
7.0 COP PLANNING STEPS

As referenced in Sections 1-3, PEPFAR programs are expected to use key data sources – including MER, financials, SID, responsibility matrix, resource alignment, above site activities, and program quality as measured within SIMS – to assess the quality, impact and efficiency of the current program, and to align resources to further the prevention interventions, ARV coverage, and viral suppression for all age groups to reach and sustain epidemic control.

Section 7 is designed to demonstrate a clear link among analysis, planning, and operationalizing of the COP through each U.S. implementing agency and its respective implementing partners. To strengthen the PEPFAR implementing agencies' transparency, monitoring, and use of financial data, together we are establishing clear linkages between COP planning budgets and targets with implementing partner budget execution and results. We also need to be able to link the above site-level technical assistance support cost, direct service delivery and site-level technical assistance costs to quality service delivery costs to understand the full investment and to allow a transparent dialogue with governments as the country reaches and maintains epidemic control through focused prevention and sustaining viral load suppression. We will need to continually refine and evolve interventions to address the needs of specific populations to each reach 95-95-95 (critical to ensuring focused prevention interventions with the first 95) and ensuring a laser focus on retention of all clients across age and gender to ensure everyone remains virally suppressed for their health and the health of the community. A clear focus on the primary measurement of sustaining current on treatment and continuous surveillance by site of net new demonstrating high programmatic retention and the critical outcome of VLS. We also need to ensure programmatic prevention and treatment activities and funding clear links with targets and outcomes for impact. This not only ensures that the U.S. taxpayer dollars are impactful but also is also providing an early warning signal of fraud, waste and abuse. The expectation that clear outcomes of all prevention programming will also be measured and noting that “reaching” an individual without a directly linked prevention or treatment services is a measure of program failure, not success.

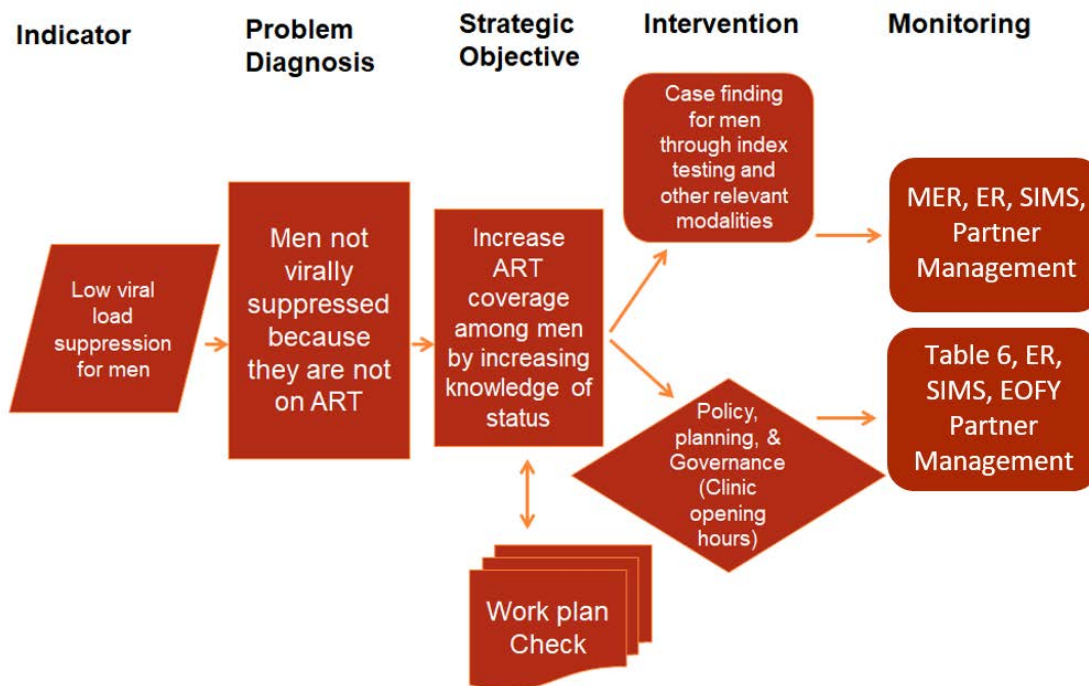
We thought it might be helpful to walk through an analysis example to determine if PEPFAR investments are in the right places for impact. A framework for these planning discussions is presented below, using the example of increasing ART coverage for men to increase viral load

suppression (illustrated in Figure 7.0.1). This is meant as just one illustration of the process of analysis for the teams to pursue.

- **Problem Statement/Indicator:** In country xx, through our quarterly monitoring and triangulation with PHIA data, we identify that men have low viral load suppression (VLS), due to low ART uptake, which is in turn, in this scenario, is due to low knowledge of HIV status. Thus, for epidemic impact, clinical services for men need to be scaled to 90% VLS directly through the first 90.
- **Problem Diagnosis:** First, all site level data was reviewed to determine if any site, district or partner had increased early HIV diagnosis in men leading to treatment linkage and VLS. If so, these sites were visited, and discussions were held with partners and site health staff and peer navigators to understand what was happening and how this could be brought to scale. If there aren't clear examples of excellence then it is key to determine why men are not being tested, linked and virally suppressed. For example, conducting focus group interviews, soliciting client feedback, and conducting demonstration projects. Once solutions are identified, tested, validated and ready for scale, the next step would be to ensure that all sites and partners were making these adjustments and the following interventions might be necessary.
- **Intervention:** "Increase VLS among HIV+ men." To achieve this, will new policies be required? When will the MoH adjust policies and distribute circulars? In parallel, agencies will evaluate partner's work plan to ensure the work plans include the new adjustments that are fully costed.
- **Monitoring and Partner Management:** Relevant targets and outcomes were set for the relevant approach(es) to have effective partner management. Ensuring site level TA, expectation of increased performance at the site and the agencies will monitor financial and programmatic performance with the relevant indicators and real time course correction will occur. These discussions will continue through the POART process and other more frequent mechanisms, such as weekly monitoring and partner management in surge scenarios.

This figure shows steps in decision making for interventions to address low viral load suppression for men.

Figure 7.0.1: Example COP planning decision tree



COP20 Guidance uses modular planning steps, similar to those used for COP17-19, for completing the COP20 process. Because this year the majority of the data analysis for COP planning was completed for the end of year agency self-assessments and routine partner management the COP20 planning steps emphasize using the data analysis to refine programming, target setting, and budgeting and to ensure quality partner performance for increased impact.

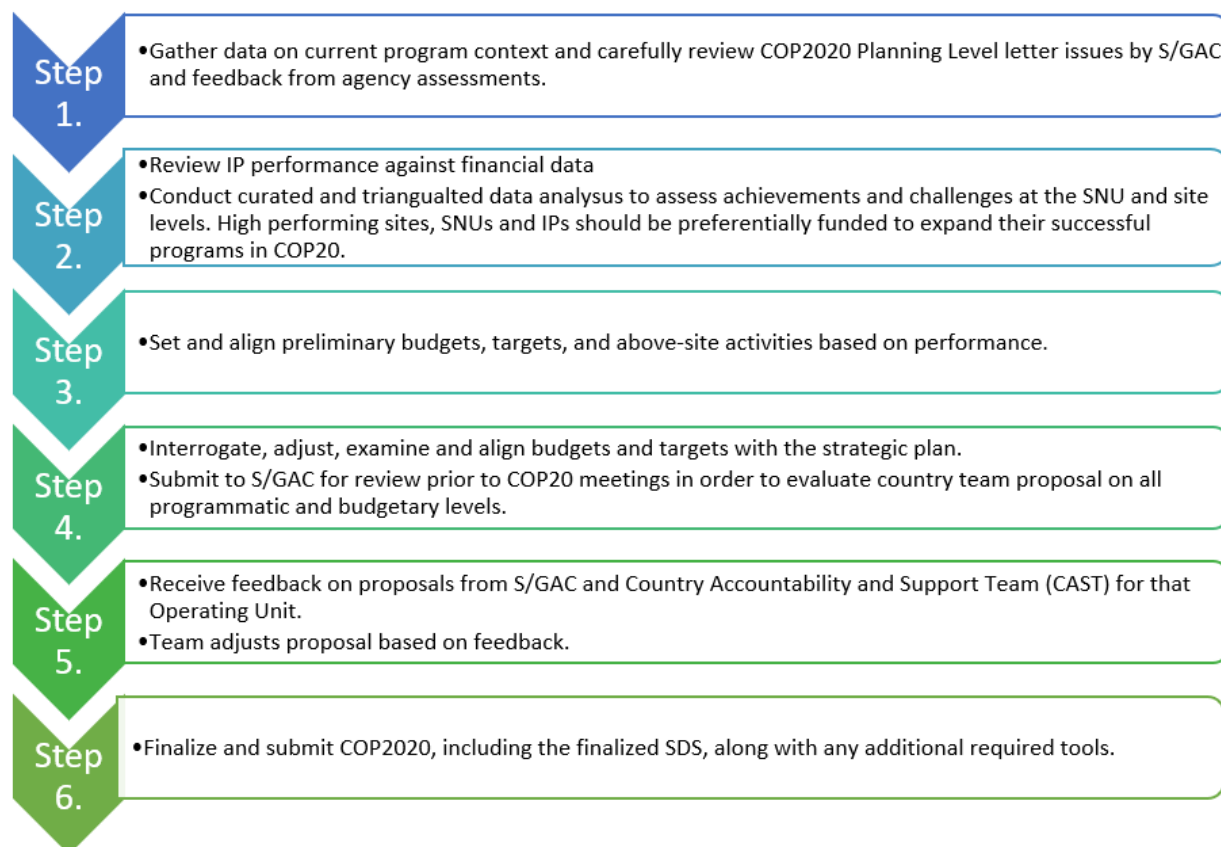
Modular Planning Steps

Successful implementation of the COP process requires the review of key analyses and decision points involving meaningful engagement across technical areas. The analyses to be reviewed for COP20 planning are a continuation of the program and partner performance routinely discussed during the quarterly POART process. This section offers guidance to countries following the process on key steps countries can take to meet planning requirements and draft a technically strong Strategic Direction Summary (SDS). The SDS should be solution focused on what will be different to address specific prevention and treatment programmatic gaps, how the difference will be monitored and how the team will course correct.

The COP20 process utilizes a flexible modular planning approach for further refining the innovative HIV prevention and treatment strategy that needs to be scaled, specific to the country

context, defined in previous COP cycles. The recommended order for these steps is illustrated in Figure 7.0.2 below.

Figure 7.0.2: COP20 process planning steps



This figure shows key steps for OUs (countries or regions) to complete the COP20 planning and submission process

As noted elsewhere in the COP20 guidance, country teams are required to engage civil society and communities inclusive of vulnerable and key populations – discussions must reflect all communities and community generated solutions, host governments, and external partners early and often in the development, implementation, and monitoring of the COP, as doing so will help to ensure a collaborative process as defined by meaningful partner engagement.

7.1 Planning Step 1: Review Data on Current Program Context, Program Performance and Financials

COP20 Planning Step 1 should seamlessly flow from the quarterly POART process, during

which country teams review program and partner performance to assess country progress toward sustainable epidemic control analyzing down to the site levels and up to the district level. These analyses should be focused on who is missing from prevention and treatment and how they will be found and supported to access prevention and treatment services. In turn, these analyses and findings should be tied to effective partner management practices.

Planning discussions for COP20 will begin from this foundation, reviewing how previous COPs were implemented and COP19 is being implemented - in terms of interventions being pursued by each implementing mechanism as well as budget levels allocated to those interventions - as documented in existing contracts, cooperative agreements and work plans. **Sharing this information across the full interagency, where feasible, is imperative to inform robust conversations and analyses to establish COP20 direction and priorities and COP20 district (or other relevant SNU) level work plans.**

Planning Step 1 requires that country teams, with their stakeholders, compile the analyses, decisions, key outcomes, and recommendations from the POART. A proposed structure, with data sources, is as follows (note: this structure is used throughout the planning steps):

- **Understanding the full funding envelope:** Using ODA (Other Donor Assistance) data the team will meet with bilateral donors that are invested in health or women and girls or education to ensure synergies with critical programs to prevent or treat HIV. DREAMS teams should meet with bilateral donors invested in aspects of the DREAMS programming to ensure maximal synergies and this will be a component of the COP discussions in Johannesburg.
- **Understanding the full multilateral investments.** Teams should be able to understand current and future concept note development and joint development of both the GF and COP execution must be demonstrated as all levels for both community and governments.
- **Understanding underlying epidemiology and program performance:** Demographic, epidemiologic data, national/regional program data to the lowest SNU possible, by age and sex (see Figure 3.1.1). Source: PHIA, Biobehavioral Surveys, SABERS, DHS, National/Subnational MER data, MOH Data Alignment, and other sources.
 - Program Performance: Information on achievement of expected results and whether basic quality standards are being met, at the SNU, site, and IM level. Source: MER, SIMS, CQI

- Above Site interventions: Information on the above site barriers to epidemic control, the activities to address them and status of achievement of benchmarks. Source: Table 6 and Above Site Tool for SIMS, POART recommendations and any Corrective Action Steps.
- Planning Level Letters and HQ feedback.
- Financial Performance (budgets, outlays, expenditures): Information on how financial resources are budgeted, outlaid and spent by IM. Source: COP budgets. ER, Outlays/EOFY.
- Planned Interventions: information on the current scope and scale of implementation of specific strategies at the IP level. Source: IP work plans.
- Sustainability: Information on the sustainability of the HIV response at the OU level. Source: SID, and country-specific sustainability framework.
- Donor and Government responsibility: Information on who is responsible for which aspect of the HIV response at the OU level. Source: Responsibility Matrix, Resource Alignment, and other multilateral resources.
- Supply chain (including all commodities): Information on flow and procurement of commodities at the OU level. Source: Commodities budgets and Supply Plan tools.
- HRH: Information on current HRH staffing investments and distribution/alignment across sites, HRH needs, and programming. Source: HRH inventories (if available), ER, IP work plans, MER indicators and National Health Workforce Accounts (where available).
- Surveys, Research and Evaluation: Information on funded surveys, research projects and evaluations. Source: Table 6 and SRE Tool, Evaluation Standards of Practice (ESOP) database.

By the end of Planning Step 1, PEPFAR teams and stakeholders should have a common understanding of:

- The current programmatic context and HIV data and
- The data available to comprehensively:
 - assess program performance and progress,
 - assess financial performance
 - identify programmatic gaps and barriers,

- identify program facilitators
- evaluate achievement toward epidemic control
- multilateral and bilateral investments and how these will be integrated to advance HIV prevention and treatment

7.2 Planning Step 2: Identify Specific Barriers and Program Gaps Based on Curated In-Country Analysis of Data on Performance

COP20 starts with the premise that, after 5 years of interpreting data and focusing on the populations and geographies with the highest burden of HIV, the in country PEPFAR team and all stakeholders understands the path to epidemic control. The focus of COP20, therefore, is on continuing to use the data to refine approaches and ensure quality implementing partner performance.

Each COP cycle teams worked together to identify SNUs for scale-up. Reviewing key epidemiologic and program data is important to understand if course corrections are needed, to determine whether acceleration to program saturation is happening at a faster or slower pace than anticipated. The primary treatment focus must be sustaining clients on treatment at all sites, in saturated districts moving away from all stand-alone testing and moving counselors to CHW supporting retention and scaling effective prevention efforts. All sites with substantial patient losses (identified through treatment current change year to year) should suspend all testing, with exceptions to testing in inpatient wards and TB clinics, until retention is improved. Continuing to add clients to programs that are failing clients cannot continue and these sites must have special attention to improvement. If there are geographically close sites that are doing well and retaining clients, additional investments should be made to high performing sites and encourage clients to move to these sites if logistically possible. To determine which sites fall into this category, country teams should assess which sites are outliers when reviewing them on a bell-curve. Give attention to age and sex bands and subgroups (e.g., key or priority populations) that may lag in reaching epidemic control, and to identify the next set of SNUs for program scale-up, and move resources that are freed up to these opportunities.

Reviewing the most granular disaggregated data is critical as evidence continues to mount regarding age, gender, and other population-related disparities in accessing HIV prevention and treatment

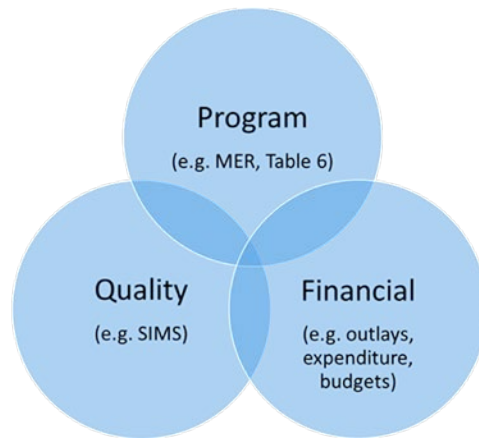
services.²⁰⁸ PEPFAR country teams must continue focusing HIV activities towards the populations with the highest HIV burden and unmet need, and therefore the highest likelihood of transmitting or acquiring HIV. Creating and supporting a health system that is welcoming and client-centered will be key to reaching this population. PEPFAR's contribution to Universal Health Coverage (UHC) is the same as that of the Global Fund. Together, we put the U in UHC – together we are on the forefront of understanding and ensuring universal means universal for all clients no matter risk, poverty, disability, geography age or gender. Health systems that PEPFAR supports must demonstrate that everyone with need in a particular geography has access, is welcomed, is supported and thrives. The community impacted by HIV are at the center of our discussions and programming. There is no U in UHC without retaining clients and this should be the focus of all health systems and above site investments.

Triangulated analysis, including financial data, plays an essential role in accompanying performance monitoring. Country teams must fully understand whether the PEPFAR program in their respective OU is reaching its anticipated impact by reviewing MER target achievements. They must also analyze financial data at the implementing mechanism level to arrive at a more comprehensive view of an IM's overall performance. PEPFAR recognizes the need for a standardized, program-wide approach, as understanding and comparing partner expenditures for the same types of services and interventions allows for correcting inefficiencies and learning from high performers.

