United States Department of State

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INFORMATION MEMO FOR CHARGE D'AFFAIRES TODD HASKELL

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

THROUGH: **Jirair Ratevosian, Chair**
Matt Wollmers, PEPFAR Program Manager

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

Dear Chargé Haskell,

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 lifesaving support for people living with HIV. PEPFAR has faced many challenges as a program during this period. Nevertheless, the PEPFAR family and our partners have carried the mission forward, even while enduring significant personal impacts from 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 dual pandemics.

Tremendous efforts have been made by PEPFAR over the past year to protect and accelerate gains against HIV while leveraging the platform to respond to COVID-19 as well.

PEPFAR Country/Regional Operational Plan (COP/ROP) 2022 (for implementation in FY2023) represents a pivotal year for 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/ROP 22 together with country governments, 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 – with a particular focus on children, adolescent girls and young women, and key populations.

While implementation continues, or in many cases, has started to scale up, most PEPFAR countries are on a path to achieving program coverage goals. With that in mind, PEPFAR programs should focus on four key themes as we approach COP/ROP 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 focus on reducing persistent inequalities experienced by children, key populations, and adolescent girls and young women.

I want to applaud the PEPFAR South Africa team for:

- The resilience of programs over the past year to ensure continued access to ART and other essential services despite the ongoing impacts of COVID-19.
- Improvements across the prevention portfolio, most notably in accelerating the delivery of PrEP to those at highest risk of infection, including key populations such as men who have sex with men (MSM), female sex workers (FSW), and adolescent girls and young women (AGYW); and continued strong achievement in serving orphans and vulnerable children (OVC).
- Swift and effective public health diplomacy in responding to COVID-19 by strategically leveraging the PEPFAR service delivery platform and a whole of government approach, which expanded access to COVID-19 testing, communications, and vaccinations.
- A strong spirit of collaboration among PEPFAR and agency field teams to align agency strengths and maximize their collective impact.

Together with the Government of South Africa and civil society leadership we have made tremendous progress together. I want to especially thank you and your team for prioritizing the importance of continued collaboration and cooperation with the Government of South Africa to advance innovative solutions and address policy and other barriers in the HIV response and across a broad range of health topics, including on overarching issues such as strengthening human resources for health planning and sustainability planning.

South Africa should be proud of the progress made over the past 18 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS. Indeed, the PEPFAR partnership has played a significant role in supporting the scientific leadership in South Africa, in HIV and COVID-19, to advance science and our collective understanding of these dual pandemics.

As you will see in COP guidance this year, changes in program direction will vary depending on where countries are in reaching epidemic control and the continued COVID-19 mitigation efforts each team is supporting. While assessing possible shortfalls in programming arising from COVID-19, overarching challenges still exist.

Specifically, more focus and attention should be given to the following key challenges in South Africa:

- The policy environment, which has included slow adoption and implementation of key fundamental policies, starting with the ongoing failure to fully implement "test and start," but also including critical areas such as the slow transition to superior ARV regimens such as TLD for adults and DTG for children, moving to universal multi-month dispensing (MMD), routine viral load services for PLHIV, etc.
- Ongoing gaps in the clinical cascade that threaten the possibility of attaining epidemic control. This is most notable across the second 95, where there was again a sizable shortfall of performance relative to treatment scale-up targets.
- Underperformance and slow rebound in VMMC and other components of prevention efforts, even if in part due to COVID-associated interruptions.
- Lagging performance in services for children and adolescents living with HIV (C/ALHIV).

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 alone, but flow directly from the partner country government's commitment to the UNAIDS and SDG 3 goals.

The PEPFAR COP 22 notional budget for South Africa is **$455,753,517,** inclusive of all new funding accounts and applied pipeline. This amount includes $5,753,517 in applied pipeline carried over from COP 21 to complete the South Africa National HIV Prevalence, Incidence, Behavior and Communication Survey (SABSSM VI). 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 South Africa and civil society of South Africa, believes is critical for the country's progress towards controlling the HIV epidemic 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 PEPFAR Chairs and PEPFAR Program Managers (PPMs), working closely with our CAST teams, will review this planning letter and the 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/ROP 22 planning and approval process. Once again, thank you for your continued leadership and engagement during the COP/ROP 22 process.

