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INFORMATION MEMO FOR AMBASSADOR VROOMAN, Rwanda

FROM: Janet Saul, PhD and Emily Kearney, S/GAC

THROUGH: Ambassador Deborah L. Birx, MD

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

Dear Ambassador Vrooman,

We 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 COVID-19. Focus groups and deep analytics of client returning to care to ensure we are addressing the critical persistent and new structural barriers Focus on areas of recent treatment interruption to understand how COVID may have created or exacerbated barriers to access and treatment continuity. Across all countries we see persistent gaps in pediatric diagnosis, treatment and viral suppression. Particular attention should be paid to the pediatric cascade and identifying challenges by district and country for clear and actionable plans. In addition, leverage OVC, DREAMS and other resources for clear accountability to work with mothers and improve early infant diagnosis by two months of age and strengthen resiliency among at-risk women and girls. Community-led monitoring must raise visibility and appropriate response to the needs of populations already vulnerable before COVID. The assessment of needs, and strategies to reinforce OVC caregivers and HIV-affected families in crisis, should contribute to budget and activity planning for care and treatment, DREAMS, OVC and wraparound resources. Furthermore, analyzing expenditures at mechanism and program area level, along with the work teams have done, to build relationships and co-planning with your partner government, the Global Fund, UN organizations and other donors. These relationships and planning efforts are critical to supply chain stability for key commodities as well as understanding COVID relief and other potential funding available in country to ensure most effective and efficient use of PEPFAR's contributions to the national HIV response in COP21.

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

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

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

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

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

We are very excited about your progress in:

- Attainment of epidemic control and the 90/90/90 benchmark; pushing towards 95/95/95
- Attainment of most prevention goals in KP, OVC, DREAMS, and VMMC
- Case based surveillance rolled out nationally

Together with the Government of Rwanda and civil society leadership, we have made tremendous progress together. Rwanda 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 Rwanda:

- Case finding is not highly targeted and yields are lower than expected.
- Some gaps remain in the clinical cascade, specifically for young adult men and potentially for children under 15 years of age.
- PrEP scale-up was challenging beyond key populations.
- Transition of commodities procurement to RMS was delayed by COVID-19 restrictions.

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. Rwanda has achieved the 2020 goals and is on track to achieve 2030 goals early which means sustaining the amazing gains will need to be our constant focus.

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

The PEPFAR Country/Regional Operational Plan (COP/ROP 2021) notional budget for Rwanda is **$70,300,000** 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 Rwanda and Rwandan civil society, believes is critical for the country's progress towards controlling the pandemic and maintaining control.

We are hoping this approach to target-setting and budget will establish an open dialogue on target-setting and empower teams to work with all stakeholders to plan a strategic and impactful COP. The expectation is for country teams and agencies to propose to S/GAC the targets they believe are achievable and feasible and hold their partner's accountable to that achievement.

PEPFAR, with partner governments, multilateral partners, and communities, continues to move rapidly toward control of the HIV pandemic and plan for sustainability of programs. Achieving epidemic control for HIV will be a remarkable accomplishment, saving millions of lives, significantly lowering the burden

of HIV/AIDS in countries and communities, reducing the future costs required to sustain the HIV response, and building sustainable public health systems capacity in host countries.

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

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

Sincerely,

Deborah Birx

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

CC: **S/GAC – Janet Saul, Emily Kearney;**
Rwanda PCO – Allie Hoagland, Aimee Rurangwa

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. Clinical Cascade: Attainment of epidemic control and the 90/90/90 benchmark; pushing towards 95/95/95. High linkage and retention despite challenges of COVID-19. For example, the national average monthly loss to follow up (LTFU) rate consistently hovers at approximately 0.2%. 3MMD was successfully rolled out.
2. Prevention: Attainment of most prevention goals. Achievement was above targets for all KP sub-populations. OVC met targets for serving vulnerable children and their families, ensuring that HIV status was known for virtually all beneficiaries, and that all children living with HIV (CLHIV) enrolled in DREAMS were on ART. DREAMS met or exceeded targets (i.e., enrollment, package completion), and is poised to provide PrEP for AGYW based on expanded eligibility in GoR policy. VMMC exceeded targets and more than three quarters of VMMCs were in the target age group.
3. Above Site: Case-based surveillance was rolled out nationally, and recency testing was being used to analyze clusters for an improved public health response.

