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INFORMATION MEMO FOR AMBASSADOR MALONEY, ESWATINI

FROM: S/GAC – Acting U.S. Global AIDS Coordinator, Principal Deputy Assistant Secretary, Dr. Angeli Achrekar, DrPH, MPH

THROUGH: S/GAC Chair, Julia Martin, and PEPFAR Program Manager, Stephanie Weber

SUBJECT: Fiscal Year (FY) 2023 PEPFAR Planned Allocation and Strategic Direction

Dear Ambassador Maloney,

First and foremost, I sincerely hope that you and your team are safe and healthy. I am extremely grateful for your leadership of the PEPFAR program and additional COVID-19 response efforts during this difficult year.

While countries around the world continue to manage the effects of the COVID-19 pandemic, and the U.S. government acts on its commitment of support, it is encouraging to see vaccines making their way around the globe. The COVID response efforts – and continued use of the PEPFAR platform to support testing and vaccine delivery and uptake at point of care settings - are essential to our ability to provide ongoing care and life saving support for people living with HIV. The PEPFAR program has faced many challenges as a program during this period. Nevertheless, the PEPFAR family and partners have carried the mission forward while enduring significant personal impacts of COVID-19. Despite these challenges, what remains true is the strength and resilience of PEPFAR in partnership with countries and communities – through our teams, and our programs in the midst of dueling pandemics.

Tremendous effort has been made by PEPFAR over the year to protect and accelerate the HIV gains, while leveraging the platform to respond to COVID-19 as well.

PEPFAR Country/Regional Operational Plan 2022 (COP/ROP 2022) (for implementation in FY2023) represents a pivotal year in PEPFAR, as several countries are reaching or approaching the agreed upon UNAIDS 95/95/95 benchmarks for attaining epidemic control. As countries approach these benchmarks, while pivoting from "scaling to close gaps" to "sustaining" epidemic control, we must ensure HIV program and population equity, address outstanding barriers that threaten to derail progress made in reducing new HIV infections and associated mortality, and tailor our programs to serve all populations.

This year it is particularly important to plan COP/ROP22 together with the country government, civil society, and multilateral partners. Across PEPFAR, the focus on equity requires vigilant attention to program data demonstrating results and gaps. A focus on equity also means a focus on population groups where our efforts to date have not closed gaps, and specific planning, resource allocation, and program tailoring are needed – depending on what the data reveal for each country – focusing on: children, adolescent girls and young women, and key populations.

While implementation continues, and with most PEPFAR countries are on a path to achieving program coverage goals, PEPFAR programs should focus on four key themes as we approach COP 22 planning and implementation:

1. Achieve and sustain epidemic control using evidence-based, equitable, people-centered HIV prevention and treatment services.
2. Support resilient and capacitated country health systems, communities, enabling environments, and local partners to build enduring capabilities.
3. Strengthen cooperation and coordination for greater impact, burden sharing, and sustainability.
4. Employ an equity lens with a persistent focus on reducing persistent inequalities experienced by children, key populations, and adolescent girls and young women.

I want to applaud the PEPFAR team for:

- Exceptional effort in responding to the most urgent needs of the COVID-19 pandemic, proving PEPFAR to be a loyal partner to the Government of the Kingdom of Eswatini, and maintaining equally exceptional HIV program results particularly in treatment coverage and viral load suppression.
- Achieving high rates of HIV/TB treatment and TB preventative treatment, which protects HIV positive persons from contracting TB and reduces the risk of poor health outcomes from TB.
- Prioritizing survey and surveillance work as a core component of sustaining epidemic control; completing field data collection for SHIMS3 under extreme conditions, and fully scaling the implementation of Recency testing on all new HIV positive test results.

Together with the Government of the Kingdom of Eswatini (GKOE) and civil society leadership we have made tremendous progress on the HIV response. PEPFAR Eswatini should be proud of the progress made over the past 18 years of PEPFAR implementation, and we are grateful for the ongoing and deep coordination with the Global Fund and UNAIDS. PEPFAR Eswatini has been especially successful and is one of a number of countries to have achieved the UNAID 90-90-90 goals and effective control of the HIV epidemic. Now we must work to sustain HIV impact and begin the long-term, gradual transformation of the program – including the merging, management, and oversight of HIV services – in more intentional alignment and integration with domestic systems. COP 22 will represent the first step in this journey.

Despite the achievement of the UNAIDS high level goals, our work is not done. In COP 22 guidance, changes in program direction will vary depending on where countries are in reaching epidemic control and the continued COVID-19 mitigations efforts each program is facing. Specifically, more focus and attention should be given to the following key challenges in PEPFAR Eswatini:

- Prevention interventions for AGYW and key populations, including PrEP, must remain a top priority. COVID-19 and civil unrest have made delivery of community services challenging: gender-based violence rates have risen, adolescent girls' vulnerability has increased (particularly those out of school), and key populations are more difficult to reach. Program innovations must be developed to respond to these vulnerabilities.
- Continued emphasis on index testing as a case-finding strategy to assist in identifying AGYW and men in specific age bands as well as children under the age of 15 years.
- Financing of the HIV response remains unpredictable. The economic challenges faced by Eswatini coupled with the increased costs in the health sector due to COVID-19 have placed pressure on HIV budgets. Continued close dialogue and careful planning with the GOKE will be essential for sustainability of the national HIV response.

A fuller set of details, including funding earmarks and specific program direction are included in the accompanying COP/ROP 22 PEPFAR Planned Allocation and Strategic Direction Summary.

