United States Department of State

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COP 2020 Planning Level Letter | PART 2

INFORMATION MEMO FOR AMBASSADOR Hushek, South Sudan

SUBJECT: Fiscal Year (FY) 2020 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly PEPFAR Oversight and Accountability Response Team (POART) calls 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:

1. PEPFAR South Sudan has managed to continue implementing HIV programming even under difficult political and security circumstances; this is a commendable achievement as South Sudan continues down the path towards peace and reconciliation.
2. To overcome specific operating challenges in South Sudan, PEPFAR South Sudan implemented several unique, low technology approaches to improve service delivery, share best practices, and monitor site level progress (for example, scale up of the ECHO platform to provide virtual technical assistance to health providers in facilities, and collecting monthly data using instant messaging platforms)
3. Achievement of Voluntary Medical Male Circumcision (VMMC) surpassed the target set in COP18, and largely within the appropriate age group

Areas of Concern:

1. Overall retention in services (including programs for prevention, orphans and vulnerable children and treatment) remains a consistent challenge, resulting in limited overall growth and less-than-ideal quality of treatment and Orphans and Vulnerable Children (OVC) programs
2. Limited scale up of effective and efficient case-finding strategies continue to negatively affect the growth of the program, resulting in lack of identification of those in need
3. Coordination among donors, such as Global Fund, in South Sudan's difficult operating and political environment, needs considerable improvement to actualize the efforts and gains of the HIV prevention and clinical program as a whole

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SECTION 1: COP/ROP 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 your agency.

TABLE 1 : All COP 2020 Funding by Fiscal Year

OU Total	Bilateral				Central	TOTAL
	FY20	FY19	FY17	Unspecified	Unspecified	TOTAL
Total New Funding	**$ 22,555,827**	**$ 15,000,000**	**$ -**			**$ 37,555,827**
GHP- State	$ 22,355,827	$ 15,000,000	$ -			**$ 37,355,827**
GHP- USAID	$ -	$ -	$ -			**$ -**
GAP	$ 200,000	$ -	$ -			**$ 200,000**
Total Applied Pipeline				**$ 430,173**	**$ -**	**$ 430,173**
DOD				$ 117,000	$ -	**$ 117,000**
HHS/CDC				$ 313,173	$ -	**$ 313,173**
HHS/HRSA				$ -	$ -	**$ -**
PC				$ -	$ -	**$ -**
State				$ -	$ -	**$ -**
USAID				$ -	$ -	**$ -**
TOTAL FUNDING	**$ 22,555,827**	**$ 15,000,000**	**$ -**	**$ 430,173**	**$ -**	**$ 37,986,000**

SECTION 2: COP/ROP 2020 BUDGETARY REQUIREMENTS

Countries should plan for the full Care and Treatment (C&T) level of $10,000,000 and the full Orphans and Vulnerable Children (OVC) level of $570,000 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	$ 10,000,000	$ -	$ -	**$ 10,000,000**
OVC	$ 570,000	$ -	$ -	**$ 570,000**
GBV	$ -	$ -	$ -	**$ -**
Water	$ -	$ -	$ -	**$ -**

** 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	**$ 7,570,000**
VMMC	$ 1,000,000
Cervical Cancer	$ -
DREAMS	$ 1,000,000

HBCU Tx	$ -
COP 19 Performance	$ 5,000,000
HKID Requirement	$ 570,000

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

SECTION 3: PAST PERFORMANCE – COP/ROP 2018 Review

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

Indicator	FY19 result (COP18)	FY20 target (COP19)
TX Current Pediatrics	1,219	3,344
TX Current Adults	23,904	57,464
VMMC among males 15 years or older	1,434	1,545
DREAMS	N/A	N/A
Cervical Cancer	N/A	N/A
TB Preventive Therapy	46	4,085

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

OU/Agency	Sum of Approved COP/ROP 2018 Planning Level	Sum of Total FY 2019 Outlays	Sum of Over/Under Outlays
OU			
DOD	1,353,061	972,226	380,835
HHS/CDC	13,008,159	12,935,740	72,419
HHS/HRSA	-	-	-
PC	-	-	-
State	-	-	-
State/AF	-	-	-
State/SGAC	-	-	-
USAID	5,838,780	4,354,613	1,484,167
Grand Total	**20,200,000**	**18,262,579**	**1,937,421**