Sincerely,

Angeli Achrekar

Attachment: **COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction Summary**
CC: **S/GAC – Jirair Ratevosian, Matt Wollmers, Suzanne Jed**

Overview: COP 2022 PEPFAR Planned Allocation and Strategic Direction

With input from the field team through the quarterly monitoring POARTs, as well as Headquarters Country Accountability and Support Team (CAST) input, a thorough program review of your country program 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:

1. Innovations developed during the past two years continue to drive resilience in keeping PLHIV on ART despite the ongoing impacts of COVID-19 and other challenges. Lessons from Menstar implementation, and findings from CLM, including adoption of patient-centered and community-led interventions, demonstrate what is possible to further accelerate efforts to close remaining treatment and virologic suppression gaps.

2. Improvements across the prevention portfolio, most notably in accelerating the delivery of PrEP to those at highest risk of infection, including key populations such as men who have sex with men (MSM), female sex workers (FSW), and adolescent girls and young women (AGYW); continued strong achievement in serving orphans and vulnerable children (OVC).

3. Strategically leveraging the PEPFAR service delivery platform and a whole of government approach to respond swiftly to COVID-19, which led to expanded testing, public health communications, and vaccinations. The implementation of Small (Community) Grants Program further enhanced these efforts.

Challenges:

1. Effective prevention and treatment services are stalled given policies and procedures are not fully implemented at the site level. As these policies are globally recognized and implemented as best practice for HIV programs, full and effective utilization of all resources cannot be realized until global policies are adapted and implemented.

2. Underperformance across the clinical cascade has contributed to the overall FY 2021 TX_CURR achievement falling approximately 1 million short of the COP 2020 target. While there was modest net new growth during 2021, it still came at a significantly slower pace than what is needed to meet 95-95-95 targets, and the number of PLHIV learning of their positive status (450,400) and being initiated on treatment (415,708) fell compared to 2020, by 22% and 18%, respectively. This continues to be a challenge, even prior to COVID-19.

3. Program areas that were most acutely affected by the onset of COVID-19 due to wholesale pauses in demand creation and elective procedures, such as VMMC, have yet to make up the amount of ground necessary to get back on track. Although multiple COVID waves impacted performance, just 52% of the annual VMMC target was hit in 2021, suggesting novel approaches and alternate service delivery modalities are warranted to drive impact. Slow uptake of PrEP among PWID, prisoners and TG also warrant concern and attention.

4. Although some gains have been made in pediatric engagement during the past year, other elements have continued to stall, and there remains room for improvement across the cascade, including in pediatric case finding, linkage, retention, and viral load suppression.

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

1. Since issues in performance across treatment and prevention program areas are directly related to the ongoing policy barriers and "in process" status of so many of the Minimum Program Requirements outlined in Table 9 below, the team should work strategically with government counterparts, civil society, and other stakeholders to redouble efforts to cultivate a more advantageous and cohesive policy environment. This will enable the team and its partners to improve patient outcomes at every level of the clinical cascade, tailor and expand effective age-appropriate prevention programming, and align funding with the growing needs of key populations.

2. To address ongoing gaps in the treatment cascade, the team should work to identify and implement innovative solutions to overcome gaps and barriers to treatment scale-up. That includes the adoption of community-led and private sector strategies that improve the patient experience through facility-based care and out-of-facility care and that cultivate community-based solutions to amplify treatment and prevention literacy, including U=U. Based on evident successes with some elements of recent HRH surges, the team should also apply analytics to improve district support partner HRH planning. Priority attention should be given to unmet ART need in focus districts taking into account age and sex gaps.

3. In order to overcome COVID-19 programming interruptions in VMMC and related prevention efforts, expand engagement and collaboration with other technical program areas across the comprehensive HIV program and improve demand generation activities. Across the prevention portfolio, target resources to the greatest need.

4. Mitigate vulnerabilities for children living with and affected by HIV/AIDS by, e.g., strengthening multisectoral collaboration, developing a new comprehensive case management G2G agreement with DSD, and generally expanding testing options for youth and improving pediatric support and services. This strategy should include a comprehensive review of charts of C/ALHIV on treatment, ensuring first that all virally unsuppressed CLHIV are prioritized for OVC enrollment and are then monitored and supported for transition to optimal regimens.