Consistent with the approach from years past, PEPFAR teams will once again be responsible for setting their own targets across PEPFAR program areas (with the treatment current target no less than the result that was to be achieved in COP 2021) in consultation with stakeholders. Teams should bear in mind that PEPFAR targets are not PEPFAR's but flow directly from the partner country government's commitment to the UNAIDS and SDG 3 goals.

The PEPFAR COP/ROP 22 notional budget for Eswatini is **$71,000,000** inclusive of all new funding accounts and applied pipeline. All earmarks and program directives provided below must be met. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team, in collaboration with the Government of the Kingdom of Eswatini and civil society of Eswatini, believes is critical for the country's progress towards controlling the pandemic and maintaining control.

Finally, in alignment with efforts by the U.S. government to support diversity, equity, inclusion, and accessibility as well as to advance equity for underserved communities and prevent and combat discrimination or exploitation on the basis of race, religion, gender identity or sexual orientation, PEPFAR will work to ensure that these principles are upheld, promoted, and advanced in all PEPFAR programs and in how we do business.

Please note that within the next few days our S/GAC Chairs and PEPFAR Program Managers (PPMs), working closely with our CAST teams, will review this planning letter and details contained, herein, with your wider PEPFAR country team. Stakeholder engagement is essential for a productive and impactful planning process, and civil society engagement will continue to be an integral part of this planning process. Included in this planning letter is an outline of the expectations for engaging key stakeholders and civil society, as we continue to finalize our approach to hosting a virtual COP/ROP22 planning and approval process.

Once again, thank you for your continued leadership and engagement during the COP/ROP22 process.

Sincerely,

Angeli Achrekar

Attachment: **COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction Summary**

CC: **S/GAC – Julia Martin, Stephanie Weber, Cheryl Amoroso**

Overview: COP 2022 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly monitoring POARTs, as well as Headquarters Country Accountability and Support Teams (CAST) input, a thorough program review of your country over time has been conducted. This includes the end of year results of the Country Operational Plan (COP) 2020 and current COP 2021 implementation as we plan for COP 2022. We have noted the following key successes and challenges.

Successes

As a country, Eswatini has faced some significant challenges: harsh waves of COVID-19 positive cases, wide-spread and ongoing civil unrest, prolonged school closures and a struggling economy. In spite of these circumstances, the national HIV response has remained strong, program integrity was maintained, and results were achieved. The PEPFAR team and partners identified gaps with precision and developed responses – often rapidly – to ensure the health and well-being of the people of Eswatini. Sincere appreciation.

Eswatini was one of a limited number of PEPFAR-supported countries that early on conducted robust population-wide surveys to better understand the impact of HIV programs on the epidemic. In 2021, the PEPAR team completed field data collection for SHIMS3 against extreme adverse conditions. Similarly, the program achieved full implementation of Recency testing, seeing all planned sites initiated and conducting Recency testing on HIV positive tests. Survey and Recency results will be critical to understanding vulnerabilities to sustained epidemic control.

Applying strong analytical rigor to testing and treatment data, PEPFAR efforts have successfully evolved HIV testing to a true case finding approach, improving index testing results and using Recency results to focus on specific age bands and populations that remain at risk for HIV. The PEPFAR team and partners continued to use program data to track and understand HIV treatment client transfers, losses and general movement resulting in high ART retention and exceptional viral load coverage and suppression. Similarly, HIV treatment among pregnant women continued to be an area of strength with the country close to achieving MTCT elimination as per the WHO definition.

Innovations in differentiated approaches to ensuring continuity of services, delivered with quality, were accelerated under COVID-19 conditions with decentralized services provided outside of facilities. Primary health services were provided on the HIV platform including access to COVID-19 preventative measures. The PEPFAR program did an exceptional job at responding to the COVID-19 crisis, quickly adopting service delivery to the context of country-wide lock-downs and showing maximum flexibility in responding to the urgency of the COVID-19 pandemic.

National efforts on HIV/TB treatment and TB preventative therapy (TPT) have been scaled with strong TB testing for ART clients and excellent TPT completion rates. Use of Gene Xpert for TB diagnosis has also been an area of strong performance with Eswatini leading among PEPFAR supported countries with more than 96% TB specimens tested with Xpert. The number of TB specimens analyzed by Xpert nearly doubled over the past twelve months.

Challenges

Recency testing results have shown persistent new infections among AGYW [15-24] and men [29-39]. At epidemic control, every case is an event. Understanding the risks behind new infections will be essential to prevention infections in the future. Similarly, in spite of overall high treatment coverage, persistent

gaps remain in viral load coverage indicating possible inconsistent access to services. Children under 15 years continue to have gaps in case finding and viral load suppression – small but notable.

For HIV prevention, key populations remain a challenge with less than 90% of estimated HIV positive population not yet diagnosed. PrEP, an important prevention intervention, underperformed as a program area among key populations, men and AGYW. PrEP is offered but acceptance does not follow. The DREAMS program interventions for AGYW encountered significant adversity with prolonged country-wide lockdowns and school closures. Completion rates of the DREAMS package were affected for 10-14 year-olds, face-to-face activities were paused and GBV prevention and response saw low results. Rates of violence have increased.

Lastly, domestic fiscal challenges, exacerbated by COVID-19, have seen reductions in government revenue met with increased pressure to boost expenditures on health and social protection to lessen the toll of the COVID pandemic. Eswatini's fiscal situation is, in places, precarious and has affected HIV domestic funding commitments. In 2020, currency devaluation and increased commodity prices left a $5.8 million gap between MOH budgeted funds for ARV and actual costs. While PEPFAR and Global Fund resources have been used to fill gaps, shifting funds to ARV procurements have left other parts of the national HIV response vulnerable to being under-resourced.

