United States Department of State

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UNCLASSIFIED

January 16, 2020

COP 2020 Planning Level Letter | PART 2

INFORMATION MEMO FOR AMBASSADOR MALAC, Uganda

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

Dear Ambassador Malac:

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:

- Uganda made consistent gains toward reaching epidemic control in COP18. The Surge for Quality and strategic use of client-centered data propelled the TLD transition, TB preventive therapy initiation, and improvement in all aspects of the clinical cascade including early client retention, viral load coverage (VLC), and viral load suppression (VLS).
- Collaboration among the PEPFAR interagency team to implement and scale effective solutions enabled national improvement across agencies and implementing partners (IPs). For example, USAID initiated the "Root Cause Analysis" approach to identify barriers to treatment, address client retention, and implement solutions to reduce loss to follow-up (LTFU). After demonstrating effectiveness, RCA was rapidly incorporated into the continuous quality improvement (CQI) strategies of multiple agencies to improve client-centered care.

Areas of Opportunity:

- Treatment retention, particularly among asymptomatic client populations, must be improved through client-centered strategies and the more rapid expansion of differentiated service delivery models (DSDM), such as 6-month multi-month dispensing (MMD).
- ART coverage and VLS among young men remains low. Additional efforts and changes to current strategies are needed to reach this population.
- Children continue to experience gaps along the clinical cascade. Significant numbers of children living with HIV (CLHIV) remain unidentified, and those engaged in treatment have

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VLS rates well below 90%.

- Key populations continue to be at increased vulnerability for seroconversion and human rights violations. PEPFAR must support locally led efforts to care for these populations, prevent new infections, and create a safe environment for access to live-saving ART.
- Prevention interventions are essential to ending the current cycle of transmission. PrEP should be accessible and promoted for all populations at risk, including adolescent girls and young women (AGYW) and pregnant and breastfeeding women (PBFW).

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 your agency.

Table 1. COP 2020 Total Budget including Applied Pipeline

OU Total	Bilateral				Central	TOTAL
	FY20	FY19	FY17	Unspecified	Unspecified	TOTAL
Total New Funding	**$ 374,477,502**	**$ -**	**$ -**			**$ 374,477,502**
GHP- State	$ 331,265,002	$ -	$ -			**$ 331,265,002**
GHP- USAID	$ 40,000,000	$ -	$ -			**$ 40,000,000**
GAP	$ 3,212,500	$ -	$ -			**$ 3,212,500**
Total Applied Pipeline				**$ 28,122,498**	**$ -**	**$ 28,122,498**
DOD				$ 5,577,730	$ -	**$ 5,577,730**
HHS/CDC				$ 11,224,500	$ -	**$ 11,224,500**
HHS/HRSA				$ -	$ -	**$ -**
PC				$ 202,732	$ -	**$ 202,732**
State				$ -	$ -	**$ -**
USAID				$ 11,117,536	$ -	**$ 11,117,536**
TOTAL FUNDING	**$ 374,477,502**	**$ -**	**$ -**	**$ 28,122,498**	**$ -**	**$ 402,600,000**

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

SECTION 2: COP 2020 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Countries should plan for the full Care and Treatment (C&T) level of $293,350,000 and the full Orphans and Vulnerable Children (OVC) level of $51,620,000 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.

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Table 2. COP 2020 Earmarks by Fiscal Year *

Earmarks	COP 2020 Planning Level			
	FY20	FY19	FY17	Total
C&T	$ 275,000,000	$ -	$ -	**$ 275,000,000**
OVC	$ 38,500,000	$ -	$ -	**$ 38,500,000**
GBV	$ 4,704,843	$ -	$ -	**$ 4,704,843**
Water	$ 3,000,000	$ -	$ -	**$ 3,000,000**

** 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. For countries with GHP-State and GHP-USAID funds the C&T and OVC earmark requirements can be met with FY20 funding from any combination of the two accounts.*

Table 3. All COP 2020 Initiative Controls

	COP 20 Total
Total Funding	**$ 95,500,000**
VMMC	$ 17,000,000
Cervical Cancer	$ 5,000,000
DREAMS	$ 23,000,000
HBCU Tx	$ -
COP 19 Performance	$ 22,000,000
HKID Requirement	$ 28,500,000

***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 Adults	**1,102,534**	**1,225,515**
TX Current Pediatrics	**62,403**	**91,698**
VMMC among males 15 years or older	**461,739**	**759,986**
DREAMS (AGYW completing at least the primary package)	**170,783 (81.5% of total AGYW reached)**	**N/A**
Cervical Cancer	**N/A**	**N/A**
TB Preventive Therapy	**100,297**	**340,621**
PrEP New	**17,825**	**30,000**

