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INFORMATION MEMO FOR AMBASSADOR LANA MARKS, SOUTH AFRICA

FROM: S/GAC Chair, Angeli Achrekar and PPM, Angela Marler

THROUGH: Ambassador Deborah L. Birx, MD

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

Dear Ambassador Marks:

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 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 areas level, along with the work teams have done, to build relationships and co-planning with your partner government, the Global Fund, UN organizations and other donors. These relationships and planning efforts are critical to supply chain stability for key commodities as well as understanding COVID relief and other potential funding available in country to ensure most effective and efficient use of PEPFAR's contributions to the national HIV response in COP21.

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

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

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

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

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

We are very excited about your progress in:

- Improved linkage due to an increased partner focus on quality services and fast-tracking linkage to care.
- Resilience of the treatment program thanks to implementation of patient-centered and community-led interventions to ensure continued access to ART despite significant challenges and negative impact from COVID-19 related lockdowns.
- Improvements in the prevention portfolio, including PrEP achievement among men who have sex with men and adolescent girls and young women, reaching priority populations, and continued strong achievement in serving orphans and vulnerable children.

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

- Underperformance across the clinical cascade, exacerbated by COVID-19 lockdowns, have contributed to the overall FY 2020 TX_CURR achievement being approximately 1 million short of the COP19 target. Low testing yields and gaps remain in case finding, affecting performance throughout the clinical cascade.
- Pediatric engagement has stagnated over the past three years, and performance is weak across the cascade on pediatric case finding, linkage, retention, and viral load suppression.
- Improvement is needed after severe COVID-19 impact on the VMMC program, and DREAMS completion decreased from FY2019.

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. South Africa has not achieved the 2020 goals and is not on track to achieve 2030 goals early, which means sustaining the amazing gains will need to be our constant focus.

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

The PEPFAR Country/Regional Operational Plan (COP/ROP 2021) notional budget for South Africa is **$450,000,000** 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 South Africa and civil society of South Africa, believes is critical for the country's progress towards controlling the pandemic and maintaining control.

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

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

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

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

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

With input from the field teams through the quarterly POARTs, the agency self-assessments and from Headquarters Country Accountability and Support Teams (CAST), a thorough program review of your country over time has been conducted. This includes the end of year results of the Country Operational Plan (COP) 2019 and current COP 2020 implementation as we plan for COP 2021. We have noted the following key successes and challenges:

Successes:

1. Improved linkage due to an increased partner focus on quality services and fast-tracking linkage to care. Given that case findings decreased in FY 2020, the PEPFAR team and partners employed interventions such as peer-based case management to achieve 90% linkage in FY 2020.
2. Resilience of the treatment program thanks to implementation of patient-centered and community-led interventions to ensure continued access to ART despite significant challenges and negative impact from COVID-19 lockdowns. The program showed signs of recovery in Q4 of FY 2020 and had a positive TX_NET_NEW in FY 2020.
3. Improvements in the prevention portfolio, including PrEP achievement among men who have sex with men and adolescent girls and young women, reaching priority populations, and continued strong achievement in serving orphans and vulnerable children.

Challenges:

1. Underperformance across the clinical cascade, exacerbated by COVID-19 lockdowns, have contributed to the overall FY 2020 TX_CURR achievement being approximately 1 million short of the COP19 target. Targets were not met despite the PEPFAR COP 2018 and COP 2019 additive $500 million USD one-time surge investment and collaboration with the Government of South Africa (GoSA) to reach the goal of reaching and maintaining at least 6.1 million people on treatment by the end of 2020. Low testing yields and gaps in case finding affect performance throughout the clinical cascade and indicate the need for optimized testing. Weak TX_NEW and loss to follow up issues contribute to low performance.
2. Pediatric engagement has stalled over the past three years, and performance across the cascade is weak on pediatric case finding, linkage, retention, and viral load suppression. Index testing for biological children of PLHIV is low, and there is a need to transition to optimal treatment regimens for C/ALHIV.
3. Improvement is needed after severe COVID-19 impact on the VMMC program, and DREAMS completion decreased from FY 2019. VMMC services were fully suspended due to COVID-19 in Q2 of FY 2020 and resumed on a very limited basis in Q4 of FY 2020. Spending on VMMC remains high despite low achievement. DREAMS programs achieved low completion, especially among 20-24 year olds.

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

1. Accelerate and complete COP 2020 focus on linkage, retention, and regaining patients lost to follow-up to reach the 95-95-95 goals. There is a need for significant pediatric performance improvements across the clinical cascade and pediatric ARV optimization.
2. Optimize testing across the program to close gaps in case finding and increase yield. Target testing to focus on populations and areas at high risk for HIV infection and improve index testing scale-up and performance.
3. Accelerate VMMC and increase DREAMS completion, focusing on GBV and economic strengthening for older AGYW in DREAMS.

