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January 13th, 2021

INFORMATION MEMO FOR: Ambassador Mary Beth Leonard, Nigeria

FROM: S/GAC Chair William S. Paul, M.D., M.P.H. and PPM Lorin Letcher, M.P.H.

THROUGH: Ambassador Deborah L. Birx, MD

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

Dear Ambassador Leonard,

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

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

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

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

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

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

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

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

We are very excited about your progress:

- The team continued a successful surge, growing the number of people on antiretroviral treatment by 279,842 in FY20, of which nearly half (131,505) was achieved in the fourth quarter.
- With increased community-based services (community testing and decentralized drug delivery) as well as client-centered services (multi-month dispensing), case finding and program growth were resilient to the impact of COVID-19, with fewer treatment interruptions.
- A concerted focus on managing and improving client services and partner performance led to improvement in viral load coverage (88%) & viral suppression (93%) by the fourth quarter.

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

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

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

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

- Gaps in continuity of treatment, manifesting especially in significant losses in the first quarter of FY20.
- Optimizing case finding, care, and treatment for Key Populations, who represented nearly one-quarter of clients started on treatment. The number of PLHIV in Key Populations on treatment tripled during the year.
- Gaps in pediatric care & treatment and prevention of mother to child transmission of HIV

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

Consistent with the approach from last year, PEPFAR teams will once again be responsible for setting their targets in consultation with stakeholders. Teams should bear in mind that PEPFAR targets are not PEPFAR's but flow directly from the partner country government's commitment to the UNAIDS and SDG 3 goals. Since 2016 PEPFAR and the Global Fund resources have been focused on achieving these global goals that have been translated to each country by UNAIDS and subsequently supported financially and technically by the PEPFAR family. Since 2016, PEPFAR has utilized these global commitment targets as PEPFAR targets with the commensurate increased funding to countries to achieve the goals set out by the Heads of State. Many countries have made tremendous progress towards these targets and others need to accelerate. Nigeria has not achieved the 2020 goals but is on track to achieve 2030 goals early, which means rapid growth while sustaining the amazing gains Nigeria has made will need to be our constant focus.

S/GAC will not assign targets to countries, but only provide notional budget levels sufficient to achieve the full SDG goal and sustain gains made. **Teams will develop their own targets across PEPFAR program areas, with the treatment current target no less than the result that was to be achieved in COP 2020.** After the PEPFAR country team submits their COP 21 targets, the notional budget will then be adjusted to the presented level of ambition.

The PEPFAR Country/Regional Operational Plan (COP/ROP 2021) notional budget for Nigeria is **$426,500,000** 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 Nigeria and civil society of Nigeria, believes is critical for the country's progress towards controlling the pandemic and maintaining control.

We are hoping this approach to target-setting and budget will establish an open dialogue on target-setting and empower teams to work with all stakeholders to plan a strategic and impactful COP. The expectation

is for country teams and agencies to propose to S/GAC the targets they believe are achievable and feasible and hold their partner's accountable to that achievement.

PEPFAR, with partner governments, multilateral partners, and communities, continues to move rapidly toward control of the HIV pandemic and plan for sustainability of programs. Achieving epidemic control for HIV will be a remarkable accomplishment, saving millions of lives, significantly lowering the burden of HIV/AIDS in countries and communities, reducing the future costs required to sustain the HIV response, and building sustainable public health systems capacity in host countries.

Please note that within the next few days our PEPFAR Chairs and PEPFAR Program Managers (PPMs), working closely with our CAST teams, will plan to review this planning letter and details contained, herein, with your wider PEPFAR country team. Where PEPFAR successfully navigated disruption due to COVID-19 during 2020, it was a result of strong teams, local partners, communities, and dedicated health and community workers, leveraging longstanding capacities and platforms established by PEPFAR. Our teams, partners, and communities worked together to adapt and further innovate program implementation and models of service delivery so that the adverse impacts of a dual pandemic threat on essential HIV services were mitigated. Stakeholder engagement is essential for a productive and impactful planning process. Included in this planning letter is an outline of the expectations for engaging key stakeholders and civil society, as we continue to finalize our approach to hosting a virtual 2021 COP planning and approval process.