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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	**15,108,639**	**14,297,502**	**811,137**
HHS/CDC	**184,414,761**	**163,114,877**	**21,299,884**
HHS/HRSA	**350,000**	**313,887**	**36,113**
PC	**2,279,686**	**1,762,372**	**517,314**
State	**1,557,627**	**238,559**	**1,319,068**
State/AF	**935,000**	**384,585**	**550,416**
State/SGAC	**-**	**-**	**-**
State/PRM	**647,566**	**647,566**	**-**
USAID	**199,260,700**	**178,106,403**	**21,154,297**
Grand Total	**404,553,979**	**358,865,751**	**45,688,228**

**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

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 $)
18502	Population Services International	DOD	777,554	1,113,808	(336,254)
17855	Research Triangle International	DOD	0	989,578	(989,578)
10281	University of California at San Francisco	HHS/CDC	0	156,257	(156,257)
13136	Infectious Disease Institute	HHS/CDC	0	20,156	(20,156)
13841	World Health Organization	HHS/CDC	0	285,098	(285,098)
9183	The AIDS Support Organization	HHS/CDC	0	23,586	(23,586)
13161	Uganda Virus Research Institute	HHS/CDC	0	156,257	(156,257)
70388	TBD	USAID	525,836	577,738	(51,902)
16594	University of North Carolina at Chapel Hill, Carolina Population Center	USAID	901,441	1,718,811	(817,370)
13924	RECO Industries	USAID	0	1,277	(1,277)

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**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	2,190,418	4,657,596	212.64%	HTS Program Area	$8,437,625	97%
	HTS_TST_POS	74,400	140,956	189.46%			
	TX_NEW	69,533	111,853	160.86%	C&T Program Area	$103,313,542	83%
	TX_CURR	695,474	658,261	94.65%			
	VMMC_CIRC	343,431	336,947	98.11%	VMMC Subprogram of PREV	$13,116,501	100%
	OVC_SERV	123,084	114,514	93.04%	OVC Major Beneficiary	$5,787,128	96%
DOD	HTS_TST	283,726	484,750	170.85%	HTS Program Area	$776,144	56%
	HTS_TST_POS	9,870	16,088	163.00%			
	TX_NEW	9,167	11,865	129.43%	C&T Program Area	$5,003,946	25%
	TX_CURR	87,574	70,882	80.94%			
	VMMC_CIRC	70,826	74,235	104.81%	VMMC Subprogram of PREV	$1,837,992	85%
	OVC_SERV	24,704	23,688	95.89%	OVC Major Beneficiary	$410,794	100%
USAID	HTS_TST	1,662,374	2,830,357	170.26%	HTS Program Area	$12,217,755	88%
	HTS_TST_POS	50,578	74,362	147.02%			
	TX_NEW	46,431	62,948	135.57%	C&T Program Area	$90,219,758	80%
	TX_CURR	477,126	429,763	90.07%			
	VMMC_CIRC	342,199	310,796	90.82%	VMMC Subprogram of PREV	$11,992,978	70%
	OVC_SERV	266,874	267,119	100.09%	OVC Major Beneficiary	$13,796,049	67%

Above Site Programs	$28,942,078
Program Management	$46,167,084

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COP/ROP 2018 | FY 2019 Analysis of Performance

PEPFAR Uganda made significant strides toward epidemic control in FY 2019. Overall improvements in early retention, TLD transition and TPT initiation were seen as a result of programmatic shifts, the CQI Collaborative, and the dynamic use of data for responsive services. Over 1.16 million people received life-saving ART. Based on current UNAIDS estimates of PLHIV, Uganda has reached ~83% national ART coverage. Progress toward key technical areas are summarized below.

Case Finding:

- PEPFAR Uganda performed 8.03 million tests and identified 232,572 people living with HIV, reaching 192% and 175% of annual targets, respectively, with an annual yield of 2.9%. The number of HIV tests declined quarter-on-quarter throughout the fiscal year.
- Index Testing: All clinical partners are performing index testing services, but the percentage of sites and contribution to positive results vary greatly by partner. Low coverage, especially among children of WLHIV, is of particular concern. It is essential to rapidly scale index testing for children (<15) such that it contributes ≥15% for HTS_TST and ≥30% for HST_POS. A noted success is that sites providing index testing services reported high uptake and yielded more than one contact per index client; however, the majority of partners fall far short of the 30% positive contribution from index testing benchmark. Partners that ended FY19 with <50% index testing coverage and/or contribution of positives <10% should be provided with intensive partner management, including URC/UPDF, HJF/MUWRP, UNHCR, World Vision/HIWA, Intrahealth/RHITES-E, URC (both RHITES-EC and Acholi), and EGPAF/RHITES-SW (see Figure 1). If no improvement is demonstrated by FY20 Q3, that partner should be placed on a performance improvement plan.
- Provider Initiated Testing and Counseling: PITC testing volume has decreased from 1,596,586 in FY18 Q4 with 3.4% yield to 1,004,218 in FY19 Q4 with 2.4% yield. While the decrease in volume is in line with current levels of treatment coverage, yield should be increasing through more focused testing. PEFPAR Uganda needs to employ CQI to rapidly roll out updated symptom and risk-based screening tools during FY 2020 implementation.
- Ante Natal Care (ANC) testing: Through the ANC platform, 1,351,416 pregnant women were provided with HIV testing in FY19, with a 1.8% yield. Testing results at Post ANC 1 indicate PBFW continue to be at high risk of seroconversion during pregnancy (87,632 tests performed, 2.7% yield).
- HIV Self-Testing (HIVST): Self-Testing was scaled-up as a new strategy to engage at-risk populations and 95,985 tests were distributed. Over 80% of self-tests were distributed among young people under the age of 34.
- Linkage: Proxy measures for treatment linkage improved from 76% in Q1 to 82% in Q4, and is calculated at 91% when repeat testing is taken into account. Even after adjusting for repeat testing, most clinical partners' linkage rates were under 90%. Partners with under 80% linkage in FY19, including Rakai/Masaka (72%), Intrahealth/RHITES-E (76%), and URC/UPDF (77%), should be provided with intensive partner management. If linkage rates have not reached 90% by Q3 FY 2020, the partner should be placed on a partner improvement plan (PIP).

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Figure 1. Index Testing Results by Agency and Partner

Partner	Number of sites supported	%sites with index testing services	Offered Index testing services	%index accepted	Ratio of contacts to index	Newly identified HIV+	Yield (excluding known positives)	Index testing contribution to positives (%)	Total positives identified (Q1-Q4)
Fort Portal	146	71.9%	9,006	92%	2.1	3,391	21%	36.0%	15,325
IDI W & WN	252	78.6%	32,192	92%	2.4	5,649	11%	30.7%	27,591
Kampala	147	57.8%	39,308	80%	1.6	5,240	22%	26.5%	40,359
Masaka	197	78.2%	17,858	79%	1.6	3,687	26%	26.1%	27,780
Mubende	138	75.4%	22,728	88%	1.8	4,624	13%	29.0%	21,255
Soroti	104	64.4%	2,041	89%	2.8	514	10%	11.4%	6,170
UPS	53	69.8%	1,139	81%	1.8	155	17%	10.1%	4,721
Overall CDC	1,037	72.3%	124,272	85%	1.9	23,260	16%	27.4%	143,201
URC/UPDF			527	95%	1.8	35	5%	1.6%	3,131
WALTER REED	116	36.2%	3,228	76%	2.1	800	14%	6.2%	13,911
Overall DOD	116	36.2%	3,755	78%	2.0	835	13%	5.4%	17,042
State/UNHCR	13	38.5%	307	92%	1.4	33	9%	2.8%	1,166
HHIWA	20	80.0%	416	48%	1.3	40	22%	6.3%	958
RHITES E	181	26.5%	1,245	87%	1.1	157	22%	3.1%	9,454
RHITES EC	151	64.2%	8,052	91%	1.7	1,157	12%	9.6%	14,564
RHITES -SW	271	44.3%	10,355	86%	1.8	3,402	27%	16.4%	25,771
RHITES-Acholi	69	82.6%	2,517	92%	1.8	683	18%	9.5%	10,417
RHITES-Lango	72	87.5%	19,975	89%	1.5	3,658	16%	31.0%	14,898
Overall USAID	764	52.5%	42,560	89%	1.6	9,097	18%	15.2%	76,062

Care and Treatment:

- Current on treatment: PEPFAR Uganda supported 1.16 million people with life-saving ART at the end of FY 2019, reaching a national treatment coverage of nearly 83% based on current UNAIDS estimates.
- Initiation and retention: Over the course of the fiscal year, 187,769 PLHIV were newly initiated on treatment, 149% of the annual target. While TX_NEW targets were exceeded, TX_NET_NEW was only 44,666 patients. Therefore, over 140,000 patients, or 12% of the treatment cohort, fell out of treatment, underscoring the challenges of treatment retention.
    - Targeted strategies to remediate LTFU improved early retention from 76% in FY19 Q1 to 82% in Q4.
    - Between FY18Q4 and FY19Q4, the percentage of males 15+ years on treatment in the program increased by only 3%. In FY19, most of the percentage increase was in males 50+ years and there was a decrease of 4% in the percentage of males on treatment in the 25-29 year old range. In addition, in the first three quarters of FY19, the program put 42% less males than females 15+ years on treatment. As such, in FY 2020, the program should continue focusing on initiating men to treatment,