As illustrated in Figure 7.2.1, country teams should step back to look holistically at country context and program performance to confirm that the overall PEPFAR program is having the intended impact. Are all parts of the strategic approach leading to epidemic control? Analyses should triangulate program, financial, and quality data to provide a holistic view of programmatic progress and this must be overlaid with the epidemiologic data to ensure impact. Such analyses should begin at the OU level, and then overlay SNU level data from program, quality, and financials, and epidemiology. Then, teams should align future resources by performance.

Figure 7.2.1: Triangulation of data to provide a holistic view of progress (first at the OU level, then at the SNU level)

²⁰⁸ UNAIDS. (2014, September). *The Gap Report*. Retrieved from <http://www.unaids.org/en/resources/campaigns/2014/2014gapreport/gapreport>



Based on the data, teams must identify (1) specific interventions or technical areas where the program is achieving or overachieving intended results (2) specific areas where the program is not achieving the intended results (3) specific interventions or technical areas where the quality of programming needs to improve to ensure delivery of client centered services at the site level; and (4) alignment of future resources based on performance. From this integrated data review, teams should be able to identify gaps and barriers that are hindering progress toward epidemic control.

Based on these analyses and recommendations from S/GAC, through this COP20 planning process, **all country teams are expected to adjust the COP19 activities and Implementing Partner mix and associated budgets accordingly for COP20. Expanding funding and geographic reach of high performing partners and limiting funding to the poorer performers. These changes should be evident in the COP20 plan.**

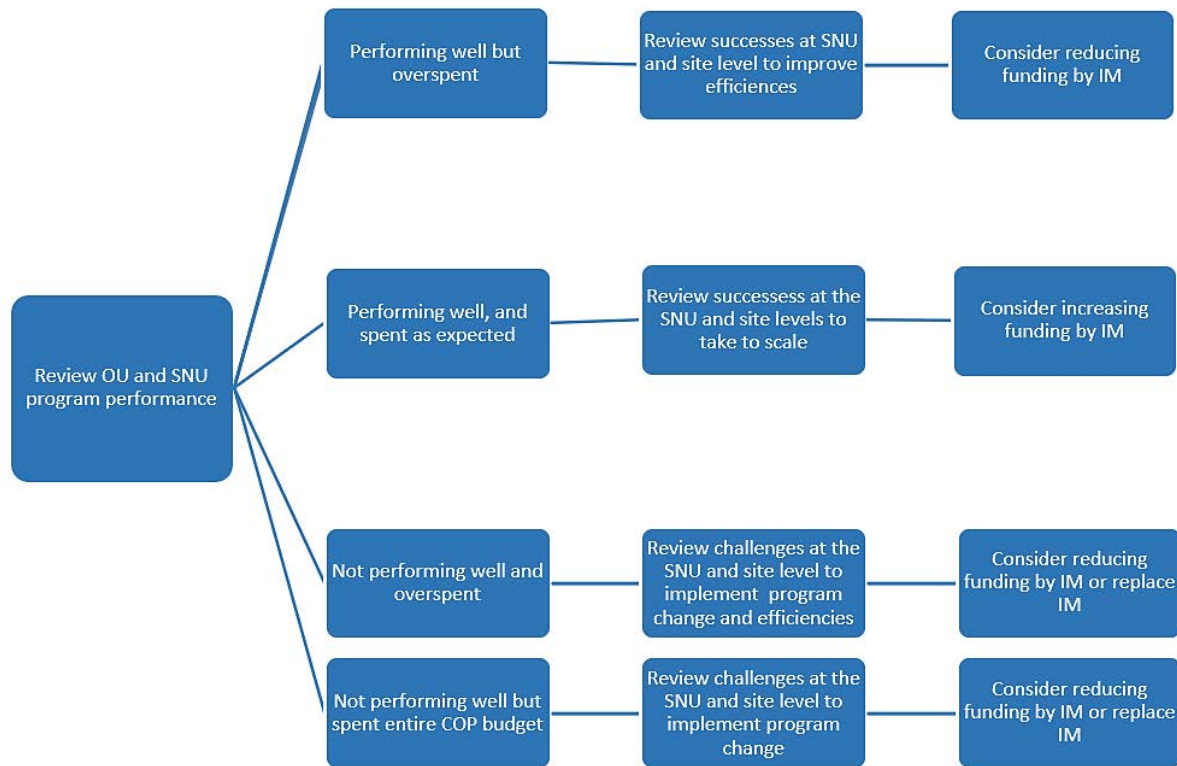
Planning Step 2 builds on Planning Step 1 by:

- Understanding progress toward epidemic control and whether the program is having the intended impact
- Triangulating data and examining investments at both site and above-site levels
- Exploring current investments and programming to understand what needs to change to achieve results at quality and scale
- Ensuring full understanding and focus of all Global Fund resources and all other bilateral and host government funding using Resource Alignment data
- Aligning future programming and investments with performance
- Understanding gaps in programming and potential barriers and facilitators to achieving or reaching sustainable epidemic control at quality at both the site and above-site levels

- Understanding gaps and barriers in developing a patient-centered approach to service delivery at the site level

The overall flow/decision tree to accomplish these goals is shown in the visual below. That is, ultimately, teams should align resources based on performance.

Figure 7.2.2: Overall flow or decision tree of assessing performance by geographic area and IM



The figures below can be used to inform the decision tree above. In Figure 7.2.3, this graph shows TX_NEW target achievement for selected partners in a country example, and then the following graphs show expenditure by program area and the percent of the budget expended in the selected program area. Figure 7.2.4 shows relevant expenditures by TX_NEW achievement at the IM level. These figures, along with the remaining sub-steps below, can be used to inform the partner performance parameter shown in the decision tree above.

Figure 7.2.3: MER and Expenditure reporting data showing expenditures by program area and percent of budget expended

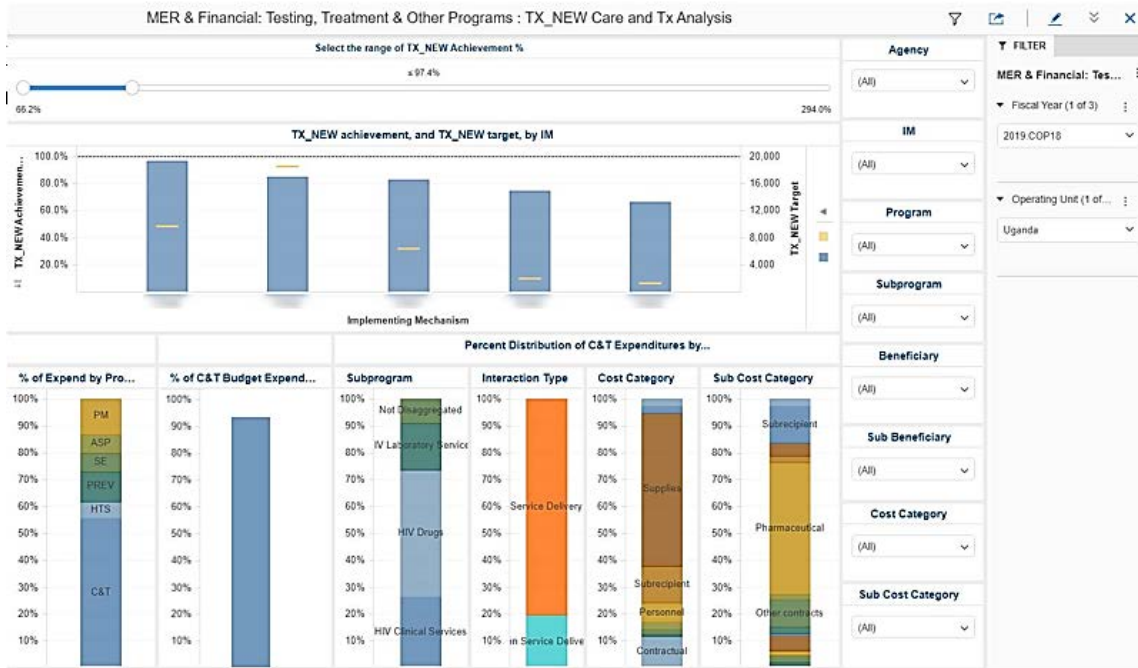
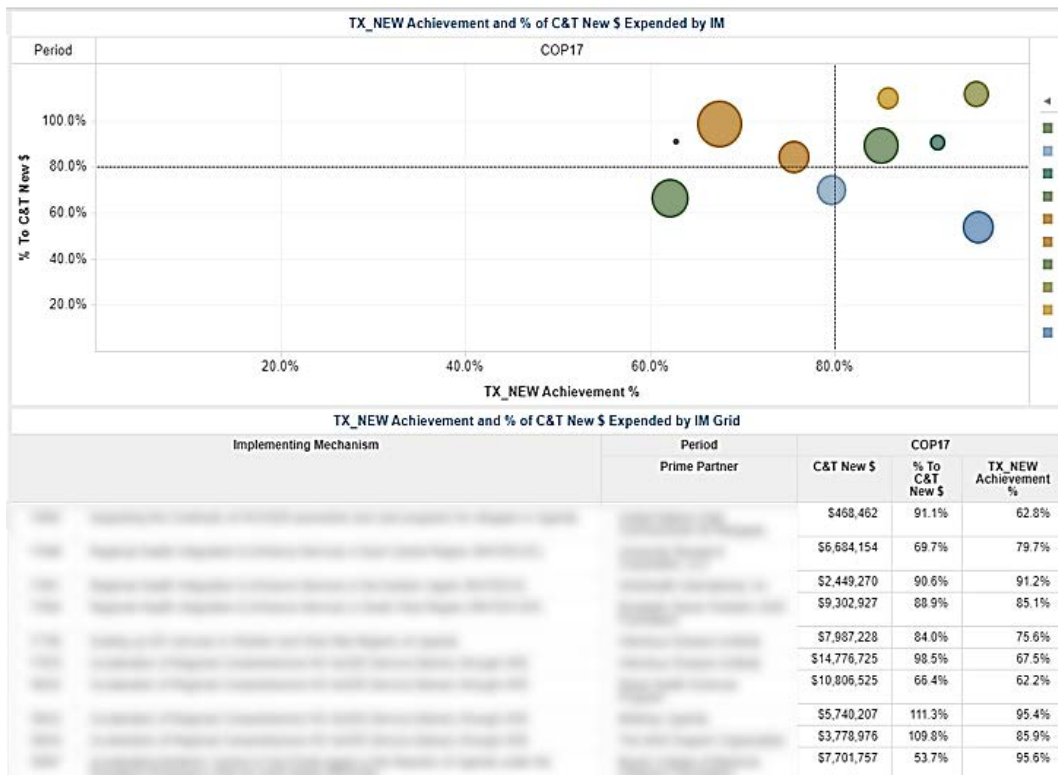


Figure 7.2.4: Expenditures by IM against TX_NEW achievement for Care and Treatment by IM, showing variable TX_NEW achievement against funds expended



With this decision tree in mind, below are analyses that must be completed to comprehensively and holistically understand program achievements, implementation, gaps and barriers, and then plan for COP20.

IMPORTANT NOTE: these steps are described using a deidentified country example, and a curated analytic approach to highlight the core questions that should be answered, and programmatic changes needed at the partner, SNU or site level. 'Deep dive' analyses have been included with additional questions to further 'drill down' and identify any root causes of partner, SNU and site level performance successes and challenges. These provided at the end of Steps A-G.

A. Who is being funded? What and how much was budgeted and spent? And to accomplish what?

We will start with looking at viral load suppression. In terms of Expenditure Reporting, care and treatment is the relevant program area, and HIV Lab Services is the relevant sub program, since viral load suppression is the metric that is being analyzed. To identify those partners with both budgets and expenditures in care and treatment and HIV Laboratory Services, use the Financial Management Dossier in Panorama. Use this dossier to identify the mechanisms with the greatest budgets and expenditures in the care and treatment and HIV Laboratory services program areas (Figure 7.2.5). This figure shows budgets and expenditures by program area, with a filter on to only display the care and treatment program area on the left, and a filter to display on HIV Laboratory Services on the right. This will provide us with the base understanding of the partners working in this area in Country X. Please be mindful of the fact that the transition to the new financial classifications began for budget data in only in COP19. Some prior year budget data has been mapped to major program areas, but would not be available for sub programs, beneficiaries or cost categories.

Table 7.2.5: Budgets and Expenditures by Program area: Care and Treatment (Left) and HIV Laboratory Services (Right) in Country X

Level 2	C&T	
	Budget	Expenditure
Level 1		
	\$3,855,408	\$2,479,486
	\$2,846,881	\$2,974,482
	\$6,689,292	\$7,071,291
	\$671,762	\$732,394
	\$6,994,275	\$8,105,121
	\$12,788,963	\$12,684,513
	\$54,181,593	\$56,949,461
	\$8,391,947	\$8,159,569
	\$5,999,818	\$5,285,084
	\$3,449,648	\$3,431,171
	\$3,015,378	\$4,727,180
	\$4,005,941	\$3,641,939

Level 2	HIV Laboratory Services	
	Budget	Expenditure
Level 1		
	\$653,451	\$387,092
	\$887,411	\$400,241
	\$1,014,037	\$704,895
	\$110,525	\$128,037
	\$1,509,087	\$1,419,523
	\$1,791,104	\$2,201,139
	\$12,413,701	\$15,685,157
	\$919,028	\$725,706
	\$543,607	\$400,241
	\$606,502	\$653,451
	\$598,712	\$400,241
	\$610,082	\$653,451

B. What is the underlying epidemiology in the country?

Overall, it remains critical to understand if there are any shifts in disease burden across the country or by population; who is need of ART by age/sex and rates of viral load suppression (Figure 7.2.6). Teams should triangulate the PHIA results (or other SRE data) with program data i.e. map program data against PHIA results by region to identify areas/populations that are underserved according to by community-level PHIA data. If PHIA data are not available, program data can be used, as shown below. In this OU example, since PHIA data are not available, program data were used and revealed clear gaps in ART coverage, viral coverage, and viral suppression by age and sex are observed, clearly highlighting that an additional focus on young people and men is needed.

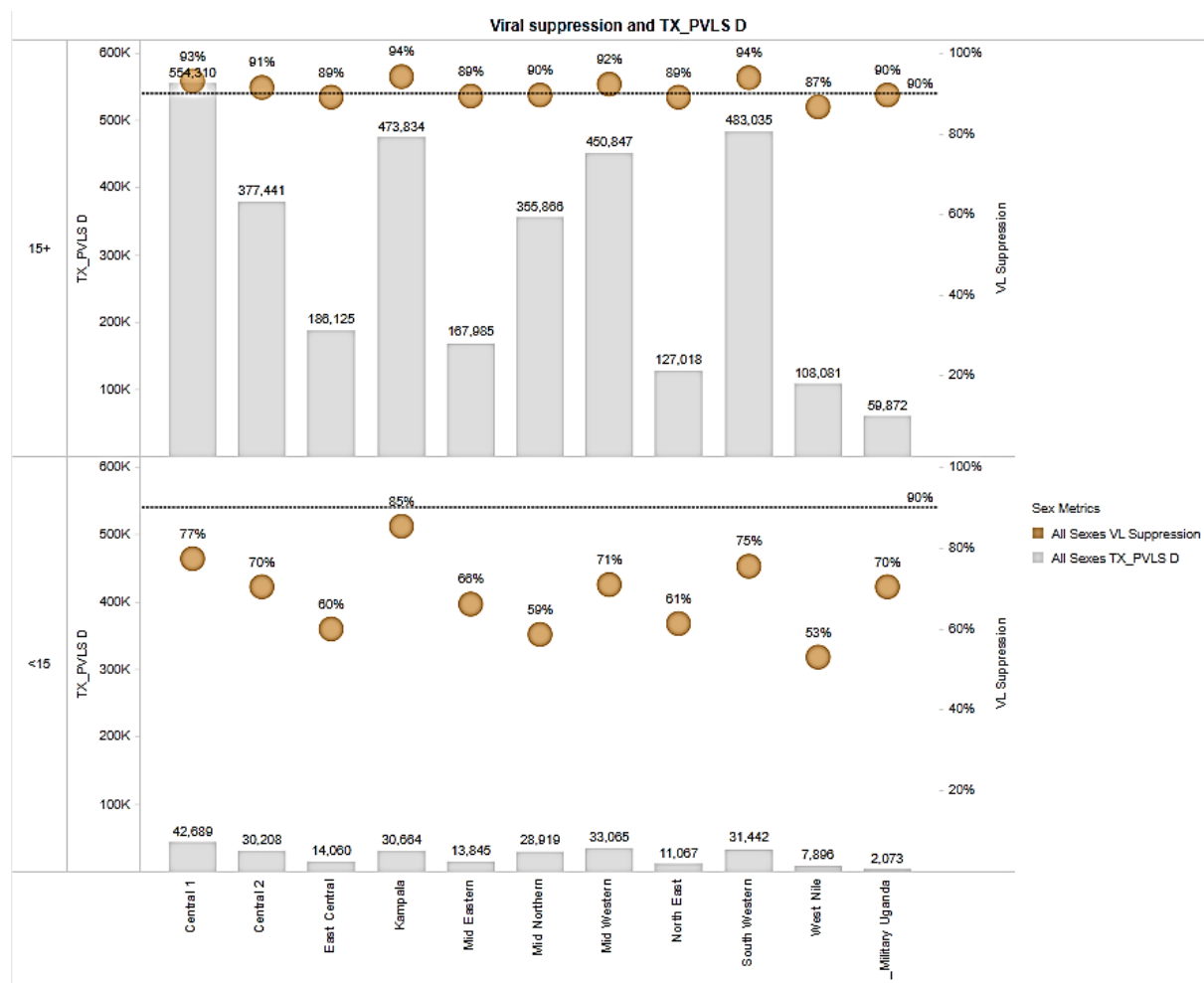
Table 7.2.6: Example Country Disease Burden and Clinical Outcomes, in country X, showing gaps in treatment and viral suppression among young people and men

Age	Sex	PLHIV	On Treatment	VL Suppressed	On Treatment	VL Suppressed
<10	Female	33,845	17,980	12,941	53.1%	38.2%
<10	Male	34,899	16,479	10,824	47.2%	31.0%
10-19	Female	55,863	34,121	24,874	61.1%	44.5%
10-19	Male	37,938	22,074	16,429	58.2%	43.3%
20-29	Female	191,563	168,757	128,631	88.1%	67.1%
20-29	Male	84,177	49,018	27,248	58.2%	32.4%
30-39	Female	244,765	230,577	191,611	94.2%	78.3%
30-39	Male	157,202	115,968	82,486	73.8%	52.5%
40-49	Female	173,370	160,644	135,448	92.7%	78.1%
40-49	Male	138,140	110,162	87,588	79.7%	63.4%
50+	Female	119,007	101,664	94,549	85.4%	79.4%
50+	Male	107,315	79,980	70,298	74.5%	65.5%
Overall		1,378,085	1,107,424	882,927	80.4%	64.1%

C. What is performance of the program and IPs by SNU and sites in relation to viral suppression?

Overall, viral load suppression is variable in the Country X by SNU and age groups (see Figure 7.2.7). Although many SNUs are not above the 90% suppression level, there remains variability at the age level (comparing adults against pediatrics). Viral load suppression across age and sex groups within an SNU depend on the ecosystem of IMs within that region. Therefore, the balance between IMs and their respective activities should be carefully considered to ensure the right interventions are being implemented to achieve viral load suppression.