I am so grateful to you and your entire team for your leadership and engagement in the planning, review and implementation of the President's Emergency Plan for AIDS Relief (PEPFAR) program, along with the community and Government to enhance PEPFAR's program impact.

Sincerely,

Deborah Birx

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

CC: **S/GAC – William S. Paul, M.D., M.P.H., Chair,**
Lorin Letcher, M.P.H. PEPFAR Program Manager, and
Mark Giambrone, PEPFAR Country Coordinator

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.

Key Successes for PEPFAR Nigeria from FY20 include:

1. Growth in of the patient cohort by over 279,000 people living with HIV (PLHIV) in FY20 with over 131,000 individuals being initiated and retained in care during quarter four alone. PEPFAR Nigeria has shown excellent success with accelerating efforts to identify PLHIV and link to care with quarter-on-quarter growth.

2. PEPFAR Nigeria has shown resilience and innovative adaptability to sustain a surge cohort growth despite the impact of the COVID-19 pandemic. For example, the team's ability to effectively use community-based testing modalities and shape tactics based on weekly results shows program flexibility and attention to a quickly changing landscape.

3. Scale-up of multi-month dispensing (MMD) from 55% in quarter 1 to 94% in quarter 4 of FY20 was a key factor in improved continuity of treatment. This quarter-on-quarter growth and maintenance of gains for MMD scale-up has allowed cohort growth from innovative case finding techniques to be maintained.

4. PEPFAR Nigeria has shown remarkable improvement in viral load coverage (88%) & suppression (93%) by Q4, building on previous successes and maintaining those gains to approach third-90 goals for the OU in a little over 6 quarters. Excellent VLC and VLS results were noted for most surge, red, and green states, and adults within the treatment cohort at FY20 Q4.

5. The orphans and vulnerable children (OVC) program achieved and exceeded all targets set for the year, including over a million OVC served by PEPFAR Nigeria by the end of FY20 with an increase in cohort growth quarter-on-quarter. Additionally, 98% of those under the age of 18 in the OVC program have a documented HIV status, and approximately 100% of those that are positive are currently on treatment. This linkage to care for this vulnerable cohort in the face of such growth is to be commended.

6. Key populations represented approximately 25% of overall growth, as the number of clients on treatment among most key populations tripled in size. With a testing yield of over 10%, the continued scale-up and maintenance of this program will be key for COP21 discussions.

7. Improvements in PrEP uptake, especially among key populations. Number of clients newly initiated on PrEP rose from 1963 in Q3 FY20 to 22,866 in Q4 FY20.

Nonetheless, PEPFAR Nigeria still has opportunities for improvement:

1. Addressing gaps in continuity of treatment particularly in a sub-set of states that experienced interruptions in patient treatment during quarter 4, and closely managing partner performance to improve treatment continuity will enhance gains already made through the surge progress.

2. PEPFAR Nigeria has historically seen patient losses from the treatment cohort during quarter 1 results reported of each fiscal year. These losses have a substantial impact on program growth. Addressing the root causes of these patient losses and implementing client-centered solutions will be key to ensuring all gains from the surge are maintained.

3. While the VLC and VLS program has seen continual improvements over FY20 quarters, the VLC program still has gaps in coverage within KPs, some PSNUs, and PMTCT that must be addressed to ensure reduced transmission among those that are most vulnerable. For example, while gains were seen in surge and red states, there are still some yellow states with VLC as low as 50% at FY20 Q4. Addressing these gaps will be key to reducing transmission across all PSNUs in Nigeria.

4. While the OVC program has exceeded associated targets, there continues to be gaps in the pediatric care & treatment program. While continued growth has been seen in the OVC cohort, the targets for cohort growth for children and adolescents still have room for improvement in both males and females. Lessons learned from OVC should be gleaned and rolled into the pediatric care and treatment program.

Given Nigeria's successful surge and progress in getting closer to epidemic control goals, the following priority strategic and integrated changes are recommended:

1. Continue to scale ART coverage. Identify and address gaps in coverage in specific age groups, PSNUs, and subpopulations. Build and sustain efficient case finding strategies, especially index testing, while maintaining strong linkage to treatment and sustained attention to continuity and prevention of treatment interruptions.