Challenges:

1. Case Finding: Only 56% of all tests were conducted through index testing and yields were fairly low, ranging from 3.2%-7.5% (average is 4%) depending on the modality. Not all safe and ethical index testing assessments have been completed, and there is a need for significant remediation in the sites where assessments were completed.
2. Clinical Cascade: Some gaps remain for specific age/sex groups, particularly young adult men and children under 15 years of age. For CLHIV, the extent of the gaps along the cascade is challenging to quantify due to data limitations.
3. PrEP Scale Up: Although the overall target was met, achievement differed by partner, with one partner greatly overachieving and another delivering very little PrEP.
4. Above Site: Transition of commodities procurement to Rwanda Medical Supply (RMS) was delayed by COVID-19 restrictions.

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

1. Finalize the pivot to focused case finding including: increasing the proportion of all testing that is index testing, increasing index testing yield, supplementing index testing with self-testing, and ensuring remediation on safe and ethical index testing practices.
2. Respond to the remaining gaps in the clinical cascade for young adult men and CLHIV <15 while also ensuring support services such as CLHIV enrollment in the OVC program.
3. Increase PrEP access beyond individuals in sero-discordant couples and FSWs to align with COP guidance (e.g., MSM, AGYW, etc.).

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	**$ 68,698,647**	**$ -**	**$ -**	**$ -**	**$ 300,000**	**$ -**	**$ -**	**$ -**	**$ 68,998,647**
GHP-State	$ 67,258,022	$ -	$ -		$ -	$ -	$ -		$ 67,258,022
GHP-USAID	$ -				$ 300,000				$ 300,000
GAP	$ 1,440,625				$ -				$ 1,440,625
Total Applied Pipeline	**$ -**	**$ -**	**$ -**	**$ 1,301,353**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 1,301,353**
DOD				$ 285,138				$ -	$ 285,138
HHS/CDC				$ 436,058				$ -	$ 436,058
HHS/HRSA				$ -				$ -	$ -
PC				$ -				$ -	$ -
USAID				$ 330,157				$ -	$ 330,157
USAID/WCF				$ -				$ -	$ -
State				$ -				$ -	$ -
State/AF				$ 250,000				$ -	$ 250,000
State/EAP				$ -				$ -	$ -
State/EUR				$ -				$ -	$ -
State/PRM				$ -				$ -	$ -
State/SCA				$ -				$ -	$ -
State/SGAC				$ -				$ -	$ -
State/WHA				$ -				$ -	$ -
TOTAL FUNDING	**$ 68,698,647**	**$ -**	**$ -**	**$ 1,301,353**	**$ 300,000**	**$ -**	**$ -**	**$ -**	**$ 70,300,000**

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

Rwanda should plan for the full Care and Treatment (C&T) level of $33,000,000 and the full Orphans and Vulnerable Children (OVC) level of $13,300,000 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	$ 33,000,000	$ -	$ -	**$ 33,000,000**
OVC	$ 13,300,000	$ -	$ -	**$ 13,300,000**
GBV	$ 800,000	$ -	$ -	**$ 800,000**
Water	$ 178,000	$ -	$ -	**$ 178,000**

**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	**$ 70,000,000**	**$ 300,000**	**$ 70,300,000**
Core Program	$ 56,277,800	$ -	**$ 56,277,800**
Cervical Cancer	$ -	$ -	**$ -**
Community-Led Monitoring	$ -	$ -	**$ -**
Condoms (GHP-USAID Central Funding	$ -	$ 300,000	**$ 300,000**
DREAMS	$ 10,122,200	$ -	**$ 10,122,200**
HBCU Tx	$ -	$ -	**$ -**
One-time Conditional Funding	$ -	$ -	**$ -**
Surveillance and Public Health Response	$ -	$ -	**$ -**
VMMC	$ 3,600,000	$ -	**$ 3,600,000**

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

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TABLE 4: State ICASS Funding

