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INFORMATION MEMO FOR Deputy Chief of Mission Danilowicz, South Sudan

FROM: S/GAC Chair, Shabeen Ally (outgoing) George Alemnji (incoming) and PPM, Ayibatari Burutolu

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

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

Dear DCM Danilowicz,

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

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

PEPFAR implementation over the past year has shown tremendous effort to maintain clients on treatment, initiating and accelerating client centered service delivery adaptations, while doing what was possible in HIV prevention programs deeply affected by COVID-19 shutdowns. The following themes have emerged across all of PEPFAR-supported countries; As the economic impact of COVID continues to be seen at both national and community levels, it is more important than ever to use granular data and expand what is working in specific SNUs for viral load coverage and suppression. We saw differential progress in this area independent of the impact of COVID19. Focus groups and deep analytics of 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:

- The rapid scale up in six month drug dispensation and transition to optimal ARV regimens like TLD. These innovations will help ensure the South Sudan people can access lifesaving ARVs in a manner which best suits them, especially when in a difficult operating environment.
- Working closely with the PEPFAR Headquarters team across implementing agencies to better understand and align the human resources for health footprint and investment based on needs in South Sudan, and thereby ensure optimal support for health facilities and communities within COP20 implementation and COP21 planning.
- Adaptations to programming for Orphans and Vulnerable children and data quality overall in response to previously identified challenges. These advancements will ensure PEPFAR programs remain responsive to the population's needs and the data demonstrating our impact and identifying gaps are accurate and reliable.

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

- ART coverage in South Sudan remains one of the lowest in the world at 18% with all populations and age groups needing specific focus. Although retention of clients on ART has improved, the ability to keep persons on lifesaving ART needs improvement.
- Effective and efficient case finding strategies to find those infected with HIV, like index testing, are still not scaled or implemented optimally – which leaves opportunities for growth and improvement
- Instability, unrest and poor quality of health services remains a key challenge for progress in South Sudan, necessitating close collaboration with the government and other multilateral organizations in South Sudan. This underscores the need for a PEPFAR Coordinator in Juba to lead and facilitate such coordination
- Viral load testing coverage and suppression remain low among all populations in this country. This is due to a combination of factors to include weak demand creation, instrument downtime and supply chain issues.

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 Sudan 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 Sudan is **$40,000,000** 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 Sudan and civil society of South Sudan, 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 – Shabeen Ally, George Alemnji, Ayibatari Burutolu**

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. PEPFAR South Sudan has successfully transitioned 99% of current patients on 6-month MMD, and over 90% to TLD within one calendar year. This was accomplished through concerted and coordinated efforts by the PEPFAR team with National government and site-level providers, community-driven demand from patients, weekly tracking of scale-up at sites, and advocacy for 6-month and TLD procurements over other regimens. As a result, South Sudan's 6-month multi-month drugs are helping to address challenges of access and distance from health facilities.
2. The PEPFAR South Sudan team worked closely with Headquarters to fully and comprehensively assess and understand the Human Resources for Health (HRH) footprint in South Sudan in a robust and data driven manner. This was a requirement of the COP20 Approval Memo. The findings demonstrated that a realignment of resources is needed in order to reach the 90-90-90 targets whereby a greater investment in clinical cadres is required (which is accounted for in the COP20 and COP21 envelopes). We believe these modifications and changes well put South Sudan in a position for success in COP20 and COP21.
3. PEPFAR South Sudan made some key program pivots in FY20, demonstrating responsiveness to program needs and known challenges. The OVC program changed its focus (and implementing partner) to better serve the HIV+ population and improve retention in the program. Similarly, a data quality assessment was conducted (even under the difficult conditions imposed by COVID-19) at several key facilities in collaboration with implementing partners and the host government. It will be essential to maintain these gains and robust implement the findings to ensure data remain reliable and accurate.