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 for South Africa 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	$ 426,358,660	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 426,358,660
GHP-State	$ 376,908,660	$ -	$ -		$ -	$ -	$ -		$ 376,908,660
GHP-USAID	$ 46,000,000				$ -				$ 46,000,000
GAP	$ 3,450,000				$ -				$ 3,450,000
Total Applied Pipeline	$ -	$ -	$ -	$ 29,394,857	$ -	$ -	$ -	$ -	$ 29,394,857
HHS/CDC				$ 27,936,226				$ -	$ 27,936,226
PC				$ 1,458,631				$ -	$ 1,458,631
TOTAL FUNDING	$ 426,358,660	$ -	$ -	$ 29,394,857	$ -	$ -	$ -	$ -	$ 455,753,517

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

PEPFAR South Africa should plan for the full Care and Treatment (C&T) level of $241,010,400 and the full Orphans and Vulnerable Children (OVC) level of $86,597,600 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	$ 241,010,400	$ -	$ -	$ 241,010,400
OVC	$ 86,597,600	$ -	$ -	$ 86,597,600
GBV	$ 14,215,400	$ -	$ -	$ 14,215,400
Water	$ 3,208,000	$ -	$ -	$ 3,208,000

**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	$ 455,753,717	$ -	$ 455,753,717
Core Program	$ 320,517,815	$ -	$ 320,517,815
DREAMS	$ 80,493,697	$ -	$ 80,493,697
OVC (Non-DREAMS)	$ 18,292,205	$ -	$ 18,292,205
VMMC	$ 36,450,000	$ -	$ 36,450,000

TABLE 4: Programmatic Controls: Programmatic controls are used to evaluate 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.

	Bilateral	Central	TOTAL
Total Funding	$ 21,102,829	$ -	$ 21,102,829
PrEP (AGYW)	$ 19,528,929	$ -	$ 19,528,929
PrEP (KPs)	$ 1,573,900	$ -	$ 1,573,900

TABLE 5: State ICASS Funding

	Appropriation Year
	FY22
ICASS	$ 412,313

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

SECTION 3: PAST PERFORMANCE – COP 2020 Review

TABLE 6. COP OU Level FY 21 Program Results (COP 20) against FY 22 Targets (COP 21)

Indicator	FY 21 result (COP 20)	FY 22 target (COP 21)
TX Current <15	**91,491**	**151,499**
TX Current >15	**3,944,021**	**4,855,418**
VMMC >15	**165,296**	**315,008**
DREAMS (AGYW PREV)	**937,183**	**504,647**
Cervical Cancer Screening	**N/A**	**N/A**
TB Preventive Therapy	**330,472**	**696,296**

TABLE 7. COP 2020 | FY 2021 Agency-Level Outlays versus Approved Budget

OU/Agency	Sum of Approved COP 2020 Planning Level	Sum of Total FY 2021 Outlays	Sum of Over/Under Outlays
HHS/CDC	$309,267,596	$295,515,023	$13,752,573
PC	$3,109,891	$844,426	$2,265,465
State	$6,438,016	$4,241,096	$2,196,920
USAID	$293,206,942	$299,510,691	-$6,303,749
Grand Total	**$612,022,445**	**$600,111,236**	**$11,911,209**

TABLE 8. COP 2020 | FY 2021 Results & Expenditures

Agency	Indicator	FY 21 Target	FY 21 Result	% Achievement	Program Classification	FY 21 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	3,978,634	**6.437,637**	162%	HTS	$11,111,943	86%
	HTS__POS	248,925	**229,817**	92%			
	TX_NEW	246,833	**206,605**	84%	C&T	$139,685,328	90%
	TX_CURR	2,430,922	**1,948,787**	80%			
	VMMC_CIRC	315,031	**164,995**	52%	PREV/VMMC	$31.057,357	98%
USAID	HTS_TST	5,409,520	**6,046,669**	112%	HTS	$3,123,980	100%
	HTS_POS	300,557	**216,511**	72%			
	TX_NEW	303,708	**207,057**	68%	C&T	$154,890,071	90%
	TX_CURR	2,575,433	**2,091,739**	81%			
	OVC_SERV	679,002	**646,174**	95%	OVC	$32,922,926	86%
					Above Site Programs	$27,078,161	
					Program Management	$80,338,431	

SECTION 4: COP 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 (MPRs)
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 the 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 COP 2022 planning meetings 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 COP 2022 planning meetings, the PEPFAR South Africa 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 FY 2023. The list will be included in the Strategic Direction Summary (SDS) as well.