2. Build on effective community-based approaches and client-centered services that support program growth and prevent interruptions in treatment. Community-based case finding, multi-month dispensing, decentralized drug distribution, and leveraging community organizations such as faith communities are examples to build on.

3. Sustain collaboration between OVC and clinical partners to improve and eliminate gaps in pediatric case finding, linkage, treatment continuity, and viral load suppression. For example, scale-up of the OVC PASS approach has been proposed as a prototypic model.

4. Strategically assess need and optimize the KP program in COP21 to support sustained treatment growth, continuity of treatment, and viral load coverage & suppression, as well as prevention services including PrEP. Implement a standardized and optimized set of prevention, testing, and treatment services.

5. Scale and maximize reach and impact of PrEP program in key populations and other priority risk groups.

6. While broad multi-faceted engagement with Civil Society is likely to support program success, specific budget and programs for Community-Led Monitoring that meet definitions in COP guidance are required.

7. Improving Nigeria's performance in prevention of maternal to child transmission (PMTCT) will ensure that all gaps in the PEPFAR Nigeria program have been addressed for the most vulnerable of populations.

8. Ensure a high standard of service is achieved and sustained and capacity continues to be built for program sustainability to maximize success of the National alignment strategy during its second year.

SECTION 1: COP/ROP 2021 PLANNING LEVEL

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

TABLE 1: All COP 2021 Funding by Appropriation Year

	Bilateral				Central				Total
	FY21	FY20	FY19	Unspecified	FY21	FY20	FY19	Unspecified	TOTAL
Total New Funding	**$ 418,215,786**	**$ -**	**$ -**	**$ -**	**$ 1,500,000**	**$ -**	**$ -**	**$ -**	**$ 419,715,786**
GHP-State	$ 366,253,286	$ -	$ -		$ -	$ -	$ -		**$ 366,253,286**
GHP-USAID	$ 50,000,000				$ 1,500,000				**$ 51,500,000**
GAP	$ 1,962,500				$ -				**$ 1,962,500**
Total Applied Pipeline	**$ -**	**$ -**	**$ -**	**$ 6,784,214**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 6,784,214**
DOD				$ 1,034,920				$ -	**$ 1,034,920**
HHS/CDC				$ -				$ -	**$ -**
HHS/HRSA				$ -				$ -	**$ -**
PC				$ -				$ -	**$ -**
USAID				$ -				$ -	**$ -**
USAID/WCF				$ 5,087,053				$ -	**$ 5,087,053**
State				$ -				$ -	**$ -**
State/AF				$ 662,241				$ -	**$ 662,241**
State/EAP				$ -				$ -	**$ -**
State/EUR				$ -				$ -	**$ -**
State/PRM				$ -				$ -	**$ -**
State/SCA				$ -				$ -	**$ -**
State/SGAC				$ -				$ -	**$ -**
State/WHA				$ -				$ -	**$ -**
TOTAL FUNDING	**$ 418,215,786**	**$ -**	**$ -**	**$ 6,784,214**	**$ 1,500,000**	**$ -**	**$ -**	**$ -**	**$ 426,500,000**

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

Countries should plan for the full Care and Treatment (C&T) level of $200,000,00 and the full Orphans and Vulnerable Children (OVC) level of $26,050,000 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

TABLE 2: COP 2021 Earmarks by Appropriation Year*

	Appropriation Year			
	FY21	FY20	FY19	TOTAL
C&T	$ 200,000,000	$ -	$ -	**$ 200,000,000**
OVC	$ 26,050,000	$ -	$ -	**$ 26,050,000**
GBV	$ 6,700,000	$ -	$ -	**$ 6,700,000**
Water	$ 437,000	$ -	$ -	**$ 437,000**

**Only GHP-State and GHP-USAID will count towards the Care and Treatment and OVC earmarks. **Only GHP-State will count towards the GBV and Water earmarks.'*

