



United States Department of State

Washington, D.C. 20520

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January 16, 2020

COP 2020 Planning Level Letter | PART 2

**INFORMATION MEMO FOR AMBASSADOR LISA PETERSON, ESWATINI**

**SUBJECT: COP 2020 PEPFAR Planned Allocation and Strategic Direction**

With input from the field teams through the quarterly POARTS and from Headquarters Country Accountability and Support Teams, we have thoroughly reviewed progress of the program in your country over time and specifically the end of year results of the Country Operational Plan (COP) 2018 and current COP 2019 implementation as we plan for COP 2020. We have noted the following key successes and specific areas of concern:

*Key Successes*

- PEPFAR Eswatini implemented a multi-intervention surge approach to achieve the national 90-90-90 HIV coverage targets by the end of FY18, and through a combination of targeted HIV testing and back-to-care efforts, have reached and enrolled 92% of HIV positive persons identified in treatment with 87% viral load suppression.
- Achieved viral load suppression results in adults of greater than 95% across all regions and in children, greater than 85% with viral load coverage between 82-85% by region.
- Consistent effort on scaling index testing has resulted in an increase in HIV positive yield to >20% and with a higher number of men identified through index texting than women demonstrating the utility of this testing modality as a means of reaching men.

*Areas of Concern*

- While the national treatment cascade shows high rates of coverage, ART coverage is less than 90% for children, young women and men 25-29 years.
- Even as index testing has been scaled, facility-based testing results had lower numbers of contacts elicited than anticipated, which, in turn, limited the effectiveness of the overall contribution of index testing to HIV positives identified.
- The trend in new positives identified has held constant over FY18 and FY19 but with limited growth in the treatment cohort as a result of difficulties with client retention, with marked differences between regions.
- As a core part of the prevention portfolio, the VMMC program reached only 50% of the target with less than 50% of VMMCs done in the 15-29 year old prioritized age band.

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**SECTION 1: COP 2020 PLANNING LEVEL**

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2019 (EOFY) tool, and performance data, the total COP/ROP 2020 planning level is comprised as follows:

(Note – all pipeline numbers were provided and confirmed by the agencies)

**Table 1. COP 2020 Total Budget including Applied Pipeline**

TABLE 1 : All COP 2020 Funding by Fiscal Year

OU Total	Bilateral			Unspecified	Central	TOTAL
	FY20	FY19	FY17		Unspecified	TOTAL
Total New Funding	\$ 69,071,994	\$ -	\$ -			\$ 69,071,994
GHP- State	\$ 68,584,494	\$ -	\$ -			\$ 68,584,494
GHP- USAID	\$ -	\$ -	\$ -			\$ -
GAP	\$ 487,500	\$ -	\$ -			\$ 487,500
Total Applied Pipeline				\$ 1,072,571	\$ 927,435	\$ 2,000,006
DOD				\$ -	\$ -	\$ -
HHS/CDC				\$ 1,000,381	\$ -	\$ 1,000,381
HHS/HRSA				\$ -	\$ -	\$ -
PC				\$ 72,190	\$ -	\$ 72,190
State				\$ -	\$ -	\$ -
USAID				\$ -	\$ 927,435	\$ 927,435
TOTAL FUNDING	\$ 69,071,994	\$ -	\$ -	\$ 1,072,571	\$ 927,435	\$ 71,072,000

\*\*Based on agency reported available pipeline from EOFY 2019.

**SECTION 2: COP/ROP 2020 BUDGETARY REQUIREMENTS\*\***

Countries should plan for the full Care and Treatment (C&T) level of \$41,400,000 and the full Orphans and Vulnerable Children (OVC) level of \$6,700,000 from Part 1 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 2020 Earmarks by Fiscal Year \***

Earmarks	COP 2020 Planning Level			
	FY20	FY19	FY17	Total
C&T	\$ 32,000,000	\$ -	\$ -	\$ 32,000,000
OVC	\$ 16,700,000	\$ -	\$ -	\$ 16,700,000
GBV	\$ 1,140,888	\$ -	\$ -	\$ 1,140,888
Water	\$ 150,000	\$ -	\$ -	\$ 150,000

\* Countries should be programming to levels outlined in Part 1 of the COP 2020 Planning Level Letter. These earmark controls above represent the minimum amounts that must be programmed in the given appropriation year.