Failure to meet any of these requirements by the beginning of FY 2023 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**: **In-process** **Issues or Barriers**: • Direct community linkage still poses a challenge as some community testing partners do not initiate treatment within the community. • Although improving, linkage of the younger population continues to be sub-optimal for multiple reasons.
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**: **In-process** For adults and children ≥30kg, TLD transition is ongoing. For children ≥4weeks of age, will extend into FY23 for transition to DTG based regimens / removal of **all** EFV based ART regimens is expected to remain challenging. **Issues or Barriers**: • South Africa is expecting to get pediatric DTG approval by end of FY22 Q2. It goes onto tender in July 2022, transitioning of treatment will take up to 6 to 12 months • EFV-based regimens are still being used for TB/HIV coinfected clients as well as diabetic clients on high dose Metformin. (SA National ART guidelines 2019) • NVP-based regimen is used to initiate CLHIV <4 weeks of age (SA National ART guidelines 2019)

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: In-process

The new Central Chronic Medicines Dispensing and Distribution (CCMDD) tender for decanting will come into effect at the beginning of FY22Q3. This will see an introduction of more 90 count packs and optimization of 3 months multi-month dispensing.

Issues or Barriers:

- Government of South Africa continues to delay the 6 months multi-month dispensing (MMD) pilot and has suspended all 6MMD discussions until further notice. Two/three (MMD) remain the standard NDoH policy as per the National Adherence Strategy (contingent on stock availability in the district)
- The 12 month-scripting policy expired at the end of FY21Q4. The South African government has not held further discussions about renewing it or making the policy permanent.
- The provision of 3-month multi-month dispensing (MMD) is not uniform across the country and some provinces have suspended it.

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: **In-process** (Target date September 2022).

Overall TPT completion rate in FY21 was 66% which was a 3% improvement from that of FY20. We now have a shorter course of a weekly rifapentine and isoniazid (3HP) therapy taken over three months, which has the potential to improve completion rates.

Issues or Barriers:

- The number of isoniazid preventive treatment (IPT) initiations have increased substantially over time; however, completion rates remain very low due to the longer duration of IPT.
- The COVID-19 pandemic resulted in devastating effects on TPT provision, including reversal of a positive trend observed from FY19 to FY21.
- Reaching all eligible ART patients who are new and already on ART requires intensified efforts to identify and overcome barriers to TB screening, TPT initiation and completion of treatment.

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: **In-process** (September 2022).

The Diagnostic Network Optimization for VL/EID, TB and other coinfections has been completed; there is currently sufficient lab capacity for testing, and specimen transportation routes and results

delivery mechanisms have been optimized.

Issues or Barriers:

- COVID-19 again resulted in limited patient mobility to access health services. Furthermore, facility closures and staff absenteeism, and gaps remain in reaching the required VL coverage rates at facility level.
- Capturing of VL results onto Tier.Net and DHIS remains a challenge with lack of interoperability with the NHLS Laboratory Information System.

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: In-process (target date: December 2022)

   Issues or Barriers:

   - LIVES training and IPV/Adverse Events protocols not up-to-date at all facilities offering Index Testing.
   - Not all districts/provinces are accepting of offering HIV Self-Screening as a secondary distribution option.
   - Focus on case-finding in certain age and sex groups need to be optimized further to reach children, adolescents, and men that do not know their status or know their status and are not yet on treatment.

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: In-process (target date: September 2022)

   Issues or Barriers:

   - Continued stigma and misunderstanding among communities and high-risk populations surrounding risk behaviors, and PrEP as a prevention technology and its effectiveness.
   - Access to, and resources for, post-violence care services at public health facilities using the decentralized approach remains limited.
   - Understanding of, demand creation for, and active linkage to comprehensive sexual and reproductive health services for AGYW and men remains limited and unintegrated.

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: In-process

Issues or Barriers:

- COVID-19 restrictions impacted program implementation:
  - Limited referral completion for HIV testing, treatment initiation and VL testing
  - Relocation of beneficiaries as a result of hard restrictions and reduced employment opportunities
  - Group-based interventions for 10-14 year old girls and boys had limited implementation during FY21 and impacted target achievement

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 (2023)

   Issues or Barriers:

   Considerable attention has been paid by South Africa's National Department of Health and Civil Society and the PLHIV sector to improve quality of HIV services for all clients, as well as reducing stigma and discrimination for vulnerable groups. Continued mentorship and training is needed for health care providers at all levels to ensure that HIV care is provided equitably throughout the country.