Challenges:

1. ART coverage in South Sudan remains one of the lowest in the world. This is exacerbated by the difficult operating environment in South Sudan
2. Effective and efficient case finding strategies needs to be fully scaled and implemented with quality. Index testing, or contact tracing/partner notification, should be effectively scaled and facilities to ensure those with HIV are identified and linked to life saving ART
3. Instability and unrest in South Sudan poses the greatest challenge to success of the PEPFAR program in South Sudan. Collaboration with other multilateral organizations in the humanitarian, health and governance space (along with the Government of South Sudan) is essential to the success of the program. Having a PEPFAR Coordinator at post in Juba is critical to facilitate these important relationships and coordinate the overall program.
4. Viral load testing coverage and suppression remain low among all populations in this country. This is due to a combination of factors to include weak demand creation, instrument downtime and supply chain issues.

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

1. Human Resources for Health (HRH): Utilize the HRH Inventory and Optimization Solution results to hire more clinical staff, focusing on SNU and site, and using available funds in COP 20 budget to complete realignment.
2. Orient planning for testing and clinical services to focus on fundamentals. This will include (1) Maintaining a client-centered approach at sites for testing and clinical services, (2) Conducting index testing with fidelity by addressing IPV and confidentiality challenges to improve HIV testing by clients, and (3) Halting expansion of treatment sites to closely monitor drug dispensation.
3. Focus on creating demand and ensuring accelerated viral load and EID testing through increased client-centered approaches, community engagement, supply chain and instrumentation, including use of point care platforms as necessary.

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	**$40,000,000**	**$-**	**$-**	**$-**	**$-**	**$-**	**$-**	**$-**	**$40,000,000**
GHP-State	$39,800,000	$-	$-		$-	$-	$-		$39,800,000
GHP-USAID	$-				$-				$-
GAP	$200,000				$-				$200,000
Total Applied Pipeline	**$-**	**$-**	**$-**	**$-**	**$-**	**$-**	**$-**	**$-**	**$-**
DOD				$-				$-	$-
HHS/CDC				$-				$-	$-
HHS/HRSA				$-				$-	$-
PC				$-				$-	$-
USAID				$-				$-	$-
USAID/WCF				$-				$-	$-
State				$-				$-	$-
State/AF				$-				$-	$-
State/EAP				$-				$-	$-
State/EUR				$-				$-	$-
State/PRM				$-				$-	$-
State/SCA				$-				$-	$-
State/SGAC				$-				$-	$-
State/WHA				$-				$-	$-
TOTAL FUNDING	**$40,000,000**	**$-**	**$-**	**$-**	**$-**	**$-**	**$-**	**$-**	**$40,000,000**

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

Countries should plan for the full Care and Treatment (C&T) level of $24,000,000 and the full Orphans and Vulnerable Children (OVC) level of $1,700,000 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of

funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

TABLE 2: COP 2021 Earmarks by Appropriation Year*

	Appropriation Year			
	FY21	FY20	FY19	TOTAL
C&T	$24,000,000	$-	$-	$24,000,000
OVC	$1,700,000	$-	$-	$1,700,000
GBV	$-	$-	$-	$-
Water	$-	$-	$-	$-

**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	$40,000,000	$-	$40,000,000
Core Program	$37,000,000	$-	$37,000,000
Cervical Cancer	$-	$-	$-
Community-Led Monitoring	$-	$-	$-
Condoms (GHP-USAID Central Funding)	$-	$-	$-
DREAMS	$1,000,000	$-	$1,000,000
HBCU Tx	$-	$-	$-
One-time Conditional Funding	$-	$-	$-
Surveillance and Public Health Response	$-	$-	$-
VMMC	$2,000,000	$-	$2,000,000

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

TABLE 4: State ICASS Funding

	Appropriation Year			
	FY21	FY20	FY19	Unspecified
ICASS	$-	$-	$-	

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	1,544	3,181
TX Current >15	32,344	57,627
VMMC >15	1,706	5,303
DREAMS (AGYW PREV)	N/A	N/A
Cervical Cancer Screening	N/A	N/A
TB Preventive Therapy	5,634	19,457