Given your country's status of achieved or are near achieving epidemic control, the following priority strategic and integrated changes are recommended taking on a public health approach maximizing the role of community, data use and surveillance:

1. **Prevent new HIV infections:**
    a. Continue to focus on the HIV prevention cascade to identify – with precision – populations most at risk and interventions most likely to interrupt infection. Men (29-39) and AGYW should remain the focus.
    b. Continue to use a case-based surveillance approach to finding new infections and interrupting transmission including Recency testing results.
    c. Scale PrEP among key populations, AGYW and men (30-35 years).
    d. Seek solutions to address gender-based violence both prevention and post-violence care.

2. **Close gaps in treatment particularly for pediatrics and adolescents**. This includes ensuring access to viral load testing and suppression, and for difficulties in suppression, utilize a continuous quality improvement approach to sustaining high levels of viral suppression in all populations.
3. **Reinforce models of integrated service delivery that reduce HIV stigma**, increase health seeking behavior and address HIV related comorbidities. Embed HIV treatment in a chronic care model.
4. **Bolster lab infrastructure**. Support for developing: policy and legal frameworks for the national public health laboratory; streamlined quality management including digital proficiency platforms; plan for in-country capacity for drug resistance surveillance, MDR TB and COVID sequencing; a sustainable approach to sample transport financing; and means to improve the LMIS-CMIS interface.
5. **Align and merge PEPFAR human resources support with GOKE health care workforce architecture.** Plan for embedding PEPFAR partner technical support and facility oversight into GOKE workstreams.
6. **Focused investments in digital platforms and right-size the current CMIS investment.** Shift towards value-added screening modules, speed deployment of software solutions (eLMIS), plan for automation of indicators, and identify and seek solutions to address infrastructure threats.

7. **Begin formal discussions and mapping of pathway to sustainability of the national HIV response.** Disarticulate technical and programmatic sustainability from financial. Consider program areas of growth/emphasis and innovations and use of all potential service providers including private sector.

SECTION 1: COP 2022 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2021 (EOFY) tool, and performance data, the total COP 2022 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency.

TABLE 1: All COP 2022 Funding by Appropriation Year

	Bilateral				Central				Total
	FY22	FY21	FY20	Unspecified	FY22	FY21	FY20	Unspecified	TOTAL
Total New Funding	$ 62,987,995	$ -	$ -	$ -	$ 1,703,000	$ -	$ -	$ -	$ 64,690,995
GHP-State	$ 62,500,495	$ -	$ -		$ 1,203,000	$ -	$ -		$ 63,703,495
GHP-USAID	$ -				$ 500,000				$ 500,000
GAP	$ 487,500				$ -				$ 487,500
Total Applied Pipeline	$ -	$ -	$ -	$ 6,309,005	$ -	$ -	$ -	$ -	$ 6,309,005
DOD				$ 187,993				$ -	$ 187,993
HHS/CDC				$ 3,476,069				$ -	$ 3,476,069
PC				$ 1,610,488				$ -	$ 1,610,488
USAID				$ 731,961				$ -	$ 731,961
State/AF				$ 302,494				$ -	$ 302,494
TOTAL FUNDING	$ 62,987,995	$ -	$ -	$ 6,309,005	$ 1,703,000	$ -	$ -	$ -	$ 71,000,000

SECTION 2: COP 2022 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Countries should plan for the full Care and Treatment (C&T) level of $31,500,700 and the full Orphans and Vulnerable Children (OVC) level of $14,077,200 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 2022 Earmarks by Appropriation Year*

	Appropriation Year			
	FY22	FY21	FY20	TOTAL
C&T	$ 31,500,700	$ -	$ -	$ 31,500,700
OVC	$ 14,077,200	$ -	$ -	$ 14,077,200
GBV	$ 1,140,888	$ -	$ -	$ 1,140,888
Water	$ 150,000	$ -	$ -	$ 150,000

**Only GHP-State and GHP-USAID will count towards the earmarks (Care and Treatment, OVC, GBV, and Water).*

***Only GHP-State will count towards the GBV and Water earmarks*

TABLE 3: COP 2022 Initiative Controls: Each dollar planned in COP can belong to only one initiative. Most COP funding will be budgeted as Core Program. In general, initiatives other than Core Program are used to track activities/programs that cannot be tracked by the combination of program area and beneficiary alone. See Appendix 1 for more detailed information on initiatives.

	Bilateral	Central	TOTAL
Total Funding	**$ 69,297,000**	**$ 1,703,000**	**$ 71,000,000**
Core Program	$ 50,410,741	$ -	**$ 50,410,741**
Cervical Cancer	$ 1,500,000	$ -	**$ 1,500,000**
Condoms (GHP-USAID Central Funding)	$ -	$ 500,000	**$ 500,000**
DREAMS	$ 10,153,084	$ -	**$ 10,153,084**
OVC (Non-DREAMS)	$ 5,733,175	$ -	**$ 5,733,175**
USAID Southern Africa Regional Platform	$ -	$ 1,203,000	**$ 1,203,000**
VMMC	$ 1,500,000	$ -	**$ 1,500,000**

TABLE 4: Programmatic Controls: Programmatic controls are used to track programmatic directives that can be tracked by a combination of program area and/or beneficiary. Programmatic controls may overlap with Initiatives, for example PrEP for Adolescent Girls and Young Women may count towards both the DREAMS Initiative and the PrEP (AGYW) programmatic control. See Appendix 1 for more detailed information on programmatic controls.