**TABLE 3 : All COP 2020 Initiative Controls**

	COP 20 Total
Total Funding	\$ 29,400,000
VMMC	\$ 1,700,000
Cervical Cancer	\$ 3,000,000
DREAMS	\$ 14,000,000
HBCU Tx	\$ -
COP 19 Performance	\$ 4,000,000
HKID Requirement	\$ 6,700,000

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

## SECTION 3: PAST PERFORMANCE – COP 2018 Review

**Table 4. COP OU Level FY19 Program Results (COP18) and FY20 Targets (COP19)**

\*Targets are from COP19 Approval Memo, unless otherwise noted

Indicator	FY19 Result (COP18)	FY20 Target (COP19)*
<b>TX Current Adults</b>	168,763 (PEPFAR-only)	188,759 (National)
<b>TX Current Peds</b>	8,365 (PEPFAR-only)	9,398 (National)
<b>VMMC among males 15 years or older</b>	6,284	21,034
<b>DREAMS (AGYW completing at least the primary package)</b>	29,320	N/A
<b>Cervical Cancer Screen</b>	27,228 (screened)	39,943 (2-yr target PLL)
<b>TB Preventive Therapy (FY19 Q2 + Q4)</b>	27,775	48,994
<b>PrEP_New (N)</b>	3,025	4,479
<b>PrEP_Curr (N)</b>	3,107	5,861

**Table 5. COP 2018 | FY 2019 Agency-level Outlays versus Approved Budget**

\*All data pulled from EOFY Tool

OU/Agency	Sum of Approved COP/ROP 2018 Planning Level	Sum of Total FY 2019 Outlays	Sum of Over/Under Outlays
<b>OU</b>	<b>\$70,631,316</b>	<b>\$62,464,815</b>	<b>\$8,166,501</b>
DOD	\$1,830,000	\$1,395,096	\$434,904
HHS/CDC	\$23,831,196	\$20,351,965	\$3,479,231
PC	\$1,140,000	\$997,289	\$142,711
State	\$1,074,929	\$600,654	\$474,275
State/AF	\$144,103	\$110,539	\$33,564
USAID	\$38,875,088	\$37,463,678	\$1,411,410
CDC (Central)	\$1,507,296	--	\$1,507,296
USAID(Central)	\$2,228,704	\$1,545,594	\$683,110

*\*Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.*

**Table 6. COP 2018 | FY 2019 Implementing Partner-level Outlays versus Approved Budget**  
(Mechanisms with 110% or more over-outlay; all data from EOFY tool)

Mech ID	Prime Partner	Funding Agency	Last Active COP	COP/ROP18/FY19 Budget (New funding + Pipeline + Central)	Actual FY19 Outlays (\$)	Actual FY 19 Outlays as % of COP 18 Budget	Over/Under FY19 Outlays (Actual \$ - Total COP/ROP18 Budget \$)	Notes
11673	U.S. Department of Defense (Defense)	DOD	2018 COP	\$ -	\$ 124,891		(124,891)	
14374	Association of Public Health Laboratories	CDC	2016 COP	\$ -	\$ 19,075		(19,075)	
70330	Baylor College of Medicine Children's Foundation Malawi	USAID	2018 COP	\$ 385,620	\$ 1,313,968	341%	(928,348)	This outlay was for purchase of hardware for CMIS during IP transition
17965	Catholic Relief Services - United States Conference Of Catholic Bishops	USAID	2019 COP	\$ 43,247	\$ 160,044	370%	(116,797)	
17972	The University of North Carolina at Chapel Hill	USAID	2019 COP	\$ 59,293	\$ 318,429	537%	(259,136)	
18602	Chemonics International, Inc.	USAID	2019 COP	\$ -	\$ 234,039		(234,039)	
18598	Population Council	USAID	2018 COP	\$ -	\$ 381,407		(381,407)	
18329	Institute for Health Measurement	USAID	2018 COP	\$ 1,197,115	\$ 1,325,214	111%	(128,099)	
18387	FHI Development 360 LLC	USAID	2019 COP	\$ 2,041,985	\$ 2,430,113	113%	(388,128)	

\*Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.

**Table 7. COP/ROP 2018 | FY 2019 Results & Expenditures**

Agency Indicator	FY19 Target	FY19 Result	% Achievement	Program Classification	FY19 Expenditure	% Service Delivery	
HHS/CDC	HTS_TST	82,642	191,831	232.1%	HTS Program Area	\$4,545,456	73%
	HTS_TST_PO S	7,088	13,287	187.5%			
	TX_NEW	8,103	9,989	123.3%	C&T Program Area	\$6,409,461	28%
	TX_CURR	103,574	103,449	99.9%			
	VMMC_CIRC	3,820	761	19.9%	VMMC Subprogram of PREV	\$241,613	100%
	OVC_SERV	N/A	N/A	N/A	OVC Major Beneficiary	N/A	N/A
DOD	HTS_TST	3,578	4,261	119.1%	HTS Program Area	\$137,269	61%
	HTS_TST_PO S	544	548	100.7%			
	TX_NEW	571	541	94.7%	C&T Program Area	\$548,837	54%
	TX_CURR	4,173	2,592	62.1%			
	VMMC_CIRC	900	192	21.3%	VMMC Subprogram of PREV	\$89,326	100%