**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/ROP 2018 | FY 2019 Implementing Partner-level Outlays versus Approved Budget

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Mech ID	Prime Partner	Funding Agency	COP/ROP18/FY19 Budget (New funding + Pipeline + Central)	Actual FY19 Outlays ($)	Over/Under FY19 Outlays (Actual $ - Total COP/ROP18 Budget $)
17805	Research Triangle Institute	DOD	1,253,061	964,544	(288,517)
17700	AFRICAN MEDICAL & RESEARCH FOUNDATIO N	HHS/CDC	1,260,000	1,314,386	54,386
13142	Association of Public Health Laboratories (APHL)	HHS/CDC	-	275,104	275,104
17832	Catholic Medical Mission Board Inc	HHS/CDC	2,146,335	2,504,874	358,539
17708	IntraHealth International, Inc	HHS/CDC	1,620,201	1,740,911	120,710
18397	IntraHealth International, Inc	HHS/CDC	2,678,042	2,798,743	120,701
17701	Trustees Of Columbia University In The City Of New York	HHS/CDC	3,303,581	2,969,663	(333,918)
18133	Catholic Relief Services - United States Conference Of Catholic Bishops	USAID	628,373	207,589	(420,784)
18236	Chemonics International	USAID	1,214,638	1,049,909	(164,729)
17713	FHI 360	USAID	-	211,738	211,738
17714	JHPIEGO CORPORATIO N	USAID	1,683,344	1,522,012	(161,332)
80066	Pathfinder International	USAID	1,298,377	699,219	(599,158)

**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.*

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

Agency	Indicator	FY19 Target	FY19 Result	% Achievement	Program Classification	FY19 Expenditure	% Service Delivery
	HTS_TST	260,440	216,276	83.0%	HTS	2,265,742	78.1%
	HTS_TST_POS	13,523	7,514	55.6%			

HHS/CDC	TX_NEW	14,102	7,392	52.4%	C&T	2,686,240	83.3%
	TX_CURR	34,121	19,833	58.1%			
	VMMC_CIRC	N/A	N/A				
	OVC_SERV	N/A	N/A				
					Above Site Programs	2,407,739	
					Program Management	3,272,347	
DOD	HTS_TST	14,604	13,561	92.9%	HTS	0	-
	HTS_TST_POS	1,414	1,204	85.1%			
	TX_NEW	1,277	849	66.5%	C&T	798,184	0.0%
	TX_CURR	2,041	1,172	57.4%			
	VMMC_CIRC	1,031	1,461	141.7%	PREV: VMMC	0	-
	OVC_SERV	N/A	N/A				
					Above Site Programs	0	
					Program Management	223,451	
USAID	HTS_TST	42,929	52,260	121.7%	HTS	1,015,960	100.0%
	HTS_TST_POS	2,316	2,402	103.7%			
	TX_NEW	2,174	1,893	87.1%	C&T	1,165,832	89.6%
	TX_CURR	5,678	4,133	72.8%			
	VMMC_CIRC	N/A	N/A				
	OVC_SERV	2,617	1,171	44.7%	SE for OVC	181,733	80.8%
					Above Site Programs	356,850	
					Program Management	1,619,389	

COP/ROP 2018 | FY 2019 Analysis of Performance
Case Finding:

- Overall, the South Sudan program consistently had challenges in implementing an effective case finding strategy. While HTS_TST has been appropriately curbed from 140% achievement (318,276/227,327) in FY18 to 88.7% (282,097/317,973) in FY19 with an increase in yield from 3.3% to 3.9%, the total number of positives identified fell below the target of 17,253 (achievement was only 11,080 or 64%)
- At the site level, 81% of HIV positives were identified at just 36% of PEPFAR supported sites (17 out of the 44 sites that reported on HTS_TST). 2 of these sites reported less than 5 HTS_TST_POS. This suggests an intense focus is needed at sites were most PLHIV are identified.
- The PEPFAR team is commended for assessing adherence to standards of quality using Site Improvement Through Monitoring (SIMS) even in South Sudan's difficult operating environment. Results from FY19 SIMS assessments demonstrate that standards related to HIV testing are not being consistently met, suggesting the quality and fidelity of HIV Testing
  Services (HTS) interventions need improvement. Remediation is underway but must be closely monitored to ensure site level changes occur.
- Index testing continues be an underutilized strategy in South Sudan. Volume of index

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testing has increased slightly – 4,078 to 4,779 – but still fell significantly short of achieving the 11,175 target in FY19. Although the yields for index testing in Juba were over 20%, the volume remains low relative to other testing modalities.