TABLE 3: COP 2021 Initiative Controls

	Bilateral	Central	TOTAL
Total Funding	**$ 425,000,000**	**$ 1,500,000**	**$ 426,500,000**
Core Program	$ 425,000,000	$ -	**$ 425,000,000**
Cervical Cancer	$ -	$ -	**$ -**
Community-Led Monitoring	$ -	$ -	**$ -**
Condoms (GHP-USAID Central Funding)	$ -	$ 1,500,000	**$ 1,500,000**
DREAMS	$ -	$ -	**$ -**
HBCU Tx	$ -	$ -	**$ -**
One-time Conditional Funding	$ -	$ -	**$ -**
Surveillance and Public Health Response	$ -	$ -	**$ -**
VMMC	$ -	$ -	**$ -**

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

TABLE 4: State ICASS Funding

	Appropriation Year			
	FY21	FY20	FY19	Unspecified
ICASS	$ 182,455	$ -	$ -	

SECTION 3: PAST PERFORMANCE – COP/ROP 2019 Review

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

Indicator	FY20 result (COP19)	FY21 target (COP20)
TX Current <15	43,889	84,922
TX Current >15	1,102,746	1,343,675
Cervical Cancer Screening	15,425	37,361
TB Preventive Therapy	313,816	352,254

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

Agency	Sum of Approved COP/ROP 2019 Planning Level	Sum of Total FY 2020 Outlays	Sum of Over/Under Outlays
Planned			
DOD	11,991,409	9,792,266	2,199,143
HHS/CDC	121,544,773	118,446,700	3,098,073
State	907,094	390,434	516,660
USAID	257,711,394	244,571,402	13,139,992
Grand Total	**392,154,670**	**373,200,802**	**18,953,868**

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

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

Mechanism ID	Partner Name	Funding Agency	Total Planning Level	Total Outlays	Outlay Delta Check
No over-outlays over %10					

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

Agency	Indicator	FY20 Target	FY20 Result	% Achievement	Program Classification	FY20 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	4,590,197	5,065,495	110%	HTS	$ 10,669,207	78%
	HTS_TST_POS	241,521	195,575	81%			
	TX_NEW	233,480	200,695	86%	C&T	$ 55,761,877	68%
	TX_CURR	793,864	709,214	89%			
	OVC_SERV	642,879	724,266	113%	SE for OVC	$ 23,102,599	73%
				Above Site Programs		$ 6,088,240	
				Program Management		$ 15,175,705	
DOD	HTS_TST	85,897	71,004	83%	HTS	$195,520	61%
	HTS_TST_POS	4,721	3,956	84%			
	TX_NEW	4,557	3,812	84%	C&T	$ 3,176,891	84%
	TX_CURR	34,649	34,841	101%			
				Above Site Programs		$ 418,916	
				Program Management		$ 1,281,605	
USAID	HTS_TST	2,969,619	3,099,335	104%	HTS	$ 17,168,559	83%
	HTS_TST_POS	148,000	141,848	96%			
	TX_NEW	146,558	142,871	97%	C&T	$179,615,884	88%
	TX_CURR	440,023	402,580	91%			
	OVC_SERV	455,738	579,929	127%	SE for OVC	$ 13,555,110	82%
				Above Site Programs		$ 2,376,462	
				Program Management		$ 17,110,764	

COP/ROP 2019 | FY 2020 Analysis of Performance

The PEPFAR Nigeria team is encouraged to maintain its continual review of OU performance data and to use these analyses to identify lessons and innovations to expand across the PEPFAR portfolio of Nigeria. Below S/GAC provides more detail on areas of achievement and opportunities for improvement as outlined from their FY19 results.

- Viral Load Coverage (VLC) targets were not met across some partners, with the exception of APIN public health initiatives LTD having achieved over 80% of their target, Henry Jackson Foundation (HJF) having achieved over 90% of their target, and Heartland Alliance having achieved over 100% of their target. Success from these partners should be studied and integrated across the PEPFAR Nigeria program.

- The FY20 results from two surge states are highlighted below, Akwa Ibom and Rivers. In Figures 1 and 2, the enhanced efforts of partners to increase yield in surge states is evident for both Akwa Ibom and Rivers. The increased efforts of partners in these states is to be commended. We encourage the PEPFAR Nigeria team to maintain the gains of Surge efforts and build off them for acceleration towards epidemic control.