	OVC_SERV	N/A	N/A	N/A	OVC Major Beneficiary	N/A	N/A
USAID	HTS_TST	170,501	<b>179,236</b>	105.1%	HTS Program Area	\$2,683,044	81%
	HTS_TST_PO S	6,390	<b>9,405</b>	147.2%			
	TX_NEW	7,811	<b>7,284</b>	93.3%	C&T Program Area	\$11,303,198	83%
	TX_CURR	77,262	<b>72,898</b>	94.35%			
	VMMC_CIRC	25,280	<b>14,174</b>	56.1%	VMMC Subprogram of PREV	\$3,710,088	97%
	OVC_SERV	66,026	<b>61,966</b>	93.7%	OVC Major Beneficiary	\$5,999,966	99%
					<b>Above Site Programs</b>	\$7,055,863	
					<b>Program Management</b>	\$11,605,881	

### COP 2018 | FY 2019 Analysis of Performance

- Eswatini has achieved 90-90-90 at a national level, however, ART coverage by specific populations lags for children, young women and men 20-39 years.
- On the path to achieving 95-95-95 Eswatini is progressing with 93% of all persons living with HIV identified, 92% of positives on treatment and 87% of those on treatment virally suppressed. To achieve epidemic control within males and females and all age bands the Eswatini program must implement strategies with known success in retaining women ages 20-34 and men ages 30-39

### HIV Case Finding

- HIV testing results showed some improvements in positive yields but lacked consistency over the FY19 period. Partners with the highest targets all exceeded the targets. The overall linkage proxy was 80%, but with male linkage rates lower than females and regional differences with a range of 52-88%. Facility-based testing is not optimized. While facility testing contributes the largest proportion of HIV positives identified, it is achieved with high rates of overall testing and a yield of ~5%.
- Index testing was a strong focus in FY19 with improvements in yields averaging 20%. Contacts elicited from index cases were low and inconsistent across quarters and across partners. Q3 and Q4 showed the strongest performance with the highest yields of nearly 30%. There have been consistently more male HIV positives found through index testing demonstrating the utility of this modality for finding men.
- Recency testing was launched and is expanding. Recency is urgently needed to better understand the population of pregnant women 30-39 years presenting as newly identified HIV positive.

**Treatment, Retention and Viral Load Suppression**

- Whereas the results of new HIV positive identified remained largely unchanged for FY18 and FY19, the treatment current cohort showed minimal growth, and in two of the four regions, results declined. With HIV positives identified and treatment new results ranging from 93% to 123% achievement of targets, the poor treatment net new results were notable.
- In FY19 Q1, approximately 20,000 clients were considered lost to follow-up post the data quality assessment and the adjustment to the 28-day definition alignment. Between Q2-4, ~15,000 clients were added to the treatment cohort; 9,222 were newly identified or newly linked (previously tested positive) with 4,090 brought back to care through the surge efforts. However, the combination of these efforts did not recover all cases considered lost to follow-up.
- Transfers between regions – silent or formal – have been noted in the surge effort to bring those lost to follow-up back to care. It is unclear how transfers are recorded upon arrival at different facilities and if or how records are transferred to avoid duplicate records. Hhohho had the highest rate of transfers and a negative treatment net new result.
- Cohort monitoring was initiated in FY19 and will be important in improving the understanding of client mobility and preference for where they want to receive services; response should be to more heavily weight funding support to those locations.
- FY19 showed strong viral load suppression in both adults and children with minimal differences by region. However, viral load coverage is less consistent across regions with lab equipment and results reporting challenges not fully resolved. Manzini has the largest gap in viral load coverage.
- TPT implementation has been prioritized by the government, but significant challenges affected program result; ineffective screening yielded only 1.2% positivity rate versus an expected rate of 5-15%, and only 20% of target achieved for enrolling TB-negatives in TPT, but for those initiated, TPT completion rates were strong.
- TLD transition has been slow with only ~30% of clients on TLD owing in part to the requirement for a viral load to be recorded prior to transition.

**VMMC, DREAMS, OVC, Cervical Cancer**

- VMMC results showed progress in the final quarter of FY19, but with only 50% of the targets achieved overall. The majority of circumcisions were still performed among boys under 15 (8,839). There was no movement on increasing 15-29 year old circumcisions.
- The OVC\_SERV achievement for OVC beneficiaries under age 18 was 91% in Eswatini for FY19 (92% USAID, 50% Peace Corps). All agencies and implementing partners should work to improve the OVC\_SERV achievement to 90% or higher. Among OVC beneficiaries, 40% are ages 10-14 with the overall known HIV status of 90%. A small percentage of the cohort is HIV positive. An area of improvement will be to increase enrollment of HIV positive children.
- Implementation of PrEP through DREAMS started in FY19 Q4. An accelerated plan will be necessary in FY20
- Strong efforts were noted in reaching the FY19 targets for screening for cervical cancer, finding 1,572 women. With only half receiving treatment for the cervical cancer, the

importance of continuing with plans and implementation of treatment services will remain critical.

- PEPFAR Eswatini has made significant investments in electronic client record systems. FY19 resulted in migration to a new version of the e-system with 85% of ART delivery sites using the platform (new and older versions). However, ongoing challenges with unique patient identifiers, on and off-line versions of the e-system, server synchronization and user interfaces have jeopardized the confidence in the system and quality of the data. FY20 must show a marked improvement in confidence in the accuracy of data collected via the e-system with all high volume sites brought on-line.