	Appropriation Year			
	FY21	FY20	FY19	Unspecified
ICASS	$ 272,234	$ -	$ -	

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	3,690	4,488
TX Current >15	118,381	126,202
VMMC >15	199,939	203,203
DREAMS (AGYW PREV)	33,119	----
Cervical Cancer Screening	----	----
TB Preventive Therapy	211	59,847

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

Agency	Sum of Approved COP/ROP 2019 Planning Level	Sum of Total FY 2020 Outlays	Sum of Over/Under Outlays
DOD	4,532,074	2,127,583	2,404,491
HHS/CDC	36,685,778	34,354,770	2,331,008
USAID	33,102,720	35,864,842	-2,762,122
Grand Total	**74,320,572**	**72,347,195**	**1,973,377**

These figures include only bilateral figures at present

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

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

Mechanism ID	Partner Name	Funding Agency	Total Planning Level	Total Outlays	Outlay Delta Check
17616	Cooperative Housing Foundation Corp.	USAID	$2,804,200	$7,173,653	($4,369,453)

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	49,367	**71,163**	144%	HTS Program Area	$1,961,957	85%
	HTS_TST_POS	2,933	**2,939**	100%			
	TX_NEW	2,685	**4,897**	182%	C&T Program Area	$15,885,149	100%
	TX_CURR	118,700	**118,701**	100%			
	VMMC_CIRC	98,440	**140,984**	143%	VMMC Sub-Program Area	$3,660,644	100%
	OVC_SERV	----	----	----	OVC Beneficiary	----	----
DOD	HTS_TST	8,098	**8,676**	107%	HTS Program Area	$322,885	100%
	HTS_TST_POS	969	**221**	23%			
	TX_NEW	284	**78**	28%	C&T Program Area	$419,650	100%
	TX_CURR	3764	**2,917**	78%			
	VMMC_CIRC	100,000	**103,014**	103%	VMMC Sub-Program Area	$1,141,076	100%
	OVC_SERV	----	----	----	OVC Beneficiary	----	----
State/PRM	HTS_TST	206	**115**	56%	HTS Program Area	$0	0%
	HTS_TST_POS	34	**5**	15%			
	TX_NEW	31	**34**	110%	C&T Program Area	$0	0%
	TX_CURR	471	**453**	96%			
	VMMC_CIRC	----	----		VMMC Sub-Program Area	----	----
	OVC_SERV	----	----		OVC Beneficiary	----	----
USAID	HTS_TST	----	----		HTS Program Area	$417,419	100%
	HTS_TST_POS	----	----				
	TX_NEW				C&T Program Area	$16,501,396	93%
	TX_CURR	----	----				
	VMMC_CIRC	----	----		VMMC Sub-Program Area	$84,637	100%
	OVC_SERV	130,237	**130,966**	100.60%	OVC Beneficiary	$3,498,232	79%
				Above Site Programs		$5,130,472	
				Program Management		$6,160,901	

COP/ROP 2019 | FY 2020 Analysis of Performance

PEPFAR Rwanda's achievements in COP19 were impressive, particularly given the challenges introduced by the COVID-19 pandemic. Restrictions on gatherings and school closures impeded the implementation of OVC and DREAMS activities, and some above-site activities were also affected by delays related to the pandemic. However, the program appears to have rebounded quickly. For example, despite VMMC services being interrupted in Q2 and Q3, by the end of the fiscal year the program had achieved 123% of its VMMC target.

In COP19, the program met and surpassed goals for almost all prevention activities, achieving 123% of targets on KP_PREV and 101% on OVC_SERV. Of all VMMCs conducted, 78% were in the priority age band of 15-29. PrEP_CURR and PrEP_NEW targets were also exceeded. Although the roll-out of TPT has been slow, with just 4% of the TB_PREV target met, it is expected to be expanded to all facilities by February of 2021 and achieve combined COP19 and COP20 targets by the end of the fiscal year.

