 584 community distribution points. The success of decentralized drug distribution in Eswatini has paved the way for additional commodities (family planning, non-communicable diseases, condoms, self-test kits and PrEP) to also be offered at community distribution points.

Challenges and Recommendations:

Sustainable government financing for ARVs has become a serious risk due to severe economic constraints of Eswatini. As the MoF will not finance ARVs in 2022 due to fiscal constraints, it is essential that their long-standing commitment to ARV procurement is re-established in 2023.

Additionally, efforts towards an autonomous Central Medical Stores must continue through coordination with the MOH/MOF Steering Committee to advocate for appropriate funding levels based on quantifications, prioritize allocations/disbursements, prioritize supplier payments, and continue to strengthen the MOH Procurement Unit while advocating for a progressive approach to increasing CMS autonomy.

FCI

Successes:

FCI has demonstrated success as a communication channel with faith based communities on a wide range of HIV related health topics including COVID-19, GBV and HIV testing, prevention and treatment during the COVID-19 lockdowns. FCI also took a strong role in HIVST distribution beginning February and scaled this service. FCI HIVSTs were the only accessible tests in some areas during lockdowns associated with COVID-19 pandemic. Through its successful community engagement, FCI initiated a PrEP program for its client base.

Challenges and Recommendations:

Focus on enhancing collaboration between the FCI program and PEPFAR mainstream programming e.g. HIV testing and linkage to treatment and with DREAMS specially on GBV prevention.

Revise approach to HIVST distribution to markedly reduce their use among persons with a known HIV positive status; testing must focus on those at risk and in particular, men.

Partner and Financial Performance

In FY20 all partners across all agencies in PEPFAR/Eswatini felt the impact of the significant COVID restrictions; all were impacted in certain program areas, particularly those that required interventions to be delivered in communities. However, as facilities struggled with supplies of PPE and health care worker absences, facility-based activities considered ‘non-essential’ were also affected.

Specifically, all partners failed to achieve targets for HTS_TST_POS and TX_NEW. Results across all partners were similar at 45-63% with only URC Lubombo achieving 80% of their TST_POS target.

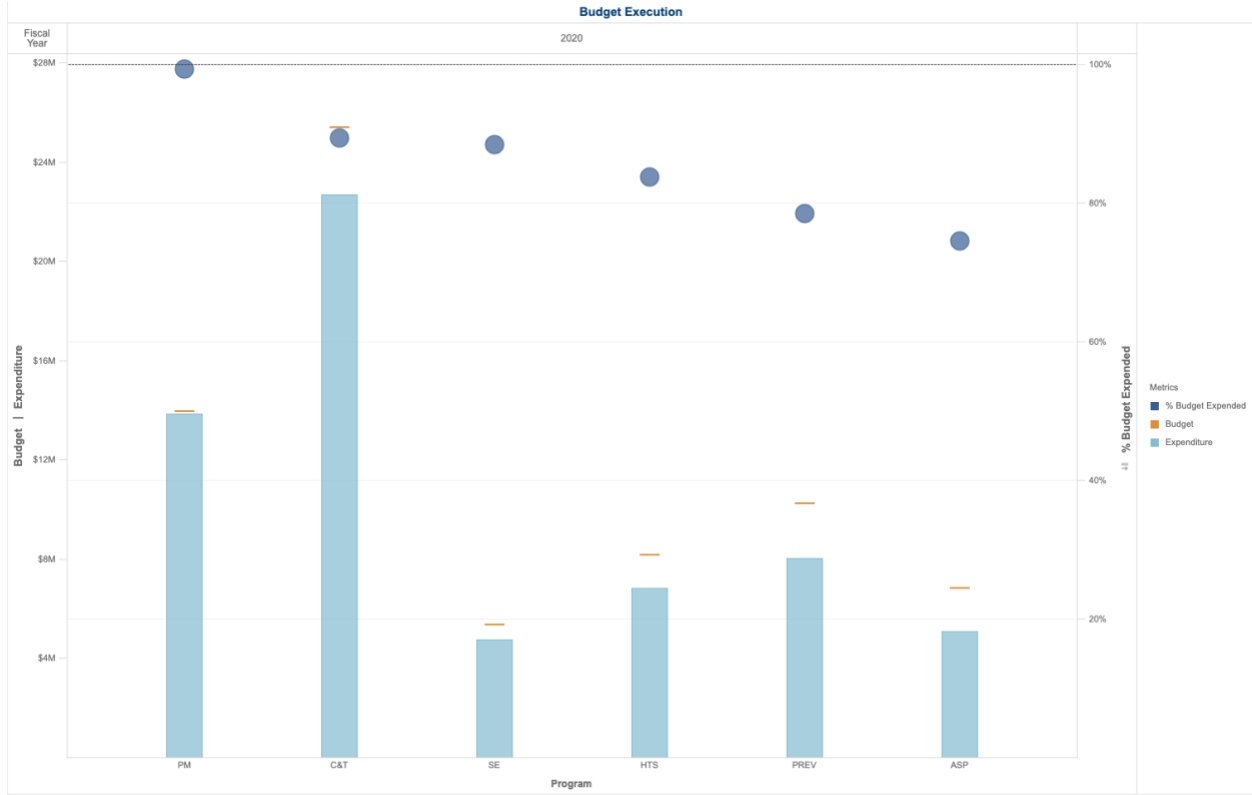
The Eswatini program overall under-outlaid by \$7,402M with over 50% of the amount from CDC partner under-outlays.