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

OU/Agency	Sum of Approved COP/ROP 2019 Planning Level	Sum of Total FY 2020 Outlays	Sum of Over/Under Outlays
OU			
DOD	1,303,061	1,420,307	(117,246)
HHS/CDC	12,908,159	12,079,649	828,510
HHS/HRSA			
PC			
State			
State/AF			
State/SGAC			
USAID	6,071,276	5,227,621	843,655
Grand Total	**20,282,496**	**18,727,577**	**1,554,919**

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.

Mechanism ID	Partner Name	Funding Agency	Total Planning Level	Total Outlays	Outlay Delta Check
17805	Research Triangle Institute	DOD	$1,158,061	$1,316,641	($158,580)

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	408,847	**327,809**	**80.2%**	HTS	$598,229	62.5%
	HTS_TST_POS	20,941	**7,793**	**37.2%**			
	TX_NEW	19,636	**7,661**	**39.0%**	C&T	$4,993,941	55.0%
	TX_CURR	49,360	**26,222**	**53.1%**			
	VMMC_CIRC						
	OVC_SERV						
DOD	HTS_TST	19,083	**9,176**	**48.1%**	HTS	$109,117	0.0%
	HTS_TST_POS	2,236	**830**	**37.1%**			
	TX_NEW	1,914	**870**	**45.5%**	C&T	$801,253	0.0%
	TX_CURR	3,425	**1,722**	**50.3%**			
	VMMC_CIRC	1,545	**1,741**	**112.7%**	VMMC Sub-Program		0.0%
	OVC_SERV						
USAID	HTS_TST	52,924	**65,410**	**123.6%**	HTS	$723,193	100.0%
	HTS_TST_POS	3,391	**2,736**	**80.7%**			
	TX_NEW	2,516	**2,148**	**85.4%**	C&T	$1,665,554	93%
	TX_CURR	8,023	**5,945**	**74.1%**			
	VMMC_CIRC						
	OVC_SERV	2,617	**2,047**	**78.2%**	SE	$545,043	58%
					Above Site Programs	$1,533,827	
					Program Management	$4,309,645	

South Sudan, with a 2.7% HIV prevalence, continues to struggle in identifying and treating positive cases. IBBS findings indicate very low knowledge of status, ART coverage and viral suppression rates among positive cases.

Case Finding

- Overall, South Sudan tested 402,395 individuals for HIV in FY20, but identified only 11,359 PLHIV. HTS_TST achievement remains constant from 88.7% in FY19 to 83.7% in FY20. While 70% more individuals were tested in FY20, there has been minimal growth in positives found. In FY19, there were 11,080 PLHIV, and in FY20, 11,359 PLHIV, resulting in a 42.8% target achievement. Testing yield has dramatically decreased from 3.9% to 2.8% in FY20.
- Index testing and TB clinics produced the highest yields among HTS modalities, but contributed to one of the lowest number of positives. In Q4, 38.2% of HTS_TST_POS were by other provider-initiated treatment centers (Other PITC), producing a 2% yield. Index testing contributed to 10% of HIV positive patients with an 8% yield, and TB clinics with an 8% yield made up 6.11% of HIV positive patients.
- Trends in adult index testing indicate marked declines in Q3-Q4. From Q2 to Q3 there was a 52% decrease in contacts tested, and a 25% decrease in index cases, resulting in 248 positive contacts in Q3, and 197 in Q4. These testing reductions are due in part by COVID restrictions at facilities put in place in Q3.
- In FY20, 79% of HIV positives were identified at 32% of PEPFAR supported sites. This demonstrates that focus on these select sites for improvements will be critical.
- Quality assurance challenges remain as demonstrated in the few SIMS assessments conducted, prior to the COVID-19 pandemic, in the areas of testing, treatment and viral load services. There were only seven assessments completed, but demonstrated limited improvements in partner services, VL monitoring and management, routine testing of children of biological parents, patient tracking and appointment spacing.
- Preventing Mother to Child Transmission (PMCTC): PMTCT testing and PMTCT_ART coverage for the OU and across counties remain high, with 98.5% PMTCT_STAT and 105.5% PMTCT_ART coverage in Q4. Steady quarterly growth in PMTCT_ART coverage is evident from 98%, 103%, and 105% coverage in Q1-Q3. This growth is largely due to increases in the number of pregnant women already on treatment, and those with known HIV status at their first antenatal care visit (PMTCT_STAT).
- Early Infant Diagnosis (EID): Although a high volume of pregnant women with HIV receive antenatal care and ART, EID coverage remains low in South Sudan. In FY20, there was 44% EID coverage of infants 0-2 months. Across facilities, 16 sites reported <50% EID coverage at 2 months, and five PMTCT sites had no EID in FYQ4.