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	**$356,259,121**	**$1,700,000**	**$50,000,000**	**$-**	**$-**	**$-**	**$-**	**$-**	**$407,959,121**
GHP-State	302,809,121	$1,700,000	$50,000,000		$-	$-	$-		**$354,509,121**
GHP-USAID	$50,000,000				$-				**$50,000,000**
GAP	$3,450,000				$-				**$3,450,000**
Total Applied Pipeline	**$-**	**$-**	**$-**	**$41,840,879**	**$-**	**$-**	**$-**	**$200,000**	**$42,040,879**
DOD				$-				$-	**$-**
HHS/CDC				$35,354,674				$-	**$35,354,674**
HHS/HRSA				$-				$-	**$-**
PC				$2,499,772				$-	**$2,499,772**
USAID				$-				$200,000	**$200,000**
USAID/WCF				$-				$-	**$-**
State				$-				$-	**$-**
State/AF				$3,986,433				$-	**$3,986,433**
State/EAP				$-				$-	**$-**
State/EUR				$-				$-	**$-**
State/PRM				$-				$-	**$-**
State/SCA				$-				$-	**$-**
State/SGAC				$-				$-	**$-**
State/WHA				$-				$-	**$-**
TOTAL FUNDING	**$356,259,121**	**$1,700,000**	**$50,000,000**	**$41,840,879**	**$-**	**$-**	**$-**	**$200,000**	**$450,000,000**

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

Countries should plan for the full Care and Treatment (C&T) level of $230,000,000 and the full Orphans and Vulnerable Children (OVC) level of $68,000,000 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	$230,000,000	$-	$-	**$230,000,000**
OVC	$68,000,000	$-	$-	**$68,000,000**
GBV	$10,000,000	$-	$-	**$10,000,000**
Water	$939,000	$1,700,000	$-	**$2,639,000**

**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	**$449,800,000**	**$200,000**	**$450,000,000**
Core Program	$319,300,000	$200,000	**$319,500,000**
Cervical Cancer	$-	$-	**$-**
Community-Led Monitoring	$-	$-	**$-**
Condoms (GHP-USAID Central Funding)	$-	$-	**$-**
DREAMS	$90,000,000	$-	**$90,000,000**
HBCU Tx	$-	$-	**$-**
One-time Conditional Funding	$-	$-	**$-**
Surveillance and Public Health Response	$-	$-	**$-**
VMMC	$40,500,000	$-	**$40,500,000**

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

TABLE 4: State ICASS Funding

	Appropriation Year			
	FY21	FY20	FY19	Unspecified
ICASS	$126,959	$-	$-	

SECTION 3: PAST PERFORMANCE – COP/ROP 2019 Review

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

Indicator	FY20 result (COP19)	FY21 target (COP20)
TX Current <15	130,663	163,298
TX Current >15	4,685,350	4,843,057
VMMC >15	117,189	315,031
DREAMS (AGYW PREV)	115,664	N/A
TB Preventive Therapy	336,492	641,255

*FY20 Results and FY21 Targets include central support.

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	160,169	245,128	-84,959
HHS/CDC	341,037,545	271,556,732	69,480,813
PC	2,375,000	1,387,832	987,168
State	4,220,720	3,804,686	416,034
USAID	376,040,149	364,171,061	11,869,088
Central			
HHS/CDC	11,800,000	345,081	11,454,919
USAID	17,262,666	7,661,095	9,601,571
Grand Total	**752,896,249**	**649,171,615**	**103,724,634**

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

The following IMs outlayed at least 110 percent in excess of their COP/ROP19 approved level. Data pulled January 12, 2021.