Figure 7.2.7: Comparison of Viral Suppression at the SNU level for Adults and Pediatrics highlights disparities by SNU and age group

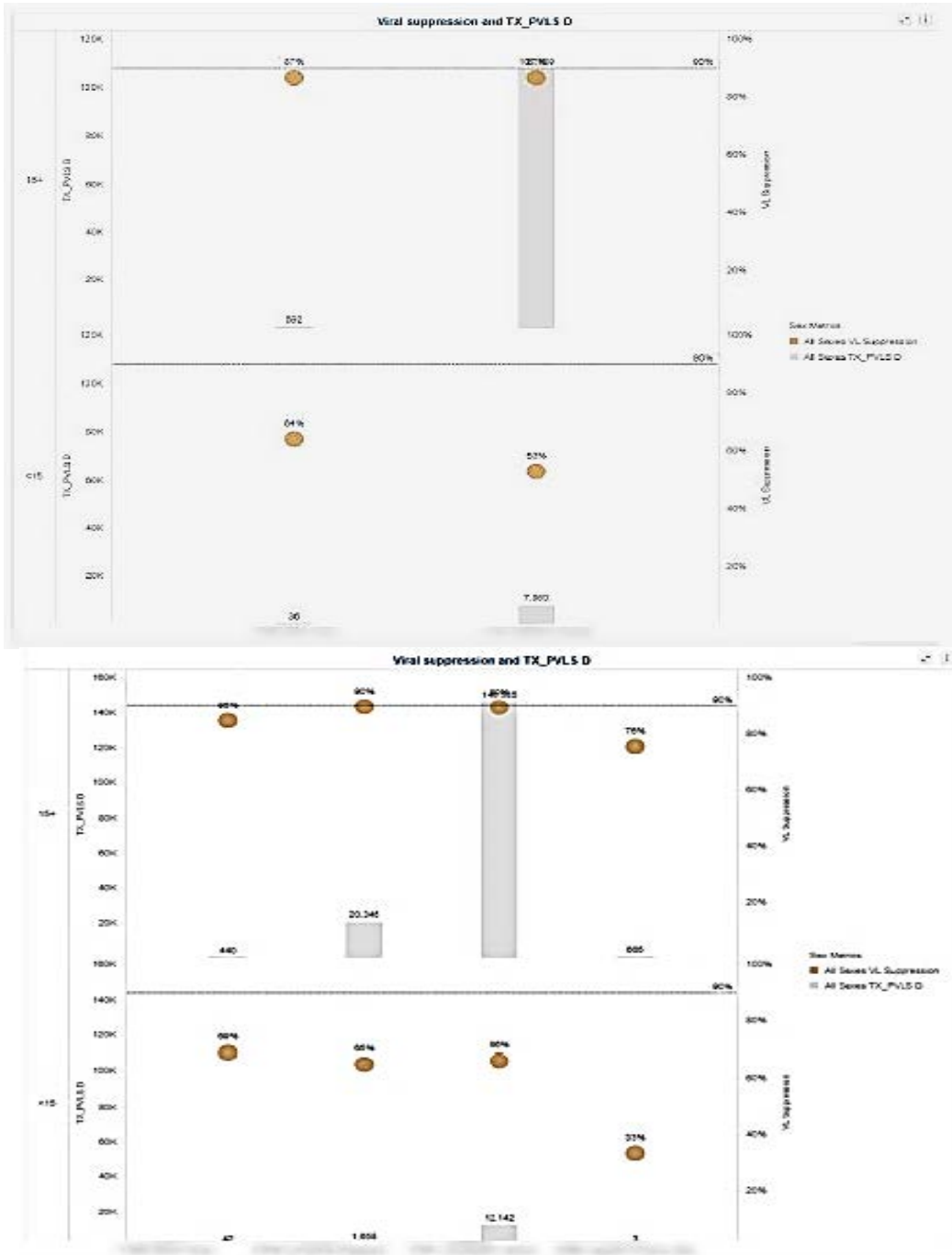


When these results are reviewed by SNU and IM, we notice there several IMs do not meet the 90% suppression mark by SNU and viral load coverage remains low. Review if this is a persistent problem and begin the contraction of those partners and the expansion of the top

performing partners again decreasing the geography of one and increasing the geography of the other continuous partner.

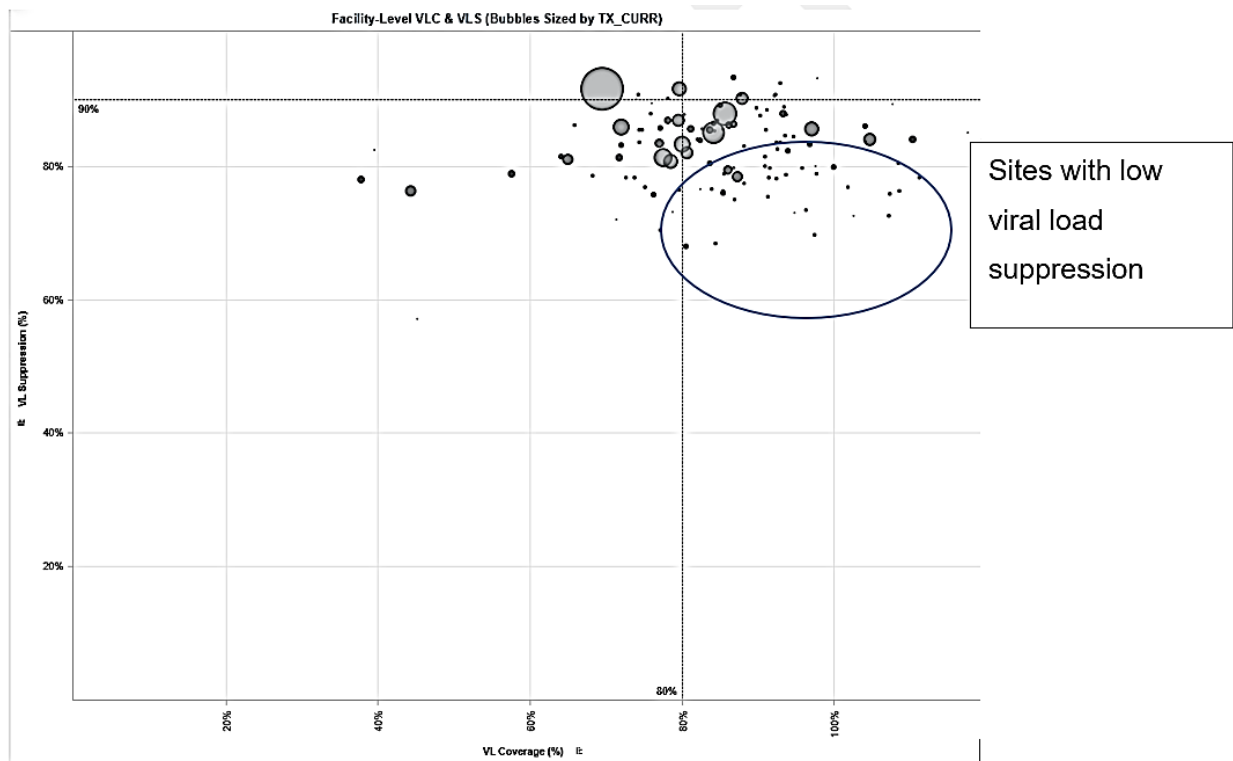
Highlighting two different high burden SNUs (SNU X and SNU Y) reveals that IMs have **differential performance both within and across SNUs in terms of viral load suppression.**

Figure 7.2.8: IMs implementing clinical programs in SNU X (top) and SNU Y (bottom) have differential performance in viral load programming



Additional analyses may include whether these viral suppression rates were maintained quarter over quarter as viral load coverage increased. However, it remains critical to assess what the performance of the potentially under-performing IM Y is at the site level. The Figure 7.2.9 below shows that, although viral suppression in some high volume sites (as denoted by the size of the bubble) is above the 80% coverage and 90% suppression marks, there are many smaller sites with low levels of both viral load coverage and suppression (as denoted by small bubbles and the sites falling below the 90% suppression and 80% coverage marks). Immediate questions around the quality of services, and whether targeted viral load testing due to treatment failure is being conducted at these smaller sites, should be considered.

Figure 7.2.9: Many small volume sites with low viral load coverage for IM Y in SNU X.



We also noted that using SIMS data for this seemingly poor-performing IM Y at the site level showed that several of these smaller sites also demonstrated challenges in delivery of quality services (i.e. those sites scored either 'red' or 'yellow' via SIMS). Additional questions may include, whether remediation occurred at the sites which led to improved achievement of quality standards. Or whether this IM consistently performs poorly in terms of quality of services all along the clinical cascade.

Figure 7.2.10: Number of times viral load related SIMS Standard scored red or yellow (i.e. needing remediation) for poor-performing IM Y

Evaluating Site CEE Score Trends					
SIMS Universal CEE ID	SIMS Universal CEE Title	Count of CEEs Scoring Red	Count of CEEs Scoring Yellow	Count of CEEs Scoring Light Green	Count of CEEs Scoring Dark Green
S_02_21	Dosing of Pediatric and Adolescent ARVs	0	0	0	162
S_02_22	Viral Load Access and Monitoring	10	14	36	100
S_02_25	Routine HIV Testing for Children and Adolescents	6	20	53	83
S_02_26	TB Screening	0	0	15	146
S_02_28	Cotrimoxazole (CTX)	1	1	2	157

With the ‘shortlist of IMs’ identified above, return to the financial data (in the Financial Management Dossier) to get a better understanding of how the IMs were implementing their activities by understanding **how they were spending their money**. The first thing to understand is how much of their money they actually spent. This can be seen in Figure 7.2.11 above by comparing budget to expenditure, which can be done at the total IM level, or within an IM at the program area level. If a shortlisted mechanism only expended a small portion of the budget, this might indicate that a mechanism overestimated their budget during planning, or was simply not operational for some of the period of performance, potentially due to a delay in funds outlaid to that partner. Consult the Obligations and Outlays report and the EOFY tool to identify if that partner under-outlaid their budget and note the explanation provided for that under-outlay. Depending on the information in these reports, course corrections may be necessary in the coming cycle, for that mechanism, either to reduce their budget, or to mitigate the risks to that extent possible that caused the break in activity. Alternatively, if a mechanism overspent their budget, this could indicate inefficiency by the mechanism and possibly a need for a reduced or reallocated budget. It may also be helpful to understand if they both over-outlaid and over expended, and if this is a trend that has existed in past periods as well, as an isolated over expenditure without over-outlay may indicate the timing of expenditures simply fell within one fiscal year, and that expenditure might be reduced commensurately in an adjacent period.

Next, it is important to understand what was purchased by the mechanism. This includes both the interventions that they spent their money on (which will reveal those program areas, beneficiaries and interaction types they funded) and what they actually purchased (which will be revealed in the cost categories).

Figure 7.2.11: Expenditures by IM interventions in Country X

Level 1	Interaction Type	Non Service Delivery	Service Delivery
	Level 2	Expenditure	Expenditure
Total		\$29,191,925	\$43,138,560
	Total	\$13,084	\$235,765
	1>HIV Clinical Services>Non Service Delivery>Non-Targeted Pop>Not disaggregated	\$13,084	
	1>HIV Clinical Services>Service Delivery>Non-Targeted Pop>Not disaggregated		\$207,674
	1>HIV Laboratory Services>Service Delivery>Non-Targeted Pop>Not disaggregated		\$28,091
	Total		\$100,697
	1>HIV Clinical Services>Service Delivery>Priority Pops>Military & other uniformed services		\$100,697
	Total	\$1,218,099	\$1,261,387
	1>HIV Clinical Services>Non Service Delivery>Non-Targeted Pop>Not disaggregated	\$852,327	
	1>HIV Clinical Services>Service Delivery>Non-Targeted Pop>Not disaggregated		\$785,683
	1>HIV Laboratory Services>Service Delivery>Non-Targeted Pop>Not disaggregated		\$387,092
	1>Not Disaggregated>Non Service Delivery>Non-Targeted Pop>Not disaggregated	\$365,772	
	1>Not Disaggregated>Service Delivery>Non-Targeted Pop>Not disaggregated		\$88,612
	Total	\$1,313,557	\$1,660,925
	1>HIV Clinical Services>Non Service Delivery>Non-Targeted Pop>Not disaggregated	\$1,120,434	
	1>HIV Clinical Services>Service Delivery>Non-Targeted Pop>Not disaggregated		\$1,453,807
	1>HIV Laboratory Services>Non Service Delivery>Non-Targeted Pop>Not disaggregated	\$193,123	
	1>HIV Laboratory Services>Service Delivery>Non-Targeted Pop>Not disaggregated		\$207,118
	Total	\$1,685,770	\$5,385,521
	1>HIV Clinical Services>Non Service Delivery>Non-Targeted Pop>Not disaggregated	\$1,089,595	
	1>HIV Clinical Services>Service Delivery>Non-Targeted Pop>Not disaggregated		\$4,680,626
	1>HIV Laboratory Services>Non Service Delivery>Non-Targeted Pop>Not disaggregated	\$426,660	

Looking at the above mechanisms, we can see a lot about what each shortlisted mechanism is doing with its funding. First, we can see that most mechanisms are offering a mix of interventions within the care and treatment program area. For viral load suppression, the program area that is most relevant is HIV Laboratory Services, both service delivery and non-service delivery. While we see the above partners working in this sub program, it is often the secondary sub program within care and treatment (HIV Clinical Services being first), and for certain partners, much of the spending on HIV Laboratory Services is non service delivery. While non service delivery interventions can be of critical importance in some contexts, if we see that a key care and treatment partner is not meeting their viral load suppression targets, and they are spending only a portion of their money on Laboratory Services, and only a portion of that on direct service delivery laboratory services, it may make sense to redirect that partner's funding into service delivery interventions related to labs and viral load.

Additionally, comparing the interventions above we can see that almost all work at care and treatment partners is being done to serve non-targeted populations. Since age or sex gaps in viral load suppression have been revealed through the analysis earlier, it may be advisable to redirect partners to fund interventions that are specifically designed to target the age or sex beneficiaries that are the known gaps in the OU or region.

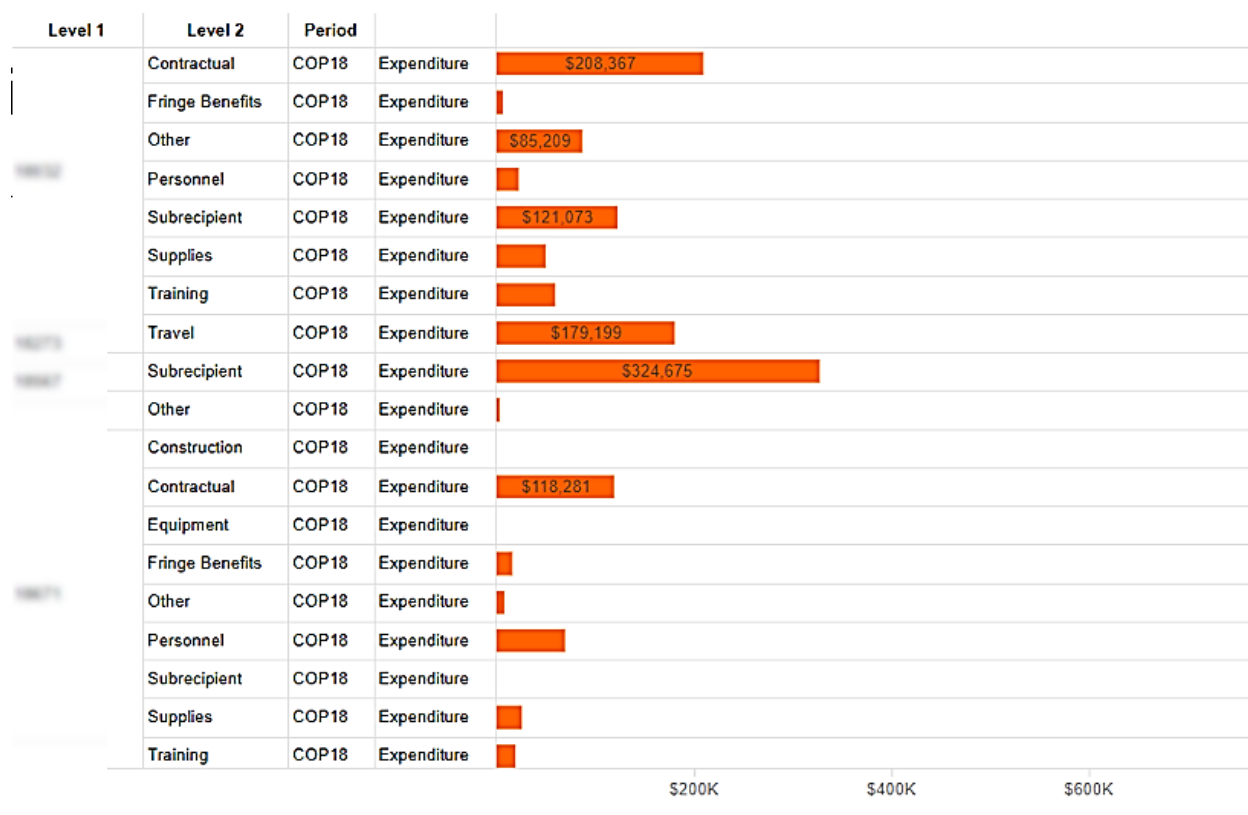
Note that in expenditure reporting, the partner may sometimes choose to lump together or not disaggregate certain interventions because smaller interventions are not large or distinct enough to be reported separately. Thus, looking at a subprogram in expenditure reporting may suggest that a partner may not be working in a program area that they have targets for, when in reality they have just lumped those expenditures into a not disaggregated intervention in that same program area. For example, in the case of viral load, a partner with TX_PVLS targets may not report expenditures in the HIV Laboratory Services because they have lumped those expenditures into Care and Treatment Not Disaggregated or even HIV Clinical Services, if the viral load piece of their work was much smaller or indistinct from the HIV Clinical Services work. Thus, it is important to look at the expenditures both at the sub program area that you are interested in, but then also at the not disaggregated and at the total program area level as well, in case the partner chose to lump together their interventions. However, if a partner is severely underperforming on viral load, and they do not report HIV Laboratory services separately, it might make sense to request that they do so going forward, and also possibly that they make the intervention more targeted and more significant and report it separately.