- At the site level, the top 6 high volume sites reported low rates of offering index testing to HIV positive individuals and low rates of contact elicitation (as per HTS_INDEX results). In conjunction with SIMS results from sites that were assessed, this suggests the fidelity of the index testing intervention needs to be addressed.
- Most positives were identified in the female 25-29 age group relative to all other age groups, and mostly in the other PITC testing modality

Early infant Diagnosis (EID) and Preventing Mother to Child Transmission (PMTCT)

- PMTCT_STAT coverage and PMTCT_ART coverage were both above 100% at OU level
- However, EID coverage at 2 months varied from 33% to 41% over each of the 4 quarters in FY19. This means that less than half of cases are diagnosed at less than 2 months.

HIV Treatment

- Linkage to treatment remains a strong point for the program with four out of five PEPFAR regions reporting over 95% linkage from testing to treatment - the exception being Eastern Equatoria where linkage was 79%.
- At a national level, ART coverage remains low across all age bands, the lowest being 6-7% among <1, 1-4, and 20-24 years. The highest coverage (24%) is among those older than 50 years of age. At PEPFAR-supported sites, most new initiates on treatment (or TX_NEW) are in 25-29 yr age band.
- TX_NET_NEW, or treatment growth, from FY18 to FY19 at the OU-level was 1,356 in comparison with TX_NEW which was 10,134.
- At FY19 Q4, 81% of the 25,123 ART patients at PEPFAR-supported facilities are at 44% (or 15 out of 34) of facilities, ranging from volumes of 3,332 to 40 patients on ART. There are only 7 sites with over 1000 patients on ART (55% of TX_CURR). However, the top seven high-volume sites, all with 1,000 or more patients on treatment, accounted for 64% of the patients lost in FY19.
- At FY19 Q4, 81% of TX_NEW was reported from just 43% of sites (or 15 out of 34). 2 sites reported TX_NEW of less than 10
- Using data from FY19 Q4 PEPFAR-supported Ministry of Health Data Alignment Activity, a total of 47 facilities reported on either TX_CURR or TX_NEW (TX_CURR total from these facilities was 28,050). All 34 PEPFAR-support facilities are included, suggesting only an additional approx. 3,000 ART patients are at the remaining 13 sites. It is thus unlikely that the over 10,000 ART patients potentially lost to treatment in FY19 are on ART at these other sites.
- Use of platforms like ECHO, supported by ICAP, demonstrated success in reaching remote sites and providing low-technology options for capacity building of providers and ultimate improvement service provision.
- Efforts at tracing patients lost to follow up were scaled up during FY19 but require more intensive efforts –TX_ML data indicate at least 50% of patients who missed their last appointment could not be located and tracing efforts were not even initiated for up to 20% of patients.

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- SIMS data highlighted significant challenges to the quality of service delivery across the testing and treatment continuum – in some cases, over 50% of SIMS standards assessed scored poorly, including Patient tracking, Management of High Viral load, Partner Services etc.

Viral Suppression

- Viral suppression remains low across almost all regions and implementing partners; adult viral load coverage is 59% and viral load suppression is at 82%. Pediatric viral load coverage is at 43% and suppression is 59%. VL coverage among pregnant and breastfeeding women is the lowest at 25%, potentially due to national policy guidelines on eligibility for viral load testing in pregnant women
- 5 of the 10 largest TX_CURR sites have low rates of viral load coverage and viral load suppression (i.e. below 80% coverage and 90% suppression)
- Using SIMS data, viral load and EID related standards scored as 'red' or 'yellow' (i.e. needing remediation) 50% of the time those standards were assessed at sites supported by IHI, ICAP and CMMB. This suggests improvements are needed to the quality of services.

TB

- Only 63.5% of ART patients were screened for TB, with 3.4% screening positive
- Only 46 patients started TB preventative therapy out of a target of 2,109 due (in part) to a lack of procurement of drugs

VMMC

- Even with a substantial increase in the target from FY18 (750) to FY19 (1,031), the VMMC program continues to grow, surpassing its FY19 target by 142%. Almost all circumcisions were in the 15+ age group (only 27 reported in the less than 15 age group).