Mechanism ID	Partner Name	Funding Agency	Total Planning Level	Total Outlays	Outlay Delta Check
70289	Maternal Adolescent and Child Health Institute NPC	USAID	$ -	$42,466,000	($42,466,000)
70290	RIGHT TO CARE	USAID	$35,752,316	$41,233,189	($5,480,873)
102130		USAID	$18,899,824	$23,052,608	($4,152,784)
70287	BROADREACH HEALTHCARE (PTY) LTD	USAID	$1,195,416	$4,036,200	($2,840,784)
70309	PATH	USAID	$1,900,000	$4,576,674	($2,676,674)
70301	WITS HEALTH CONSORTIUM (PTY) LTD	USAID	$9,291,201	$10,862,955	($1,571,754)
14631	Pact, Inc.	USAID	$8,159,628	$9,467,047	($1,307,419)
81887	University Research Co., LLC	HHS/CDC	$1,666,667	$2,666,667	($1,000,000)
9569	Education Development Center, Inc.	USAID	$4,630,324	$5,354,793	($724,469)
83000	Remote Medicine Inc.	USAID	$0	$508,000	($508,000)
70294	World Health Organization	HHS/CDC	$1,100,000	$1,499,878	($399,878)
81907	AFRICA RESOURCE CENTRE	USAID	$750,000	$1,100,991	($350,991)
80004	MOTHERS2MOTHERS SOUTH AFRICA	USAID	$2,290,526	$2,570,247	($279,721)
18594	Population Council, Inc., The	USAID	$52,000	$232,115	($180,115)
81903	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	USAID	$1,004,000	$1,156,374	($152,374)
104130		DOD	$160,169	$245,128	($84,959)
17505	Unicef	HHS/CDC	$350,000	$407,261	($57,261)
70288	KHETHIMPILO AIDS FREE LIVING	USAID	$119,867	$165,000	($45,133)

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	5,519,921	5,565,518	101%	HTS Program Area	$19,138,673	93%
	HTS_TST_POS	478,504	253,208	53%			
	TX_NEW	458,444	219,937	48%	C&T Program Area	$163,844,492	88%
	TX_CURR	2,052,411	1,590,385	77%			
	VMMC_CIRC	312,000	144,622	46%	VMMC Sub-Program Area	$24,684,721	98%
Peace Corps	OVC_SERV	2,292	1,333	58%	OVC Beneficiary	$1,036	100%
State/AF	HTS_TST	N/A	116,772	N/A	HTS Program Area	N/A	N/A
	HTS_TST_POS	N/A	5,375	N/A			
	OVC_SERV	N/A	1,246	N/A	OVC Beneficiary	N/A	N/A
USAID	HTS_TST	7,558,747	6,948,610	92%	HTS Program Area	$19,032,773	100%
	HTS_TST_POS	609,867	307,733	50%			
	TX_NEW	602,751	287,195	48%	C&T Program Area	$192,214,834	89%
	TX_CURR	2,828,957	2,220,475	78%			
	VMMC_CIRC	207,998	15,117	7%	VMMC Sub-Program Area	$10,306,095	100%
	OVC_SERV	626,562	642,698	103%	OVC Beneficiary	$27,072,803	86%
					Above Site Programs	$32,167,696	N/A
					Program Management	$81,431,880	N/A

COP 2019 | FY 2020 Analysis of Performance

Case Finding

HTS performance indicates that South Africa's HIV testing program requires further targeting to focus on populations and areas at high risk for HIV infection. In the 27 high burden districts, South Africa over-tested, achieving 97% of their HTS_TST target but only 52% of TST_POS. Index testing remains low across districts, and only 9% of all HTS_TST_POS came from index testing. 62% of HTS_TST_POS came from Other PITC with a yield of 4%. The COVID-19 pandemic has had impact on all HTS indicators, primarily due to a lower headcount within health facilities. However, FY 2020 Q4 data shows improvements in TST_POS and HTS_INDEX testing indicating that the program is beginning to rebound. For example, HTS TST has increased by 23% (after a 42% drop in Q2) and HTS_POS increased by 23% (after a 44% drop from in Q2). In addition, there was a 13% increase in the number of contacts reached for testing within the index testing program in Q4. PEPFAR South Africa has made progress ensuring that index testing programs meet safe and ethical standards outlined in PEPFAR guidance. A total of 1,345 sites have been assessed to determine if they meet minimum standards. Of these, 14% (189) meet 100% of the minimum standards. All sites that did not meet minimum standards have quality improvement plans in place. In terms of district and partner performance within the 27 high-burden districts, HTS_POS district performance ranges between 32%- 72% and ranges between 42%-66% by partner. The highest performing partner for HTS_POS was Right to Care, funded by USAID, at 66% and the highest performing district is Ehlanzeni district at 72% towards the annual target. Index testing performance against target per partner ranges from 9% to 59%. HST, funded by CDC, is the best performing partner for index testing at 59% toward achievement.