Next, it is important to understand what each mechanism actually is buying. This is what cost category within ER tells us. Remember that cost categories are only available in expenditure data, as budgeting does not currently incorporate this classification. Mechanisms can be compared by filtering to only show HIV laboratory interventions (or if treatment coverage is of interest, either care and treatment HIV Clinical Services or Care and Treatment not disaggregated), and then comparing what each mechanism spent in the cost categories for laboratory interventions, or for all care and treatment interventions taken together as budgeting does not currently incorporate this classification (Figure 7.2.12 below). This figure below reveals that a large amount of lab expenditures was made to contracts, most likely contracted interventions related to viral load tests, or stipends to staff on site who take samples for viral load testing. If this approach proves to be correlated with poor performance on viral load suppression, it may be wise for partners to redirect their expenditures into cost categories may have a more direct impact on patient outcomes, like personnel-health care workers, or pharmaceutical supplies or to re-evaluate their contracts if certain contracted interventions are underperforming. Other large cost categories seen below are travel and training, both of which may be secondary priorities for an underperforming partner.

Another critical piece of information that cost categories can tell you is what type of personnel the partner has working under the mechanism. There are three important types of personnel that are cost categories: Personnel: Healthcare Workers, Personnel: Other staff and Contracted

Healthcare workers. This will tell you if the staff is operating as a healthcare worker who provides healthcare services directly to patients or one who is operating in another capacity. In some cases, it is critical that the partner is supporting healthcare workers, which would be visible in that sub cost category in ER.

Figure 7.2.12: Expenditures by Cost categories for Lab interventions by IM

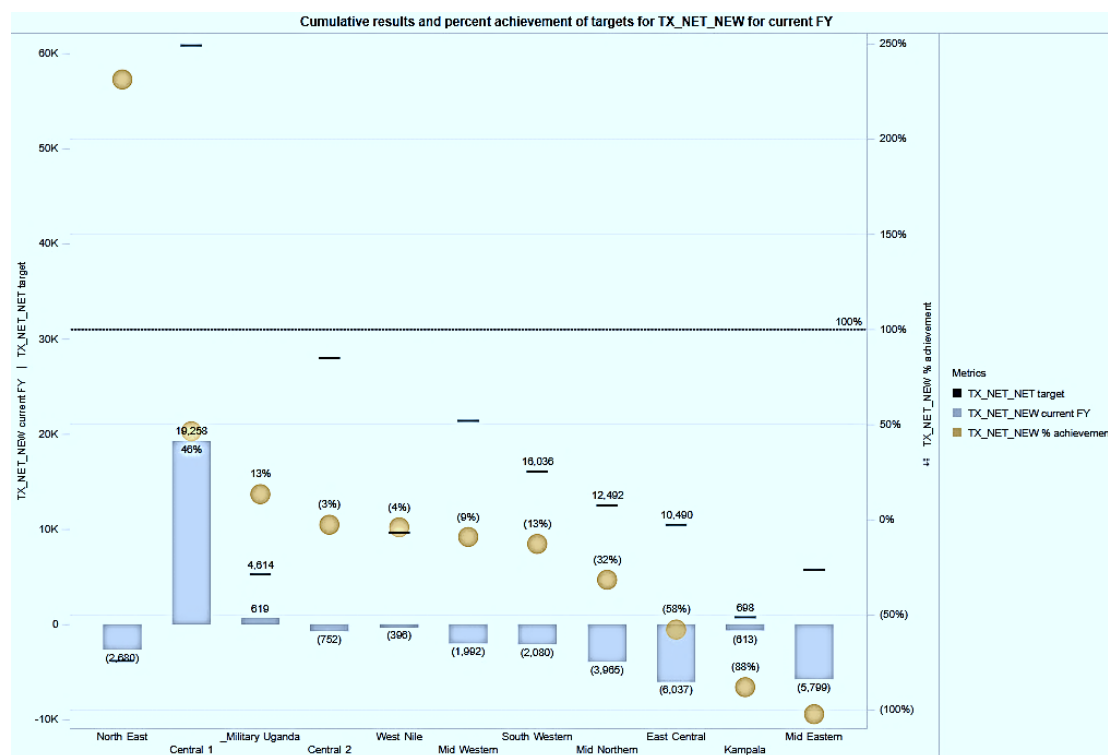


Lastly, it may be helpful to look more broadly at the cost categories for the shortlisted IMs, to see if their cost category selection is unique to the HIV Laboratory services program area, or if they have a different approach for different interventions.

D. What is performance of the program and IPs by SNU and sites in relation to retention and treatment growth?

For these two IMs selected we know that additional questions remain about how these IMs are performing in relation to treatment growth and retention on clients on treatment. In Figure 7.2.13 below, we can see that SNUs overall struggle with increasing the number of patients on treatment as evidenced by the negative NET NEW numbers across several SNUs. In this example, this difference could not be explained by data quality issues at sites within those SNUs.

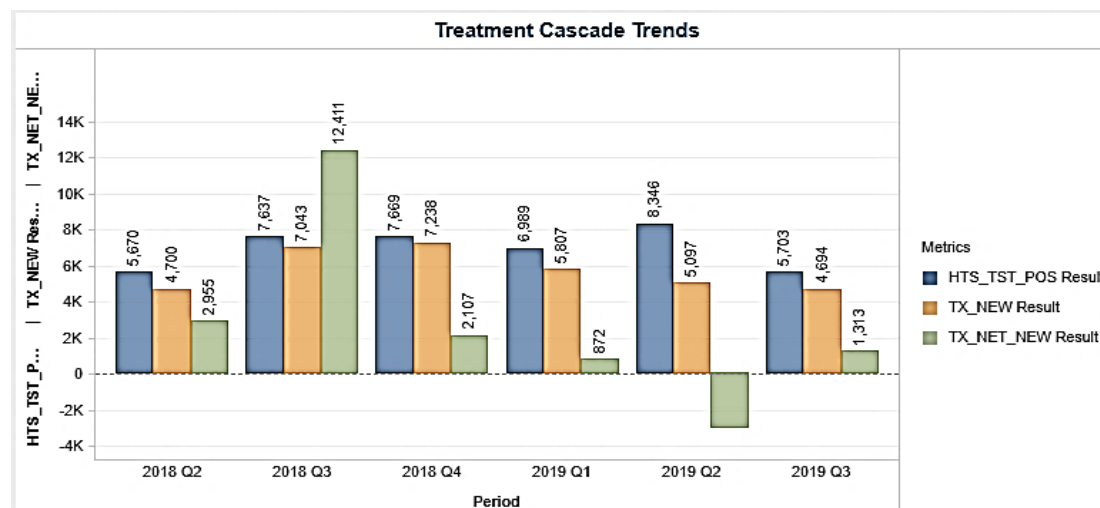
Figure 7.2.13: Net Change in the treatment cohort (TX_CURR) across SNUs



These results were also apparent at the site level (data not shown).

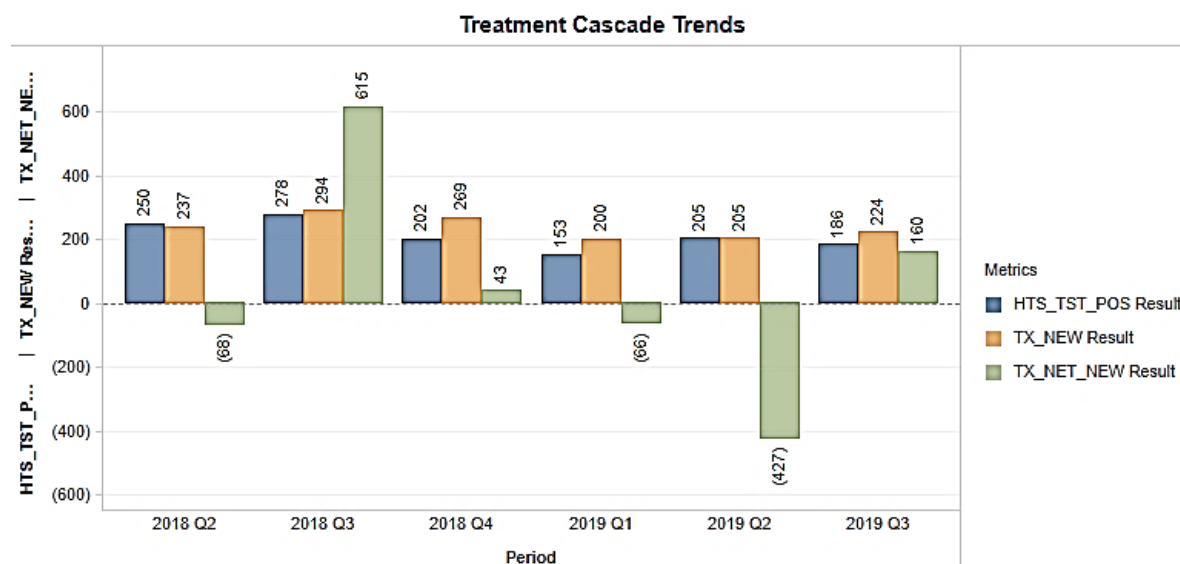
Looking at whether these results are the same quarter over quarter, we continue to see the same challenges in which TX_CURR growth is not keeping pace with TX_NEW. Specifically looking at IM X from the viral suppression analysis, we see that this pattern holds true overall, even when comparing under 15 to over 15 (Figure 7.2.14 and 7.2.15) across all SNUs.

Figure 7.2.14: Treatment growth in all SNUs supported by IM X by over 15 yrs



Finally, the disparities in IM X's treatment performance in a single SNU by age also hold when looking at retention by sex over time. We see that retention declined among women over time, suggesting the bulk of the recent losses are from women. Although retention among men has improved recently improved in this SNU, trends over time suggest challenges in retaining men also exist.

Figure 7.2.15: Treatment growth in all SNUs supported by IM X by under 15 yrs



In all these cases, it will be important to understand the number and proportion of patients at the site level who are (1) accessing 3 or 6 month ARV dispensation options (2) taking the optimal drug regimen of TLD (3) utilizing differentiated service delivery models. Furthermore, knowing whether ARVs are consistently available at the site level (through triangulation with supply plan data and SIMS stockout data) may shed light on site level structural or operational challenges which may be affecting access and delivery of treatment services. Similarly, quality of services or access to services could also be affecting overall retention at sites (see [Section 3](#) on Quality). Collectively such information could help us better understand the factors that may be contributing to this IM's retention and treatment growth challenges.

E. What is performance of the program and IPs by SNU and sites in relation to case finding?

The financial analysis described in Step 2 A, around viral load, can be replicated as analysis for other program areas. In sub-section E, case finding is the focus, and thus the corresponding program area of interest would be Testing. The largest testing partners by budgets and

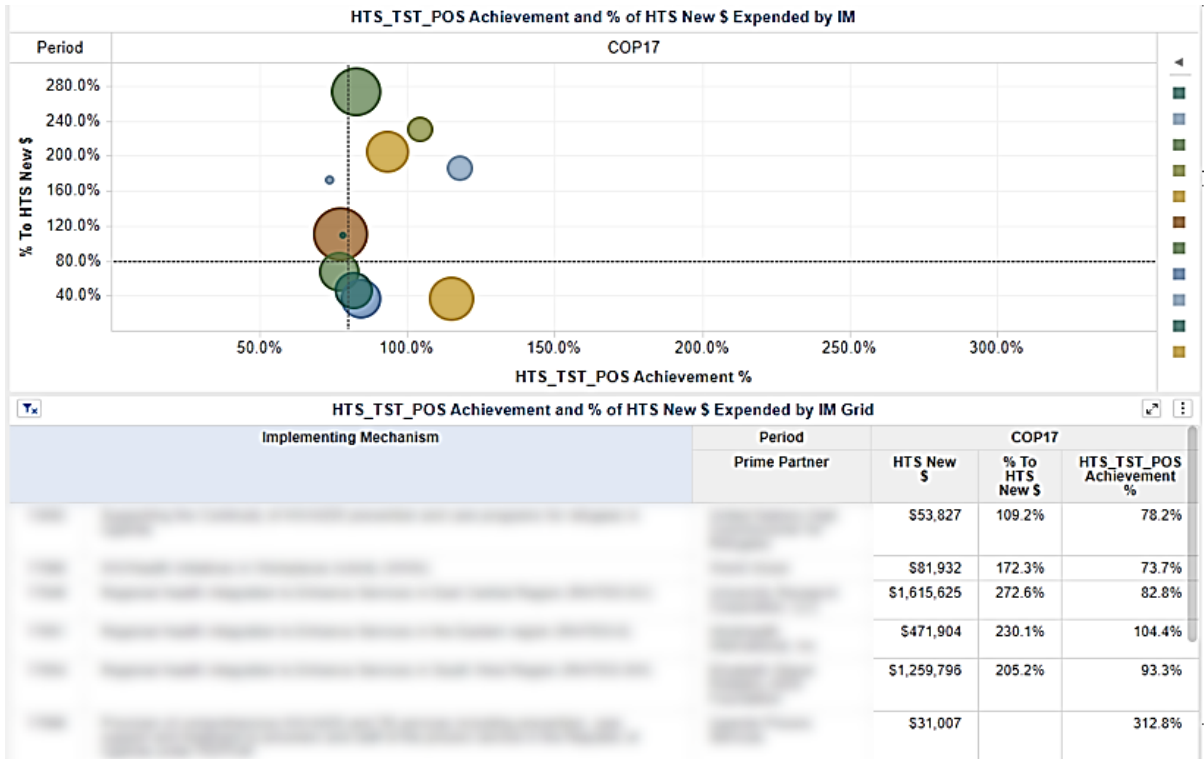
expenditures can again be identified using the Financial Management Dossier, filtering to only show testing budgets and expenditures (shown below).

Figure 7.2.16: Testing Budgets and Expenditures by IM

Level 2	HTS	
	Budget	Expenditure
Level 1		
	\$287,167	\$178,482
	\$0	\$244,295
	\$1,080,000	\$1,071,951
	\$131,500	\$6,824
	\$266,945	\$218,268
	\$24,669	\$16,848
	\$56,132	\$50,000
	\$304,803	\$336,490
	\$396,169	\$335,477
	\$1,628,608	\$1,395,291
	\$13,000,000	\$15,019,037
	\$2,846,881	\$3,440,529

As partners are identified through MER and SIMS analysis for further review, they can be investigated using the Financial Management Dossier to identify their interventions, program areas, sub program areas, beneficiaries and interaction types (service delivery vs. non-service delivery) as well as the EOFY and O&O report to understand their outlays. The Financial Management Dossier will also reveal their cost category purchases.

Figure 7.2.17: HTS_TST_POS Achievement and % of HTS \$ New Expenditure by IM

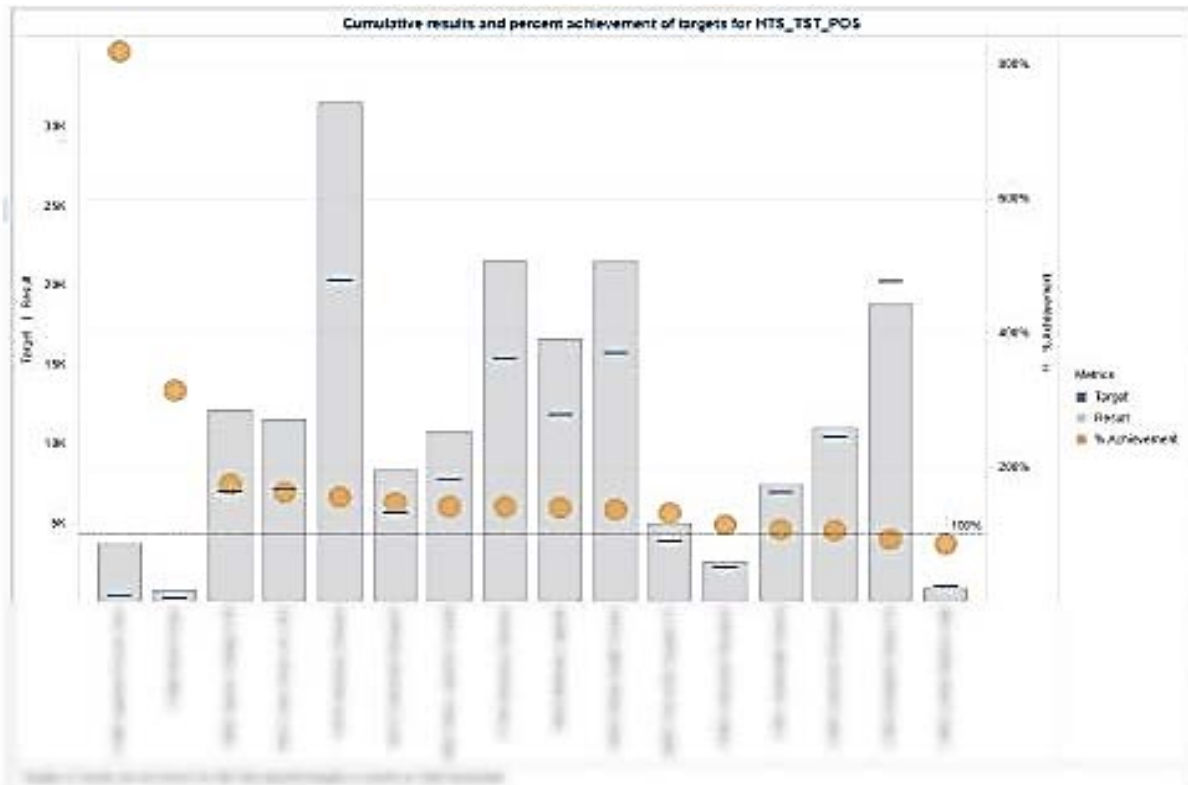


Partner performance at the OU by IM demonstrates clearly that all IMs are over-testing to achieve their HTS_TST targets (Figure 7.2.17 below). These results do not vary considerably by SNU suggesting the need for efficiencies in case finding across the board. Moreover, the majority of partners over tested by 106% to 200%, causing programs to potentially spend more on a less effective approach than orient towards a more effective approach.