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specifically within the 25-34 year age band, and attaining viral suppression among this group.
  - PEPFAR Uganda continued to support movement toward optimized ART regimens and by the end of FY 19, a third of adult patients transitioned to TLD, reaching 73% of the annual target.
  - Partner Performance: IDI West & West Nile, URC/RHITES-EC, HJF/MUWRP, and UNHCR reached under 85% of their annual TX_CURR targets despite over achieving TX_NEW targets.
- Preventive TB treatment scaled rapidly with over 86,000 clients completing IPT, 86% of those expected. Significantly more clients initiated TPT in FY19 Q3 and Q4 as a part of the 100 day campaign. If completion rates are maintained, Uganda will be on track to achieve the 2-year TPT targets.
- Viral Load: National viral load coverage (VLC) improved from 80% in FY18 Q4 to 94% in FY19 Q4. Viral load suppression (VLS) improved from 89% to 91% in the same time period. This progress is largely consistent across regions and IPs.
  - Site-level analysis of adult VLS demonstrated variability between surge and non-surge sites, with surge sites achieving better VLS outcomes, reaching 92% at Q4. At non-surge sites, 88% of patients were virally suppressed with increasing variability in site-level outcomes as the number of patients on treatment declined. Even within surge sites there was a significant number of facilities with VLS < 90%, for example, Olilim Health Centre III reported VLS of 74%, in contrast to Kashenshero Health Centre III's report of 94% VLS among a similar client volume. High volume sites with <90% VLS should receive focused support during FY 2020 implementation.
  - Overall pediatric VLS improved from 69% in FY18 Q4 to 74% in FY19 Q4, but remains lower than the target of 90%. Pediatric VLS rates among the highest volume PEPFAR-supported sites, accounting for 50% of pediatric clients, is 80%, significantly higher than national average. Smaller sites reported high variability in pediatric outcomes and PEPFAR Uganda should consider whether centralization of pediatric services might be warranted in some cases and what wrap-around services may be needed. There was also significant variability in partner-level pediatric VLS with several partners reporting 70% or less at FY19 Q4; including JSI/RHITES-N. Lango, URC/RHITES-N. Acholi, TASO/Soroti, URC/RHITES-EC, IDI/West & West Nile, Intrahealth/RHITES-E, and UNHCR. PEPFAR Uganda should immediately deploy intensive site management with these partners to improve pediatric outcomes.
  - CLHIV linked to OVC programming have improved outcomes with over 80% VLS. The proportion of OVC beneficiaries that are CLHIV varied greatly by agency; CLHIV accounted for 14% of CDC, 10% of DOD, and 5% of USAID OVC beneficiaries. PEPFAR Uganda should continue to link CLHIV to OVC services in FY 2020.

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Prevention of Mother to Child Transmission:

- PMTCT programming continues to drive progress toward elimination of mother to child transmission. ART coverage for HIV+ pregnant women remained steady at 97% in FY19 Q4. EID coverage was 55% at 2-months, and 80% at 12 months, but varied by partner. Partners UPS, World Vision/HIWA, URC/UPDF, Intrahealth/RHITES-E, URC/RHITES-EC, and Rakai/Masaka reported less than 50% coverage at 2 months for FY19. EID proxy positive rates reduced in FY19 to 0.8% at 2-month and 4.6% at 12-month. EID linkage to ART increased from 81% in FY 18 Q4 to 92% in FY 19 Q4.

OVC:

- PEPFAR Uganda served over 409,000 OVC beneficiaries (97.8% of annual target) with over 70% of those receiving services under the age of 18. Over 61,000 OVC beneficiaries graduated and approximately 20,000 left the program without graduating. HIV positive children in OVC programs had better VLS outcomes than those in general pediatric treatment. Two partners, IDI/Kampala and URC/UPDF, achieved less than 80% of their OVC_SERV target.
- OVC_HIVSTAT was 95% or greater for all agencies in FY19. In FY 2020, all OVC implementing partners and agencies must 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. Additionally, 95% or higher of OVC living with HIV should be on ART.