Care and Treatment

Analysis of COP 2019 performance for Care and Treatment shows underperformance across the cascade, partly due to the impact of COVID-19 and related lockdowns. The highest impact to the program occurred during Q3 of FY 2020, when COVID-19 cases peaked, decreasing headcount in facilities and causing facility closures due to lack of staff. Prior to the peak in Q2, clinical indicators including TX_CURR, LTFU from TX_ML, linkage, and viral load coverage were improving across almost all partners and provinces, but suffered declines in Q3. For FY 2020 PEPFAR South Africa achieved 3,806,434 TX_CURR, more than 1 million short of its COP 2019 target of 4,876,824. In the 27 highest burden districts the program achieved 48% of the TX_NEW target and 8% of the TX_NET_NEW target for COP 2019. As case finding remained low, linkage improved in FY 2020, with annual linkage among the 27 highest burden districts at 90% due to increased effort by partners to provide quality services and fast-tracking linkage to care. In terms of district and partner performance, annual achievement for TX_NEW by district ranged from a low of 33% in Buffalo City to a high of 70% in Ehlanzeni and annual achievement in the metros ranged from 45% in eThekwini to 56% in Cape Town. Annual TX_NEW achievement by partner ranged from 39% (BroadReach, funded by USAID) to 62% (Right to Care, funded by USAID).

Retention remained an issue in COP 2019. Despite 198,370 patients returned to care in FY 2020 Q4, 262,215 clients who had been on treatment for >3 months were lost to follow up in that same quarter. Loss to follow up rates for new patients are still approximately 15% and problematic across the country. While significant focus has been made with the MINA campaign to engage men, programming needs to be designed to reduce LTFU events for women ages 30-45, who make up a significant number of LTFU events. For TX_CURR growth, district targets were not reached but the majority had positive growth in Q4. Overall TX_CURR achievement ranged from 73% (Aurum) to 88% (Right to Care). Overall clinical cascade performance within the five high-burden metros yielded the following: HTS_POS achievement ranged from 47% in eThekwini-MatCH sites to 61% in CoJ (Anova); Linkage ranged from 84% in Ekurhuleni (Aurum) to 110% in Cape Town (Anova); TX_CURR achievement ranged from 68% in Ekurhuleni (Aurum) to 83% in eThekwini-HST sites; growth in treatment ranged from -4% in eThekwini-MatCH sites to 6% in eThekwini-HST sites.

Viral load coverage remained low at 75%, while viral load suppression was sustained at 93%. Viral load completion was lowest in children, adolescents, and young adult men, while viral load suppression remains low in children and adolescent males with general improvement seen with age.

MMD and decanting to CCMDD or external pick up points have been expanded, which has helped to mitigate inherent challenges to clients' access to medications due to the COVID-19 pandemic. While ARV and specifically TLD stock constraints affected some provinces, several priority districts provided MMD or decanted over 50% of TX_CURR by the end of FY 2020. In FY 2020 Q4 it was estimated that approximately 50% of TROA was on TLD.

DREAMS

Analysis of the DREAMS program shows disruption due to COVID-19 and need for greater acceleration. The South Africa program reached 115,664 active DREAMS beneficiaries during FY 2020. Compared to FY 2019 there was a 49% decrease in completion of the primary package and a 143% increase in "Incomplete" (i.e., did not complete primary package or primary package plus a secondary service). However, AGYW in DREAMS districts contributed 33% (208,364) of total PP_PREV results, and there was a 61% increase in AGYW PrEP initiations from FY19 Q4 to FY20 Q4, despite COVID-19 related challenges. Also, AGYW account for large proportion of the GEND_GBV results and of those, the majority of services delivered are for sexual violence, indicating the ability of the DREAMS program to link AGYW to services.

VMMC

All VMMC services were fully suspended in FY 2020 Q2 due to COVID-19 and resumed in Q4 in select provinces and districts based on analysis of the local COVID-19 data. Overall FY 2020 achievement was 159,739 VMMCs performed, which was 31% of the annual target. Districts in the Eastern Cape showed the strongest performance due to a VMMC campaign embedded in the annual traditional male initiation process. PEPFAR South Africa discontinued the circumcision of boys aged 10-14 years old when services resumed in Q4 in order to focus on older age groups with higher impact on interrupting HIV transmission.

OVC

PEPFAR South Africa's OVC program had strong achievement except for program completion. In FY 2020 PEPFAR South Africa had OVC_SERV achievement of 103% and OVC_SERV<18 years achievement of 101%. In FY 2020 Q4, 91% of OVC had known HIV status and 99.9% of HIV positive clients were on ART. However, only 29% of children and caregivers graduated from the OVC program in FY 2020.