Figure 7.2.17: IM level Testing performance against targets shows all IMs over-tested by FY19Q3

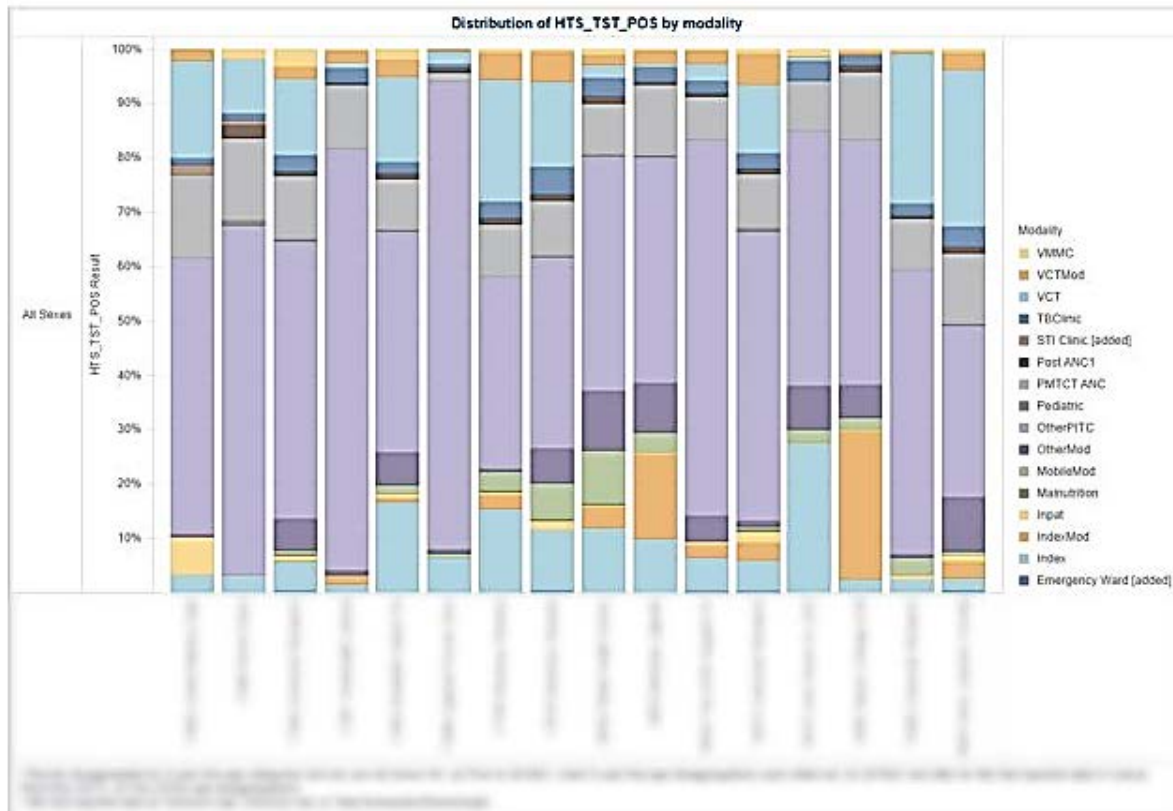
		Uganda		
		FY19 Cum. Results	FY19 Target	FY19 %
		6,171,413	4,165,870	148.1%
Uganda Private Services	17788	93,871	8,265	1135.6%
The AIDS Support Organization	18018	306,609	157,905	194.2%
Substance Abuse Institute	17718	987,053	512,981	188.5%
InterHealth International, Inc	17921	459,294	262,450	175.0%
Mpigi College of Medicine (Children's Foundation/Ingenia)	18087	442,589	266,982	165.8%
University Research Corporation, LLC	18275	257,508	163,389	157.6%
United Nations High Commissioner for Refugees	17882	45,229	29,352	154.1%
World Vision	17788	30,026	19,518	153.8%
University Research Corporation, LLC	18082	80,689	54,465	148.1%
University Research Corporation, LLC	17788	539,585	373,541	144.5%
Substance Abuse Institute	17718	747,271	526,259	142.0%
Henry Jackson Foundation	8001	318,073	229,261	138.7%
Mpigi Uganda	18012	446,877	326,531	136.8%
Nakasongola Health Sciences Program	18012	505,712	391,485	129.2%
Johns Hopkins (USP)	18274	290,027	241,209	120.2%
Elizabeth Glaser Pediatric AIDS Foundation	17924	841,140	802,267	106.5%

Figure 7.2.18: Achievement of HTS_TST_POS targets by IM only possible by high volume of testing



Of these IMs only three IMs had over 20% of their POS results from index testing, further suggesting the need for effective and efficient testing modalities scale up with fidelity (Figure 7.2.19).

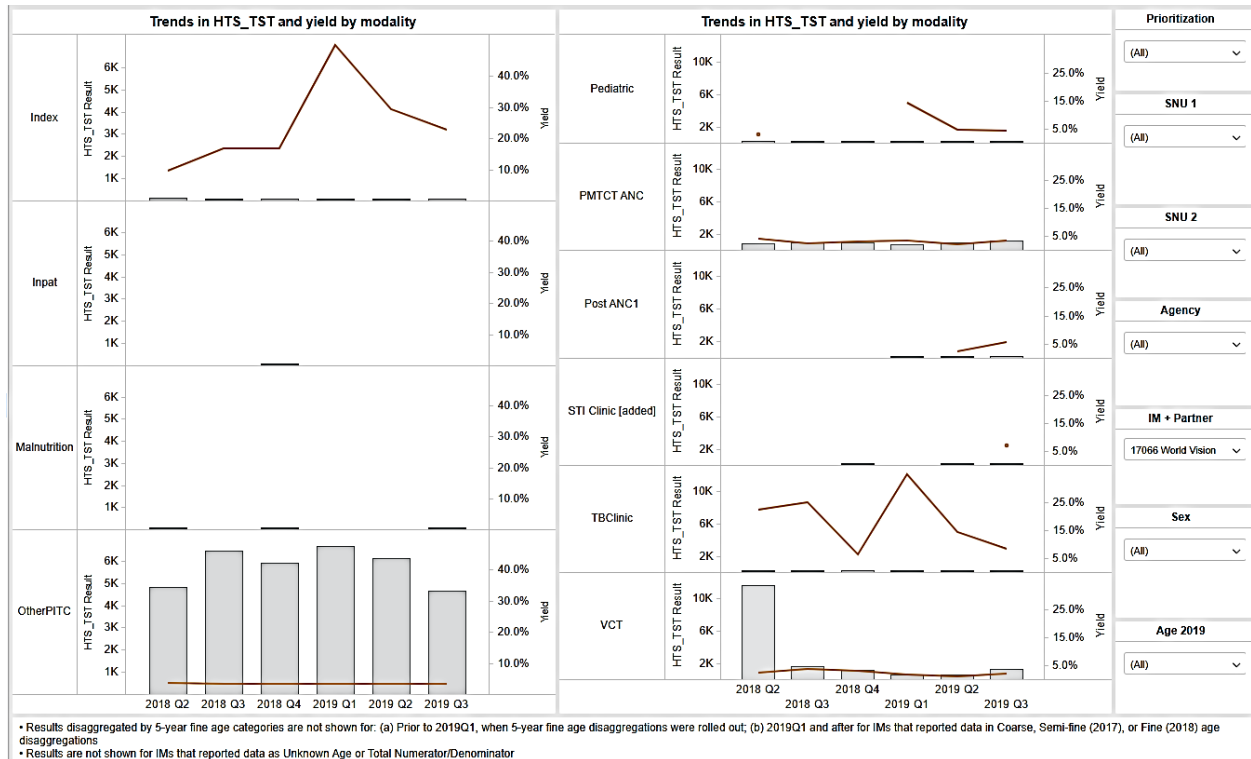
Figure 7.2.19: Distribution of POS from testing modalities demonstrates lower than expected scale up of index testing by modality



A deeper analysis of IM Y identified in the previous viral load suppression and retention analysis showed that overall this IM tested 174, 438 persons using PITC while only finding 586 positives (0.3% yield) compromising cost and human resource time while index testing, although demonstrating a high yield of 27.6%, only identified 16 POS (Figure 7.2.20 below). This program review demonstrates the need to optimize case finding with highly focused PITC and rapidly scale up index testing as means to identify PLHIV.

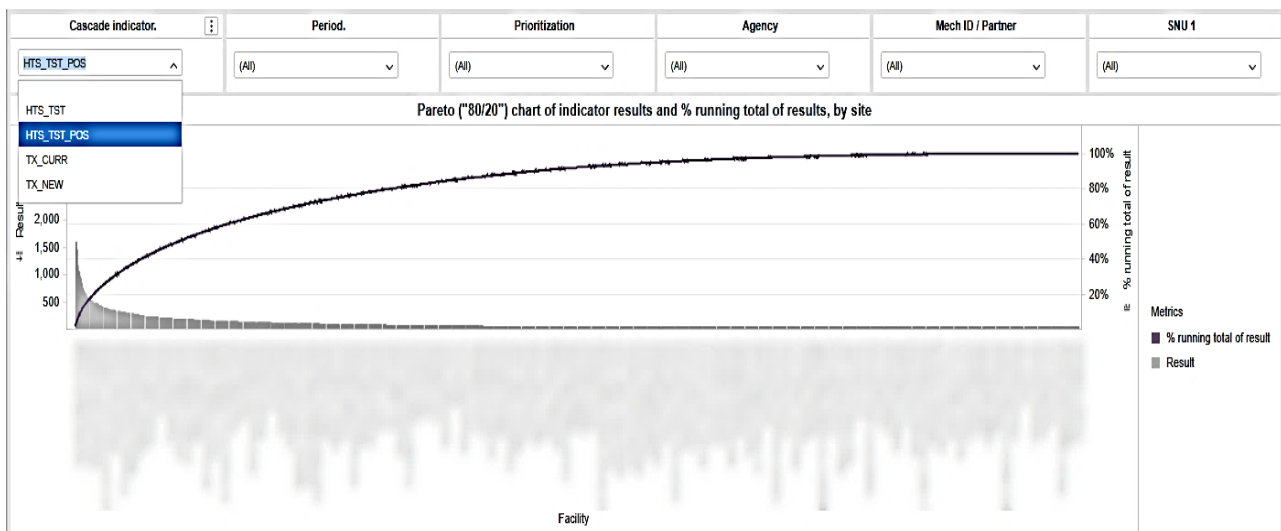
Triangulating against SIMS data, analysis of standards related to routine testing of children of HIV positive mothers demonstrated that 37% of sites assessed do not meet the basic standard of offering this service – leaving many children with HIV undiagnosed and without access to life saving services. Even after remediation and follow-up assessment, 39% of sites assessed still did not meet this standard. This suggests there are opportunities for improvement and scale up of index testing that are being missed.

Figure 7.2.20: Comparison of testing modalities implemented by IM Y demonstrates limited scale up of index testing



Furthermore, a critical question here is overall performance of this IM at the site level. An analysis of the number of positives being identified at the site level should be conducted (Figure 7.2.21). Importantly, if 20% of the sites are identifying 80% of the positives, then resources need to be refocused to optimize investment.

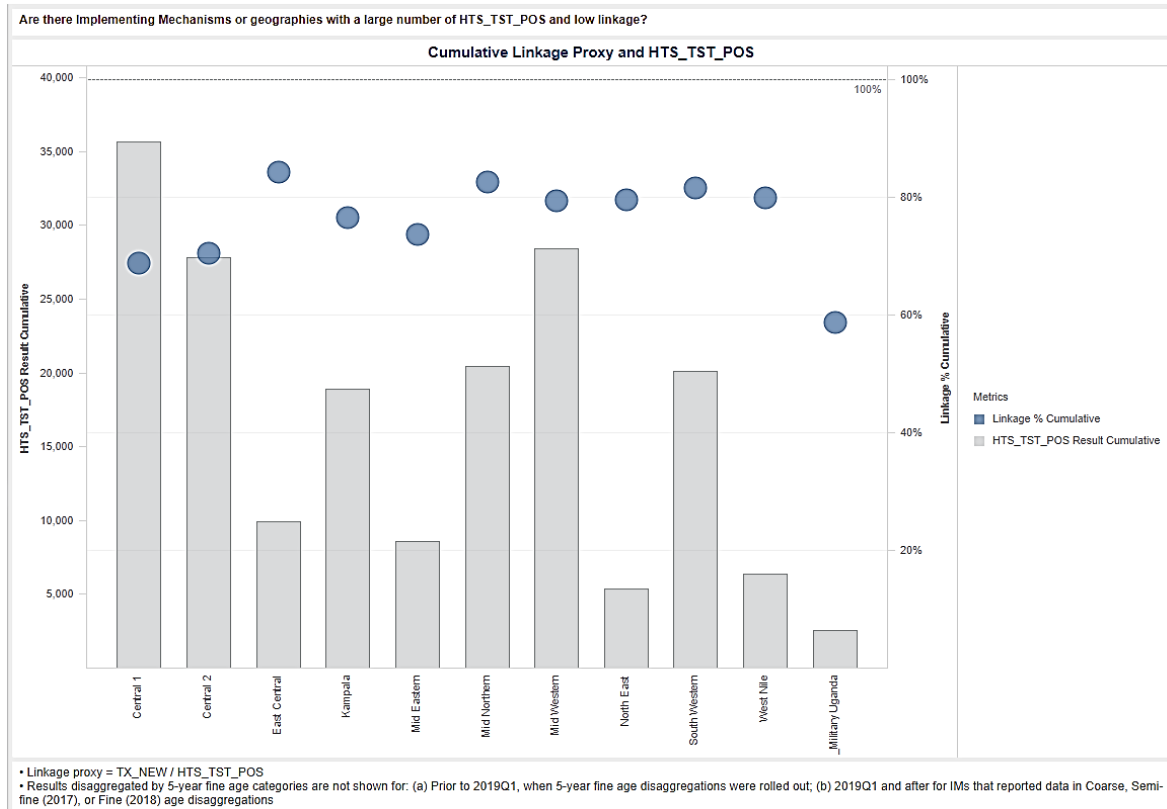
Figure 7.2.21: Site level analysis of HTS_TST demonstrating that a small number of sites are identifying 80% of the POS



F. How is the program performing in terms of linkage and access to treatment services?

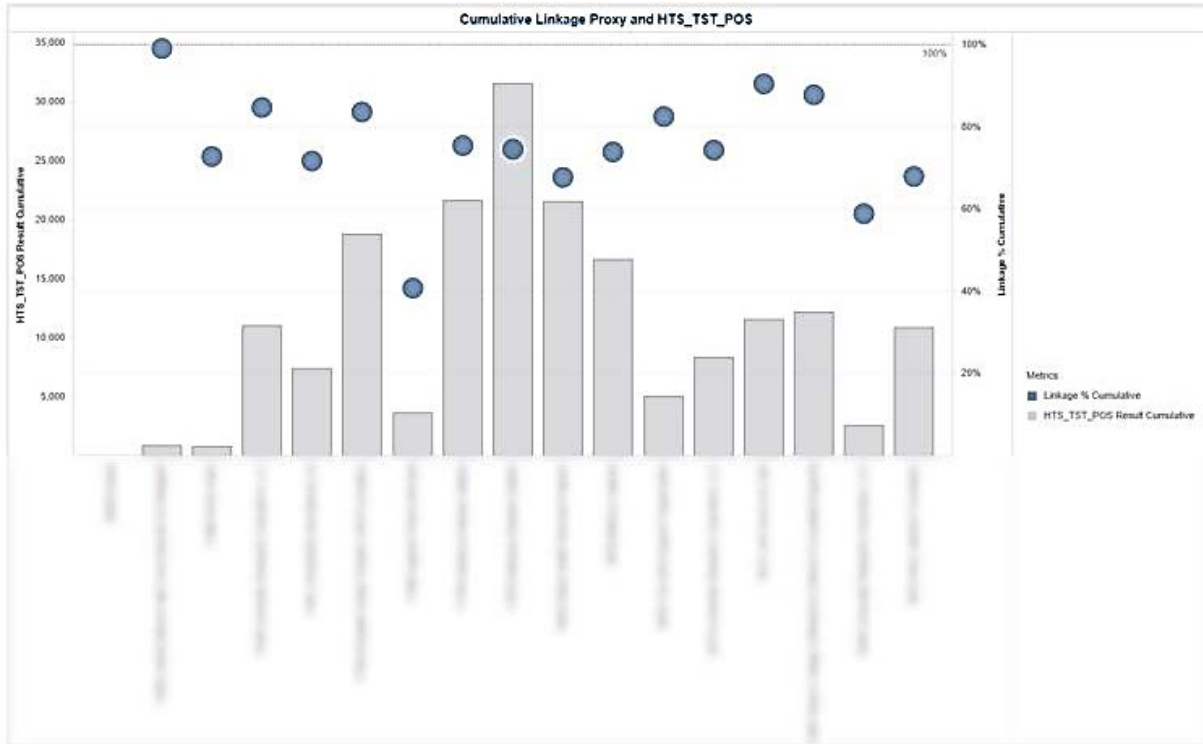
Much like treatment growth and retention, linkage to treatment is also variable by SNU (Figure 7.2.22). Here we see that many SNUs are below even the 80% linkage to treatment threshold, leaving large numbers of persons unlinked to treatment services.