DREAMS:

- DREAMS served 408,131 AGYW in FY19, with 197,902 completing at least the primary package of services. AGYW aged 10-14 had the highest primary package completions rates at 88%, and those aged 20-24 the lowest completion rate at 78%. USAID partners implementing in the Apac, Oyam, Lira, and Gulu Districts reported the lowest completion rates. A DREAMS Surge for quality was initiated in FY19, showing improvement by FY19 Q4 with current primary package completion rates ranging between 43% and 68% in these districts.

VMMC:

- Uganda PEPFAR completed 727,548 total VMMC in FY19, 257,441 (36%) for males <15 years of age, and 461,739 (64%) for males aged 15+. VMMC performance was close to target at 96.2%. Several IPs circumcised a higher number of 10-14 year olds in FY19. In COP19, PEPFAR Uganda greatly reduced targets for those under age 15. Partners should use FY20 to refine targeting strategies for VMMC among the 15+ age cohort as COP 2020 Guidance prohibits PEPFAR funds being used for VMMC of males <15 years of age. Agencies should review partner performance by age band and target TA to partners that disproportionately circumcise males 10-14 years. Partners with more than 40% contribution from the 10-14 year old age in FY19 are highlight for review, including UNHCR, Intrahealth/RHITES-E, IDI/West & West Nile, Rakai/Masaka, and Baylor/Fort Portal.

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Key Populations:

- The socio-legal environment continues to impact key population programming in Uganda. In FY19, 261,863 KP were reached with prevention programming, 102% of the annual target. According to program data, over 137,000 key population clients were tested for HIV, with an overall yield rate of 6%, treatment linkage of 43%, VLC 83% and VLS 91%. Outcomes, however, varied greatly by key population. The Key Population Investment Fund is improving engagement and programs tailored for these populations in FY20, including scaling targeted case finding approaches, optimizing linkage and retention through engaging locally led partners, and the use of client-centered data analytics across the cascade.

Above-Site:

- Uganda has made steady and sometimes considerable progress in some key areas of sustainability from COP 2015 and 2017 to the present across numerous domains; however, significant work to ensure resilience in the HIV response remains across several key elements (e.g., commodity security and supply chain, laboratory, and epidemiological and health data). COP18 investments supported improvement in overall coverage of electronic medical records (EMR), and 100% of 550 high volume sites have EMRs in the HIV clinic. Health Information Exchange (HIE) and HIS interoperability projects have continued to move forward. The groundwork was laid for the rollout of recency testing, which will continue into COP 2019. Investments were made in systems to improve supply chain security and stock level management, and at the site level to improve commodity storage capacity.

Financial Management:

- PEPFAR Uganda improved overall financial management in FY 2019 compared to FY 2018, reducing both the number of implementing mechanisms that over-outlaid, and the total amount over-outlaid. Several IMs outlaid in excess to planned levels or outlays extended into a new fiscal year. PEPFAR Uganda should continue to closely monitor partners to ensure outlays occur in the planned budget cycle and that any close out costs expected in out years are captured in budget planning tools.

Summary: In general, partners working in prevention, testing and treatment achieved targets, though gaps in the clinical cascade persist as noted in the bullets above and summarized in Figure 2 below. Where indicated, PEPFAR Uganda should work with their partners to remediate performance concerns. Inability to demonstrate quarter on quarter performance improvement will result in discussions regarding partner target and resource reallocation prior to COP20 implementation. One partner, URC/RHITES-EC, performed below 90% on almost all indicators discussed above and will require further discussion during COP development.

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Figure 2. FY 2019 Clinical Cascade by Agency and Partner