Figure 1. FY20 Performance of Surge State Akwa Ibom

Indicator	2020						
	Q1 Result	Q2 Result	Q3 Result	Q4 Result	Cum. Results	Target	% Achievement.
HTS_TST - N	321,897	427,264	301,802	516,929	1,567,892	1,478,793	106.0%
HTS_TST_POS – N	17,657	20,283	14,985	29,104	82,029	86,037	95.3%
TX_NEW - N	15,926	19,119	15,720	27,379	78,144	86,512	90.3%
TX_NET_NEW – N	10,501	21,824	14,588	27,802	74,715		
TX_RTT - N	1,767	7,036	6,425	3,452	18,680		
TX_CURR - N	72,446	94,270	108,858	136,660	136,660	138,746	98.5%
TX_PVLS - D	44,413	59,675	65,375	91,922	91,922	108,447	84.8%

Figure 2. FY20 Performance of Surge State Rivers

Indicator	2020						
	Q1 Result	Q2 Result	Q3 Result	Q4 Result	Cum. Results	Target	% Achievement.
HTS_TST - N	359,853	474,369	557,551	591,916	1,983,689	2,092,816	94.8%
HTS_TST_POS - N	13,226	14,335	15,413	21,171	64,145	124,500	51.5%
TX_NEW - N	11,243	14,262	15,074	21,007	61,586	123,633	49.8%
TX_NET_NEW - N	9,984	13,270	14,225	23,467	60,946		
TX_RTT - N	5,307	5,384	3,200	4,235	18,126		
TX_CURR - N	48,771	62,041	76,266	99,733	99,733	159,062	62.7%
TX_PVLS - D	23,278	31,495	38,855	54,651	54,651	112,007	48.8%

Partner Performance

The PEPFAR Nigeria team is encouraged to maintain its continual review of partner performance. Additionally, they are advised to use this review to prevent, identify, and intervene in the face of partner underperformance and over-expenditure. Regarding this, analyses conducted at S/GAC makes the following observations about partner performance. Please note that the results below exclude PSNUs with large partner shifts and the two surge states whose performance have been discussed above. Because of the transition to Global Fund, Anambra was removed from all the analysis below.

- APIN Public Health Initiatives, funded by CDC, have met and have above-average performance across TX_NEW (126.6%) and TX_CURR (96.5%), and for TST_POS (99.8%). Of those initiated on care, 29,289 PLHIV were reflected as TX_NET_NEW of the 41,419 PLHIV linked to care in FY20. S/GAC commends this partner for their excellent performance and recommends CDC agency personnel work with APIN partner staff to better understand lessons learned from their performance.

- The Institute of Human Virology (IHVN), funded by CDC, have met and have above-average performance across multiple indicators, including TST_POS (165.0%), TX_NEW (165.9%), and TX_CURR (94.1%). Additionally, IHVN had a positive program growth during FY20 with approximately 28,468 PLHIV who were linked to care growing the cohort. Similarly, IHVN displayed excellent performance in Rivers across FY 20. Based on this assessment, S/GAC commends the country team for the careful monitoring and management of this partner in both surge and non-surge PSNUs.

- Family Health International (FHI), funded by USAID, overperformed within TST_POS (569.8%) and TX_NEW (826.3%), and within TX_CURR (261.6%). While this partner performed well in many respects, the negative net growth of the patient cohort in non-surge PSNUs should be monitored by the country team. Successes from the partner's program in Akwa Ibom as noted earlier should be rolled across non-surge PSNUs.

- The Catholic Caritas Foundation of Nigeria partner, funded by CDC, have met their targets or performed above average on target achievement in non-surge PSNUs, particularly with TST_POS (95.8%), TX_NEW (104.4%), and achieved 89.3% of the TX_CURR target. Additionally, this partner had a positive program growth of 31,847 PLHIV from non-surge PSNUs during FY20. S/GAC recommends that CDC agency personnel work with partner staff to understand the driving forces behind this achievement and integrate them into the partner management strategies across CDC.