Key Populations

Despite the impact of COVID-19 lockdowns, all KP partners except for those serving prisoners met most targets across the cascade, but viral load suppression rates among FSW and PWID continue to be less than 90%, while the VLS rate among TG is 77%. PrEP program does well especially for MSM, but FSWs were severely impacted by COVID-19 lockdown. PrEP initiation for MSM increased from 329 in FY19 to 4,889 in FY20 through aggressive use of social media, VIP clubs, and e-pharmacy. However, FSWs saw a drop in PrEP_NEW in Q4 due to COVID-19 which resulted in loss of income and high mobility of FSWs. Proxy linkage rates for MSM and FSW improved significantly since FY18, though the program saw a decline in Q3 related to COVID-19; however resurgence in Q4 shows innovations are effective in new operating context. Viral load coverage is low across the for key populations (except for TG at 86%), but viral load suppression among MSM remains high at 93%

Above-Site

PEPFAR-supported FTE HRH achieved 107% of the COP 2019 target, while community health worker-like cadres achieved 132% of their target. CHW activities carried on throughout COVID-19 with modifications and training. PEPFAR's Surge effort came to a close in COP 2019, but at the request of NDoH and Civil Society, PEPFAR is maintaining its current level of HRH support through the first six months of COP 2020. The PEPFAR HRH TWG is working closely with NDOH to prepare for full transition to NDoH after COP 2020. However, COVID-19 impact on HIV-related health financing in South Africa will potentially constrain GoSA capital investments in PEPFAR priorities such as multi-month dispensing and digital health infrastructure in COP 2020 and potentially beyond.

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 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.	**Status:** Test and Start was rolled out in 2016. National ART Guidelines stipulate that patients should initiate ART within 7 days including on the day of diagnosis when possible. During FY20, the PEPFAR program achieved 100% proxy linkage in Q3 and 90% linkage overall for the year, with linkage consistently ranging from 95-100% at Siyenza sites. **Issues:** In spite of improvements, overall proxy linkage for FY20 was 90%, which was lower than our target of 95%. Challenges still exist with ensuring those who aren't initially eligible for treatment are rapidly and continuously engaged and in ensuring those identified in the community are linked to treatment. The program must ensure 95% linkage for all clients across all age, sex, and risk groups.

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.	**Status**: GoSA updated national guidelines to include TLD as a first-line option for all eligible clients in August 2019. Roll-out did not officially begin until Q1 of COP19 with limited uptake. The PEPFAR team worked closely with the National Department of Health (NDoH) to remove barriers, roll-out targets for TLD scale-up and increase the availability of provider and patient information to improve TLD uptake. TLD uptake this year increased with nearly half of first-line ART patients now receiving TLD. Children over 3kg and 4wks are eligible for DTG, but 5mg and 10mg dispersible tablets have not yet been approved and overall uptake among eligible children and adolescents for DTG 50mg tablets remains low. NVP remains an option for infants under 4wks and 3kg and EFV remains available for clients with contraindications to TLD. **Issues**: South Africa faced significant shortages of TLD for much of calendar year 2020. These stock shortages resulted in temporary holds on TLD transitions and limited the ability to provide 3-month dispensing with TLD in spite of an otherwise favorable policy environment. Ensuring stock stability and reinvigorating TLD transitions are occurring currently during COP20. In COP20, immediately make DTG and other pediatric friendly regimens available.
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.	**Status**: In South Africa, two/three months multi-month dispensing (MMD) is the standard NDoH policy as per the National Adherence Strategy (contingent on stock availability in the district). While the NDoH steering committee has approved a 6MMD prescription for stable patients, the GoSA has delayed implementation to April 2021 citing supply chain challenges caused by COVID-19. COVID-19 has however seen the introduction of 12-month scripting to reduce facility congestion. SAHPRA now has registered multiple vendors of 90 count preparations. Decanting guidelines were updated in FY20 to include children 2 years and upwards for multi-month dispensing. A matrix of interventions supporting these updates was developed by the pediatric workstream, approved by NDoH on Sep 30, 2020, and is currently being rolled out. **Issues:** The provinces have been experiencing stock availability challenges to varying degrees. Factors affecting the introduction of 3, 6, or 12- month MMD include: 90 and 180 count pack sizes of TLD are not on the SA government ARV contract; 180 count packs are not registered in South Africa; changes required in CCMDD tender with the GoSA; and implementation of 6 MMD, which would require accurate supply planning and an upfront investment in additional commodities for buffer stock. In COP20, the country must immediately optimize 3 MMD and swiftly move to 6 MMD as soon as possible.
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.	**Status:** South Africa provides IPT for 12 months in adult ART patients (15 years and above), and 6 months of IPT for children living with HIV and children <5 yrs who were exposed to TB (regardless of HIV status) once TB disease has been excluded. SA is however expected to introduce 3HP, pending SAHPRA approval. The SOP on enrollment and management of patients on preventive treatment for latent TB Infection, treatment for DS-TB or RR/MDR-TB onto the CCMDD Programme has been finalized. Stable patients on ART eligible for TPT are to be enrolled on CCMDD. **Issues**: Despite TPT availability in all PEPFAR supported districts, initiation and completion is still below target. The overall TPT completion rate remains low at