Overall, the program also demonstrated exemplary performance across the clinical cascade, exceeding key treatment targets. This is especially commendable given the close alignment all agencies demonstrated between their budgets for testing and care and treatment and their respective expenditures. At the aggregate level, the program spent 102% of its testing budget and 100% of its treatment budget. While results on testing, treatment, and viral suppression in pediatrics and adolescents—and the 10-14 age band in particular—raise some potential concerns, the accuracy of data on this age group in Rwanda is uncertain. Thus, the team is currently working with global partners to arrive at a more accurate picture of CLHIV in Rwanda, and estimates are expected in the next 1-2 months. These estimates should be used for COP21 planning purposes.

With respect to case finding, the program over-tested by 140% while reaching 81% of its target for new positives. The program's success in meeting its targets for identifying new positives varied among age bands, with higher achievement of targets among adults than children. Self-testing results were low at just 42% of the target, but these activities have been scaling up rapidly, with nearly 20,000 tests dispersed in Q4 vs. 3,257 in Q1. Proxy recency testing coverage was 44%.

PEPFAR Rwanda's performance on treatment was remarkable, with 167% achievement on new clients put on treatment and 95% retained on treatment. Retention has been high, even during COVID-19, with average monthly rate of LTFU consistently around .2%. Uptake of 3MMD has been good, but there are opportunities for improvements among adults, and 6MMD is scaling up and is expected to achieve targets in COP20. Viral load suppression was very good at 96%, but there were challenges with viral load coverage. Viral load suppression among CLHIV <15 was 86%.

In terms of above-site activities, the shift of procurement of HIV commodities to Rwanda Medical Supply (RMS) has been delayed, but there is a clear path forward to this goal with the transition supported by USAID technical assistance. Community-based surveillance has been rolled out to 97% of PEPFAR sites, and national coverage of recency has been achieved. Coverage of rapid recency testing of new HIV positive clients is 67%.

There are several program areas that are expected to be completed/rolled out by the end of COP20. The team has a plan for each of these, and we will continue to monitor these closely during the current fiscal year. These activities include: providing TPT for all PLHIV, scaling up 6MMD, ensuring no VMMC

among <15 year olds, rolling out community level monitoring, scaling up the digital version of CBS, and transitioning to DTG-based regimens for children who are >4 weeks of age and weigh >3 kg.

Partner and Financial Performance

CDC

Overall, CDC's performance was very good, with the agency meeting or exceeding targets for most key indicators. The agency achieved 95% of its target for retaining clients on treatment and 182% of its target for clients newly initiated on treatment, spending 101% of its C&T budget. The agency did over test at 144% percent of its target, but reached 100% of its target for newly identified PLHIV, spending 109% of its testing budget.

CDC partner Rwanda Ministry of Health (MOH) demonstrated excellent performance across most program areas, surpassing its targets for case identification, treatment, PMTCT, and VMMC. CDC's Society for Family Health (SFH) IM also demonstrated commendable performance, exceeding all of its case finding and prevention targets.

One area where partner performance was notably divergent was related to PrEP activities. While SFH achieved 433% of its PrEP_NEW target and 607% of its PrEP_CURR target, the MOH met only 2% of its PrEP_NEW target and 3% of its PREP_CURR target. MOH figures are partially explained by high viral load suppression at health facilities which limited eligibility; expansion of eligibility criteria during COP20 should contribute to higher achievement on this indicator in the future.

DOD

DOD performed well on VMMC, exceeding its target and performing 81% of VMMCs in the priority age band. However, DOD underperformed on other key indicators. The agency tested at 107% percent of its target, reached 23% of its target for newly identified PLHIV, and spent 77% of its testing budget. In terms of treatment, the agency achieved 28% of its target for clients newly initiated on treatment and 78% of its target for retaining clients on treatment. The agency spent 73% of its C&T budget.

JHPIEGO performed very well, reaching 101% of its VMCC target. Alliance for Healthy Communities (AHC) also performed well on VMMC and PMTCT, but fell short on other indicators across the clinical cascade. Available data on DOD's SFH mechanism seems to indicate encouraging performance on many indicators, but potential data quality issues complicate more detailed analysis. All DOD partners will receive comprehensive SIMS assessments as soon as COVID-19 restrictions allow. DOD has begun transitioning all activities to AHC starting with COP21, and AHC will report data biweekly to help identify and implement any necessary programmatic shifts.