- The Centre for Integrated Health Programs (CIHP), funded by CDC, performed well across multiple programmatic areas, particularly TST_POS (180.2%), TX_NEW (242.7%), TX_CURR (98.6%). This performance is particularly noteworthy as an excellent

improvement from the prior year assessment. Based on this review, S/GAC commends the field team for monitoring this partner's performance closely and enhancing their partner management of CIHP as appropriate to achieve improved performance.

- The Heartland Alliance International partner, funded by USAID, have met and exceeded their targets particularly TST_POS (246.3%), TX_NEW (206.1%), TX_CURR (219.5%) and are performing well. S/GAC recommends that USAID agency personnel review lessons learned from any innovative approaches of this partner and integrate them into their partner management across the portfolio.

- The Henry M. Jackson Foundation, funded by DoD, achieved their TX_CURR target (100.6%), and are to be commended for their FY20 performance. However, there is opportunity for improvement in achievement of TX_NEW (83.7%) and TST_POS (83.8%). Any innovative approaches for retention that can be integrated into Nigeria's wider strategic plan should be identified by agency staff for the benefit of PEPFAR Nigeria.

SECTION 4: COP/ROP 2021 DIRECTIVES

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

Minimum Program Requirements (MPR)

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

All PEPFAR programs are expected to meet all of the requirements below, and the COP21 Planning Meeting will include a review of the status of each requirement, including assessment of implementation (including barriers) at the point of client services. To the extent that any requirement(s) have not been met by the time of the COP21 Planning Meeting, the PEPFAR OU team will need to present a detailed description of existing barriers and the remediation plans proposed that will allow them to meet the requirement(s) prior to the beginning of FY2021. The list will be included in the Strategic Direction Summary (SDS), as well.

Failure to meet any of these requirements by the beginning of FY2022 may affect the OU budget. The minimum requirements for continued PEPFAR support include the table on the following page.

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

Minimum Program Requirement	Status and issues hindering Implementation
Care and Treatment	
1. Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	>90% Implementation. Test and Start policy adopted and implemented. Linkage rates consistent >95% across groups; adolescent males 91% for FY20
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.	>90% Implementation of TLD transition; pediatric optimization approx 75%.
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.	Substantially expanded MMD during FY20. 94% MMD3 or MMD6 at Q4 for OU; All PSNUs implementing. Only nine PSNU still have >10% non-MMD
4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by the end of COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	TPT judged to be 75% in most PSNUs. (OU treats once, so clients with previous completion of TPT are not restarted, impacting MER figures)
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.	Judged to be 90% in surge states, 75% in other states.
Testing	
1. Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	Implementation 75% in red and yellow states; 90% otherwise
Prevention and OVC	
1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices*)*	With KP focus, estimated implementation 75%

2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV	90% in surge states; 75% in red and green states; yellow states not prioritized to date
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.	90% in red, green, and surge states; yellow states not prioritized/assessed.
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.	Anecdotally this is prominent in IP narratives and in agency reports.
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.	Funding to CSO in COP20 to address this.
4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Local 50% for FY19; 67% for FY20 and FY21
5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	The Nigerian Government currently procures ARTs for 100 k patients a year. However, there is still opportunity for more progress and measurable milestones to be reached for this MPR.
6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	75% in surge states; otherwise not reported
7. Scale-up of case surveillance and unique identifiers for patients across all sites.	Unique identifier 30-50%. EHR 100% and