Figure 7.2.22: Variable rates of Linkage to Treatment by SNU in Country X



When exploring this pattern by IM, we see that IMs identifying large and/or small numbers of POS have variable linkage to treatment rates. IM X from our previous analysis has a linkage to treatment rate of under 80%, demonstrating (as mentioned above) that diagnosed PLHIV are not accessing lifesaving treatment services. It thus becomes even more important to understand the root causes of both the variability and the overall lower than expected linkage rates.

Figure 7.2.23: Highly variable rates of Linkage to treatment by IM in Country X

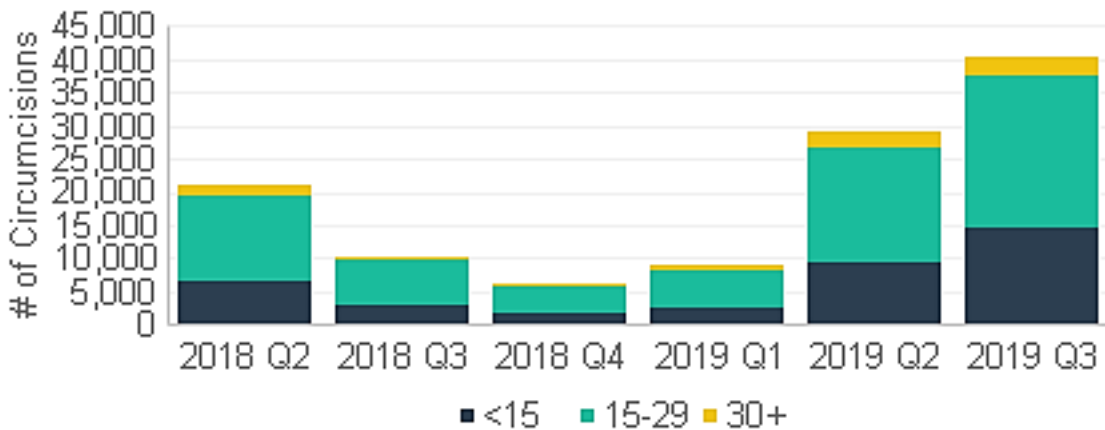


G. How are programs performing in terms of other Prevention interventions?

a. VMMC

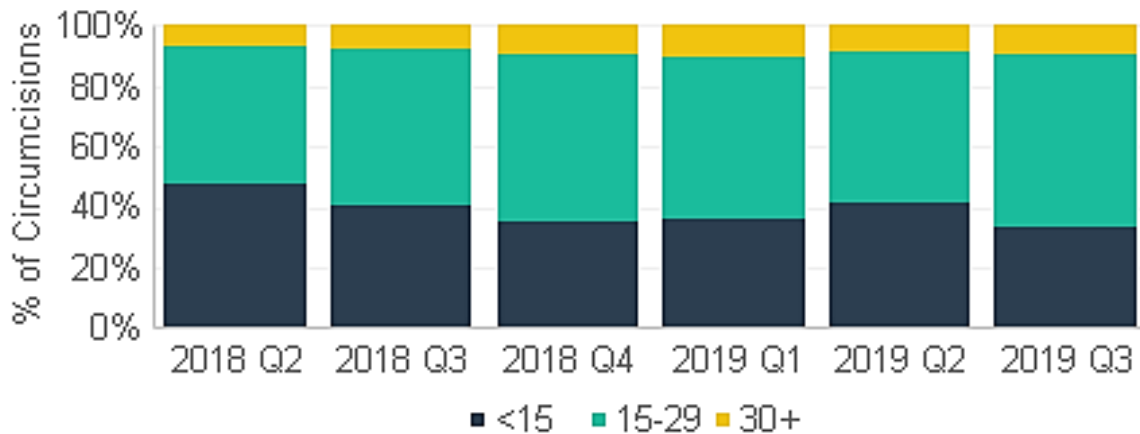
Critical questions for VMMC programs include whether the program is increasingly performing more circumcisions overall and in the priority groups. In Figure 7.2.24, we see that country X has been increasing the volume of circumcisions quarter over quarter for the last six quarters.

Figure 7.2.24: VMMC volume in quarterly trends of circumcisions by priority age bands increasing over time in Country X



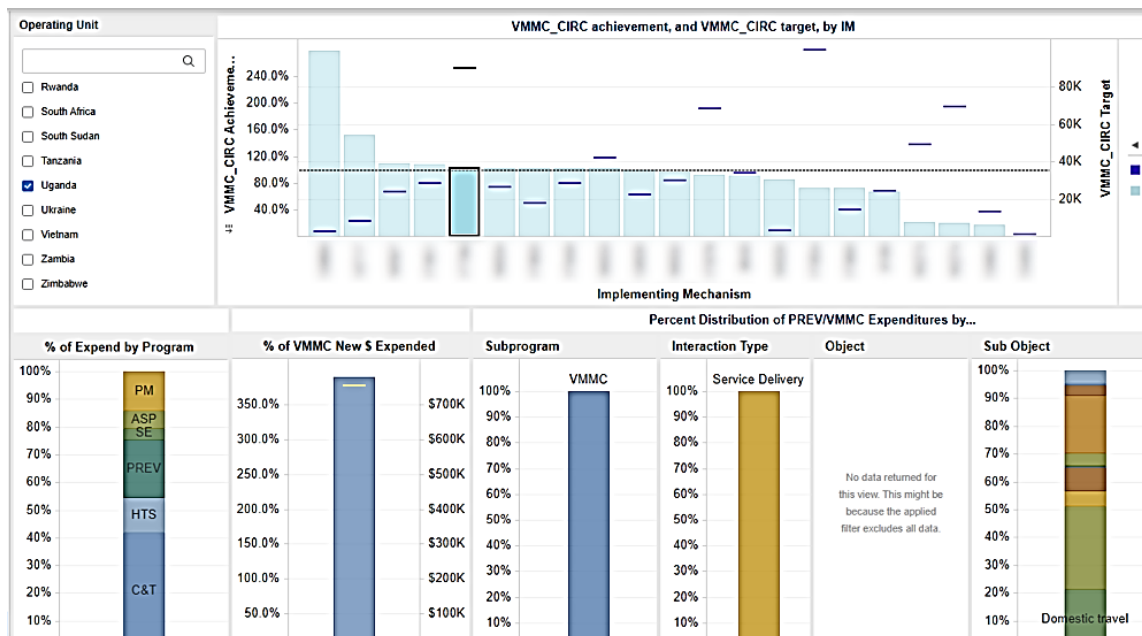
We also see that the relative proportion of circumcisions in the priority age bands has remained steady quarter over quarter (Figure 7.2.25). These patterns hold true for the largest VMMC IMs (data not shown).

Figure 7.2.25: Proportion of circumcisions in priority age bands remained steady over time



Finally, using expenditure data it may be worthwhile to compare IM level expenditures against target achievement to determine if all IMs are using resources in an effective and efficient manner. From Figure 7.2.26 below, we see that some IMs under-performed in terms of target achievement and it would be useful to better understand how those IMs resources were expended.

Figure 7.2.26: VMMC target achievement and expenditure in Country X



b. DREAMS

Using ER data, we can select the adolescent girls and young women sub beneficiary in the Financial Management Dossier to identify the partners working in this area, and to see the program areas that they work in to serve AGYW. Below we see that the four IMs working in DREAMS spend their money primarily in socioeconomic interventions, with small amounts spent in Prevention as well. This provides useful context for our triangulation of MER and SIMS data below.

Figure 7.2.27: Identification of IMs who support DREAMS programming through largely socioeconomic interventions

Budget and Expenditure by Level 1, Level 2				
Level 2	PREV		SE	
	Budget	Expenditure	Budget	Expenditure
Level 1				
			\$70,383	\$160,186
			\$4,127,687	\$3,374,397
			\$827,511	\$1,265,464
	\$123,724	\$134,484		

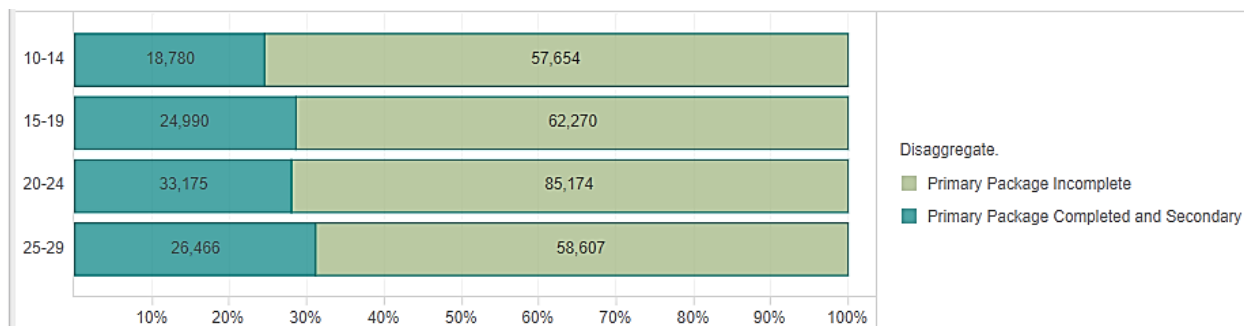
Similarly, we also see that all expenditures are service delivery (as expected) and cover areas or interaction types such as human rights protection, economic strengthening, behavior norms etc. (Figure 7.2.28 below). Such information on how resources were spent can also inform the lens with which we view MER and SIMS results from DREAMS IMs and SNUs in Country X.

Figure 7.2.28: Expenditures by Service delivery interaction type for DREAMS IMs in Country X

Level 1	Interaction Type	Expenditure		
		Non Service Delivery	Service Delivery	Total
Level 2				
	Total		\$160,186	\$160,186
	4>Legal, human rights & protection>Service Delivery>Females>Young women & adolescent females		\$160,186	\$160,186
	Total		\$3,374,397	\$3,374,397
	3>Comm. mobilization, behavior & norms change>Service Delivery>Females>Young women & adolescent females			
	4>Case Management>Service Delivery>Females>Young women & adolescent females		\$506,875	\$506,875
	4>Economic strengthening>Service Delivery>Females>Young women & adolescent females		\$1,659,724	\$1,659,724
	4>Education assistance>Service Delivery>Females>Young women & adolescent females		\$1,207,798	\$1,207,798
	Total		\$1,265,464	\$1,265,464
	4>Not Disaggregated>Service Delivery>Females>Young women & adolescent females		\$1,265,464	\$1,265,464
	Total		\$134,484	\$134,484
	3>Comm. mobilization, behavior & norms change>Service Delivery>Females>Young women & adolescent females		\$134,484	\$134,484

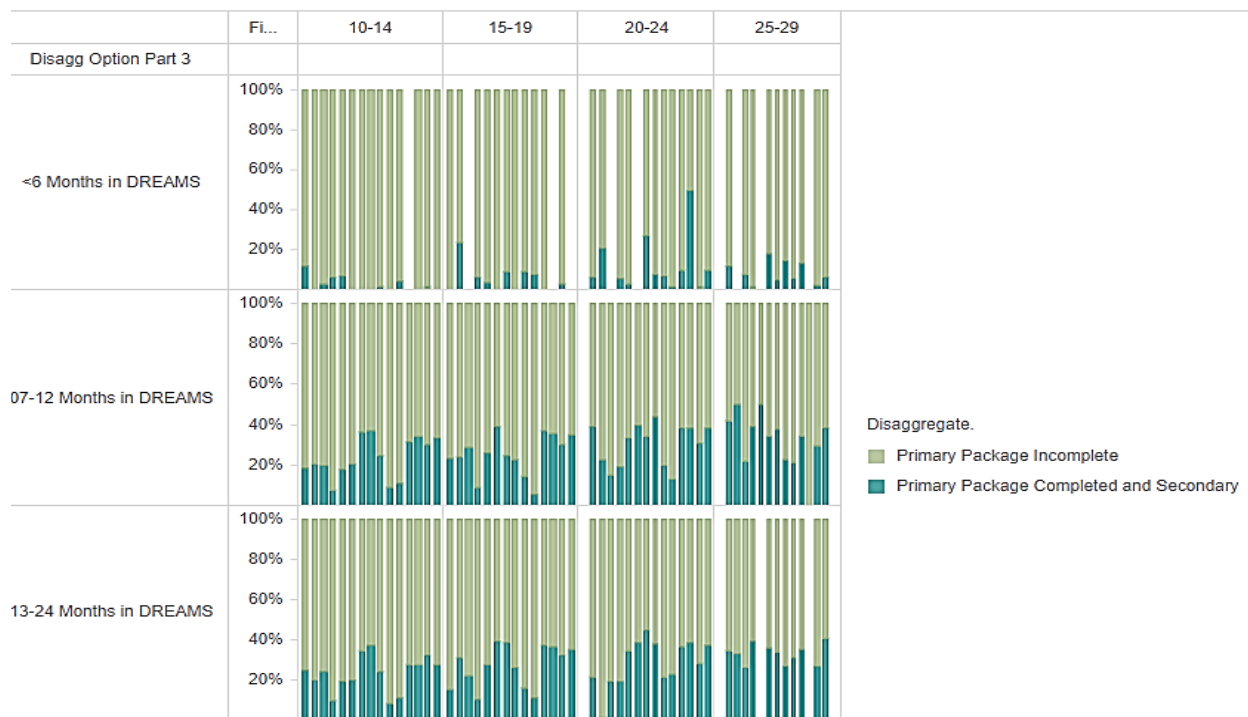
Form our MER data, we know that 205,609 out of 367,116 AGYW (or 56%) are in the priority age group of 15-24 yrs in Country X (Figure 7.2.29). These results do not vary considerably by SNU in Country X (data not shown). Teams should consider what may be needed to ensure DREAMs programming is increasing targeting that priority age group.

Figure 7.2.29: Proportion of AGYW who are within the priority age band (15-24 yrs) in Country X



Similarly, the proportion of AGYW who do not complete even the primary intervention package remains high across SNUs, regardless of how long the DREAMs beneficiary has been in the program (Figure 7.2.30). This suggests there may be broader challenges or barriers to completing the DREAMs primary package that are independent of time in the program.

Figure 7.2.30: Rates of completion of Primary Package of services by SNU do not increase with time in DREAMs, in Country X



Our SIMS analysis in Country X demonstrated that standards related AGWY programming scored a ‘red’ or ‘yellow’ at least the following percentage of the time these standards were assessed: preventing HIV amongst AGYW (25%), case management (38%) and gender norms (53%). These results show standards of service quality are not being met consistently, which compromises the overall quality of the DREAMs package available. Note also that ER review above revealed that IMs were spending resources in these specific areas of programming that were also assessed through SIMS. Triangulated analysis such as this between MER, SIMS and ER results may help shed light on what may be contributing to the lower than expected rates of completion of the primary package.

c. OVC

Critical questions for OVC programming include whether we are increasingly serving beneficiaries aged 10-14, and if the distribution of beneficiaries by age/sex and program status and rates of exiting without graduation vary across IMs. From the figures below, we see that the two main IMs are serving a large group of 10-14 yr olds, although the relative proportion of this group is smaller than others (such as 18+). Although, in the first example IM A, almost all beneficiaries were active in FY, but 10,917 beneficiaries exited without graduation. This suggests that populations reached with services may not be staying in the program.

Figure 7.2.31: Distribution of OVC_SERV results for IM A by program status and age/sex demonstrate potential for improvement in reaching 10-14 year olds may be needed

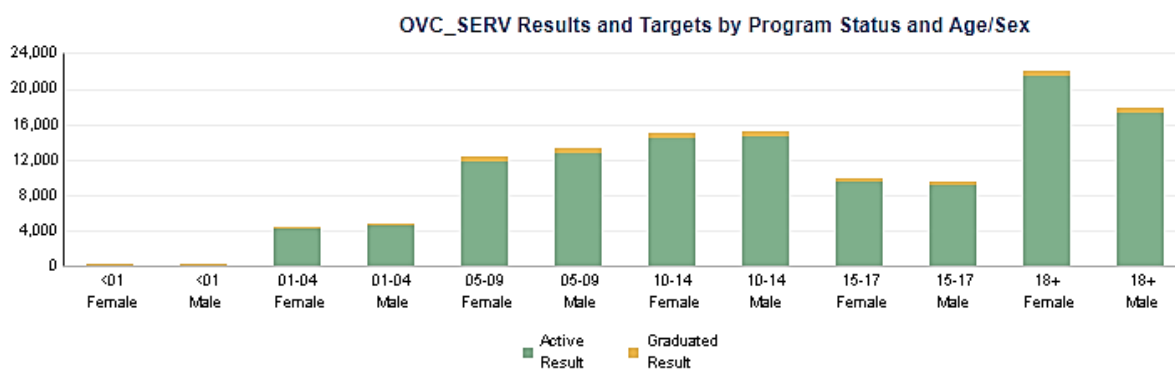
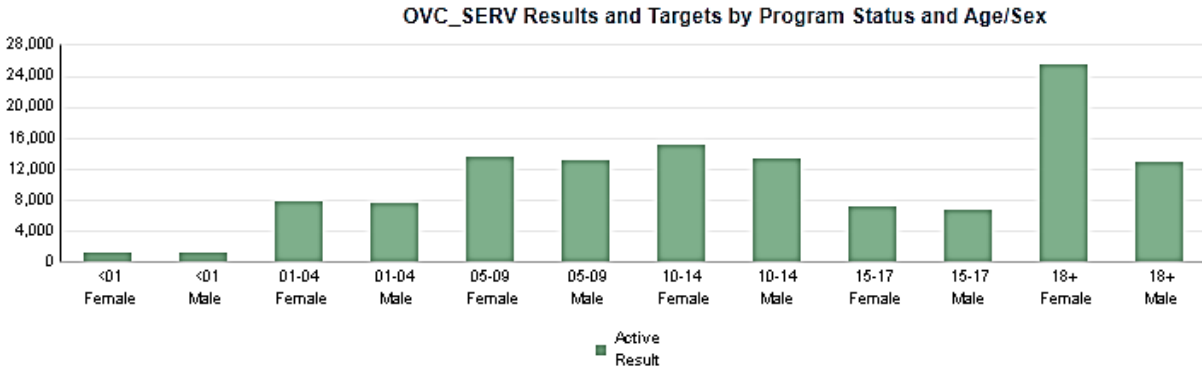


Figure 7.2.32: Distribution of OVC_SERV results IM B by program status and age/sex demonstrate potential for improvement in reaching 10-14 year olds may be needed



Triangulation with SIMS data demonstrates that both IMs scored a ‘red’ or ‘yellow’ at least 20% of the time, at sites where standards related to OVC were assessed. This also suggests that a need may exist to understand the quality of services being provided as a way to understand the high rates of exiting without graduation.