Care and Treatment

- South Sudan still maintains very low ART coverage of 18%

- TLD and Multi-Month Dispensing: Within one year, South Sudan has successfully transitioned 99.5% of current patients to six-month Multi-month dispensing. Over 90% of patients have transitioned to TLD in most sites. The rebound of patient gain in FYQ4 has been largely due to MMD and the back to care efforts by IPS.

- Linkage: Linkage remains high, with all but one county reporting rates higher than 95% in Q4.

- PEPFAR-supported sites cover 95% of national TX_CURR. In FY20, 80% of TX_CURR were at 26% of sites and 80% of TX_NEW were at 40% of sites. In the high disease burden counties, ART coverage is higher in females 25-29 years, and males 30-49 years, however gaps remain amongst all populations. This again demonstrates a need to understand the challenges at these specific sites.
- Continuity of Treatment: Significant quarterly gains in treatment are evident in FY20, with the largest gains in females 40-44. However, despite treatment gains, retention continues to be an issue. Most individuals lost to treatment were 20-34 years proportionally distributed among men and women, and were on treatment for three or more months before missing their appointments. In Q4, data finds high rates of missed appointments (94.7%, 1543/1629), and low rates of transfer to other sites (1.6%, 26/1629), and death (3.7%, 60/1629). In FY20, facility level losses were largely in high volume treatment sites concentrated in western and central Equatoria. Almost all of the facilities with the highest TX_NEW also had the highest losses.
- Return to Treatment: Efforts to return patients to treatment have been mildly successful, with a 5% loss in Q1 to a .9% gain in Q4. However, these TX_CURR gains are attributable to TX_RTT at high volume facilities with the highest losses, and the implementation of six month MMD, but not necessarily from case findings.
- Tuberculosis (TB): Over the past three years, the number of ART patients screened for TB has steadily increased. In Q4, 86.4% ART patients were screened for TB, and 2.1% screened positive. The counties with the lowest TB screening are located in high volume areas that contribute the most to TX_CURR.
    - TPT completion increased from 35.6% in Q2 to 71.4% in Q4, but still fell short of the 85% goal. The facilities with the lowest performing rates of TPT completion are centered in Juba County (Central Equatoria), but there are also a number of lower-performing facilities across Western Equatoria.
- Viral Load: South Sudan continues to have low viral load coverage and suppression. In Q4, VLC is 56%, the lowest since FY19 Q1. Conversely, VLS is 86%, the highest in the past two years. Pediatric coverage (56%) and adult coverage (57%) are similar, while pediatric suppression rates remain low at 62%, and adult suppression is 87%. In Q4, VL coverage among pregnant women is variable but continues to decline, reporting 18%, much lower than the 31% in Q2 and 27% in Q1.
    - VL trends indicate the testing gap is increasing quarterly for patients eligible for VL testing, with the highest prevalence among those 25-34 years old. Of the 29,222 patients eligible for VL testing in FY20, only 56.5% (16,507) had a documented VL, and 48.8% (14,248) had a suppressed VL. County variability in VLC and VLS are evident among

lower and higher volume facilities, with larger regions such as Juba County demonstrating high VLS (87%), but low VLC (67%). Some of these variabilities in Juba are due to COVID delays which caused shortages in commodities and access.