## Partner Performance

### Overall Program Performance – 3 Years

Operating Unit	Indicator	Numerator/ Denominator	FY16 Cum. Results	FY17 Cum. Results	FY18 Cum. Results	FY18 Target	FY18 %	FY19 Cum. Results	FY19 Target	FY19 %
Eswatini	HTS_INDEX_NEWPOS	N						3,713		
	HTS_TST	N	369,330	444,930	407,574	345,624	117.9%	363,747	256,721	141.7%
	HTS_TST_POS	N	25,819	24,546	24,183	35,857	67.4%	22,278	14,016	158.9%
	TX_CURR	N	133,139	150,987	175,912	172,342	102.1%	177,128	186,461	95.0%
	TX_NET_NEW	N	20,152	17,848	24,925			1,216		
	TX_NEW	N	18,878	23,086	17,850	35,105	50.8%	17,228	16,485	104.5%
	TX_PVLS	D		83,478	134,965	153,305	88.0%	138,944	178,489	77.8%
	N		76,532	125,354	138,001	90.8%	133,907			

### Treatment current performance (see table below)

For CDC, ICAP achieved 108%; PSI with 94.9%, and URC-Lubombo achieved 89.5%. For USAID, JSI (AIDSFree) achieved 93.3% on average, but by regions differences in performance show Hhohho at 97.7% and Shiselweni at 79%.

For DOD, URC achieved the lowest treatment on current at 62.1%. To see improvement in the treatment current results and core indicators as part of the treatment cascade, DOD/URC will be required to provide the following as part of COP20 planning: (1) program target and results disaggregated by military/civilian populations; (2) separate military cascade results over time up to the end of FY19; and (3) details on the number of military sites and the services offered at each site.

Funding Agency	Partner	Implementing Mechanism		Indicator	Operating Unit			
					Eswatini			
					Numerator/ Denominator	FY19 Cum. Results	FY19 Target	FY19 %
USAID	JSI Research And Training Institute, INC.	17465	AIDSFree	TX_CURR	N	71,191	76,449	93.1%
USAID	THE LUKE COMMISSION SWAZILAND	17967	Comprehensive Mobile Clinical and Prevention Services (CMCPS)	TX_CURR	N		588	
		80103	Integrated Treatment Care and Prevention Services for Vulnerable Populations Activity in Eswatini	TX_CURR	N	1,707		
HHS/CDC	University Research Co., LLC	17460	URC - Lubombo	TX_CURR	N	39,770	44,423	89.5%
HHS/CDC	Population Services International	18169	CIHTC Follow-on	TX_CURR	N	1,673	1,763	94.9%
HHS/CDC	Trustees Of Columbia University In The City Of New York	17463	ICAP-Manzini	TX_CURR	N	62,006	57,388	108.0%
DOD	U.S. Department of Defense	11673	DoD/USDF Umbutfo Swaziland Defence Force	TX_CURR	N		4,173	
	University Research Co., LLC	18272	University Research Corporation, LLC	TX_CURR	N	2,592		

### Treatment Net New Performance

JSI had the highest lost to follow-up in FY19 results with negative net new on treatment in Hhohho and Shiselweni. Current treatment cohort results for FY19 were lower than FY18. The partner did not over-outlay its allocated budget. This partner is expected to provide an improvement plan for treatment retention and work closely with other partners to implement a system of client tracking for silent and formal transfers in/out of facilities. If, through cohort monitoring, it is determined that clients have transferred to other regions, and are electing to seek care and treatment in other geographic areas for reasons unrelated to quality of services, consideration should be given for shifting funds to the location and supporting partner where clients choose to receive services.

SNU 1	Indicator	Operating Unit	Eswatini			
		Numerator/ Denominator	FY16 Cum. Results	FY17 Cum. Results	FY18 Cum. Results	FY19 Cum. Results
<b>_Military Eswatini</b>	<b>TX_CURR</b>	<b>N</b>	2,119	2,520	1,915	2,592
	<b>TX_NET_NEW</b>	<b>N</b>	237	401	(605)	677
	<b>TX_NEW</b>	<b>N</b>	392	359	320	541
<b>Hhohho</b>	<b>TX_CURR</b>	<b>N</b>	41,047	47,620	52,606	49,656
	<b>TX_NET_NEW</b>	<b>N</b>	3,478	6,573	4,986	(2,950)
	<b>TX_NEW</b>	<b>N</b>	5,838	6,796	4,532	4,707
<b>Lubombo</b>	<b>TX_CURR</b>	<b>N</b>	33,497	30,481	37,908	39,770
	<b>TX_NET_NEW</b>	<b>N</b>	6,334	(3,016)	7,427	1,862
	<b>TX_NEW</b>	<b>N</b>	4,127	4,596	4,017	3,426
<b>Manzini</b>	<b>TX_CURR</b>	<b>N</b>	50,798	51,481	60,266	65,240
	<b>TX_NET_NEW</b>	<b>N</b>	10,704	683	8,785	4,974
	<b>TX_NEW</b>	<b>N</b>	7,804	8,985	7,546	7,691
<b>Shiselweni</b>	<b>TX_CURR</b>	<b>N</b>	5,678	18,885	23,217	21,543
	<b>TX_NET_NEW</b>	<b>N</b>	(601)	13,207	4,332	(1,674)
	<b>TX_NEW</b>	<b>N</b>	717	2,350	1,435	1,448