In FY20 there were 11 implementing mechanisms that outlaid in excess of their COP19 budget for a total of **\$4,178,025**. This is an increase of **\$1,138,340** (27%) over FY19 over-outlays. The agency breakdown is noted below. Strict management of partner overlays is required. Agencies with ongoing issues in this area will be requested to provide a full accounting for over-outlays and mitigation plans for avoidance in FY21.

USAID	\$3,714,538 with 89% of total over-outlay; 6 IMs reporting late posting of expenditures (JSI, JHU, WHO, CHAPS, FEI and Remote Medicine); 2 IMs received delayed FCI funds
CDC	\$339,249 (2 IMs); ICAP late posting; error in accounting
DOD	\$124,238 (2 IMs); USDF last posting; error in accounting

COP19 Budget vs. Expenditure by Program Area

In FY20, all program areas under-expended with the exception of Program Management which expended near to 100%. Prevention and above site support expended under 80% of the allocated budget.



SECTION 4: COP 2021 DIRECTIVES

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

Minimum Program Requirements (MPR)

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

All PEPFAR programs are expected to meet all of the requirements below, and the COP21 Planning Meeting will include a review of the status of each requirement, including assessment of implementation (including barriers) at the point of client services. To the extent that any requirement(s) have not been met by the time of the COP21 Planning Meeting, the PEPFAR Eswatini 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 FY2022. 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 21 (FY 22) 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.	Maintenance of full-scale implementation
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.	TLD transition continues as drug supply and TLE expiry-avoidance allows, increasing from 40% of all clients at the end of FY19 to 83% of the adult population by Q4 FY20.
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.	Maintenance of full-scale implementation
4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by the end of COP21, and	Currently all supported HIV sites are providing TPT services. Rates of TPT uptake differs across facility and uptake

<p>cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.</p>	<p>has been affected by stockout in 2020. TPT is provided in DSD models including community models designed in adaptation to COVID-19. Scale up of TPT in DSD models and introduction of alternative TB regimens is planned in FY21.</p>
<p>5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.</p>	<p>VL testing decentralized to all four regions and Nhlngano lab fully transitioned from Biocentric to Panther (Phase 1)</p> <p>CAP/CTMs at NMRL are being replaced by Panther and Roche 6800. In FY21, EHLS will determine which platforms to replace those in Moneni and Lubombo Referral. EID testing remains centralized to NMRL (Phase 2)</p> <p>One VL testing lab (NMRL) and one TB lab (NTRL) have received SADCAS accreditation and PEPFAR continues to support the two sites to maintain the status</p>
Testing	
<p>1. Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.</p>	<p>Adult index testing continues to be scaled. Implementation of pediatric index testing for all children and adolescents under 19 is currently underway with a specific focus on biological children of newly identified and virally unsuppressed WLHIV</p>
Prevention and OVC	
<p>1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)</p>	<p>National scale up being implemented</p>
<p>2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for</p>	<p>Increased enrollment of C/ALHIV in the OCV program; coordination between the OCV program and DREAMS and clinical partners established with MOUs in progress.</p>

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	
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.	There are no user fees.
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.	Continued CQI at facility level, IP workplans and national policy.
3. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	<p>Through FCI trained 655 faith leaders and 632 community carers on HIV treatment and prevention basics and provided materials to improve community treatment and viral load literacy.</p> <p>Through male engagement programming Community Expert Clients established and managed 323 CAGs and 215 active support groups to reach 1042 PLHIV with treatment literacy training</p>
4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Increasing progress towards local, indigenous partner prime funding.
5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	Due to the currency devaluation and commodity price increases caused by the global pandemic, the host country government is unable to meet financial commitments for ARVs during FY21. Projections for GDP contraction and sharp revenue reduction will also lead to inability to maintain status quo commitments for at least another year following. The fiscal situation does not reflect the political will to fund the HIV response, nor the MOH responsibility for the overall delivery of services which has been strong up to the point of the financial crisis.