Orphans and Vulnerable Children (OVC)

- There has been target growth in OVC_SERV from 44.7% achievement FY19 to 78.2% in FY20. In FY20 the OVC program had a 52% increase in participants active in the program (978 in FY19 to 2,047 in FY20), resulting in achieving 93% (2047/2201) of the target. From Q2-Q4, more OVC beneficiaries have been retained in the program, resulting in no beneficiary existing before graduating in Q4. This is a dramatic difference from the results at Q2 when a large proportion of the OVC cohort had exited without graduation.
- In FY20, 70.5% (1,443/2,047) of OVC beneficiaries are younger than 18, however, only 19.6% (402/2047) are in the target age range of 10-14 years.
- From FY18-20 there has been a steady increase in the number of children with HIV in the OVC program. In FY20 Q4, of the 1,248 who had facility-based test-confirmed HIV status, 30.3% (379) were HIV positive, of which 100% were on ART.

Key Populations

- There were increasing yields in counties where KP programs were being implemented. However the program was not started in some counties in part due to COVID-19 delays; however the budget was fully expended.

Voluntary Medical Male Circumcision (VMMC)

- The VMMC program maintains high target achievement in FY20 at 112.7% (1741/1545). A FY20 quarterly review indicates a majority of males are 15-29 years, given it is a military only program.

Above Site:

- Data and service quality challenges in FY20 made it hard to understand the true extent and scale of areas of improvement in the PEPFAR program. Moreover, not all data were being reported from sites where services were provided. The above SI partner needs to ensure this is an area of focus in COP21.

Partner and Financial Performance

- Several mechanisms have closed out in FY20 (AMREF, SPPHC, 4 Children, and CMMB) due to low-performance end of cooperative agreements. A few are due to end in FY21 Q1 (SPPHC, and Evidence to Action). AMREF and CMMB are funded by CDC; SPHHC and 4 children are funded by USAID, and Evidence to Action by Pathfinder International. Overall, partner performance continues to vary, with most partners consistently under performing in Care and Treatment, while others exceed benchmarks for Testing Services, OVC and VMMC.