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: completed

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: In-process (2023)

    Issues or Barriers: Siyenza in South Africa is being implemented at 417 facilities as of the end of FY22Q1. PEPFAR South Africa has transitioned to a hybrid model of support including virtual and in-person site-visits involving from PEPFAR, DSPs, and DoH. Focal areas for site-level improvement include streamlining decanting/CCMDD enrollment, differentiated ART service delivery use of external pick-up points and community ART, and community HTS and HIV self-screening, as well as ensuring that adequate social distancing measures are in place and PPE is widely available for all staff. In addition, PEPFAR SA has supported NDoH's COVID-19 vaccination efforts at public health facilities and within communities.

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: In-process** (2023) **Issues or Barriers:** GoSA, with support from PEPFAR South Africa, has implemented several campaigns to improve treatment and viral load literacy including 1) the MINA brand to promote treatment adherence & U=U among men; 2) the Dablapmeds brand to promote differentiated models of care; 3) The Zenzele campaign to promote treatment literacy; 4) the eLab platform to provide viral load counseling and results; 5) a pediatric surge targeting children and their caregivers; and 6) plans are underway to expand The New Status as the new messaging approach to promote U=U in SA. All PEPFAR-supported partners and provinces are implementing these campaigns in COP21 to improve ART retention, viral load suppression, and treatment adherence.
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:** In-process **Issues or Barriers:** PEPFAR SA continues to expand support directly to key population led organizations including the Sex Workers Education and Advocacy Taskforce (SWEAT), Sisonke, OUT Wellbeing (one of the oldest MSM-led organizations in South Africa, and the South African Network of People who Use Drugs (SANUPD). The program continues to exceed the target of 70% of PEPFAR funding be awarded to local, indigenous partners. In COP 21, PEPFAR SA was at 82%, which is an increase from 79% in COP20. PEPFAR South Africa adheres to COP guidance recommending that the majority of prime partners are local/indigenous (86 of 106).
14. Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended. **Status:** in-process (2024) **Issues or Barriers:** There is clear commitment by the GoSA to increase budgetary support for the HIV response, although COVID has resulted in some budget cuts, including reductions in DOH staffing. PEPFAR SA should continue to collaborate with GoSA to identify additional domestic resources and efficiencies in HIV spending to maximize HIV-related health outcomes at the national-, provincial-, and district-levels and support sustainable, host government-led initiatives to maintain progress in the HIV and COVID epidemics.
15. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. **Status:** in-process (2024) **Issues or Barriers:** South Africa's national morbidity and mortality reporting system is supported by a range of data sources and institutions, including the District Health Information System, Birth and Death Registries, Census and cause- specific data reporting systems. PEPFAR SA should continue supporting expansion of effective national HIV patient-level data reporting systems that allow for real-time analysis and monitoring for program improvement.
16. Scale-up of case surveillance and unique identifiers for patients across all sites. **Status:** In-process (2023) **Issues or Barriers:** HPRS is deployed in 3,159 health facilities, which represents 83.1% of

NDOH-supported health facilities and is an increase from 82% last year. As of November 2020, 45.3 million individuals have been registered, which represents 78.1% of the total population of South Africa and is an increase from 77.5% last year. Case surveillance in South Africa has been implemented in four districts in KwaZulu-Natal in COP21. Currently an algorithm is being used to link electronic medical records to lab results and to prevent duplication in over 50 facilities with over 72,000 patient records of PLHIV, and this will increase in the next fiscal year to include over 1,000 facilities in all districts of KwaZulu-Natal and Gauteng Provinces.

In addition to meeting the MPRs outlined above, it is expected that PEPFAR South Africa will consider all of 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