### VMCM Performance

Partner and strategy changes were made as a result of poor performance in FY18, however, overall under-performance of the VMCM program persisted in FY19. Funding to CHAPS (USAID) in COP18 was for VMCM service delivery, demand creation, and technical assistance to the national VMCM program. During COP18, CHAPS met 50% of its targets; USAID terminated the partner agreement and responsibility has shifted to funding to a bridging mechanism. Additionally, in FY19 Q3, to accelerate uptake of services and enhance demand, USAID shifted funds to The Luke Commission (TLC). In FY19 Q4, overall responsibility for VMCM programming shifted from USAID to CDC (JHPIEGO). USAID holds responsibility for procurement of commodities and service delivery implementation in two regions using its clinical partners.

### Financial Performance

Overall, the Eswatini PEPFAR program under-outlayed in FY19 by 11.5 % (\$8,166,501). However, 11 Implementing Mechanisms (IMs) over-outlayed (as noted in the Table 6 above). Of the 11 IMs with over-outlays, 8 were USAID mechanisms for a total of \$2,856,881. Three of

11 IMs over-outlays due to closeouts costs for a total of \$260,763 (8.6% of over-outlay total). Additionally, some partner activities were delayed in FY18 and completed in FY19.

Budget and Expenditure by Level 1 and Interaction Type

Level 1	Period		
ASP	COP18	Budget	\$5,006,925
		Expenditure	\$5,921,721
C&T	COP18	Budget	\$29,232,606
		Expenditure	\$6,816,300 (blue) + \$10,837,720 (orange)
HTS	COP18	Budget	\$5,449,397
		Expenditure	\$5,577,039 (orange)
PM	COP18	Budget	
		Expenditure	\$11,525,607
PREV	COP18	Budget	\$11,174,122
		Expenditure	\$8,305,578 (orange)

Subject to COP Dev

**SECTION 4: COP 2020 DIRECTIVES**

The following section has specific directives for COP 2020 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.

For COP 2020, failure to meet any of these requirements will result in reductions to the Eswatini budget. (See Section 2.2. of COP Guidance)

**Table 8. COP 2020 (FY 2021) Minimum Program Requirements**

	<b>Minimum Program Requirement</b>	<b>Status</b>	<b>Outstanding Issues Hindering Implementation</b>
<b>Care and Treatment</b>	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups. <sup>1</sup>	Test and Start adopted and fully implemented since October 1, 2016. Implementing programs to improve access across all age, sex and risk groups through client-centered approaches and DSD models (specific focus on KP, AGYW, OVC and men). Linkage rate of >95% not yet attained. Q4 proxy linkage was 72% for males and 86% for females.	
	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 weighing $\geq 20$ kg, and removal of all nevirapine-based regimens. <sup>2</sup>	At the end of FY19 only 61% of National treatment cohort were 'eligible' to transition to TLD of which 58% of eligible ART clients have transitioned to TLD. ~30% of the national cohort has transition. All new positives initiate on TLD.	Policy change is needed on viral load requirement to TLD transition; access and timing of scheduled VL tests is a barrier to transition.

<sup>1</sup> Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

<sup>2</sup> Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

	3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents. <sup>3</sup>	Standard dispensing is 3 months. COP19 plans for 6 months dispensing delayed based on inadequate stocks of TLD due to government financial constraints. DSD models currently implemented include CAGs, teen clubs, fast track, starter pack dispensing, and community drug dispensing. Expanding community drug dispensing targeting specific populations is a priority for COP19 (KPs, rural populations and men).	
	4. All eligible PLHIV, including children, should have been offered TB preventive treatment (TPT) by end of COP20; cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. <sup>4</sup>	TPT is currently provided at no cost to all eligible PLHIV. TPT is fully integrated into the HIV clinical care package.  The completion for TPT reported for APR2019 is 88%, while TPT coverage was 17-23%.	Provider hesitancy to use TPT due to concerns of creating resistance if treating with INH only.
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in	Completed recommended network optimization (making replacements with Panther and Roche high throughput machines in all regions).  PEPFAR supports 22 main laboratories through a structured mentorship program and direct support for lab information systems,	