6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Through scale up of the use of CMIS at covering 89% of the HIV treatment cohort, monitoring health outcomes is documented and reported.
7. Scale-up of case surveillance and unique identifiers for patients across all sites.	Continue to improve access to patient IDs. Not funded to implement roll out of biometrics with the exception of fingerprint ID within CMIS planned for FY21.

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

Table 10. COP 21 (FY 22) Technical Directives

Eswatini Specific Directives
HIV Treatment
1. Pediatric viral load coverage must exceed 90% in all age bands in all regions. Utilize electronic patient record and lab systems to track clients and understand access barriers.
2. Shift testing from OPD to engage most at-risk populations before they seek testing at an OPD. Target specific age bands for men (25-39) and women (15-24) for OPD testing.
3. Positive but unlinked to treatment within 15 days - males (30-39) and females (20-29); strategies deployed to improve linkage rates.
HIV Prevention
1. Consider adaptations to the DREAMS program that will allow access to AGYW that remain at high risk for HIV infection even in the case of prolonged COVID related lockdowns.
2. Focus on adapting VMMC delivery to the COVID context to enable young men access to VMMC, particularly in those areas where recency testing shows young women and men as new positives.
Other Government Policy or Programming Changes Needed
1. Flexibility in adapting VMMC delivery to allow for program services to be optimized under the COVID context.
2. Secure government commitment for ARV procurement in 2022 and beyond.
3. Advocate for permitting trained personnel other than laboratory staff to operate the near POC GeneXpert platforms and initiate POC testing for VL specifically for improving coverage of PBFW and <15 yo.

COP 2021 Technical Priorities

Client Centered Treatment Services

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

Pediatric- and Adolescent-Centered Services

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

Community-led Monitoring

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

Pre-Exposure Prophylaxis (PrEP)

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

TB/HIV

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

accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

Advanced HIV disease

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

DREAMS

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

OVC

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

VMMC

Funds have been provided to conduct VMMC for males 15 years or older. The team is reminded of the revised guidance which allows surgical VMMC for those 15 or older. While Shang ring may be considered for those below age 15 with headquarters approval, it should be limited to those age 13 or above who are able to understand the procedure and provide informed consent, along with parental consent as dictated by local laws. All VMMC providers must adhere to the requirements for reporting of Notifiable Adverse Events.

Cervical Cancer Screening and Treatment:

Funding for cervical cancer screening and treatment of pre-invasive lesions. The target for screening must be equal to half of the TX_CURR for women age 25-49. All teams performing cervical cancer screening must adhere to the PEPFAR screening guidance and report into the cervical cancer MER indicators. Basic treatment should be available for pre-cancerous lesions at the site of screening except under exceptional circumstances. All sites performing screening should establish clear referral mechanisms for patients needing treatment not available on site such as LEEP or evaluation for potential invasive cancer. Patient referral between sites should be facilitated and outcomes of the referral tracked to assure appropriate treatment and to allow reporting of results.

Condoms and Lubricants

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

Eswatini 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 Eswatini 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 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 Eswatini 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 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 to introduce and discuss all COP 2021 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP 2021. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2021, PEPFAR will convene virtual meetings where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations, faith-based organizations/faith communities, and multilateral partners. Specific guidance for the 2021 virtual meeting delegations will be provided separately.

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

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment (C&T): COP 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): COP 2021 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2021 GHP-State and GHP-USAID funding. The OVC earmark will be calculated as the sum of the following:

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

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

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

<p>Numerator</p> <p>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)</p> <p>+</p> <p>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)</p> <hr/> <p>Denominator</p> <p>Prevention: primary prevention of HIV and sexual violence (all populations)</p> <p>+</p> <p>Prevention: community mobilization, behavior, and norms change (all populations)</p> <p>+</p> <p>50 % Prevention: Not disaggregated (all populations)</p>
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Gender Based Violence (GBV): COP 2021 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2021** funding programmed to the GBV cross-cutting code. Your COP 2021 earmark is derived by using the final COP/ROP 2020 GBV earmark allocation as a baseline. The COP 2021 planned level of new FY 2021 funds for GBV can be above this amount; however, it cannot fall below it.

Water: COP 2021 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2021 funding** programmed to the water cross-cutting code. Your COP 2021 earmark is derived by using the final COP 2019 water earmark allocation as a baseline. The COP 2021 planned level of new FY 2021 funds for water can be above this amount; however, it cannot fall below it.

Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. PEPFAR has set a 70% goal **by agency** by the end of FY21, and must meet 40% by FY20. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY21 as appropriate through their COP 2020 submission.

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

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

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