For Eswatini, there are no programmatic controls for PrEP for COP22 and thus no Table 4 included herein. However, PrEP is a program priority for Eswatini for COP22. Eswatini may approach PrEP as a program priority through target setting for COP22 and should also plan to be clear on the breakdown of what activities are supported plus the budget amounts (i.e., commodities, national support, training, comms, etc.) for COP22 so S/GAC may have a clear understanding of how PEPFAR Eswatini is supporting country advancement.

TABLE 5: State ICASS Funding

	Appropriation Year
	FY22
ICASS	$ 292,044

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

SECTION 3: PAST PERFORMANCE – COP 2020 Review

TABLE 6. COP OU Level FY21 Program Results (COP20) against FY22 Targets (COP21)

Indicator	FY21 result (COP20)	FY22 target (COP21)
TX Current <15	9,371	9,424
TX Current 15+	207,853	210,712
VMMC 15+	5,542	6,983
DREAMS (AGYW PREV)	68,850	62,522
Cervical Cancer Screening	23,730	41,009
TB Preventive Therapy	36,521	36,495

***Source: Panorama Data Tables: Single OU pulled January 10, 2022**

TABLE 7. COP/ROP 2020 | FY 2021 Agency-level Outlays versus Approved Budget

OU/Agency	Approved COP/ROP 2020 Planning Level	Total FY 2021 Outlays	Over/Under Outlays
Eswatini	**$82,977,584**	**$71,737,649**	**$11,239,934**
DOD	$2,346,092	$2,713,858	-$367,766
HHS/CDC	$30,786,980	$25,504,189	$5,282,791
PC	$1,618,900	$244,025	$1,374,875
State	$1,192,675	$972,011	$220,664
USAID	$34,695,850	$29,924,990	$4,770,859
USAID/WCF	$12,337,087	$12,378,576	-$41,489
Grand Total	**$82,977,584**	**$71,737,649**	**$11,239,934**

TABLE 8. COP/ROP 2020 | FY 2021 Results & Expenditures

Agency	Indicator	FY21 Target	FY21 Result	% Achievement	Program Classification	FY21 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	63,441	141,298	223%	HTS	$2,546,983	64%
	HTS_TST_POS	3,903	8,055	206%	HTS		
	TX_NEW	4,177	5,389	129%	C&T	$8,892,630	51%
	TX_CURR	117,776	129,097	110%	C&T		
	VMMC_CIRC	4,130	3,269	79%	VMMC	$1,160,621	45%
DOD	HTS_TST	2,588	3,100	120%	HTS	$24,000	0%
	HTS_TST_POS	294	291	99%	HTS		
	TX_NEW	280	277	98%	C&T	$1,106,287	71%
	TX_CURR	3,301	3,329	101%	C&T		
	VMMC_CIRC	442	440	100%	VMMC	$68,328	100%
USAID	HTS_TST	57,594	96,409	167%	HTS	$1,551,559	100%
	HTS_TST_POS	3,732	4,699	126%	HTS		
	TX_NEW	3,426	4,632	135%	C&T	$19,569,673	81%
	TX_CURR	83,182	84,936	102%	C&T		
	VMMC_CIRC	2,779	1,970	71%	VMMC	$645,309	100%
	OVC_SERV	67,365	97,017	144%	OVC Beneficiary	$5,103,673	97%
PC	OVC_SERV	N/A	116	N/A	OVC Beneficiary	$0	N/A
					Above Site Programs		$4,968,284
					Program Management		$13,615,000

Source: Panorama Data Tables: Single OU and Financial Management Single OU Pulled January 10, 2022. Note: DOD's FY21 TX_Curr target reflects manual data entry as system of record shows a duplicated target due to TBD mechanism.

SECTION 4: COP/ROP 2022 DIRECTIVES

The following section has specific directives for COP 2022 based on program performance noted above. Please review each section carefully including the minimum program requirements.

Minimum Program Requirements (MPR)
All PEPFAR programs – bilateral and regional– must ensure the following minimum program requirements are in place. Adherence to these policies and practices is essential to the success of all PEPFAR programs at the national, subnational, and service delivery levels (e.g. facility, school, community). Evidence demonstrates that lack of any one of these policies/practices significantly undermines HIV impact and results in inefficient and ineffective programs.

All PEPFAR programs are expected to meet all of the requirements below, and the COP22 Planning Meeting will include a review of the status of each requirement, including assessment of implementation (including barriers) at the point of client services. To the extent that any requirement(s) have not been met by the time of the COP22 Planning Meeting, the PEPFAR OU team will need to present a detailed description of existing barriers and the remediation plans proposed that will allow them to meet the requirement(s) prior to the beginning of FY2023. The list will be included in the Strategic Direction Summary (SDS), as well.

Failure to meet any of these requirements by the beginning of FY2023 may affect the OU budget. The minimum requirements for continued PEPFAR support include the table below.

TABLE 9. COP 2022 (FY 2023) Minimum Program Requirements

Care and Treatment	
1.	Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups. Status: Policy fully adopted; maintenance-mode Issues or Barriers: Low public knowledge of HIV and stigma requires ongoing consideration
2.	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens. Status: Maintenance of ART optimization, TLD transition continues with a 72% achievement during COP21. Issues or Barriers: None noted
3.	Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups. Status: Underway and will be accelerated to reach goal of 80% of 6MMD for eligible clients Issues or Barriers: ARV commodities – sufficient stock
4.	All eligible PLHIV, including children and adolescents, should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.