<sup>3</sup> Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

<sup>4</sup> Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

	<p>morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.</p>	<p>laboratorians, phlebotomists, sample transportation and reagents. To assess progress towards the implementation of LQMS, annual audits are carried out on all laboratories using the WHO AFRO SLIPTA checklist. Additionally, both the National Molecular Reference Lab and the National TB Reference Lab underwent accreditation assessment by the Southern African Development Community Accreditation Services (SADCAS). Both laboratories received full accreditation status for the ISO 15189:2012 standard for quality and competence of medical laboratories in August 2019.</p> <p>The Diagnostic Network Optimization activity for VL/EID is complete. The platform is now fully reagent rental. Aggressive roll out of DBS for adolescents and children is being implemented in COP 19. Return of results varies by region from 7 days to three weeks. In COP 19, an interface between the laboratory information system and CMIS is being installed to decrease turn-around time. EID coverage is 100% in Hhohho and Lumbombo, 97% in Manzini and 96% in Shiselweni.</p>	
<b>Case Finding</b>	<p>6. 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 must be tested for HIV.<sup>5</sup></p>	<p>Index testing scaled up and OU intensively working to improve index cascade. Higher yields in index testing in community compared to facility, but higher volumes from facility index testing. Implementing model of “specialized counselors” to improve facility index testing.</p> <p>Self-testing being scaled up now that test kits are available. The faith and community initiative (FCI) will greatly enhance self-test kit distribution and utilization.</p> <p>Currently testing all biological children of HIV+ mothers through index testing. Testing of all children &lt;19 of both biologic parents is currently not in SOPs.</p>	
<b>Prevention</b>	<p>7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to</p>	<p>Currently, prevention services including PrEP are offered to all high-risk populations testing negative. In addition, expanding a successful model for integrating PrEP eligibility screening with the HIV testing risk-screening tool. The majority of PrEP recipients are AGYW. In Q3</p>	

<sup>5</sup> Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 <https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/>

	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) <sup>6</sup>	and Q4, there has been an increase in PrEP uptake.	
	8.Alignment of OVC packages of services and enrollment to provide comprehensive prevention and 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) 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.	All children in the OVC program are assessed for HIV risk. HTS is facilitated for all OVC screened to be at risk.  C/ALHIV receive full case management services tracking ART adherence and providing family-based support.  9-14 year old OVC receive primary prevention of HIV and sexual violence (OGAC modules incorporated). OVC adolescent girls aged 10- 14 access DREAMS services.	
<b>Policy &amp; Public Health Systems</b>	9.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	No user fees for HIV services.	

<sup>6</sup> Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (<http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en>).

	as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention. <sup>7</sup>		
	10. 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. <sup>8</sup>	All MOH facilities receive ongoing training and CQI. Small grants available to facilities for quality improvement projects. 4 clinical facilities received in 2019 ISO 9001 certification. QI is supported in IP work plans and national policy.	
	11. 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.	Treatment and VL literacy education actively integrated into community programming and facility service delivery. In COP 19, this is a focus, as FCI will expand reach of literacy programs and stigma reduction messages through faith and community platforms.	
	12. Clear evidence of agency progress toward local, indigenous partner prime funding.	USAID: Increase in COP 19 to 18.7% from 11.6% in COP18. CDC: Increase in COP 19 to 14% from 8% In COP18.	
	13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	While the current financial situation has rendered increases in domestic funding for HIV challenging, the host government has continued to meet the commitment to funding first line adult ARVs for the population. In FY20, continuing to meet this commitment led to the Government approving a supplemental budget of over 9 million USD additional funds to ensure there was no interruption in ARV supply, further demonstrating commitment to	

<sup>7</sup> The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

<sup>8</sup> Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

		responsibility for the HIV response in spite of economic challenges.	
	14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Eswatini supports the development and piloting of birth, marriages, and death (BMD) forms and development of an annual vital statistics report. In COP19, the OU will intensify focused work in this area.	
	15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Currently in the CMIS, 56% of all clients have a unique identifier; and 85% of all ART clients have a unique ID. The CMIS is linked to the Home Affaires database and is able to pull a person's ID if person is registered there. OU is also actively working with community partners to register beneficiaries in the CMIS with their unique IDs and will continue to work with GKoE to improve overall national ID registration.	

In addition to meeting the minimum requirements outlined above, it is expected that Eswatini will:

**Table 10. COP 2020 (FY 2021) Technical Directives**

<b>OU –Specific Directives</b>
<b>HIV Treatment</b>
<ol style="list-style-type: none"> <li>1. Case Finding – sharpen case finding strategy within KP programs; accelerate and utilize Recency in ANC testing to better understand ‘new’ positives in pregnant women.</li> <li>2. Cohort monitoring – continue and expand to improve understanding of client movement between regions and within a region; utilize results to improve retention. Provide draft SOP endorsed by government for discussion at COP regional planning meeting. Back to care strategies – implementing partner mentoring for health care providers to change judgmental attitudes towards returning clients.</li> <li>3. Community ART delivery – map current models, look for differences in positive impact on retention and intentional scale-up of most impactful approaches. TPT – provider training and incentive scheme to increase number of persons TB negative initiated on TPT.</li> </ol> <p>Policy Changes:</p> <ul style="list-style-type: none"> <li>• TPT – change screening algorithm to increase sensitivity for identifying TB+.</li> <li>• VL – change the requirement for VL test within recent past before switching to TLD.</li> </ul>
<b>HIV Prevention</b>

VMMC:

- Monitor impact of new communication strategy on accessing men ages 15-29; adjust quickly if communication ineffective.
- Recommend and support alternative approaches for NERCHA and MoH technical lead for overall VMMC coordination and implementation.
- Consider new approach to target setting and partner attribution to allow for creative facility-community partnership.