FY2019Q1_Q4 HIV Clinical Cascade

Agency	IM Name	HTS_TST (FY2019)	% HTS_TST Achieved by FY2019Q4	HTS_TST_POS (FY2019)	% HTS_TST_POS Achieved by FY2019Q4	Linkage	Linkage Adjusted for Repeat Tests	TX_NEW (FY2019)	% TX_NEW Achieved by FY2019Q4	TX_CURR (FY2019Q4)	% TX_CURR Achieved by FY2019Q4	Proxy Retention	TX_NET_NEW (FY2019Q4-FY2018Q4)	VL Coverage (Using FY2019Q2 TX_CURR)	% VL suppressed
CDC	UPS	123,442	1494%	4,721	1061%	43%	90%	2,020	401%	5,971	99%	71%	-367	76%	89%
	IDI W & WN	1,234,243	241%	27,591	180%	78%	91%	21,547	151%	100,908	84%	84%	2,920	93%	88%
	Kampala Region	975,984	185%	40,359	199%	76%	85%	30,835	161%	210,745	95%	89%	3,845	98%	94%
	Masaka Region	644,784	165%	27,780	177%	70%	72%	19,467	134%	121,288	97%	103%	22,831	98%	92%
	Mubende Region	580,616	178%	21,255	179%	78%	85%	16,488	150%	73,902	87%	83%	1,628	103%	91%
	Soroti Region	395,077	250%	6,170	163%	83%	88%	5,139	146%	43,428	100%	94%	2,508	93%	88%
	Fort Portal Region	572,976	215%	15,325	220%	88%	89%	13,559	207%	85,340	92%	87%	533	95%	93%
	CDC Overall	**4,527,122**	**207%**	**143,201**	**192%**	**76%**	**86%**	**109,055**	**157%**	**641,582**	**92%**	**90%**	**33,898**	**97%**	**92%**
USAID	HHIWA	201,218	1031%	958	408%	76%	81%	730	390%	2,367	120%	84%	283	89%	90%
	URC/RHITES EC	673,387	180%	14,564	139%	86%	89%	12,513	130%	77,770	81%	85%	-1,626	84%	88%
	Intra Health/RHITES E	469,544	179%	9,454	137%	74%	76%	6,981	109%	53,946	91%	90%	1,234	92%	88%
	EGPAF/RHITES - SW	723,397	120%	25,769	127%	82%	88%	21,221	115%	155,073	92%	89%	1,914	94%	93%
	RHITES-Acholi	454,292	278%	10,390	184%	77%	87%	7,993	153%	60,219	94%	90%	1,399	88%	89%
	RHITES-Lango	356,843	148%	14,898	211%	91%	100%	13,510	207%	80,388	92%	91%	5,832	89%	86%
	USAID Overall	**2,878,681**	**173%**	**76,033**	**150%**	**83%**	**89%**	**62,948**	**136%**	**429,763**	**90%**	**89%**	**9,036**	**90%**	**90%**
DOD	WALTER REED/MUWR	405,402	177%	13,911	181%	71%	84%	9,819	137%	50,881	79%	86%	1,368	93%	91%
	URC/UPDF	110,395	203%	3,160	144%	65%	77%	2,046	103%	20,001	86%	97%	1,412	98%	90%
	DOD Overall	**515,797**	**182%**	**17,071**	**173%**	**70%**	**83%**	**11,865**	**129%**	**70,882**	**81%**	**89%**	**2,780**	**95%**	**90%**
STATE	State/UNHCR	60,559	206%	1,166	118%	95%	106%	1,103	88%	6,031	74%	78%	-609	82%	90%
	PEPFAR Overall	**7,982,159**	**192%**	**237,471**	**175%**	**78%**	**87%**	**184,971**	**146%**	**1,148,258**	**91%**	**89%**	**45,105**	**94%**	**91%**

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.

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 Uganda budget. (See Section 2.2. of COP Guidance)

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Table 9. 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 is national policy and implemented throughout the country. The Surge for Quality has improved outcomes and continues to expand. FY2019 linkage proxy results are reported as 81% linkage to treatment, which increases to 91% when repeat testing is taken into account.	None noted.
	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]	In FY2019, over a third of patients transitioned to optimized regimens (TLD), reaching 73% of the annual target. Patients receiving nevirapine-based regimens were greatly reduced and further reduction is supported by the commodity supply plan in FY20.	Supply chain security is essential to the TLD transition. Commodity stock-outs are less frequent but continue to be a concern. Global supply of LPV/R has slowed transition of pediatric patients off of NVP-based regimens.

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	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.[3]	Uganda treatment guidelines recommend dispensing 3 months of medication for stable patients and allow for longer scripts. Guidelines are under revision to expand 6-month MMD, and the supply plan includes 6-month pill bottles.	Perceived supply chain insecurity by clinical staff has slowed roll out of greater than 3-month dispensing.
	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]	TB preventive treatment was scaled rapidly in CY 2019. Over 528,000 patients were initiated on TPT. Completion rates reached 86% of those expected.	None noted.

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	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.	Viral load coverage for adults has improved over time, and was 94% in FY19 Q4. EID 2-month testing coverage improved from 49% in FY18 Q4 to 56% in FY 19 Q4, but ongoing TA is needed. COP19 includes investments to expand EID coverage.	None noted.
Case Finding	6. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and	Index testing is scaled nationally though some gaps remain in site-level coverage. Self-testing is available. Index testing protocols include screening and treatment	None noted.

[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
[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 Health Organization, 2018

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	assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	for IPV. Gains need to be made in testing of children; this is a priority and best practices from some partners have been identified and shared through the national CQI collaborative.	
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 is available to key populations. Guidelines are under revision to include AGYW and PBFW.	Current government guidelines are a barrier. The National HIV Consolidated Guidelines are under review and revisions are expected to be released in early 2020.
	8. Alignment of OVC packages of services and enrollment to provide comprehensive	OVC programs meet all requirements per COP19 Guidance.	None noted.