- Almost all partners under-expended in care and treatment. IntraHealth SI and AMREF, both funded by CDC, spent less than 70% of their budget, while RTI, funded by DoD expended 119% of their budget.
- Expenditures for Care and Treatment were not correlated with achievement. Most partners reached only 50% of target achievement for TX_CURR, and TX_NEW. CMMB, funded by CDC, had the lowest performance, with 18% TX_NEW achievement, and 48% TX_CURR achievement, but spent 89% of their budget allotment. However, JHPEIGO, funded by USAID achieved 85% of TX_NEW and 74% TX_CURR targets, and spent 91% of their budget. JHPEIGO was the highest performing partner for care in treatment over the past 2 years, but in FY20 had difficulty achieving higher target benchmarks set for TX_PVLS.
- Overall, the partners have improved in treatment growth compared with FY19, but still exhibit slow growth and retention challenges. Rates of quarterly TX_NET_NEW varied by partner, with increases in Q1-Q2, but decreases in Q3-Q4, possibly due to COVID restrictions. However RTI showed the least amount of treatment growth and progress in FY20. Although they did return over 800 patients to treatment, their TX_CURR in FY20 only increased by just over 500 people.
- Testing services produced more variable results in both expenditures and performance. While most partners met or exceeded their targets for testing, almost all struggled with finding positive cases. All partners under expended, some by significant amounts. ICAP, funded by CDC, spent only 30% of their budget, testing 60.7% more patients in FY20 (218,867) than FY19, but found only 27% more positives (6,731) than last fiscal year. Their testing yield decreased from 3.8% to 3.1%. This trend in low case finding and low testing yields is demonstrative of the issues that exist throughout South Sudan with other partners and agencies. JHPEIGO and Pathfinder International, funded by USAID, demonstrated positive progress towards HTS_TST_POS benchmarks. JHPEIGO expended 90% of their budget, and achieved 78% of the target achievement, but experienced a decrease in testing yield from 4% to 3.7%. Pathfinder International met 100% of the target for HTS_TST_POS, but also experienced a decline in testing yield from 7.2% to 6.9%.
- Conversely, RTI struggled the most in testing, using 73% of its budget, but only reaching 36% of HTS_TST_POS and 48% of HTS_TST targets. CMMB performed the lowest for HTS_TST_POS, with a 17% achievement. In Q3-Q4 CMMB experienced notable reductions in HTS_TST and HTS_TST_POS.
- RTI, funded by DoD maintains high achievement for VMMC_CIRC (113%) and TX_PVLS (107%), but consistently underperforms in most areas of testing and treatment. In testing, RTI used 73% of the allotted budget, and reached only 36% of HTS_TST_POS and 48% of HTS_TST targets. In Fy20, RTI also overoutlayed by 109%.While RTI they do not have the breadth of facilities as the other partners, they should strategize ways to positively contribute to the case finding and treatment moving forward.
- Overall, although all partners expended their full budget, the largest expenditures were in the areas of program management and indirect costs; with under-spending in testing and Care and treatment. Moreover, almost 60% of the budget was expended on non-service delivery, similar to previous years.

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.	Facility-based is ongoing with same day initiation in greater than 95% of all facilities. Community-based has scaled down due to suspension of community-based HIV testing
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.	As of October 31, 2020, over 90% of current patients have transitioned to TLD.
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.	As of October 2020, 99.5% of current clients on six-month MMD
4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by the end of COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	Currently at 78.3% TPT Completion in FY20 Q4. Limited commodities for patients, especially children available. INH deliveries due to low stock resulted in

	increased TPT initiation in following months.
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.	Conducted in COP20 and activities are ongoing through COP21.
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.	Reductions in index testing due to COVID, client preferences, and stock outs. Transition to virtual/phone counseling due to COVID.
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*)*	N/A -No funding for PrEP through Global Fund Grant proposal (all commodities are procured through Global Fund. PEPFAR does not procure commodities).
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	The program has focused on enrolling new HIV positive OVCs for all children at risk (C/ALHIV, HIV+ parents or caregivers and children of HIV+ FSW). The preparatory process has been completed for group-based HIV and sexual violence prevention interventions for 9-14 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.	N/A
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.	SIMS implementation delayed due to COVID, but should resume soon in Juba. Other CQI-like interventions are being implemented virtually in several facilities.
3. Evidence of treatment and viral load literacy activities	Funded in COP20 and should be continued

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.	in COP21 (especially through civil society organizations).
4. Clear evidence of agency progress toward local, indigenous partner direct funding.	N/A
5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	N/A
6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	N/A
7. Scale-up of case surveillance and unique identifiers for patients across all sites.	Initial sentinel surveillance activities begun.