	61% for FY20 Q4. The program continues to work with NDoH to ensure consistent supply of INH and increase TPT coverage. In addition, PEPFAR will support NDoH to roll out 3HP in 4 pilot districts this year upon SAHPRA approval, with broader expansion anticipated in COP21.
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.	**Status:** The program saw an initial increase in VL coverage from 76% in FY19 Q4 to 81% in FY20Q1. This was however, followed by a reduction in viral load coverage to 75% by FY20 Q4, as facility attendance and laboratory testing decreased in the setting of the COVID-19 pandemic. eLABS, a technology to improve VL coverage and use, was expanded from 413 facilities at the beginning of COP19 to 1412 facilities currently in COP20. **Issues:** COVID-19 lockdowns resulted in limited patient mobility to access health services. Despite increasing COVID-19 cases, NHLS remains with sufficient laboratory analyzer capacity for projected VL specimen volumes for FY2021, although analyzers and personnel used for VL, EID and TB testing are now also being utilized for COVID-19 testing. Turnaround times may be slightly affected but remain within 4 weeks. Gaps remain in reaching the required VL coverage rates at facility level. Activities to improve coverage are being implemented in COP20 and should continue in COP21 (e.g., eLABS patient support system).
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.	**Status**: The NDoH has prioritized and is supporting full implementation of index testing for sexual partners and children of PLHIV. NDoH, with PEPFAR support, increased the age of children who are considered contacts for index testing cases from 14 to 19 years of age. HIV self-screening is also being scaled up and fully supported. Both modalities are now included in the revised National HTS register. The NDoH index testing guidance includes specific procedures to ensure consent, protect confidentiality and prevent harm related to intimate partner violence, informed by broad consultations. Minimum standards tools for Index Testing has been rolled out successfully across the 27 PEPFAR supported districts to ensure continued monitoring of Index Testing Services with a dashboard developed to ensure monitoring of implementation of these tools. **Issues:** Index testing contribution to HTS_TST_POS is at 10%. In COP20 & 21, continued scale up of index testing for all populations, including children (=<19) to greater than or equal to 30% TST_POS from index. Some provinces in SA are not supporting HIV SS as a secondary distribution modality (i.e. KZN) for HIV SS kits (Oraquick).
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	**Status**: Analysis of the PrEP program reveals significant achievement in FY20, with a 108% increase in all PrEP initiations between FY19 and FY20, and a 61% increase in AGYW PrEP initiations from FY19 Q4 to FY20 Q4. Immediate PEPFAR priorities in COP20 include: continuing support for NDoH PrEP scale-up by achieving ambitious PEPFAR interagency PrEP_NEW targets, to be implemented as part of a comprehensive package of prevention services. In DREAMS, the priorities will be: 1) continue strengthening of DREAMS layering with PrEP as part of the DREAMS secondary package in order to keep AGYW HIV negative, and 2) focus on PrEP adherence and retention support throughout

high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices*)*	an individual's period of risk. Priorities for Key Populations are: 1) expand PrEP rollout in prisons, and 2) increase PrEP initiations through aggressive use of social media, VIP clubs, and e-pharmacy and (3) increase appropriate use of PrEP including event driven PrEP and continued use of PrEP as appropriate through enhanced psychosocial support including social workers at all KP drop in centers **Issues:** For successful PrEP scale-up, PEPFAR will prioritize strengthening demand creation, adherence and continuation/retention in COP20 and COP21, and will utilize/implement special studies and operations research to better understand the changing risk profiles of AGYW.
2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV	**Status:** Through effective case management, household visits, and improved use of data and targeting, OVC implementing partners continue to identify the most vulnerable children (including AGYW, children and adolescents living with HIV) and provide 1:1 support that empowers OVC to stay in and progress in school; access health services and grants; reduce violence and abuse; prevent HIV infection; and be adherent and retained in HIV care services. **Issues:** Structured group-based interventions targeting 9-14 year-old girls and boys will be limited as a result of COVID-19 related restrictions, as well as limited access to children (in schools) in addition to the absence of suitable venues to ensure safe facilitation of the interventions. Challenges with the POPI Act limit the bi-directional referrals between C&T and OVC for strengthening viral load suppression and continuity of treatment for CALHIV 0-17 year-olds.
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.	**Status**: South Africa prohibits, through legislation, informal and formal user fees for HIV, TB, antenatal care, and all primary level care in the public sector. PEPFAR SA continues to work at the national, provincial, and district levels to ensure that this policy is implemented in facilities and that all people have access to HIV services. **Issues**: No outstanding issues or barriers.
2. OUs assure program and site standards are met by	**Status**: Siyenza in South Africa is being implemented at 422 facilities as of the end of FY20. Due to the COVID-19 epidemic, PEPFAR South Africa has