[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).

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	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.		
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	There are no user fees levied to patients.	None noted.

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	treatment and prevention.[7]		
	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.[8]	MOH leads the national CQI program and all IPs participate.	None noted.
	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	These activities were included in COP19 planning. U=U messaging has been rolled out, and updated messaging is a particular focus of KPIF and FCI activities.	None noted.

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

	treatment and prevention.		
	12. Clear evidence of agency progress toward local, indigenous partner prime funding.	Minimum requirement is met.	None noted.
	13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	As requested in COP 2019, the Government of Uganda committed an additional $13 million toward ARV commodity procurement, bringing total investment to $39 million.	S/GAC would like to see this investment maintained for ARV, and ideally additional resources committed by GoU for ARV, Human Resources for Health and other HIV commodities. The transition of PEPFAR supported HRH to GoU is progressing slower than initially anticipated. An additional barrier is lack of formal recognition for Community Health Extension Workers.
	14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	PEPFAR Uganda has started reporting on TX_ML. COP19 investments support updating national systems.	None noted.
	15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Recency testing is rolling out in COP19 with the goal to reach national scale by the end of the fiscal year. Several UI pilots could be used as examples for scaling nationally.	Legislation will require updates to allow for UIs to go to scale. The political environment may hinder movement at parliamentary level this year.

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

Table 10. COP/ROP 2020 (FY 2021) Technical Directives

OU –Specific Directives
Overarching: PEPFAR Uganda has demonstrated incredible use of data to inform decision making and improve program outcomes collaboratively through the government led CQI. The primary recommendation is to continue doing just that, with a focus on ensuring all sites deliver client centered services that retain all populations in treatment, scaling effective prevention interventions for AGYW, and building the systems needed to maintain epidemic control. Some specific considerations:
Case Finding 1. Ensure PEPFAR support for HIV testing services aligns with COP 2020 Guidance in order to maintain the treatment cohort at the end of FY20. Testing beyond guidance can be considered as a part of ambition funding, for example, to close any remaining gaps in identifying men and children. 2. CQI to ensure all newly identified PLHIV are offered contact tracing for partners and children. 3. Refine quality of implementation for recency testing for case-based surveillance. 4. Expand distribution of HIV ST for hard to reach populations like KP.
HIV Treatment 1. Continue to expand DSDM and 6-month MMD. Consider multilateral partner investment and revision to the supply plan to support expansion of the national buffer stock of ART. 2. Continue to optimize pediatric regimens. Consider procurement of pediatric DTG (10 mg dispersible tablet (DT) scored) so that Uganda is prepared to incorporate the regimen as the medication is approved. Support revision of national pediatric ART guidelines to include WHO-recommended dosing for dolutegravir for pediatric patients </= to 20 kg. 3. The PEPFAR team should consider the successes and lessons learned from MenStar to improve treatment outcomes for men. In COP20, the program should continue focusing on retaining men on treatment, specifically within the 25-34 year age band, and attaining viral suppression among this group. Meeting clients where they are with what they need at each stage of the treatment cascade will be critical to advancing life-long continuity of ART. This requires a better understanding of client needs in order to remove barriers to treatment. New guidance from MenStar is forthcoming. 4. Consider applying for ambition funding to support targeted service strategies to address remaining gaps in treatment for men in urban settings, such as Kampala/Wakiso (and other urban centers if warranted by epi).

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5. VLS among children is highly variable in low-volume sites. The team should review low volume sites and determine if centralization of services is appropriate and would improve VLS.
TB Preventive Therapy 1. As funding permits, consider transition of TPT from IPT to 3HP.
HIV Prevention 1. Rapidly scale access, demand and utilization of PrEP for AGYW and PBFW following approval of revised PrEP guidelines. 2. In accordance with COP20 Guidance, target VMMC to males aged 15+ and discontinue VMMC for males 14 years and under (with noted exceptions in COP20 Guidance). The team should continue to pursue saturation among the 15+ age group in high burden districts in COP 2020. Consider applying for additional ambition funds for high performing partners. 3. Strengthen AGYW prevention programming through the AGYW integrated strategy; ensure revision and implementation of the AGYW risk and vulnerability assessment; improve economic strengthening interventions.
OVC 1. In COP20, OVC and clinical implementing partners in Uganda must work together to ensure that 90% or more of children and adolescents on ART in OVC SNUs are offered the opportunity to enroll in the comprehensive OVC programs. 2. The OVC transition to USAID is expected to take place according to the county team's transition plan and as current CDC and DOD partner awards naturally come to an end. Ensuring no disruption of client services will be critical as transition occurs. In order to assess the first OVC partner transition and identify lessons learned for the future, a headquarters/field interagency TDY should occur in FY 2021 Q1.
Key Populations 1. Strengthen KP programming to address specific population needs, utilizing lessons learned from KPIF implementation to develop innovative approaches to client-centered care. 2. With current political environment, design programs to reach MSM through broader male-friendly services (as opposed to those targeted specifically to one KP). 3. Ensure KP programs are compliant with updated COP 2020 Guidance for index testing among KP.