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

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

OU –Specific Directives
HIV Treatment
1. Begin real-time use of recency testing to define, develop, and implement a public health investigation and response capability that helps identify drivers of transmission and shapes program response.
2. Additional attention should be paid to increase the proportion of positives from index testing for both pediatric and adult case finding. Index testing should be scaled with fidelity in low-rate states. Pediatric case-finding should focus on both family index testing and testing children with TB or malnutrition. Consider expanding HIVST, including caregiver-assisted HIVST for children aged 2-11 years.
3. Maximize effective interventions to reduce treatment interruptions for clients—particularly client-centered and community-based strategies that have been successful in surge states--and re-engage clients who disengaged in 2020.
4. Implement a harm reduction strategy for people who inject drugs (PWID), based on medically assisted therapy is needed to ensure they are retained in care in achieve viral suppression. Additionally, attention to children of PWIDs also need to be paid, linking them to OVC programs. Lastly, developing a prevention strategy for PWID who are HIV negative will also be important as part of comprehensive KP strategy.
5. PMTCT program should consider community-based or faith-based strategies to engage women not attending facility-based ANC in prevention. While the PMTCT program has done an excellent job of ensuring identified positives from pregnant women are linked to care, ensuring all HIV exposed infants are linked to care and documentation of this linkage will be important for strengthening the program.
6. During COP21 the PEPFAR Nigeria program should identify contributing factors to high peds mortality, and work to implement innovation solutions around these factors. Ensure that HIV positive children under 5 are receiving appropriate prophylaxis, are being evaluated for advanced disease, TB and other co-morbidities.
7. Create and implement routine system for assessing, monitoring, evaluating, and reporting efforts to prevent, detect, and intervene in advanced HIV disease.
HIV Prevention
1. Build on success of PrEP scale-up, ensuring access for populations/patients at high risk of HIV acquisition and maintain this success with quarter-on-quarter growth. This includes but likely is not limited to KP.

2. Proportion of positive screens for TB has declined: team should assess reasons and implement quality assurance to verify TB screening is done regularly and with fidelity. Address gap in proportion of clients with +TB screen who receive WHO-recommended molecular diagnostic screening in limited number of states that are below 90%.
3. Strategically assess the need and expand the Nigeria KP program to accelerate progress towards epidemic control, ensure KPs found through the PEPFAR Nigeria KP program in COP supported states are retained in care. This may include access to testing and care& treatment services for children of KPs. Adaptive approaches, such as greater use of virtual strategies and activities to mitigate structural barriers are warranted.
4. Cervical Cancer screening program must improve linkage to treatment to optimize the impact on women's health. Program implementation must be in line with COP guidance, and SDS for COP21 should describe implementation plans in detail, including any plans for HPV screening.
Commodities, Government Policy, or Programming Changes
1. The PEPFAR Nigeria team should work with Government of Nigeria and the Global Fund to streamline the phased realignment of services and commodities.
2. Improve global standards and traceability for pharmaceutical products by enhancing master data and moving toward GS1 technology: This activity is aimed at working with the FMOH/NAFDAC to incrementally operationalize global standards and traceability for pharmaceutical products. The master data program is supported through a National Product Catalogue (NPC) / Product Information Management (PIM) system that improves interoperability and integration among disparate health and supply chain information systems.
3. Decentralized Drug Distribution: Most patients are on facility-based fast-track models, expand other options, especially community-based approaches such as community-based ART refill groups. Develop a coordinated strategy and implement across surge and red states which can then be replicated across the country.

COP/ROP 2021 Technical Priorities

Client-Centered Treatment Services

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

Pediatric- and Adolescent-Centered Services

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

Community-led Monitoring

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

Pre-Exposure Prophylaxis (PrEP)

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

TB/HIV

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

Advanced HIV disease

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

OVC

To support the Minimum Program Requirement described above, in COP 21 clinical sites and OVC implementing partners should jointly develop formal relationships, such as a memoranda of understanding (MOU), outlining the roles and responsibilities of each member of the multi-disciplinary care team and addressing key issues such as bi-directional referral protocols, pediatric case finding, case conferencing, shared confidentiality, joint case identification, and data sharing. In high volume clinics

within high burden SNUs, at least 90% of children (<age 19) in PEPFAR-supported treatment sites should be offered enrollment in OVC programs. OVC staff placed in clinics (e.g., as linkage coordinators, case managers, etc.) should have the capacity to assess child and family needs (including food and economic security) and to offer appropriate referrals. PEPFAR-supported treatment clinicians should play a key role in training OVC community case workers to build their knowledge in areas such as adherence, retention, and disclosure.

Cervical Cancer Screening and Treatment:
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.