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.	temporarily pivoted to virtual weekly conference calls/Zoom meetings in place of in-person site-visits that include staff from PEPFAR, DSPs, and DoH. Focal areas for site-level improvement include streamlining decanting/CCMDD enrollment, differentiated ART service delivery use of external pick-up points and community ART, and community HTS and HIV self-screening. NDoH has continued to support 'Operation Phuthuma' in 756 facilities in FY20 and conducts regular provincial meetings virtually, as well as routine Nerve Centers meetings in all provinces. Lessons learned are regularly applied to smaller volume facilities in all districts through Operation Phuthuma's quality improvement activities. **Issues**: In addition to challenges related to COVID-19, an upgrade to TIER.Net, South Africa's electronic HIV/TB register, has prevented DSP clinicians and PEPFAR technical staff from having access to near-real-time data to identify challenges and address performance gaps quickly. TX_CURR and TX_NET_NEW are impossible to track accurately on a routine basis, and this upgrade has affected tracking and tracing of ART clients, reduced TLD roll-out and decanting, and limited above-site monitoring and analysis.
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.	**Status:** The country has implemented a national strategy to improve linkage and retention at all sites. In COP19, PEPFAR South Africa and NDoH launched the following national campaigns: The Mina campaign that promotes U=U among men; The DabLap campaign to promote differentiated models of care; The Zenzele campaign to promote treatment literacy; a U=U campaign targeting women is also planned in COP20, due for approval in March 2021. The NHLS is also developing U=U messages to be incorporated into viral load counseling practices as part of the eLab platform. These national campaigns amplify PEPFAR district support partners' additional support to reduce stigma and encourage treatment. **Issues:** All PEPFAR-supported provinces should implement the U=U campaign now in COP 20 to promote completion of treatment adherence, VL tests, and youth-friendly treatment literacy.
4. Clear evidence of agency progress toward local, indigenous partner direct funding.	**Status:** The program continues to exceed the target of 70% of PEPFAR funding be awarded to local, indigenous partners. In COP20, PEPFAR South Africa was at 79%, which is an increase from 78% in COP19. PEPFAR South Africa adheres to COP guidance recommending that the majority of prime partners are local/indigenous (35 of 58) **Issues**: No outstanding barriers
5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	**Status**: There is clear commitment by the GoSA to continuously increase budgetary support towards the HIV response. However, the South African economy has suffered due to the COVID-19 epidemic and the SA National Treasury is looking to cut spending by R300 billion (~20b USD) until 2023. Earlier GoSA budget allocations for HIV indicated a continued increase from $1.7 billion in 2018/2019, to $2.1 billion in 2020/2021, accounting for over 70% of the country's HIV expenditure, but it is expected that the South African government will approve significant budget cuts—including for HIV—as part of their 2021 Mid-Term Expenditure Review due to finalize in April 2021. The U.S. government committed to only a two-year surge of approximately $500 million in COP18 and COP19 in addition to their COP base.

	Issues: The GoSA should continue to invest domestic resources to maximize HIV-related health outcomes at the national, provincial, and districts and ultimately to sustain the HIV response; however, it is unlikely for the GoSA to afford increasing budget allocations in the mid-term (3-5 years) compared to prior years.
6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	**Status**: South Africa's national morbidity and mortality reporting system is supported by a range of data sources and institutions, including the District Health Information System, Birth and Death Registries, Census and cause-specific data reporting systems. Current GoSA investments include capacity development to improve the completeness and accuracy of existing data systems and to strengthen reconciliation and triangulation of data from various sources and at all levels **Issues**: PEPFAR South Africa should continue supporting expansion of effective national HIV patient-level data reporting systems including implementation of the Health Patient Registration System (HPRS) infrastructure support at the facility level and supporting activities to improve estimates of HIV cause-specific mortality, as well as facilitating access of key health data for program decision making and planning.
7. Scale-up of case surveillance and unique identifiers for patients across all sites.	**Status:** HPRS is deployed in 3,093 health facilities, which represents 82%% of NDOH-supported health facilities, which is an increase from 73% last year. As of March 2020, 44.8 million individuals have been registered. This represents 77.5% of the total population of South Africa, which is an increase from 73.3% last year. **Issues:** Use of HPRS remains inconsistent and challenging. Some of the outstanding issues relate to internet connectivity, gaps in informatics capacity, and system integration barriers that DSPs at facility or district level are unable to resolve.