	Status: TPT has been scaled up and all supported ART sites are currently providing TPT services routinely. Focus is now on scaling up alternative TPT regimens and TPT in DSD models. Issues or Barriers: None noted
5.	Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks. Status: Optimization of VL testing has been achieved with decentralization of testing to regions and the placement of high throughputs in the National Reference Laboratory and Nhlangano (Shiselweni region). Issues or Barriers: Results return and fully integrated LIS and CMIS interface
	Case Finding
6.	Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV. Status: Re-oriented HTS providers on ethical and safe index testing principles. Optimize index testing for all newly HIV diagnosed virally unsuppressed clients and PLHIV biological children <19 years. Scale up HIVST distribution to priority population and during index testing. Implementing oral based pediatric HIV self -testing as agreed during COP20 discussions. Issues or Barriers: None noted
	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) Status: National scale up of PrEP in process. By FY21 Q1 a total of 121 of the 152 sites had been scaled up, with full coverage expected by FY21 Q4. Issues or Barriers: Low acceptance of PrEP among key populations, men and AGYW. Packaging, dispensing locations and low public HIV and risk knowledge levels
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 infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV. Status: Comprehensive OVC track targets children with known vulnerabilities, especially C/ALHIV with family-based case management and retention in care; preventative OVC track provides primary prevention of sexual violence and HIV to 9-14yo boys and girls. Issues or Barriers: Collaboration between clinical and OVC partners to maximize use of OVC platform to support HIV positive children.
	Policy & Public Health Systems Support

9.	In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups. Status: In-process Issues or Barriers: Stigma, violence against women and girls and barriers to access to services for key populations remain areas of significant challenge with societal norms and placing key and vulnerable groups at heightened risk of HIV and poor health outcomes.
10.	Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention. Status: There are no fees. Issues or Barriers: None noted
11.	OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy. Status: Continued CQI at facility level supported by partners and national policy Issues or Barriers: None noted
12.	Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other partner country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention. Status: Treatment and VL literacy education actively integrated into community programming and facility service delivery, leveraging FCI support and delivered through Faith Leaders, community caretakers, expert clients and support groups. The patient health literacy campaign launched by MOH and stakeholders. Campaign messages placed in all platforms including social media for national level awareness. Issues or Barriers: None noted
13.	Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses. Status: Increasing progress towards local, indigenous partner prime funding including FY21 transition of two local subs to Prime and an additional transition planned for FY22. Issues or Barriers: Small number of civil society and indigenous organizations in Eswatini and capacity to manage larger grants must be developed over time.
14.	Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended. Status: Government funds most ARV, facility and HRH costs. Pandemic-related economic issues led to FY21 shortages alleviated through additional GF and PEPFAR support. Economic pressures expected to continue in the upcoming years, though program responsibility and political will

remain unchanged. Issues or Barriers: Economic instability with wider regional influences.
15. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. Status: An FY21 WHO assessment on civil registration and vital statistics will inform PEPFAR FY22 investments to improve reporting on cause of death for PLHIV and improve interoperability of relevant data systems. Issues or Barriers: Fiscal space to support effort and government time to invest given multiplicity of priorities.
16. Scale-up of case surveillance and unique identifiers for patients across all sites. Status: CBS technical concept has been developed and efforts are underway to plan for a stakeholder engagement and mapping exercise to take stock of the landscape in advance of implementation. CMIS generates a unique ID that is complementary to the National ID (the primary ID in CMIS). CMIS is now scaled up to 92% of ART sites. Issues or Barriers: None noted

In addition to meeting the minimum requirements outlined above, it is expected that Eswatini will consider all the following technical directives and priorities. A full list of COP/ROP 2022 Technical Priorities and Considerations are listed in COP guidance and can be referenced in Section 6.

Table 10. COP 2022 (FY 2023) Technical Directives

Eswatini Specific Directives
HIV Clinical Services
1. Improve VL coverage among children, females (10-29 years), males (20-39 years), and pregnant women. Reported VLC proxy among pregnant women was 50%. Data from partners suggests higher VLC than what is reported. Continue to improve reporting on this indicator and identify solutions to data collection challenges. Continue to offer DBS as an alternative sample type to improve access of VL to PBFW and also consider expanding POC VL for PBFW. VLC coverage for children <15 years remains consistently low for <5-year-olds at 54% and low for 10-14 year-olds at 76%. Address low VLC using pediatric blood draw supplies, POC and DBS, depending on the location. Offer VL testing using family-centered approaches including during community drug distribution
2. Continue to shift testing from OPD to engage most at-risk populations before they seek testing at an OPD. Target specific age bands for men (25-39) and women (15-24) for OPD testing.
3. Gaps among children and adolescents (<15 years) for case finding. 65 new children were identified in FY21Q4 and most in the pediatric wards. Index testing contributed 18.8% of positives. Continue index testing efforts and offer testing of biological children through facility, community and in homes (as appropriate). Continue peds-OVC collaboration to offer index testing.