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

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

OU –Specific Directives
HIV Case Finding • Client-centered approach at sites for HTS and clinical services. • Implement Index with fidelity and quality, addressing IPV and confidentiality challenges to improve use of HIV testing by clients. • Continue case finding strategies of improving volume in high yield sites/locations, populations, applying risk screening tool in low yield locations to optimize index testing. • To address decline in index testing, expand index case testing at additional sites if safe and ethical guidelines can be adhered to, focusing on VL non-suppressed and new HTS_POS, as per guidance. • The site list at FY20 Q4 should be the site list for COP21. Additional expansion to new sites is not recommended.
PMTCT, EID • Retention support and longitudinal monitoring systems need strengthening using a CQI approach to ensure infants receive ongoing care and testing during the exposure period, final outcomes are ascertained, and these outcomes are accurately reported until 18-24 months or 3 months after cessation of BF (whichever comes first). • Close partner management, quality improvement approaches including mother-infant pair tracking are needed to address both the programmatic (clinical) and laboratory barriers leading to persistently low 2 month EID coverage in South Sudan across all implementing partners. Additionally, mothers with unknown HIV status should continue to be tested with provider-initiated HIV testing at postnatal care to establish HIV-exposure status. • HIV testing should be offered to all infants with unknown exposure in high yield settings, such as TB clinics, malnutrition wards, and pediatric inpatient facilities.
HIV Treatment and Viral Load • Current site list approved in COP20 should be used in COP21. Further expansion to other sites and counties is not recommended. Current sites should provide high quality services in alignment with services being rendered at those sites. • Close monitoring of drug dispensation and stock availability at sites is needed to ensure the gains of 6MMD are maintained • Immediate and rapid implementation of last mile delivery of commodities which was funded in COP20 ($1.5 million) is needed to ensure timely and accurate delivery of commodities to sites • The site list at FY20 Q4 should be the site list for COP21, including designations of full service sties vs sites only providing drug dispensation. Additional expansion to new sites is not recommended. • Continued investment in viral load to close the existing gaps in all populations and need to understand site-specific challenges. Close monitoring of turnaround times is needed to ensure results are shared with sites in a timely manner for action.
OVC, KP, and DREAMS • Continue South Sudan-specific DREAMS program focused on GBV amongst young girls

($1 million). • Continue OVC in Juba only and conduct improved wraparound services to enroll PLHIV and improve EID coverage, with a continued focus on enrolling children of female sex workers. • Improve testing coverage within KP program while ensuring that programming is in alignment with findings of Integrated Biobehavioral surveys (iBBS). No additional expansion to new counties (i.e. program should remain in COP20 counties especially since there were delays in implementation in some counties)
VMMC • Continue implementation of VMMV program with the DoD program only. Additional expansion to new sites is not recommended.
Above Site • Human Resources for Health (HRH): Utilize the findings of the COP20-completed HRH Inventory and Optimization Solution results to hire more clinical staff, focusing on SNU and site, and using available funds in COP 20 budget to complete realignment. Lay cadres should not be expanded and every effort should be made to provide a living wage to those who are funded through PEPFAR • Data Quality: Given previous consistent challenges in data quality. IHI SI should ensure that monitoring and improving data quality is a key focus area for this implementing partner. This should include ensuring that site level staff are able to implement data quality improvement activities in conjunction with routine service quality improvements. DQ discussions must be integrated into routine SIMS and CQI activities for M&E and clinical staff. • Sentinel surveillance data should be leveraged to better understand where infections are occurring and close monitoring of positivity • Given the need to focus on the site level, all COP21 funded Above site activities must have a clear and direct relationship to site level activities and investments. Above service delivery investments should only account for 40% of the COP21 envelope. Close collaboration with the Global Fund is needed to ensure timely, efficient, and accurate forecasting and delivery of commodities to sites. PEPFAR investments in supply chain should be limited to a third party logistics partner funding last mile delivery. All other HIV- and TB- related commodities procurements and supply chain management are handled by the Global Fund under the 2021-2023 grant proposal.
Other Government Policy or Programming Changes Needed • PEPFAR Coordinator at post using State COP20 funds for COP21 pipeline, with any additional costs to support USDH to come from existing COP21 envelope. • Across all implementing partners, improved fiscal management of resources is needed to ensure maximal resources are expended on HIV programming at the site level

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.

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 Sudan 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 Sudan 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 4 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.