USAID

USAID's performance was commendable, in particular the agency's success in nimbly adapting to, and overcoming, the challenges presented by COVID-19. The agency has met or exceeded nearly all of its OVC targets. Enrollment of CLHIV in the OVC program more than doubled in COP19; however, it is still well below the desired goal of 90% enrolled.

PrEP enrollment has increased four-fold since December 2019. Performance on DREAMS was also strong with all IPs surpassing AGYW enrollment targets and 100% primary package completion for all AGYW within 12 months of enrollment. TLD has been scaled up rapidly and outpaced targets. The agency achieved 83% of its targets for MMD, and this is growing steadily over time. USAID continues its efforts to shift procurement of all ARVs to RMS and support it to increasingly assume supply chain functions. While these efforts have been delayed, in COP20 RMS will begin to procure HIV

commodities; USAID expects to shift from RMS procurement of 70% of ARVs in COP20 to 100% in COP21. The agency will provide a targeted package of technical assistance and oversight to ensure a successful transition.

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.	Attained (fully adopted), no hindrances
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.	**On schedule** for TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential) **In progress** for DTG-based regimens for children who are ≥4 weeks of age and weigh >3 kg ❖ Preparation underway (development of guidelines and SOPs)

	❖ Recent quantification considered DTG 5 and 10 mg **<u>Completed</u>** removal of all NVP- and EFV-based ART regimens.
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.	3MMD is fully implemented. 6MMD was initiated in July 2020 in three districts of Kigali. The original implementation plan of starting in all health facilities was affected by Covid-19. Expect to achieve targets by COP 20
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.	Initiated at the end of COP18, currently being scaled
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.	Attained, no hindrances
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.	In progress, index testing is conducted at all facilities
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*)*	In progress, scale up of PrEP for AGYW in COP20
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	Attained, no hindrances

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.	Attained, no hindrances
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.	In progress, COVID-19 limited the ability of USG teams to conduct field visits from March 2020 to date
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.	Attained, no hindrances
4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Attained, no hindrances
5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	In progress, capacity of GoR is limited and impacted by COVD-19 response needs
6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Attained
7. Scale-up of case surveillance and unique identifiers for patients across all sites.	In progress and on track

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

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

OU–Specific Directives
HIV Case Finding and Treatment
1. Implement a focused case finding plan to improve the quantity and quality of HIV testing services. Specifically: increase the proportion of all testing that is index testing; increase index testing yield; supplement index testing with self-testing; and ensure remediation on safe and ethical index testing practices.
2. Establish a plan for filling the remaining gaps in the clinical cascade for young adult men. Look to lessons from MenStar and the Faith and Community Initiative for potential solutions.

3. Review data to accurately understand the true picture of CLHIV in Rwanda – ensure a response to those data to get to 90/90/90 in <15; 90% of CLHIV need to be referred to OVC for support for them and their families.
HIV Prevention
4. Increase PrEP beyond individuals in sero-discordant couples and FSWs. Targets should be based on estimates of individuals in populations at increased risk for HIV acquisition (e.g., MSM, AGYW, people diagnosed with STIs, etc.)
Above Site
5. Create a detailed plan, including a timeline with clear milestones, to fully transition commodity procurement to RMS. Specifically note how long PEPFAR will provide TA to RMS and the rate of decline of that support.
Other Government Policy or Programming Changes Needed
6. Work with the Government of Rwanda to incorporate CBS and recency testing as standard programming for all PLHIV.
7. Work with the Government of Rwanda to ensure that the expanded PrEP policy is implemented as intended and no barriers remain to allow for the optimization of PrEP as a prevention intervention.
8. Work to create a long-term plan for government financing and sustainability. By the end of the first quarter of COP 21, in conjunction with the Government of Rwanda, civil society, and other development partners, the PEPFAR team should develop a review of functional and financial barriers to local responsibility for HIV epidemic control with the goal of initiating a process to increase the sustainability of the national and local HIV response.

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.

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 SNUs 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 SNUs.

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.

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.

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.

Rwanda will have access to $300,000 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 Rwanda 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 Rwanda 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.

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 Rwanda 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.