PEPFAR-South Africa-Specific Directives
HIV Clinical Services
1. Challenge previous assumptions and consider novel approaches to improve performance across the clinical cascade, particularly across all aspects of continuity of treatment/the second 95, across age/sex disaggregates, and across geographies, to include a review that starts with the national gap between the estimated number of PLHIV (8 million) and those on ART (5.5 million).
2. Triangulate findings from HSRC survey, in real time, with key programmatic data and other sources to gain deeper understanding of PLHIV and treatment cohorts (e.g., how many PLHIV are not currently on treatment, how many have previously been on treatment but are not currently, how many are aware of their status but never on ART, etc., and help design client-centered, evidence-based approaches that can accelerate filling of clinical cascade gaps).
3. Through further implementation of best lab, EID, etc. practices, work to improve VLS and VLC across adult and pediatric populations. Improving viral load coverage should be a multi-pronged approach including increasing demand, improving harmonization of clinical appointments, med pickups and blood collection, and community-based VL sample collection, where feasible—especially in the setting of COVID restrictions.
4. South Africa has a Tx_New Gap in all age groups, and should therefore intensify efforts to test all eligible and high-risk patients visiting facilities, offer index testing to all newly identified PLHIV, and test their contacts and link those testing positive to ART. In all PEPFAR-supported districts, 80% of those eligible should be decanted by the end of FY22 Q4. The work to ensure universal access to a minimum of 3 MMD should continue, including increasing demand.
5. Integrate HRH data into annual planning exercises, especially in light of the strong correlation between HRH personnel and TX_Curr achievements. Conduct an across geographies review and develop a plan that focuses on right-sizing HRH personnel in order to maximize efficiency and cost-effectiveness in the current resource-constrained environment. Additionally/more specifically, in preparation for COP 22: • Perform a MER performance analysis to identify districts that are lagging behind on performance targets and adjust HRH staffing allocation and effective staffing models based on HRID and NDOH staffing data, ensuring complementary staffing to encourage joint

ownership of the HIV program by IPs and DOH. This should be developed using an evidence-base workforce planning methodology or tool.

- Conduct staffing compensation analysis to assess alignment of DSP clinical and ancillary staff with government pay scales and identify where adjustments may be required to guide future transition.
- Increase technical assistance to subnational leadership on HRH planning, management functions, performance management tools to monitor staff performance and M&E best practices (including financing and budget execution for HRH), to build capacity to sustain future HRH transition efforts.

6. Improve TB detection and timely treatment by supporting DSP implementation of the NDOH TUTT strategy in PEPFAR-supported districts. DSPs should improve TB case finding performance among all ART patients by improving symptom screening and coordinating with NDOH plans to add XPert and CXR to their TB screening algorithm. Additional diagnostics such as TB LAM should also be more fully utilized. In order to reach full TPT Coverage in COP 22, partners should identify at site level PLHIV who remain eligible for TPT and take action to close the 49% TPT completion gap in the country. Further, IPs should ensure availability of mWRD testing at site level and aggressively implement the national policy on using mWRD (GeneXpert, Truenat) as the prefered TB diagnostic test for PLHIV.

7. To address ongoing 1st 95 gaps, continue to scale-up index testing at the appropriate scale and with fidelity, by offering index testing services to all newly diagnosed individuals and ART clients with an unsuppressed viral load. Secondary distribution of HIV self-test kits (to caregivers to screen HIV-exposed children and to index clients to take home to their sex partner) is another strategy that can help improve the number of contacts that are tested within index testing programs.

PEPFAR/SA should work with implementing partners to ensure all sites meet the minimum standards for safe and ethical index testing and put remediation plans in place with clear timelines at all sites and for personnel not meeting these standards.

Recency will also be a critical component of the national testing and treatment strategy that is used to identify and investigate potential transmission hotspots and use results of investigation to address programmatic gaps. Recency implementation should move forward as quickly as possible, with the following components: a recency surveillance dashboard, implementation of CQI on recency including but not limited to site monitoring, proficiency testing, etc.; and development of a data use and public health response strategy. As recency is scaled, the team should share and communicate study progress, findings, and lessons learned with in-country stakeholders including MOH to gain support and promote in-country buy-in.

HIV Prevention Services

1. PrEP: In COP 2022, PrEP should continue to be significantly scaled up with a focus on ensuring policy and programmatic access to PrEP for higher incidence populations. Populations prioritized for PrEP should be tailored to South Africa's epidemic context with a focus on 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 other identified higher-incidence populations.

2. DREAMS: With the expansion of DREAMS programming in COP 20, no later than COP 22, the team should conduct a comprehensive review of the DREAMS program to assess successes and

challenges and better align programming by selecting the most successful interventions moving forward. If not already underway, a deep dive saturation analysis is also warranted.