4. Fully offer TPT to all eligible PLHIV and scale up 3HP as budget allows. 71% of TB_PREV targets achieved in FY 21. NTP and partners should continue data optimization and alignment of information systems to identify all PLHIV eligible for TPT. Partners should identify at site level all PLHIV eligible for TPT through folder audits and line listing to close gap in TPT coverage. Assess coverage of interventions and set targets accordingly. TPT targets should aim to ensure that 95% of TX_CURR will have received TPT, and the other TB indicators should meet 95% coverage of the denominator. Improve quality of TB screening: The TB presumptive yield for new and those already on ART was only 3.5% - well below the 10% and 5% target respectively. TB screening yield performance could be improved by conducting an audit of TB screening SOPs, tools, strengthening capacity building of health care providers by training on revised algorithms, enhanced supervision and mentoring and implementing CQI initiatives all PLHIV sites.
HIV Prevention Services
1. PrEP should continue to be scaled up with a focus on ensuring policy and programmatic access to PrEP for populations with higher HIV incidence. Populations prioritized for PrEP should be: Key Populations (including sex workers, men who have sex with men, transgender people, people in prisons and other closed settings, people who inject drugs), adolescent girls and young women including pregnant and breastfeeding AGYW, and men (30-39). While PrEP has increased in FY21, especially among AGYW 20-29, Eswatini must continue to scale PrEP simplifying and standardizing how PrEP is offered in facility and community entry points. Enhance additional engagement and demand creation with priority populations including AGYW (15-24 years), men (30-39), KP groups, and pregnant and breast-feeding women. Strengthen efforts to improve PrEP continuation especially for these priority populations. Additional resources from within Eswatini's COP22 planning level will be needed to improve the standard of PrEP care across all facility and community entry points. Additional provider training on simplified PrEP service delivery for those who test negative will be an important nation-wide activity. Implementation of demand creation is required. Enhanced retention efforts are also required. PEPFAR Eswatini will be required to provide a comprehensive plan and budget for PrEP scale up with a means of tracking budget expenditure that can be comparable year on year.
2. Eswatini should strength bi-directional referral for post-violence care services, improve access to GBV services (e.g., expand health facilities' capacity to provide post-GBV care and options for on-demand or regularly scheduled mobile services), educate AGYW about the need to access services within 72 hours, and conduct GBV quality assurance assessments at mobile units and facilities providing post-violence care services.
3. DREAMS programming: Focus on completion of primary package and secondary interventions, target AGYW who have been in the program 13-24 months and confirm loss to follow-up and barriers for completion; consider implementing a special project to conduct root cause analysis of barriers to completion, particularly for AGYW in the program longer than 13 months.
4. Eswatini VMMC program to continue safe implementation with optimal performance and increasing adaptations for COVID-19. Monitoring sites and external assessments will enhance continuous quality of care. Those that still have underperformance need to increase adaptations to improve performance.

Eswatini VMMC program to scale up task shifting of nurse-led implementation country wide. Enhanced supervision and mentoring systems will be increasingly important as the nurse-led program establishes and expands.
5. Enrollment of C/ALHIV into the OVC program has seen a gradual but slow increase. OVC program coverage of TX_CURR <20 ranges by regions from 20 - 44%. The program should accelerate efforts to offer OVC program enrollment to C/ALHIV, including offering an adapted service package to children refilling in locations other than their home residence with a focus on virally unsuppressed C/ALHIV. A revised/renewed approach to the collaboration between OVC implementers and clinical implementers should be developed to ensure that virally unsuppressed children and those most vulnerable are enrolled in the OVC program.
Other Government Policy, Systems, or Programming Changes Needed
1. COP/ROP 22 plans should prioritize and take specific steps to address the structural barriers that impede scale up of KP-led and KP-competent differentiated HIV services, as well as the lack of robust data to guide key populations programming. To strengthen strategic information to guide KP responses, plans may include efforts to strengthen individual level data systems and analyses and address gaps in subnational data. Addressing structural barriers should entail improving the enabling environment for HIV service delivery; mitigating harmful policy and social norms that fuel stigma, discrimination and violence faced by key populations; strengthening the capacity of key populations organizations; and strengthening the KP competency of HIV service providers. PEPFAR teams should ensure they are coordinating strategically with relevant State and U.S. government units (e.g. DRL), partner government, multilateral, and other donor funding streams and institutions. As part of the new COP 22 MPR, PEPFAR teams will be expected to describe and present their approach to improving KP data and addressing barriers to accelerated KP-centered HIV services during COP/ROP 22 planning meetings.
2. Advocate for a change in policy that would permit trained personnel other than laboratorians to operate POC GeneXpert platforms to initiate POC testing for VL specifically for improving coverage of PBFW and <15-year-olds.
3. PEPFAR Eswatini to be actively engaged in the implementation of HIV/NCD models of care through the Quality Improvement pilot at 15 sites currently supported with Global Fund financing. Scale-up will be dependent on the success of this pilot.

COP/ROP 2022 Active Engagement with Community and Civil Society (see section 2.5.3 of COP Guidance)

The full participation of community stakeholders and civil society in every stage of PEPFAR programming, planning, and monitoring, as appropriate and consistent with applicable law, regulations and policy, from advocacy to service delivery, is critical to the success and sustainability of PEPFAR and the global effort to combat HIV. Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional, and international civil society and community stakeholders, multilateral partners and the partner country government.

Civil society organizations are essential and to be invited to participate in the virtual COP22 strategic retreats, planning meetings, as well as approval meetings. In particular, engagement with local CSOs at the country-level is required and should begin early and continue during the entirety of the COP planning, monitoring, and implementation process.

This engagement of civil society, including faith-based organizations/faith communities, specifically includes the sharing of FY 2021 Q4 and FY 2021 Annual Program Results (APR), analyses, and the convening of an in-country planning retreat with local stakeholders, no later than the week of February 7, 2022, in order to introduce and discuss all COP/ROP 2022 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2022. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund, with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In March 2022, PEPFAR will convene virtual meetings where outstanding decisions will be discussed and finalized. In addition to partner country representatives, the meetings will also include representatives from local and international civil society and community organizations, faith-based organizations/faith communities, private sector, and multilateral partners. Specific guidance for the 2022 virtual meeting delegations will be provided separately.

Engagement with all stakeholders is required beyond the meetings and throughout COP/ROP 2022 development, finalization, and implementation. As in COP/ROP 2021, the draft Strategic Direction Summary (SDS) is required to be shared with both CSO and FBO stakeholders for their input and comments at least 7 days prior to submission to S/GAC. Please refer to the COP/ROP 2022 Guidance for a full list of requirements and engagement timelines. In addition, a more detailed timeline for sharing key data visualizations and other information with stakeholders is forthcoming.