DREAMS:

- Dramatic expansion of DREAMS programming, especially among vulnerable girls under 20.

Scale up PrEP in KP and DREAMS populations.

Key Populations - revise and FOCUS strategies on MSM in specific locales; accelerate planned program change.

**Health Information Systems**

1. Implement CMIS 2.0 in all high-volume sites
2. Accelerate roll-out and use of off-line version of CMIS 2.0
3. Finalize a standard procedure for eliminating/deactivating known duplicates at site level on a routine basis;
4. Develop standard procedure to account for inter-facility transfers (between regions and within a region)
5. Establish a functional power back-up system for all sites to mitigate system downtime

**COP/ROP 2020 Technical Priorities**

Client and Family Centered Treatment Services

COP 2020 planning must specifically and thoroughly address the challenge of interrupted antiretroviral treatment and client loss, especially among young adults. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous ART for a population that is often young and 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 convenient and fit the lives of the clients, and make it easy for patients on ART to continue treatment. PEPFAR requires development and full implementation of key client-centered policies and practices at the site-level, including optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient ARV pick-up arrangements, and community and client participation in design and evaluation of services. Eswatini must ensure 100% “known HIV status” for biological children of TX\_CURR clients (15+), including chart review and retrospective elicitation of eligible

biological children.

### Community-led Monitoring

In COP20, all PEPFAR programs are required to develop, 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)

Groups to be prioritized for PrEP include those testing negative in index testing but remaining at increased risk of HIV acquisition by virtue of unprotected exposure to a PLHIV with unsuppressed viral load, key populations including sex workers, men who have sex with men, transgender persons, people who use drugs, adolescent girls and young women, including pregnant and breastfeeding women, in areas with high HIV incidence or with high risk partners, and other identified serodiscordant couples. (Groups will be tailored to country context).

### TB Preventive Treatment (TPT)

TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP20; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

### DREAMS

DREAMS is receiving an increase in new funding which should be used for the following:

- **Interagency expansion into new districts with increased DREAMS funding:** Prioritize districts that are classified by UNAIDS as having extremely high or very high incidence among AGYW, but no DREAMS or Global Fund AGYW programming.
  - The four regions for Eswatini were all classified as Extremely High (ranging from 2.63% – 2.27%) in the UNAIDS analyses. However, PEPFAR and Global Fund AGYW programming is being implemented in 39 Tinkhundla. DREAMS should expand into the 16 Tinkhundla that are not currently covered by DREAMS or Global Fund.
- **PrEP:** Significantly scale-up PrEP for AGYW in all DREAMS districts.
- **STIs:** Eswatini is one of the countries where the introduction of STI testing and treatment is planned. \$153,000 of new funds should be dedicated to STI testing and treatment. Further details on the number of AGYW that will need to be tested, the cost of testing and treatment for each type of STI will be provided.
- **VACS:** Conduct a repeat VACS that oversamples DREAMS clusters. Further detail, including a detailed budget, will be provided.
- **Minimum Requirements for new funds:** To receive additional funds, Eswatini must present a strategy and a timeline at the COP meeting for the following:
  - Hire a dedicated DREAMS Coordinator (100% LOE)
  - Hire a DREAMS ambassador for each district to support DREAMS coordination and oversight
  - Implement approved, evidence-based curricula in line with the current DREAMS Guidance

- Ensure a fully operable layering database with unique IDs across IPs and SNUs
- Ensure a full geographic footprint in all districts
- Address challenges and ensure DREAMS implementation in all districts with fidelity

Layering: Eswatini's layering result (AGYW\_PREV) shows that 93% of active DREAMS beneficiaries had completed at least the primary package or the primary package plus components of the secondary package of DREAMS interventions. By subpopulation, the completion rates were 93% for AG 10-14 (8,075/8,641), 90% for AG 15-19 (7,788/8,645), 94% for YW 20-24 (7,537/8,047) and 95% for YW 25-29 (5,920/6,264).

### OVC

To support the Minimum Program Requirement described above, in COP20 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, case conferencing, shared confidentiality, and joint case identification. 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.

In COP20, OVC and clinical implementing partners in Eswatini must work together to ensure that 90% or more of children and adolescents on ART with PEPFAR support in OVC SNUs are offered the opportunity to enroll in the comprehensive OVC program.

### 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 under the age of 15 only by the dorsal slit method and only for those who have attained Tanner stage 3 or higher of development and are able to provide full informed consent for the procedure. While Shang ring may be considered for those below age 15 regardless of Tanner stage, the same informed consent issues apply. All VMMC providers must adhere to the requirements for reporting of Notifiable Adverse Events.