H. How sustainable is the HIV response? And who is responsible among donors and host governments? What are the above site investments tied to performance and achievement of epidemic control? What remains to be funded at the above site level?

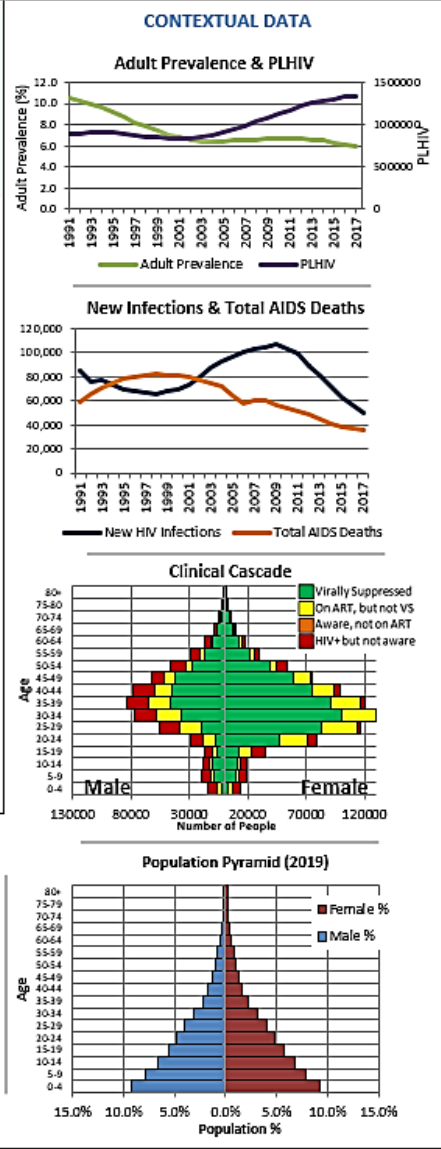
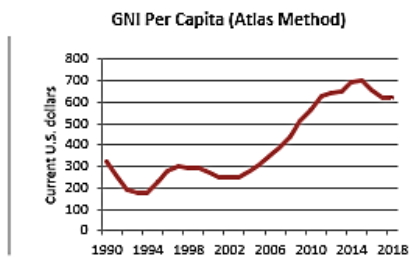
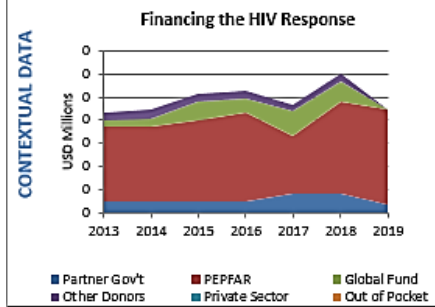
In Figure 7.2.33 of Country X’s SID, we see that the national response has persistent gaps in service delivery and strategic financing over time. It will be important to understand why such problems persist, who the responsible parties may be, and what needs to change to see improvement in these areas.

Figure 7.2.33: SID results demonstrate persistent gaps over time in Service Delivery and Strategic Financing in Country X

Sustainability Analysis for Epidemic Control: Uganda

Epidemic Type: Generalized
 Income Level: Low income
 PEPFAR Categorization: Long-term Strategy
 PEPFAR COP 19 Planning Level: 410000000

	2015 (SID 2.0)	2017 (SID 3.0)	2019	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	8.67	9.33	10.00	
2. Policies and Governance	7.17	8.19	7.48	
3. Civil Society Engagement	5.00	5.00	7.29	
4. Private Sector Engagement	3.98	7.40	8.25	
5. Public Access to Information	6.00	6.00	7.33	
National Health System and Service Delivery				
6. Service Delivery	5.88	3.80	5.12	
7. Human Resources for Health	6.92	6.20	6.71	
8. Commodity Security and Supply Chain	4.54	3.80	4.24	
9. Quality Management	6.24	6.52	8.33	
10. Laboratory	5.69	5.25	4.61	
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	2.78	5.36	4.84	
12. Technical and Allocative Efficiencies	1.31	4.16	6.46	
13. Market Openness	N/A	N/A	6.67	
Strategic Information				
14. Epidemiological and Health Data	5.30	4.65	4.87	
15. Financial/Expenditure Data	6.25	5.00	7.50	
16. Performance Data	8.30	7.23	8.33	
17. Data for Decision-Making Ecosystem	N/A	N/A	4.67	



To this end, it's important to know the financial investments by donor and program area/sector in-country. For country X, you can see that several different parties are engaged in funding the epidemic across multiple sectors (Figure 7.2.34). Efforts to leverage and maximize all investments and programming are key to achieving epidemic control.

Figure 7.2.34: Summary of donors and investments in Country X by Sector, 2016-2017

Recipient country
 Uganda

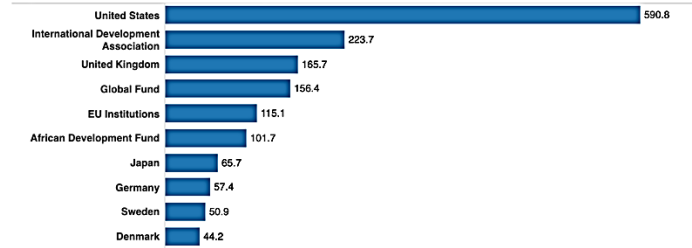
Receipts for Uganda

	2015	2016	2017
Net ODA (USD million)	1,628.3	1,756.9	2,008.1
Net ODA/GNI (%)	6.1	7.4	7.9
Gross ODA (USD million)	1,693.5	1,812.5	2,069.3
Bilateral share (gross ODA) (%)	57.8	59.7	63.3
Total net receipts (USD million)	2,983.3	2,170.0	2,119.6

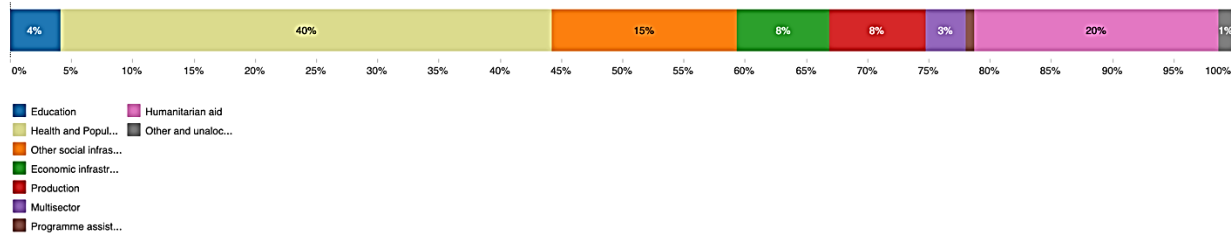
For reference

	2015	2016	2017
Population (million)	40.1	41.5	42.9
GNI per capita (Atlas USD)	670.0	630.0	600.0

Top Ten Donors of Gross ODA for Uganda, 2016-2017 average, USD million

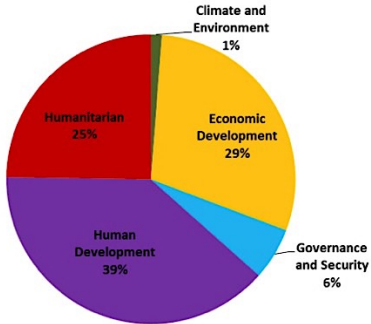


Bilateral ODA by Sector for Uganda, 2016-17 average



Similarly, what other bilateral partners are investing in health or AGYW programs, and what is the scope of their work? From Figure 7.2.35 below, we see that other bilateral partners have substantial investments in the health and AGYW programs with the aim of achieving the Global Goals. For example, 40% of bilateral funds are used for Health and Population programming. As with the analysis above, understanding and leveraging these investments and donor activities (while avoiding duplication) towards collective goals is key, and should be considered when planning for COP20 activities and setting COP20 budgets by IM.

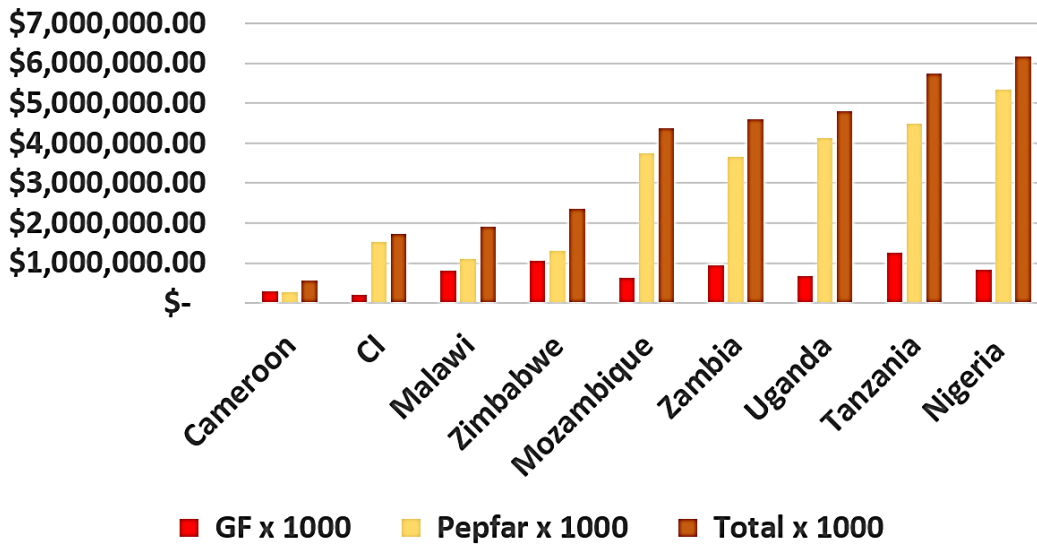
Figure 7.2.35 Planned bilateral budget for one donor in Country X

Planned budget for 2018/19	£100m						
Planned budget for 2019/20	£96m						
Sector breakdown of 2018/19 bilateral plans 	Top 3 planned spending programmes in 2018/19 (as at 9th May 2018) <table border="0"> <tr> <td>Building Resilience and an Effective Emergency Refugee Response</td> <td>£35m</td> </tr> <tr> <td>Strengthening Uganda's Response to Malaria</td> <td>£10.3m</td> </tr> <tr> <td>Northern Uganda: Transforming the Economy through Climate Smart Agribusiness</td> <td>£8.8m</td> </tr> </table>	Building Resilience and an Effective Emergency Refugee Response	£35m	Strengthening Uganda's Response to Malaria	£10.3m	Northern Uganda: Transforming the Economy through Climate Smart Agribusiness	£8.8m
Building Resilience and an Effective Emergency Refugee Response	£35m						
Strengthening Uganda's Response to Malaria	£10.3m						
Northern Uganda: Transforming the Economy through Climate Smart Agribusiness	£8.8m						
Contribution to the Global Goals and other government commitments (achieved as at March 2018)[†] <p>248 thousand children under five years old, women and adolescent girls reached through nutrition related interventions</p> <p>572 thousand additional women and girls provided with modern methods of family planning</p> <p>56 thousand children supported to gain a decent education</p> <p>130 thousand people with sustainable access to clean water and/or sanitation</p>							
Headline deliverables <ul style="list-style-type: none"> • Economic development: UK support has led to a 62% average time reduction at targeted border crossings, a 50% reduction in customs clearance times from 3 days to 1.5 days and a reduction in cargo transit time from 8 days to 2 days to provide goods to the East African market serving over 200 million people. We will continue to unlock opportunities for the UK and other businesses to bid for US \$24 billion of public private partnerships projects and support increased incomes for 331,000 people. This will help Uganda create jobs for its people and become a greater trading partner for the UK in the future. • Women and girls: We focus on strengthening health and education systems nationally in order to help manage Uganda's population growth rate. We are also helping to bring positive social change by increasing choices for women and girls, tackling violence against women and girls and managing high birth rates. Over the next five years we will support over 360,000 women and girls with modern methods of family planning; and help 200,000 women and girls receive an education. Young people and the disabled, often marginalised because of cultural and structural barriers, are at the core of our work. • Humanitarian: Between December 2016 and February 2018, we provided food for over 1,000,000 people; supported 64,000 women and 146,000 under-fives with immunisation and food supplements; 							

Similarly, it is key to know how GF and PEPFAR resources synergized or aligned to achieve epidemic control, as shown in Figure 7.2.36. In addition, it will be important to know what are PEPFAR, Global Fund and Host Country Government's planned investments, and whether we have a complete view of HIV funding in country and how they are aligned towards the goals of achieving epidemic control.

Figure 7.2.36: Cumulative investment of PEPFAR and Global Fund in select countries

Cumulative Investment



PEPFAR, the Global Fund and host country governments are the primary financiers of the HIV response. To maximize efficiency and impact of these investments, it is important to understand the distribution of resources across the three stakeholders and other contributors where possible. Timing of PEPFAR’s COP20 and Global Fund’s grant planning cycles along with availability of Resource Alignment data provide country teams a unique opportunity to ensure investments are strategically aligned, there’s no duplication, and spending is in line with program priorities and gaps. This will help determine who is paying for what, and whether investments across all stakeholders fully aligned towards the goals of achieving sustained epidemic control.

The following figures provide trend in planned investments across the three stakeholders and planned 2020 HIV investments across PEPFAR, Global Fund, and host country government by program areas (incl. commodities). This information is helpful in prioritizing resource allocation in some areas instead of others and identifying funding gaps in important PEPFAR focus program areas that may not have enough funding from other sources.

Figure 7.2.37: Trends in total budget by stakeholder in Country X

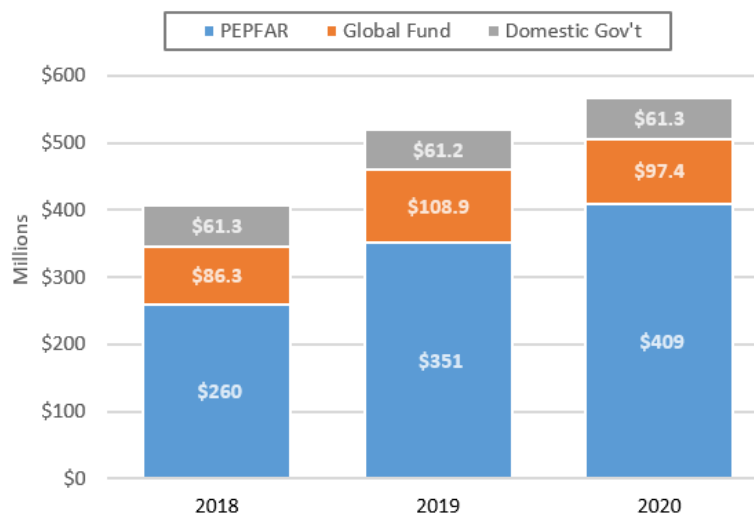
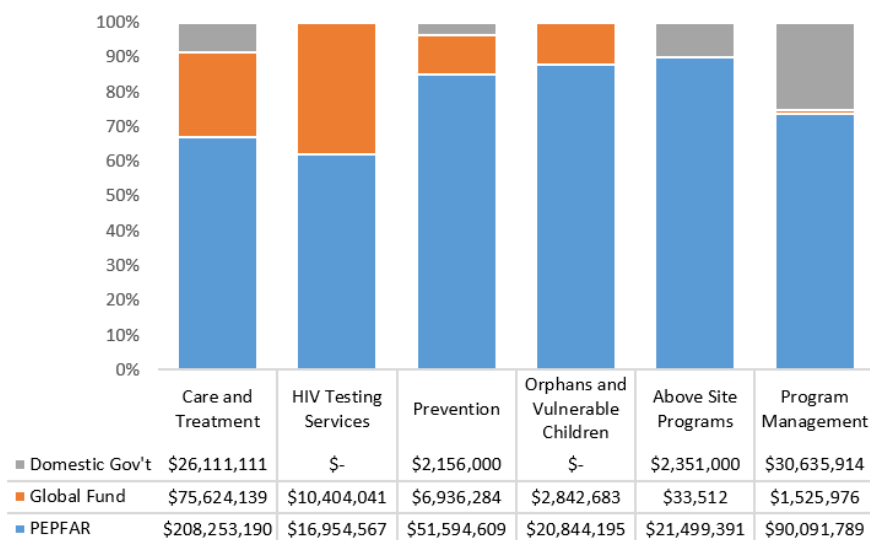
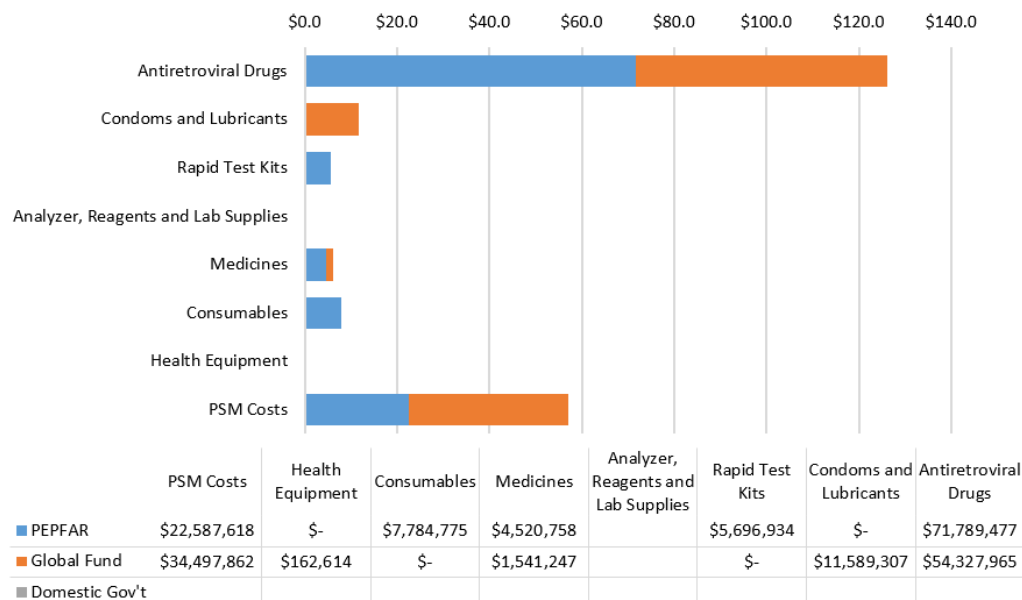


Figure 7.2.38: Budget Proportions by Program Area, 2020, in Country X



The following visual and table provide planned 2020 HIV commodity investments by type across PEPFAR, Global Fund, and host country government.