Key Populations

- Achievement against KP_PREV declined from FY18 to FY19 (96% to 83%), although a greater proportion of those reached with PREV services were tested in comparison with FY18.
- Yields among FSW tested ranged from under 6% to over 10% quarter over quarter. However, not all those identified were initiated on treatment

OVC

- Achievement of targets for OVC_SERV also remains low (under 40%) with one out of every two of the 2,854 OVCs enrolled in the program exiting without graduation (1,683/2,854).
- The OVC_SERV achievement for OVC beneficiaries under age 18 was 44% for FY19. The new COP20 incoming implementing partner should work to improve the OVC_SERV achievement to 90% or higher.
- In FY19, 59% of OVC beneficiaries exited without graduation, reflecting program quality and retention issues. The percentage of OVC beneficiaries that exit the OVC program without graduation should be 10% or lower.
- The OVC_HIVSTAT known HIV status proxy for FY19 in South Sudan was 73%, well below the goal of 90%.

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- Although the rates of linkage to treatment remain high in comparison with two years ago, only 10% of the OVC beneficiaries in the program are HIV positive

Above Site

- COP18 budget, as provided in Table 6, was $2,440,992 while FY19 Above Site expenditures totaled $2,764,589, suggesting improved tracking of resource use and milestone achievement is needed.

Laboratory, including Viral Load (VL) and Early Infant Diagnosis (EID)

- Processing and return of VL and EID results were hindered by continued breakdowns of equipment at the National Public Health Lab (NPHL) and lack of a sustainable back-up solution. Power interruptions and lack of fuel for generators powering the VL/EID machine exacerbated the issue and further added to the delays in clearing the testing backlog once repairs were completed. This occurred despite specific above site lab support to address items related to improving laboratory strengthening, mitigating inadequate sample transport, and development of lab policies and guidelines (totaling $442,000 in COP18).
- Collaboration with other donors, including Global Fund and World Health Organization (WHO), needed improvement in COP18 given the interconnected nature of donor support to the national lab program.

Partner Performance

- Partners with limited programmatic results continued to execute funding at the constant rate irrespective of performance, leading to a mismatch in results as compared to budgetary outlays and expenditures as well as significant over-outlays. PEPFAR South Sudan should ensure active partner management strategies and policies are in place (in accordance with COP20 Guidance) to ensure corrective actions are implemented in a timely manner.
- Results for HTS_TST_POS vary widely by partner – with partners such as ICAP achieving over 104% while CMMB fell below 50% achievement.
- Even with the roll out and scale up of more effective HIV testing strategies in the country during this period, CMMB, funded by CDC, underperformed with HTS_TST_POS, decreasing from 1,525 in FY18 to 1,457 in FY19.
- Wide variability in testing yields at the IM level, ranging from under 2% by CMMB and over 8% by RTI
- Across all agencies and implementing mechanisms, without exception, treatment partners struggled to reach their targets for TX_CURR (ranging from CMMB with 23% achievement to JHPIEGO and ICAP with 73% achievement), even though JPEIGO, RTI and CMMB executed their full care treatment budget (as measured through Expenditure reporting against COP18 budget). Only ICAP and IHI expended less than their full Care and Treatment budget at just over 60% and under 20% respectively.
- Only ICAP and JPEIGO achieved greater than 80% achievement of TX_NEW targets, at 109% and 87% respectively. CMMB, IHI and RTI achievement ranged from 23%, 28% and 68% respectively.
- At the site level, the bulk of the treatment cohort losses were from sites supported by CMMB and ICAP (granted these IMs also support a larger proportion of the treatment cohort).
- Site level Human resources for health (HRH) investments varied by IM (using

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HRH_CURR and ER data), and were consistently in alignment with site-level TX_CURR volume

- IHI, funded by CDC, continued to underperform into FY19, initiating just over 800 patients on treatment in FY19 (against a target of 2,983). During that same period, the treatment cohort only grew by 81 patients at IHI-supported sites. This partner was closed out in Q4 of FY19 due to persistent performance challenges.
- Despite poor performance for TX_CURR (54%), TX_NEW (23%) and almost all other indicators, CMMB continued to execute the entirety of its budget (107%) and over-outlaying by 117%. CMMB also performed poorly on over 50% of SIMS standards, related to care and treatment, that were assessed at sites. With approximately one-third of the treatment cohort (8,116/29,178) and supporting several high volume facilities, CMMB's performance challenges represent a significant risk for the South Sudan program.
- 4Children specific performance challenges were highlighted in the section of FY19 performance for OVC

SECTION 4: COP/ROP 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. Targets for VMMC, DREAMS, cervical cancer and PreP should be set based on FY19 performance. Funds for these programs have been allocated based on FY19 performance.