Community-led Monitoring (CLM)

In addition to prescribed and routine engagement during PEPFAR's annual business cycle, including around COP/ROP planning and quarterly POART processes, all PEPFAR programs are required to develop, support, and fund community-led monitoring (CLM) in close collaboration with independent, local civil society organizations and host country governments. Community-led monitoring in COP22 should build on prior activities in COP21 and be designed to help PEPFAR programs and health institutions pinpoint persistent problems, challenges, barriers, and enablers to effective client outcomes at the site level. In addition to being data-driven and action-oriented, CLM should continue to ensure indicators are defined by communities and health service users, and data should be additive and not a duplicate collection of routine data already available to PEPFAR through MER or SIMS. New in COP22, PEPFAR-supported community-led monitoring programs must include an explicit focus on key populations. CLM should be utilized to advance equity and to support improvement in programs, especially for populations who have not yet fully experienced the benefits of HIV epidemic control. For

example, OUs with pediatric care and treatment programs should consider utilizing CLM to track and ensure accountability for child, adolescent, and family-centered care.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment: Each OU's COP/ROP 2022 minimum requirement for the care and treatment earmark is reflected in Table 2. If there is no adjustment to the COP/ROP 2022 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The Care and Treatment earmark will be calculated as the sum of the following:

- 100% Care and Treatment (C&T) Program Areas
- 50% Testing (HTS) Program Areas
- 100% Above Site Program: Laboratory System Strengthening
- 70% Pregnant and Breastfeeding Women Beneficiary Group
- Proportional % Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the C&T earmark)

Orphans and Vulnerable Children (OVC): Each OU's COP/ROP 2022 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The OVC earmark will be calculated as the sum of the following:

- 85% (DREAMS initiative funding — commodities planned under DREAMS initiative — Any HTS interventions planned under DREAMS initiative — Any C&T intervention planned under DREAMS initiative)
- 100% (OVC Beneficiary group funding — commodities planned under any intervention with OVC beneficiaries — Any HTS planned under interventions with OVC beneficiaries
- Proportional Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the OVC earmark)

Abstinence, Be Faithful/Youth (AB/Y) Reporting Requirement: If AB/Y-programmed activities do not reach a 50 percent threshold of all sexual prevention funding, as calculated by the formula below, in any country with a generalized epidemic, S/GAC is required to report to the appropriate Congressional committees on the justification for the decision. Generalized epidemic countries which do not meet the 50 percent threshold must provide a brief written justification in FACTS Info, explaining the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors.

Abstinence, Be Faithful/Youth (AB/Y) programming, formerly captured in the HVAB budget code, will now be captured by using a combination of prevention program areas and beneficiaries, which are identified in the formula below. The numerator captures those interventions that are Abstinence, Be Faithful/Youth (AB/Y) programming, and the denominator approximates all sexual prevention activities. The proportion of Abstinence, Be Faithful/Youth (AB/Y) programming as a proportion of all sexual prevention activities is calculated by dividing the numerator by the denominator:

Numerator

Prevention: primary prevention of HIV and sexual violence

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, and boys)

+

Prevention: community mobilization, behavior, and norms change

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, boys, adults, not disaggregated)

Denominator

Prevention: primary prevention of HIV and sexual violence (all populations)
+
Prevention: **community mobilization, behavior, and norms change** (all populations)
+
50 % Prevention: **Not disaggregated** (all populations)

Gender Based Violence (GBV): Each OU's COP/ROP 2021 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2022** funding programmed to the GBV cross-cutting code. Your COP/ROP 2022 earmark is derived by using the final COP/ROP 2021 GBV earmark allocation as a baseline. The COP/ROP 2022 planned level of new FY 2022 funds for GBV can be above this amount; however, it cannot fall below it.

Water: Each OU's COP/ROP 2021 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2022 funding** programmed to the water cross-cutting code. Your COP/ROP 2021 earmark is derived by using the final COP/ROP 2021 water earmark allocation as a baseline. The COP/ROP 2022 planned level of new FY 2022 funds for water can be above this amount; however, it cannot fall below it.

Initiative Controls: Table 3 shows initiative controls where S/GAC has directed funding for a set of activities that cannot be accounted for through program areas and/or beneficiaries alone. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned.

The four initiative controls below (**Cervical Cancer**, **DREAMS**, **OVC (non-DREAMS)**, and **VMMC**) have been assigned to the appropriate OUs. For OUs where these controls are designated in the PLL, the amounts reflect the minimum required. These initiative controls can be exceeded without a control change, but a control change request would be required before a lower level for these activities can be planned.

Cervical Cancer - This initiative provides funding for all activities related to cervical cancer screening and diagnosis and treatment of precancerous cervical lesions for women living with HIV as outlined in the COP Guidance.

DREAMS - The DREAMS initiative should capture all funding specifically allocated as DREAMS in the OU's planning level and must be used for the goal of HIV and sexual violence prevention among adolescent girls and young women (AGYW) ages 10-24 years (unless otherwise approved) in approved DREAMS SNUs in accordance with the DREAMS and COP Guidance. The DREAMS initiative can also include prevention interventions in DREAMS geographic areas for girls and boys aged 10-14 which may be cost shared with the OVC (non-DREAMS) initiative as noted in the COP guidance.