A variety of strategies for DREAMS should be further adopted and implemented for the remainder of COP 21 and in COP 22:

- Improved alignment of DREAMS program across all IPs would strengthen program. Multisector collaboration should also be increased.
- Further enhance ES activities to link beneficiaries to job readiness, income-generating, and employment opportunities, including in the health care field.
- Continue to expand post-violence care services in health care facilities and through community-based services. In addition there is a need for expanded violence prevention in DREAMS and with males and communities

3. PMTCT: PMTCT should be strengthened through a variety of strategies. In COP 22, South Africa should optimize client tracking of positive infants and implement case management support. Another effective strategy to support HEI linkage is point of care testing (POCT) for early infant diagnosis (EID), which has been shown to significantly reduce turnaround times and increase rates of ART initiation. To avert incident infections, PEPFAR South Africa should focus on implementing PrEP for PBFW at the facility and community level by establishing PrEP targets for PBFW of all ages. Consideration also be given to integrating PrEP into ANC services.

4. VMMC: To improve VMMC performance, the team should expand engagement and collaboration with other technical program areas across the comprehensive HIV program and enhance demand generation activities. Any use of private practice providers for VMMC services must be accompanied by robust monitoring of compliance with all training, safety, and data quality standards. The team should also continue quality improvement efforts in collaboration with NDOH to include support for external quality assessments and the necessary safety improvements prompted by findings.

5. Closing the gaps in PEPFAR-supported countries with highest Pediatric/PMTCT needs:
Despite our successes, significant challenges remain to eliminate vertical transmission of HIV and close the treatment gap for children and adolescents. Seven PEPFAR-supported countries have the largest gaps per UNAIDS 2020 estimates triangulated with PEPFAR data/footprint: Nigeria, Mozambique, Zambia, South Africa, Tanzania, Uganda, and DRC. COP 22 submissions for these focus countries must clearly describe existing gaps (including those related to service delivery and socioeconomic needs) and how their respective OU will program to achieve specific goals/targets that will address these gaps. Budgetary specificity for each of these beneficiary groups should be provided in the FAST. Pediatric and PMTCT human resources should be allocated, as needed, to reach goals/targets. Throughout the year these countries will be expected to have dedicated, regular, review meetings to monitor and evaluate progress and take corrective action if necessary through the POART process. Reviews should also include detailed expenditure analysis to ensure appropriate resources are directed to closing PMTCT/Pediatric gaps.

Other Cross-Cutting Program Area, Government Policy, Systems, or Programming Changes Needed

1. HIV-related stigma and discrimination: South Africa has been selected to participate in the focal countries collaboration, an effort among the Global Fund, UNAIDS, and PEPFAR to measurably reduce stigma and discrimination through increased coordination, collaboration, and planning with communities, governments, and national partners over a 3-5 year period. The focal countries collaboration will help advance efforts toward meeting the 10-10-10 societal enabler targets and

PEPFAR's minimum program requirement #9, and will build upon existing initiatives, activities, and coordinating mechanisms. As an initial step, PEPFAR teams are asked to work with partners to convene a meeting during the strategic planning meeting window (January 24 – February 11) to take stock of key opportunities to advance national efforts to address HIV-related stigma and discrimination, including, as applicable, national strategic plans, settings prioritized under the Global Partnership For Action to Eliminate All Forms of HIV-Related Stigma and Discrimination, new evidence provided by the PLHIV Stigma Index 2.0 and GF Breaking Down Barriers mid-term assessments. It is expected that such stock-taking will inform coordinated action in funding and implementing comprehensive programmatic strategies to reduce stigma and discrimination at scale and promote partner government and community leadership at the country level.

2. Addressing structural barriers to KP service delivery: COP 2022 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, AF), 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 22 planning meetings.

Additionally, in South Africa, since BBS studies are only conducted in several urban centers, Small Area Estimates (SAE) are needed for subnational geographies where the study was not implemented and to calculate national estimates. A workshop with key stakeholders would be useful to triangulate existing data and arrive at a consensus on the most up-to-date estimates. Finally, rolling out individual level information systems and conducting data analysis for key populations across RSA is a valuable tool for continuous quality improvement and tailoring of the program to the needs of subpopulations. Analysis of these data sets will determine age and sub-populations at highest risk of infection or experiencing an IIT to inform the response and allow for constant course correction during the COP year.

National PrEP guidelines should be updated to align with existing and forthcoming WHO guidelines to simplify PrEP service delivery, including minimize testing requirements, encourage the implementation of ED-PrEP for all cisgender men and TG not on gender-affirming hormones, allow for self-testing, decentralize PrEP and promote community delivery of PrEP. Finally, explore the feasibility and program readiness for potential new PrEP modalities, including long-acting.