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements in place no later than the beginning of COP/ROP 2019 implementation (FY 2020). Adherence to these policies and practices are essential to the success of all PEPFAR programs at the national, subnational, community, and service delivery levels. 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.

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

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

	Minimum Program Requirement	Status	Outstanding Issues Hindering Implementation
Care and Treatment	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.[1]	Test and start adopted, with some challenges across along groups to be fully addressed	Large internally displaced population contributes to difficulties in confirming treatment initiation
	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 ≥20kg, and removal of all nevirapine-based regimens.[2]	TLD rollout and scale up was delayed but by end of December 2019 an estimated 80% of treatment cohort will be on TLD. NVP- based regimens not fully removed.	Initial delayed TLD shipments and distribution were addressed, but full concurrence by all parties and removal of NVP-based regimens is needed.
	3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve	MMD coverage steadily increasing after some delays. As of November 2019, 48% of TX cohort, at the ten largest PEPFAR-supported facilities, accessed MMD.	Given overall low ART coverage across all ages and population groups, rapid MMD scale up is needed. Improved provider knowledge of MMD benefits and consistent availability of 6

[1] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015
[2] Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

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	identification and ARV coverage of men and adolescents.[3]		month drug stocks at all sites is needed.
	4. All eligible PLHIV, including children, should have been offered TB preventive treatment (TPT) by end of COP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	Current TPT coverage is very low, although national TPT policy is adopted. Cotrimoxazole is not fully integrated.	Limited availability of cotrimoxazole and TPT in-country, Procurement and distribution of TPT and cotrimoxazole by appropriate parties needs to occur.
	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.	Timely access to VL/EID and TB-related testing and return of results is compromised by repeated service interruptions at the National Public Health Lab (NPHL).	Immediate resolution, continuing into COP20, to the following at NPHL: VL and EID equipment maintenance contract renewals, fuel shortages, official confirmation of backup lab support in Uganda, procurement of related commodities and supplies.
Case Finding	6. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of	Increased scaling of index testing from FY18 to FY19, but improvements in fidelity and quality needed across all sites.	Many sites are not meeting quality standards related to provision of partner services, accuracy of reporting, and routine testing of

[3] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016
[4] Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World

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Health Organization, 2018

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	intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]		children of HIV positive biological parent. Stigma and conflict-associated gender-based violence may be adversely affecting scale up efforts.
Prevention and OVC	7. 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)[6]	PrEP policy adoption at national level, in discussion with government stakeholders, is needed	Development and adoption of PrEP national policy, and procurement, and distribution of necessary commodities. Ensure providers and clients are aware of standards and benefits of use (for example, PrEP literacy) especially among AGYW in metropolitan areas and KPs.
	8. 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	Although efforts to design and implement a new OVC program are commendable, a revamped approach that fully aligns with this program requirement and tailored to needs of OVC in a recent conflict zone (like South Sudan) is needed.	New implementing partner starting in FY20 Q2 should address previous challenges.

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[5] 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/

[6] 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).

	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.		
Policy & Public Health Systems Support	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 as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	NA	NA
	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	PEPFAR Team began routinely implementing PEPFAR QA methodology (SIMS) in FY19. Current CQI practices need review so ensure at all data being collected are used for program improvement and partner management,	Regular, routinized access to sites may be restricted by political and socioeconomic environment. Development and scale up of simple, but effective, interventions to monitor and manage sites is needed.