### Cervical Cancer Screening and Treatment:

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

For Eswatini, additional funding of \$1,500,000 is provided within the cervical cancer budget of \$3,000,000 to fund a partner to conduct an evaluation of the antibody response to two doses versus three doses of 9-valent HPV vaccine among girls and women living with HIV receiving ART. The evaluation is part of PEPFAR's participation in the Go Further Partnership with the

George W. Bush Institute, UNAIDS, and Merck, Inc. Vaccine will be provided by Merck. Please work with the PQ and PSE teams to clarify requirements.

### PLHIV Stigma Index 2.0

PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised Stigma Index 2.0, or complement Global Fund or other donors financing implementation of the Stigma Index 2.0, if it has not already been implemented in the OU. This revised U.S. government compliant version can begin the process of baseline data collection for evaluating the future impact of interventions on reducing stigma, and can inform future HIV program planning. If the revised 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 20, whether supported by PEPFAR or other resources.

### **COP/ROP 2020 Stakeholder Engagement** (see section 2.5.3 of COP Guidance)

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. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of COP/ROP 2020 remains a requirement for all PEPFAR programs, and as such the COP/ROP 2020 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2019 Q4 and FY 2019 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2020 in order to introduce and discuss all COP/ROP 2020 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2020. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund New Funding requests with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2020, PEPFAR will convene in-person meetings in Johannesburg, South Africa, Bangkok, Thailand, and Atlanta, GA 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 and multilateral partners. Specific guidance for the 2020 meeting delegations have been provided elsewhere. Engagement with all stakeholders is required beyond the meetings and throughout the COP/ROP 2020 development and finalization process. As in COP/ROP 2019, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP/ROP 2020 Guidance for a full list of requirements and engagement timelines.

**APPENDIX 1: Detailed Budgetary Requirements**

TABLE 11 : New Funding Detailed Initiative Controls

	COP 2020 Planning Level			
	FY20			COP 20 Total
	GHP-State	GHP-USAID	GAP	
Total New Funding	\$ 68,584,494	\$ -	\$ 487,500	\$ 69,071,994
Core Program	\$ 57,884,494	\$ -	\$ 487,500	\$ 58,371,994
COP 19 Performance	\$ 4,000,000			\$ 4,000,000
HKID Requirement ++	\$ 6,700,000			\$ 6,700,000

++DREAMS countries with GHP-USAID funding can use FY20 GHP-USAID funding to meet their FY20 HKID Requirement. These countries include: Kenya; Nigeria; South Africa; Tanzania; Uganda; and Zambia

*Care and Treatment:* If there is no adjustment to the COP 2020 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment amount from Part 1 of the planning level letter across all funding sources. Additionally, due to Congressional earmarks, some of the care and treatment requirement must be programmed from specific funding sources, as indicated above in Table 2. Your care and treatment requirement for the purposes of Congressional earmarks is calculated as the sum of total new FY 2020 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS, HLAB budget codes, 80% of the total funding programmed to the MTCT budget code, and 50% of the total funding programmed to the HVCT budget code.

*Orphans and Vulnerable Children (OVC):* Countries must program to the full OVC amount from Part 1 of the planning across all funding sources. Your OVC requirement is made up of the HKID Requirement (see details below) and 85% of the DREAMS non-HKID programmed funds for all new FY 2020 funds. Additionally, due to Congressional earmarks, some of the OVC requirement must be programmed from specific funding sources, as indicated above in Table 2. The COP 2020 planned level of new funds for the OVC earmark can be above this amount; however, it cannot fall below it.

*HKID Requirement:* OU's COP 2020 minimum requirement for the HKID budget code is reflected in Table 3 and is a subset of the OVC earmark. Your COP/ROP 2020 HKID requirement is derived based upon the approved COP/ROP 2019 HKID level inclusive of OVC and prevention intervention for children under 19 budget codes. The COP/ROP 2020 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.

*Gender Based Violence (GBV):* OU's COP 2020 minimum requirement for the GBV earmark is

reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2020** funding programmed to the GBV cross-cutting code. Your COP 2020 earmark is derived by using the final COP/ROP 2019 GBV earmark allocation as a baseline. The COP 2020 planned level of new FY 2020 funds for GBV can be above this amount; however, it cannot fall below it.

Water: OU's COP 2020 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2020 funding** programmed to the water cross-cutting code. Your COP 2020 earmark is derived by using the final COP/ROP 2019 water earmark allocation as a baseline. The COP 2020 planned level of new FY 2020 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 FY20 and must meet 40% by FY19. 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 FY20 as appropriate through their COP/ROP 2019 submission.

#### **COP/ROP 2020 Applied Pipeline** (See Section 9.1.2 Applied Pipeline of COP Guidance)

All agencies in Eswatini should hold a 3 month pipeline at the end of COP/ROP 2020 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending COP/ROP 2019 implementation (end of FY 2020) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP/ROP 2020, decreasing the new funding amount to stay within the planning level.