Nigeria will have access to $1,500,000 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 Nigeria will support condom programming in FY22 with funds from your base COP21, the Condom Fund, the GF and/or other donors, and the host-country government. Please note that in FY22 there will also be limited funding available to cover unexpected or emergency condom and/or lubricant requests from PEPFAR-supported countries. Access to these funds will be provided on a first come, first served basis, and OUs will be required to provide a justification for why their special request is being made.

PLHIV Stigma Index 2.0
PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised PLHIV Stigma Index 2.0 utilizing the standard methodology, or complement Global Fund or other donors financing implementation of the PLHIV Stigma Index 2.0, if it has not already been implemented in the OU. If the revised PLHIV Stigma Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 21, whether supported by PEPFAR or other resources. Completion of the PLHIV Stigma Index 2.0 should be accompanied by a response and action plan discussed and agreed upon by all stakeholders that will address findings. Where the PLHIV Stigma Index 2.0 has already been conducted, COP/ROP 21 focus should be on concerted action to address findings.

Human Resources for Health (HRH) and Sustainability
Using data from the HRH Inventory completed in COP20 Q4, OUs are expected to complete a comprehensive HRH analysis to optimize staffing at the site- and above-site-levels. PEPFAR programs in

countries that will be near to or reach 95/95/95 in the COP20 implementation cycle are required to develop and implement plans to sustain their progress and effectively retain clients in quality HIV treatment programs. Results from the Sustainability Index and Dashboard (SID) 2019 should inform the OUs on their progress and gaps related to the policies and technical areas for inclusion in the sustainability plans. Resource alignment data should be used to understand the HIV funding landscape--especially with a more granular understanding of PEPFAR and GFATM investments-- who is paying for what services in order to enhance strategic collaboration and coordination and avoid duplication during the program planning cycle.

Cross-HIS Data interoperability - Use and Analysis
Improved data visibility, and analysis are essential for better understanding the HIV epidemic and reaching epidemic control.

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

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

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

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

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

The full participation of community stakeholders and civil society in every stage of PEPFAR programming, planning, and monitoring as appropriate and consistent with applicable law, regulations and policy, from advocacy to service delivery, is critical to the success and sustainability of PEPFAR and the global effort to combat HIV. Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR

teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government.

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

This engagement, of both civil society, and of faith-based organizations/faith communities, specifically includes the sharing of FY 2020 Q4 and FY 2020 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2021 in order to introduce and discuss all COP/ROP 2021 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2021. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

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

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

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment (C&T): OU's COP/ROP 2021 minimum requirement for the C&T earmark is reflected in Table 2. If there is no adjustment to the COP/ROP 2021 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment earmark amount across new FY 2021 GHP-State and GHP-USAID funding. The Care and Treatment earmark will be calculated as the sum of the following:

- 100% Care and Treatment (C&T) Program Areas
- 50% Testing (HTS) Program Areas
- 100% Above Site Program: Laboratory System Strengthening
- 70% Pregnant and Breastfeeding Women Beneficiary Group
- Proportional % Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the C&T earmark)

Orphans and Vulnerable Children (OVC): OU's COP/ROP 2021 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2021 GHP-State and GHP-USAID funding. The OVC earmark will be calculated as the sum of the following:

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

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

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

Numerator

Prevention: primary prevention of HIV and sexual violence

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, and boys)

+

Prevention: community mobilization, behavior, and norms change

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, boys, adults, not disaggregated)

Denominator

Prevention: primary prevention of HIV and sexual violence (all populations)

+

Prevention: community mobilization, behavior, and norms change (all populations)

+

50 % Prevention: Not disaggregated (all populations)

Gender Based Violence (GBV): OU's COP/ROP 2021 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2021** funding programmed to the GBV cross-cutting code. Your COP/ROP 2021 earmark is derived by using the final COP/ROP 2020 GBV earmark allocation as a baseline. The COP/ROP 2021 planned level of new FY 2021 funds for GBV can be above this amount; however, it cannot fall below it.

Water: OU's COP/ROP 2021 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2021 funding** programmed to the water cross-cutting code. Your COP/ROP 2021 earmark is derived by

using the final COP/ROP 2019 water earmark allocation as a baseline. The COP/ROP 2021 planned level of new FY 2021 funds for water can be above this amount; however, it cannot fall below it.

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

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

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

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