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

	agreements, and national policy.[8]	remediation plans are implemented, and oversight of partner workplans is consistently conducted.	
	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.	Given high proportion of displaced persons, socioeconomic and political conditions etc., current prevention, treatment and viral load literacy remains low.	Organized and effective engagement of civil society organizations at the site and community level is needed, including working directly with implementing partners.
	12. Clear evidence of agency progress toward local, indigenous partner prime funding.	NA	NA
	13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	NA	NA
	14. Monitoring and reporting of morbidity and	NA	NA

[8] Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

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	mortality outcomes including infectious and non-infectious morbidity.		
	15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	NA	NA

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

Table 9. COP/ROP 2020 (FY 2021) Technical Directives

HIV Case Finding • Carefully review and improve reporting of HTS_INDEX by all IMs, especially CMMB and RTI given data quality and program implementation challenges • Ensure scale up of index testing at all sites – including improvements in quality of services being provided • As for HIV treatment below, expansion to additional testing sites (satellite or otherwise) should be limited to high-volume sites (using FY19 2019 MOH Data Alignment data)
HIV Treatment • All service delivery partners should ensure their programs are optimized to address and resolve barriers to retention in services. • Completion of scale up of 6-month multi-month drug dispensation and provision of TLD to all eligible ART patients, including key populations • Implement and expand routinized tracing and follow-up of patients lost to treatment, in collaboration with other donors in the humanitarian response, like UNHCR where feasible (especially given the large number of displaced persons and/or citizens returning to South Sudan) • Scale up of the ECHO platform to all facilities with greater than 100 patients on ART (23 sites) with a focus on providing opportunities for health providers to discuss best practices and share lessons learned (as opposed to limiting to didactic sessions). • Scale of up of field supervision model to ensure monthly site level monitoring data and continuous quality improvement (CQI) and SIMS findings are used and 'actionable' at the site level • To ensure quality of treatment programs at sites and recover patients lost to treatment, consider inclusion of any ART sites with greater than 100 patients on treatment as PEPFAR-supported sites in COP20 (use MOH Data Alignment data as the verifiable data source). This criterion also applies to any 'satellite sites'. • Fully utilize the community-led monitoring activity in COP20 to ensure community engagement along the clinical cascade

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TB • To facilitate rapid and full scale up of TB preventative therapy, ensure related site level service delivery needs and commodity procurement (in collaboration with Global Fund) are prioritized. $800,000 of the COP20 budget can be utilized for TB preventative therapy.
Key Populations • Share and review iBBS findings from Wau and Yambio (completed in October 2019) prior to considering or implementing any expansion of the key populations program. • Carefully consider COP20 Guidance on index testing among key populations to ensure all testing services are provided with the safety and security of KPs in mind. • To ensure provision of comprehensive program that meets the needs of key populations in South Sudan, review the overall package of services especially in light of GEND_GBV results and reports of sexual violence. • Ensure all children of female sex workers are considered and able to participate in the OVC program. • Focus on linking to treatment and improving retention in treatment among those identified at HIV positive, including establishment of direct linkages with facilities to facilitate access to clinical services (such as, 6 month drug dispensation and viral load testing) • Consider community-based dispensation of ARVs to address needs of the mobile FSW population, especially in Juba.
Viral Suppression • To ensure all those who are eligible for a viral load test can receive one, S/GAC advises for the removal of restrictions, at the national level, on VL eligibility for pregnant and breastfeeding women • Identify and address barriers to low viral load coverage among children, and variability in viral load suppression rates across sites.
VMMC • PEPFAR South Sudan is receiving $1 million in funds to be used to support VMMC (in accordance with the updated guidelines). However, the team should carefully consider any expansion outside the current military barracks given political sensitivities and conditions on the ground.
HIV Prevention • PEPFAR South Sudan is receiving $250,000 in funds that can be used to support PrEP delivery and/or commodities in high burden SNUs and among high-risk populations (see also the relevant MPR in Table 8). This should be discussed in collaboration with Global Fund and national government. • S/GAC encourages the timely adoption of a national PrEP policy to ensure any related service delivery aligns with international standards of quality and safety
OVC • 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.

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- Implement a defined package of required services (tailored to South Sudan needs), specifically gender-based violence, testing referrals, adherence counseling, VL testing referrals, and accurate monitoring of service utilization.
- Improve alignment with package of services to avert Gender-based violence from UNHCR, align with FAO food distribution, and WASH activities with other donors.
- Targeted enrollment of HIV+ children, children in families with HIV+ caregivers and children of FSW through provision of wraparound services with clinical and KP implementing partners.
- Recover, where possible, those OVC beneficiaries who exited without graduation in FY19.
- Ensure that 90% or more of OVC beneficiaries under age 18 have a known HIV status or are deemed not to need a test based on a standard HIV risk assessment. Prioritize HIV risk screening and testing for those with unknown status in FY21 Q1.