3. C/ALHIV and OVC: Minimum requirements for OVC programs include actively facilitating testing for all children at risk of HIV infection, and linkage to treatment and providing support and case management for vulnerable C/ALHIV.

It is important to also consider the total estimated coverage of OVC programs compared to the number of C/ALHIV current on treatment across the OU and supported by PEPFAR. For South Africa, this is estimated at 112% for TX_CURR <15 and 59% for TX_CURR <20. As part of COP22 planning, the South Africa OVC programs should conduct analyses to understand how well the OVC

program is geographically aligned with clinical programs/sites. If South Africa does not already have a consensus definition for high-volume pediatric sites, the team should reach out to their SI and PEDS, OVC liaisons for further guidance and support. Pending the results of these analyses, and key factors such as A/CLHIV population dispersion, shifts in geographic placement and target allocation for OVC partners may be necessary. VLS remains unchanged and is suboptimal for CLHIV, especially 1-4 yos (69%) and ALHIV (10-19 years) (81%). District Support Partners should undergo an exercise to review all charts of C/ALHIV on treatment and actively transition to optimal regimens, ensuring that all virally unsuppressed CLHIV are prioritized for OVC enrollment to monitor and support the transition to optimal regimens. Intensified Monitoring and accountability are needed to ensure ALHIV are included in the TLD transition. Enhanced coordination with SAPHRA to facilitate rapid approval of pediatric DTG 10mg dispersible tablets, monitoring IIT by fine age band to target intensified case management resources for C/ALHIV at high risk, and targeted interventions to improve low VLC rates in children <5 yo are needed. To close the treatment gap for C/ALHIV, the team must intensify their case finding efforts through an optimal mix of testing modalities, most importantly scaling family index testing, policy advocacy for caregiver-assisted HIV self-tests, and ensuring HIV testing services and directly-assisted HIV self-tests are conducted in community based care centers.
4. Community Grants: Scale the Ambassador's Community Grants Program to increase support for CSO-led monitoring in the HIV response and ensure oversight, management, and administration of all state PEPFAR grants to community organizations.
5. PCO office: Support PCO office to provide high-level coordination and representation on behalf of the US Embassy in South Africa; provide decisions, guidance, and activities that align with One Mission of PEPFAR and USG.
6. Scale CLM and implement findings: Sufficiently resource CLM to scale and put into action community-led solutions to further address programmatic gaps and policies across the HIV program. Implementation should occur in real time when feasible.
7. Financial Sustainability, Innovative Financing, and All-Market Approaches: As South Africa continues to advance implementation of NHI, it is critical to support the mobilization of additional domestic resources and client-centered service models to support near and longer-term sustainable HIV programs to achieve and maintain epidemic control. This includes the exploration of novel cost-effective and integrated service delivery models that successfully demonstrate the use of communication technologies, telehealth, virtual training platforms, and private or social health indemnity/risk pool strategies to reduce costs, improve case-finding, and expand access to services. It also includes strengthening data-sharing practices and enhancing patient management systems.

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 are to be invited to participate in the virtual COP 22 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.

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 COP 2022 should build on prior activities in COP 2021 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 COP 2022, PEPFAR-supported community-led monitoring programs must include an explicit focus on key populations. CLM should be used 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: PEPFAR-South Africa's COP 2021 minimum requirement for the Care and Treatment earmark is reflected in Table 2. If there is no adjustment to the COP 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): PEPFAR-South Africa's COP 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.

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 AB/Y programming, and the denominator approximates all sexual prevention activities. The proportion of 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): PEPFAR-South Africa's COP 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 2022 earmark is derived by using the final COP 2021 GBV earmark allocation as a baseline. The COP 2022 planned level of new FY 2022 funds for GBV can be above this amount; however, it cannot fall below it.

Water: PEPFAR-South Africa's COP 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 2021 earmark is derived by using the final COP 2021 water earmark allocation as a baseline. The COP 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 participating 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 in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. If an agency/OU combination has a history of over-outlays, or in cases where an agency/OU COP envelope has increased in recent years, there may not be sufficient funding to maintain 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 COP 19 Guidance, PEPFAR set a goal that 40% of partners must be local by the end of FY 19, and 70% by the end of FY 20. While considerable progress was made in this effort, the 70% mark was not achieved by all agencies in all OUs, and thus in FY 22 and FY 23, 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 FY 23 as appropriate through their COP/ROP 2022 submission.