OVC (non-DREAMS) - OVC (non-DREAMS) is a new initiative in COP/ROP 2022. OUs should use the initiative to budget for OVC (non-DREAMS) programming, including all OVC comprehensive activities as outlined in the COP Guidance. The OVC (non-DREAMS) initiative should include ASP, SE, and PREV costs (except PrEP and VMMC) linked to any OVC beneficiary (including sub-beneficiaries such as OVC caregivers). As the initiative is new for COP/ROP 2022, OUs should pay particular attention to funds programmed under OVC (non-DREAMS) to ensure that the current cohort of children enrolled in the comprehensive program receive continuity of care for FY 2023. The OVC (non-DREAMS) initiative can also include prevention interventions for girls and boys aged 10-14 which may be cost-shared with the DREAMS initiative as noted in the COP guidance. The OVC (non-DREAMS) initiative cannot be met with any HTS, C&T, PM or commodities costs.

VMMC - All services and equipment related to providing surgical and ShangRing VMMC for boys/men ages 15 and above, and ShangRing circumcision only for boys age 13 and 14 years, should be budgeted using the VMMC initiative.

While the CLM initiative does not appear in PLL budget tables, as CLM remains a requirement in COP/ROP 2022 for all OUs, each OU is responsible for programming a portion of funds under the **Community-Led Monitoring** initiative.

Community-Led Monitoring - During COP/ROP 2020, PEPFAR invested in expansion of community-led monitoring, making it a requirement of all OUs, as a critical way to listen to community voices in assessment of program quality and design of client-centered services. Community-led monitoring remains a requirement in FY 2023.

In addition to the five initiatives above, S/GAC may also allocate funding to OUs under two additional initiative controls: **Condoms (GHP-USAID Central Funding)** and **One-Time Conditional Funding**. If the OU was designated to receive funding under either one or both these initiatives in COP/ROP 2022, Table 3 will reflect these amounts. Unless otherwise noted, country teams should meet these funding controls when programming in their FAST.

Condoms (GHP-USAID Central Funding) - This initiative control denotes the amount of GHP-USAID central funding the country team may use to procure male and female condoms, lubricants, and to ship these commodities to the OU. Any additional condoms and lubricants to be procured with PEPFAR funding should be budgeted in the FAST with bilateral funding.

USAID Southern Africa Regional Platform - This initiative is for the country's share of the costs to operate the USAID Southern Africa Regional Platform, which provides administrative and technical support for Angola, Botswana, Eswatini, Lesotho, and Namibia. These funds were previously planned as part of the bilateral COP funding, but are now budgeted and notified centrally, with country amounts included as central funding in the overall COP levels for Angola, Botswana, Eswatini, Lesotho, and Namibia. Only these 5 countries may use this initiative, and this initiative can only be used with central funding specifically provided as part of the PLL controls.

One-Time Conditional Funding - The release of any funding made available under this initiative is contingent upon the OU's ability to meet all requirements outlined in their final COP/ROP approval memo. OUs that fail to meet these minimum standards may be ineligible to receive these funds for programmatic implementation in FY 2023.

No control is set in the PLL for the **HBCU Tx** and **Surveillance and Public Health Response** initiatives, but OUs may include relevant funds under these initiatives instead of Core Program as appropriate.

All funding not attributed to one of the nine COP/ROP 2022 initiatives above should be attributed to the **Core Program** initiative.

For additional details on initiatives, see the PEPFAR Financial Classifications Reference Guide.

Programmatic Controls: Table 4 shows programmatic controls where S/GAC has directed funding for certain programmatic activities. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned. Since every dollar programmed in COP must belong to one initiative, programmatic controls will be a subset of one or more initiative controls, even if the standard Core Program initiative.

PrEP (AGYW) – The PrEP (AGYW) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for the Females – Adolescent Girls and Young Women sub-beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the number of AGYW on PrEP wherever possible. Countries with a PrEP (AGYW) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

PrEP (KPs) – The PrEP (KPs) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for all sub-beneficiaries under the KP beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the number of KPs on PrEP wherever possible. Countries with a PrEP (KPs) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

State ICASS: Table 5 shows the amount that the OU must program under State for ICASS Costs.

Funds Programmed under State/SGAC (S/GAC TBDs)

No funding may be programmed under State/SGAC without prior approval from S/GAC M&B. In general State/SGAC TBDs are only used in extraordinary and or unusual circumstances. To the degree that funding is approved, the rationale and any conditions attached to the funding will be documented by M&B. Any S/GAC TBDs approved during COP/ROP 2022 planning will require supplemental language in the OU's COP/ROP 2022 approval memo, clearly outlining the process for how these funds can be accessed. Any funds that have not been distributed to agencies before the end of FY 2023 may be subject to reprogramming in future planning cycles towards the same OU or another OU.

COP/ROP 2022 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

Whenever possible, all agencies within an OU should hold several months of pipeline at the end of COP/ROP 2022 implementation to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. If an agency/OU combination has a history of over-outlays, or in cases where an agency/OU COP envelope has increased in recent years, there may not be sufficient funding to maintain this buffer. With the exception of Dominican Republic, Ethiopia, Haiti, South Sudan, Zimbabwe, Asia Regional Program, and Western Hemisphere Regional Program, which should hold up to four months of pipeline, all other OUs are permitted to hold no more than three months of buffer pipeline.

Any agency that anticipates ending COP/ROP 2021 implementation (end of FY 2022) with a pipeline in excess of three or four months is required to apply this excessive pipeline to COP/ROP 2022, decreasing the new funding amount to stay within the planning level.

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. In COP19 Guidance, PEPFAR set a goal that 40% of partners must be local by the end of FY19, and 70% by the end of FY20.While considerable progress was made in this effort, the 70% mark was not achieved by all agencies in all OUs, and thus in FY22 and FY23, teams must continue to prioritize this so that the 70% goal can be realized. 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 FY23 as appropriate through their COP/ROP 2022 submission.