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Cervical Cancer Screening for WLHIV 1. Launch and scale services to improve morbidity and mortality outcomes for WLHIV through cervical cancer screening and treatment services. Per PEFAR guidance, PEPFAR Uganda should plan to scale such that all eligible WLHIV are screened every 2 years.
Supply Chain – The supply chain should support client-centered services and maintenance of people on treatment. With this focus and within budget directives, consider: 1. Expanded use of decentralized distribution models for ARVs. 2. Increased use of local private sector supply chain partners for procurement, warehousing and distribution. 3. Procurement of all-inclusive laboratory reagents through Vendor Managed Inventory (VMI) solutions via newly executed PEPFAR VL RFP. 4. Increased data visibility through the implementation of ERP to SDP. 5. Increase government procurement and monitoring of locally manufactured pharma. 6. Operationalize Health Information Exchange for community, district, and national levels.
Health Information Systems 1. Continue to expand electronic medical record and electronic patient management systems. 2. Support efforts to integrate information management systems, potentially leveraging available resources managed by agency headquarters or S/GAC. 3. Support Government of Uganda to develop and scale use of Unique Identifiers.
Human Resources for Health 1. Work with GoU to continue to transition health workers to GoU support and to recognize community cadres. 2. PEPFAR Uganda needs to complete the HRH inventory tool prior to coming to the regional planning meeting in Johannesburg.
Other Recommendations 1. 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 National Public Health Lab (NPHL) in Juba, South Sudan. These agreements will be formalized through an MOU. Budget for VLS 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. 2. PEPFAR Uganda should increase the number of facilities that receive SIMS visits. This can be accomplished by combining SIMS visits with ongoing visits as part of intensive-site management.

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3. Uganda to move rapidly to complete ABC costing in FY 2020 so that the analysis and UPHIA 2.0 data are available by the end of CY 2020.

COP/ROP 2020 Technical Priorities

Client and Family Centered Treatment Services

COP20 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. Uganda 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 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 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)

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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.

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

- Expansion into new districts: The following district should receive new DREAMS funds for COP20 as it has very high incidence, but no DREAMS or Global Fund AGYW presence.

Country	DREAMS SNU	UNAIDS F15-24 Incidence Estimate	UNAIDS Incidence Classification	PLHIV (COP19 DataPack)
Uganda	Kalangala	1.42	Very high	22,786

  - NOTE: The geographic expansion mentioned here is limited to NEW DREAMS funds. Any expansion within the existing DREAMS envelope is subject to the criteria laid out in COP20 Guidance (i.e., must have reached saturation, must have shown progress via WAD modeling data, or some other data).
- PrEP: Significantly scale-up PrEP for AGYW in all DREAMS districts.
- Minimum Requirements for new funds: To receive additional funds, Uganda 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

In addition, DREAMS Uganda should focus on the following:

- Layering: The Uganda team should focus on ensuring that each AGYW in DREAMS receives a layered package of services. Q4 AGYW_PREV data show that 12-22% of AGYW in DREAMS have not completed the full primary package of services (variation by age band). The most significant challenges of completion are seen among the 20-24 year old age band.

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.

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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. 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

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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			
	FY2 0			COP 20 Total
	GHP-State	GHP-USAID	GAP	
Total New Funding	**$ 331,265,002**	**$ 40,000,000**	**$ 3,212,500**	**$ 374,477,502**
Core Program	$ 280,765,002	$ 40,000,000	$ 3,212,500	**$ 323,977,502**
COP 19 Performance	$ 22,000,000			**$ 22,000,000**
HKID Requirement ++	$ 28,500,000			**$ 28,500,000**

++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/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.

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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.

Gender Based Violence (GBV): OU's COP/ROP 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/ROP 2020 earmark is derived by using the final COP/ROP 2019 GBV earmark allocation as a baseline. The COP/ROP 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/ROP 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/ROP 2020 earmark is derived by using the final COP/ROP 2019 water earmark allocation as a baseline. The COP/ROP 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 Uganda 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

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to COP/ROP 2020, decreasing the new funding amount to stay within the planning level.

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