DREAMS

- South Sudan is receiving $1 million in DREAMS funds this year which can be used to address increased HIV risk from informal sex work/transactional sex and gender-based violence among young women affected by recent conflict.
- Prior to the COP meeting, work with Implementation Subject Matter Experts (iSMEs) and the S/GAC DREAMS team to identify appropriate geographic areas and components of the DREAMS core package that are most relevant to addressing this issue.
- At the COP 20 meeting, present a strategy and a timeline for proposed activities using these funds.

Other Government Policy or Programming Changes Needed

- To ensure effective implementation of HIV programming leading to accelerated growth of the HIV program in South Sudan, improved donor coordination is critical (this includes donors like, Global Fund, UNHCR, FAO, UNAIDS etc.).
- Given potential inconsistencies in data reported under HTS_INDEX and TX_CURR, a Data Quality Assessment (DQA) should be conducted in COP20 to cover at least 80% of TX_CURR as of FY20 Q1. This should be conducted in collaboration with S/GAC and Implementing Agencies Headquarters.
- Continue use of SIMS and (as needed) additional Continuous Quality Improvement approaches to help ensure the quality of services at the site level (facility and community). The team should carefully review all data being collected on a monthly basis to ensure that all data collected are used. The team should also report findings to S/GAC on a monthly basis (including any indicator data that is collected by Implementing Partners).
- Partner management should be routinized and improved to ensure resources are expended as budgeted, and programming is in keeping with expectations and targets
- Sentinel surveillance data and the most recently completed iBBS data (both funded by PEPFAR) should be used for COP20 planning and determination of PLHIV estimates
- Conduct a review of current Human Resources for Health investments at the site level by IM, and realign health cadre at sites against (1) needs and gaps at the site (2) volume of treatment or testing or prevention services (3) site level performance
- All above site investments should be carefully reviewed against milestones, and must be in alignment with site-level service delivery needs and/or technical area directives provided herein.

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Lab

- Ensure reliable, continual, and coordinated support of the VL program (at the National Public Health lab and at site level) across all concerned stakeholders (including PEPFAR, Global Fund, and the national government)
- S/GAC recognizes the collaborative nature of PEPFAR Uganda and the willingness to act as a 'back-up' for viral load and EID testing for South Sudanese clients, only when there are challenges or interruptions at the NPHL in Juba, South Sudan. These agreements will be formalized through an MOU. Budget for VL and EID consumables and some quality assurance support will be provided for in the PEPFAR South Sudan COP20 planning level and through the central commodity procurement mechanism.
- Prioritize the hiring of a lab manager (preferably locally-employed) to help oversee management and monitoring, and ensure the gains made from COP19 and COP20 investments in lab are not lost.

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 of services. South Sudan 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 COP 20, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through a suitable mechanism, 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.

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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 funding is allocated within your COP 2020 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 2020 Guidance. In addition to ensuring that all DREAMS beneficiaries complete the core package of relevant services, priorities for COP20 DREAMS implementation include: systematically identifying and engaging AGYW that are most vulnerable to HIV acquisition, improving the package of economic strengthening services offered to AGYW (including exploring potential job opportunities through PEPFAR), and accelerating PrEP uptake for AGYW.

OVC
To support the Minimum Program Requirement described above, in COP 20 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.

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 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 age 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.

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.

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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			FY19			FY17			COP 20 Total
	GHP-State	GHP-USAID	GAP	GHP-State	GHP-USAID	GAP	GHP-State	GHP-USAID	GAP	
Total New Funding	$ 22,355,827	$ -	$ 200,000	$ 15,000,000	$ -	$ -	$ -	$ -	$ -	$ 37,555,827
Core Program	$ 16,785,827	$ -	$ 200,000	$ 15,000,000						$ 31,985,827
COP19 Performance	$ 5,000,000									$ 5,000,000
HKID Requirement ++	$ 570,000									$ 570,000
										$ -

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										$ -
										$ -
										$ -

++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/ROP 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/ROP 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.

*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 South Sudan should hold a 4 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

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implementation (end of FY 2020) with a pipeline in excess of 4 months is required to apply this excessive pipeline to COP/ROP 2020, decreasing the new funding amount to stay within the planning level.

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