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

Table 10. COP 2021 (FY 2022) Technical Directives

OU –Specific Directives
HIV Treatment
1. Treatment and Retention: Continue COP20 focus on critical program gaps in case finding, retention, and regaining patients lost to follow-up to reach epidemic control. Continue to scale interventions for new patients, including linkage facilitators, community-facility handshake models, and individualized virtual or in-person support structures. Design programming to reduce LTFU, including among older women (especially ages 30-45). Scale eLabs and site-level U=U for universal VL coverage, suppression, and understanding for reaching the 3rd 95. Capitalize on recent decanting gains to provide decentralized modalities for drug pick-up and service delivery choice for all eligible clients. No agency partner shifts for care and treatment clinical partners are needed; all DSPs are aligned geographically for impact. For COP 20 and COP 21, we must work to complete and transition HRH.
2. Case finding: Optimize high-yield testing modalities into all client touch points (CCMDD, independent pharmacies, Mina campaign, and case management). Introduce a risk screening tool at health facilities with a high volume of tests conducted but a low yield of positives identified. Scale recency testing and public health response to incident infections. At all health facilities, ensure all TB presumptive and confirmed cases receive an HIV test. Continue efforts to assist NDOH to develop a national register and SOP for index testing services (ITS), strengthen the linkage between community and facility partners to improve tracing and testing of elicited contacts, and continue using GIS mapping and recency results (when they become available) to identify where new positives are being identified and focus index testing scale-up efforts in those areas (microtargeting).
3. Pediatrics: Need significant pediatric performance improvements across the clinical cascade and pediatric ARV optimization. Optimize index testing for biological children (<19) of PLHIV and implement pediatric HIV risk screening tools as well-child and sick-child entry points for all Siyenza surge sites. Increase efforts to strengthen linkage to treatment and case finding in FY21. Intensify efforts to optimize ART treatment and strengthen viral suppression.
HIV Prevention
1. PrEP: Continue PrEP scale-up. Explore feasibility & acceptability of new and improved biomedical tools such as the Dapivirine Ring and Injectable PrEP.
2. DREAMS: Even with a sustained, robust DREAMS investment and several years of discussions around standing up a system to track layering, the DREAMS South Africa program continues to experience ongoing challenges with capturing consistent and accurate layering data and less than ideal MER and DREAMS modeling data outcomes. The latest MER data shows that there is a gap in linking DREAMS AGYW to secondary services (current completion is 1%), which is either indicative of an issue with active linkages and/or systemic underreporting. Team must expedite compliance with previous guidance around establishing a consistent and accurate system for tracking layering and establish standardized reporting processes across all DREAMS implementing partners. Team must also expedite establishing an adequate coordination structure (i.e., DREAMS Coordinator, DREAMS Ambassadors district/provincial/ward-level coordinators, etc.) to support reporting processes and improvements to DREAMS implementation at all levels (e.g., ward, district/metro, provincial).
3. GBV: GBV remains a tremendous challenge for AGYW in South Africa, and although services are being rendered in DREAMS, they are still failing to reach the scale and meet the expressed needs of AGYW in DREAMS districts. Team must assess existing GBV services in DREAMS districts and begin access expansion for AGYW in DREAMS districts.

4. VMMC: Ensure ongoing safe program implementation with the over 15 year old cohort based on national and PEPFAR guidance.
Other Government Policy or Programming Changes Needed
1. Establish universal 3MMD and mandatory 6MMD across all PEPFAR sites, and ensure TLD transition across all PEPFAR sites – South Africa lags behind most other countries in this regard. MMD plans should align with plans for the scale-up of the TLD transition to prioritize the goal for clients to be dispensed the most optimal regimen (TLD) with as many months possible given supply constraints, while at the same time, reducing other barriers to medication access to the greatest degree possible by expanding PuPs and other community-based models of ART distribution. Ensure DTG 10mg is included in revised national guidelines and procurement planning.
2. Continue investment and CSO site level involvement in Community Led Monitoring
3. Determine efficiencies for Above Site Data Systems Investments. Strengthen interoperability of patient-level data systems at the national and provincial levels for improved patient management, program monitoring and decision making, and to enable scale-up of case-based surveillance.
4. HRH transitioning - Make rapid additions to existing costing studies that update assumptions on HRH and service delivery in post-COVID situation (to be completed in early 2021)
5. Supply Chain: Continue to leverage USAID FY22 emergency commodity procurement to drive stock availability and MMD.

COP 2021 Global 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.

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 South Africa 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 South Africa 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.