Figure 7.2.39: Country X Commodity Budgets by Stakeholder, 2020



In COP18 in Country X, the following Table 6 investments were prioritized: case-based surveillance, scale up of PreP, HRH investments and supply chain. Given the challenges identified in earlier Steps 2A-H, and the known gaps in national service delivery, should these remain to be the main investments at the above site level? It may be important to consider, what above site investments would be needed to address known site and SNU level challenges in service delivery around retention of patients on ART and delivery of client-centered services. Other factors to consider based on the donor profiles above for Country X would include improving ways to leverage other bilateral funds in a complementary manner to achieve Global Goals and epidemic control.

I. How should funding be allocated and aligned to performance at the IM, SNU, and site level?

As described at the beginning of Step 2, triangulated and integrated program data analysis at the OU and SNU levels should be overlaid with financial data in order to align funding to performance. At the end of Step 2H, country teams should:

(1) Cross-check the IMs they shortlisted (as performing well or poorly) as they completed the sub-steps, against the COP Matrix and Figure 7.2.3 from Step 2A. That is, teams should cross-check their shortlisted IMs against budgets, outlays, and financial reporting by IM and agency to understand the scale and scope of each IM.

(2) Detail the main program areas and interventions that need to be scaled with fidelity in order to achieve epidemic control, with a focus on retaining patients in client centered services

Teams will use this cross-check and detail of program areas to determine how to set preliminary budgets by IM and program area (i.e. using the principal of incremental budgeting, what needs to go up, and what needs to go down?). Based on this analysis, above-site investments, surveillance activities to be funded etc. can be then be determined.

In general, well-performing SNUs and IMs should be preferentially funded while those under-performing should have funding decreased. Similarly, sites within SNUs that continue to perform and grow should also be preferentially funded in a manner commensurate with SNU-level targets although site level target setting is not required to be submitted. Where relevant, new SNUs should be assessed based on PLHIV burden. Additional details about targets for such SNUs and IMs can be found in [Section 7.5](#).

‘Deep Dive’ Questions: TO BE COMPLETED AS NEEDED

As mentioned above, these additional analytic questions are provided to help understand what the root causes or implementation challenges may be. As such, Steps A-F are required, while these ‘Deep Dives’ should be answered as needed.

- Underlying Epidemiology: What is the demographic, epidemiologic, and national/regional program data to the lowest SNU possible as well as age and sex disaggregated data?
 - If PHIA data are available, teams should triangulate the PHIA results with program data - map program data along PHIA results by region to identify areas/populations that are underserved by community-level PHIA data and address programmatic data and targeting. Overall, this type of analysis identifies those in need of ART by age/sex. PHIA data should also guide the need for program data audits, i.e., program data treatment over-reporting compared to PHIA data on treatment.
 - What does MOH data alignment data demonstrate about the PEPFAR vs. national response? Are there any discrepancies, and why?
 - Are certain sites or PSNUs performing better than others?
 - Are MOH sites with linkage rates over 100% in similar geographies to PEPFAR sites with linkage rates below 90%? And vice-versa?
- Program Performance via MER: Who are we missing?
 - Case Finding:
 - What is the **quality and scale** of implementation of **index testing**?

- What proportion of newly identified positives are offered and accept index testing services?
- How many contacts are elicited and tested (by age/sex)?
- How many new positives were identified and what was the yield?
- What algorithm is used?
- What is the status of recency testing across districts and sites
- What is the right strategic mix of testing modalities, given your epidemic and current ART coverage by SNU, age/sex with a special focus on number of POS and yields from Other PITC and Index testing modalities?
- Using FY19 data at a minimum, develop ART coverage and testing tables (i.e. at a minimum, ART coverage and testing data by modality and age/sex) by SNU – either PSNU-level or grouping SNUs depending on your context.
- Refer back to your OU's planning level letter for HTS-specific guidance on prioritized testing modalities depending on ART coverage.
- Using the data and conclusions from above, map out the following by SNU:
 - ART Coverage
 - Recommended testing modalities and expected yields (for example, expectation of 20-40% yield from index testing)
 - Any age/sex focus populations as per COP Guidance or other data supporting unmet need (for example, if ART coverage amongst men remains low, those populations should be prioritized for index testing approaches)
- Reconcile the tables you developed with the 'mapping' above. That is, determine what shifts are needed in terms of **contribution of positives** and expected yields to align with your 'mapping'. Use these inputs to understand the 'right strategic mix' of testing modalities to be implemented AND expected outcomes from those

modalities (such as, contribution of positives and yields by modality and age/sex)

- Were there any documented instances of test kit stockouts and/or challenges with distribution of kits?
- Treatment: Who are we missing in terms of linkage to treatment?
 - What is linkage by age, sex, and geographic location and testing modality? PEPFAR teams should be able to describe with data how many newly initiating ART patients can be expected from each of the HTS entry streams.
 - What is the linkage rate at sites with the highest number of un-initiated newly diagnosed PLHIV?
 - Do initiation rates differ by sex? By age? By SNU?
- Treatment: Who are we not retaining on treatment?
 - Who are losing from treatment by age/sex and SNU? How does this loss compare with the rate of treatment growth? How many people are being lost for each person gained? Figures 7.2.40.

Figure 7.2.40: Treatment growth by age and sex, FY18Q4 to FY19Q4 for Country X

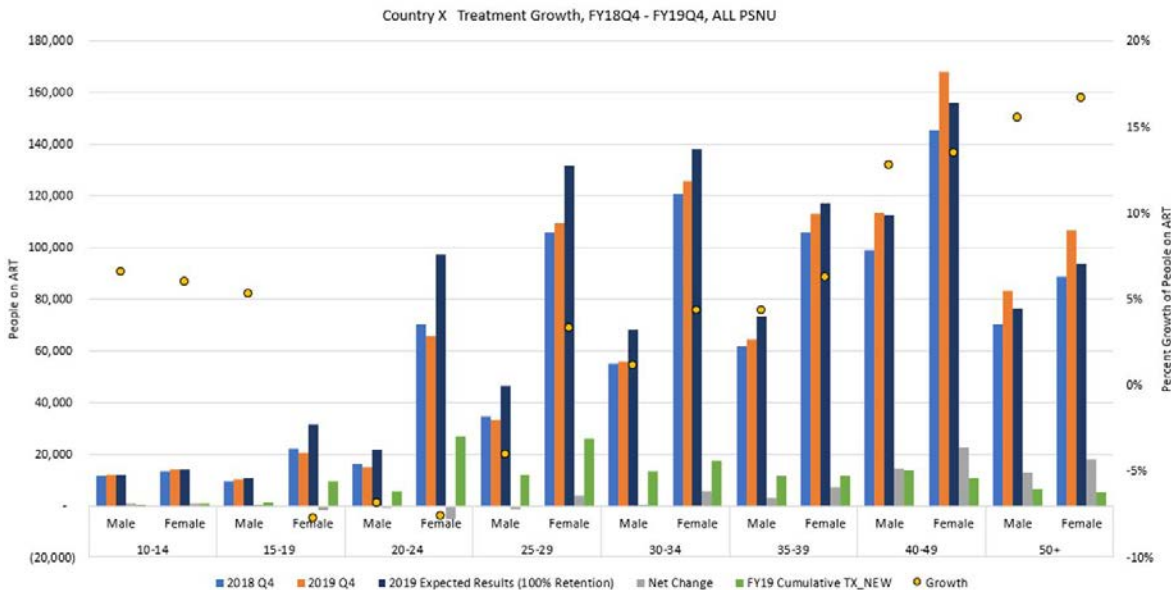
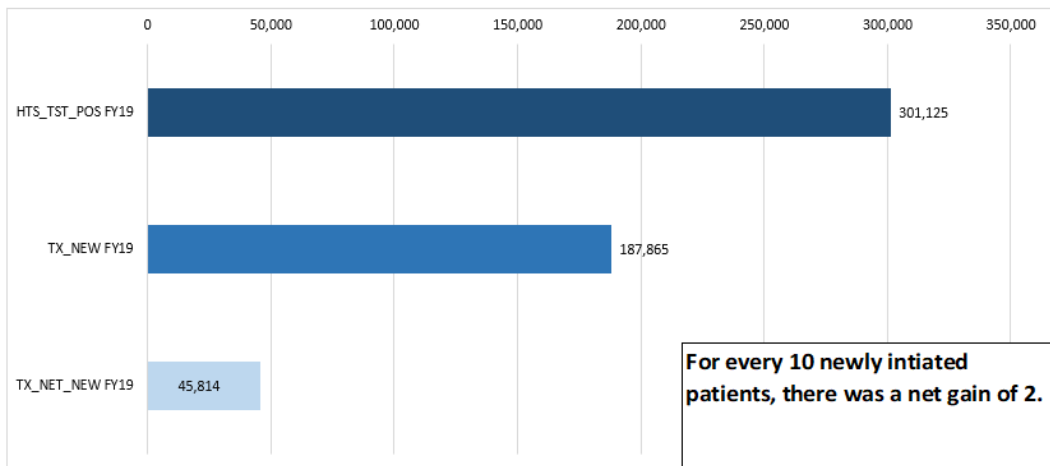
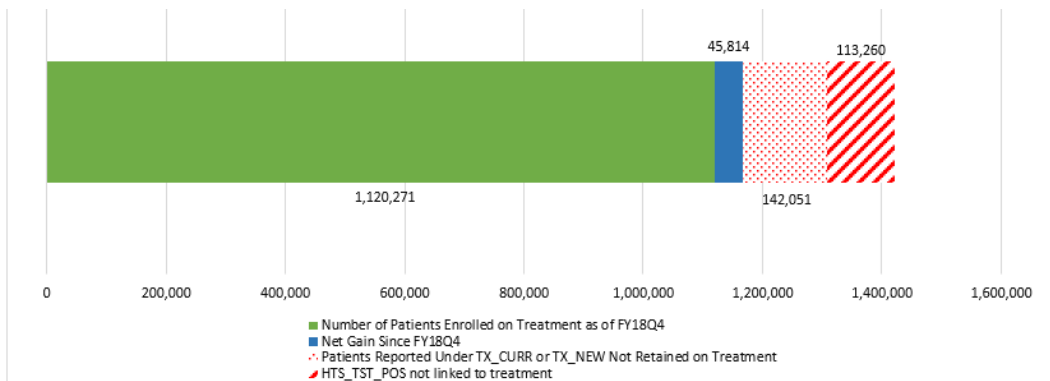


Figure 7.2.41 Progress on retaining individuals in life long treatment in Country X in FY19



- What is treatment program growth and retention of all clients over time (TX_CURR over time), and in relation to treatment initiation (TX_NEW) and program loss (TX_ML), and program return to treatment (TX_RTT)?
- Are all patients eligible for multi-month dispensing accessing and using MMD options? Are all patients eligible for TLD on TLD? How many sites meet these criteria, and what is the volume of patients at those sites?
- Does the geography of the site have an impact on retention (i.e. urban vs rural)?
- Were there any documented instances of ARV stockouts and/or challenges with distribution of ARVs?
- Viral Suppression: Who are we missing?
 - What is coverage of viral-load testing by age/sex/geography? What are the barriers to 100% coverage?
 - What is VLS by age/sex/geography?

- Are those eligible for annual viral load tests getting annual viral load tests? Are results being returned to the client record?
 - Tuberculosis:
 - What is testing coverage of PLHIV for TB by age/sex? Who is missing?
 - What is the progress on scale up of IPT? What are the barriers?
 - What is the testing and treatment coverage of TB+ patients for HIV? What are the barriers to full coverage?
 - What are TB therapy completion rates for HIV/TB co-infected patients? What are the barriers to 100% completion rates?
 - Prevention:
 - What is the coverage of prevention interventions, including VMMC, condoms (and lubricants), PrEP, and DREAMS interventions (especially among relevant target populations)? Modeling tools can assist countries estimate unmet need for VMMC for adolescent boys and men, particularly for those age 15-29 years. Where available, incidence data from surveys, including those showing higher HIV incidences in men older than 30 years, should be considered in age targeting, so that MC program efforts include age groups with the highest HIV incidence.
 - Is PrEP available for pregnant and breastfeeding women, serodiscordant couples, or other high risk populations?
 - Are we reaching saturation in high-burden districts for VMMC?
 - DREAMS:
 - Have 90% of active DREAMS beneficiaries completed at least the primary package after being in DREAMS for 13+ months?
 - Who are we missing in terms of performance on PrEP_NEW and PrEP_CURR by relevant AGYW age band (and among high-risk AGYW)?
 - Key Populations
 - What is the performance of the overall clinical cascade? What are the HIV testing modalities, volume, and yield? What are rates of linkage to treatment, retention and viral load suppression?
 - What is the proportion of prevention (KP_PREV) reach versus testing reach?

- What is the uptake of PrEP among relevant target populations? What are the barriers?
- How are MAT programs performing (where implemented)?
- OVC
 - Country teams should pay careful attention to risk trends across the age span, noting for example high risk of morbidity and mortality among adolescent girls in East and Southern Africa, reductions in numbers of children orphaned, and reductions in the number of children infected via PMTCT. Countries should also look at trend data as the number of children orphaned by AIDS continues to decline with advanced ART coverage. Important MER results data from FY19 Q4 to take into consideration include the following:
 - OVC_SERV<18, disaggregated by age and sex for age 10-17
 - OVC with known HIV status (OVC_HIVSTAT)
 - Number of children living with HIV (HTS_TST positive<15), HIV+ Children (<15) TX_CURR, HIV+ Children (<15) with high VL, HIV+ Children (<15) Newly on ART, HIV+ Adolescents TX_CURR (15-19), HIV+ Adolescents (15-19) with high VL, HIV+ Adolescents (15-19) Newly on ART
 - Number of HIV exposed children (PMTCT_HEI_POS), pregnant women PW who are newly positive, adolescent pregnant women PW (10-19)
 - Number of PLHIV (HTS_TST to estimate number of children living with HIV+ adult)
 - KP data (HTS_TST_KP)
 - GEND_GBV <19
 - Estimates of orphaned children (by all causes) are generally available via DHS and MICS. To better profile risk within this subgroup, it is important to look at disaggregation by age and by status (i.e., single vs. double orphan). Additional data, including Violence Against Children Surveys (VACS) and data on children out of school, school attendance, and school progression (particularly among adolescent girls) are useful to inform an understanding of vulnerability.
- Cervical Cancer (if relevant):

- What is the progress by sex against the target, and along the screening to treatment cascade? What are the gaps in linking from screen positive to treatment?
- Program Performance via Quality (SIMS, CQI, community-led monitoring):
 - What do SIMS results show about overall achievement of quality standards for key interventions? Does these vary by partner or geography?
 - What do SIMS results show about barriers and facilitators to implementing or scaling patient-centered approaches at the site level, especially in sites with challenges in retaining patients? See [Section 3](#).
 - What CQI steps have been implemented to improve site level service delivery, and tailor services to the needs of urban, well, young and/or male clients?
 - What did you learn from any community-led service quality monitoring activities at sites? See Community-led Monitoring section in [Section 3](#).
 - What do we learn about patient-provider barriers, motivations, facilitators to accessing and/or providing quality client centered services?
 - Does elicitation of contacts under 15 years and Identification of new positives under 15 years remain low despite clear WHO guidelines and unacceptable high risk of morbidity and mortality among the missing children? Using MER data, we know that the number of HIV positive children identified even through index testing remains low. In particular, the number of contacts who are under 15 elicited from women is lower than expected. This suggests that there may be incomplete coverage of routine testing of children of mothers who are HIV positive. Using SIMS data, we see that performance of the SIMS Standard on Routine Testing of HIV positive mothers performs poorly across all OU. Using these data together, this suggests improvements are needed to ensure all HIV positive mothers are offered HIV testing of their biological children.
- Financial Performance: Budgets, Outlays, and Expenditures
 - What were the major interventions by planned and actual spending? Were these aligned to strategy?

- Did what IPs purchase align to what was the stated purpose, i.e. if the budget was for HIV clinical service delivery, did IPs procure health care workers, commodities, or how else did they directly interact with beneficiaries?
- Using the budgets and outlays as reported through the EOFY tool:
 - What are, by agency, approved spend versus actual outlays (as per EOFY)?
 - What is the approach to obligating and approving outlays for an IP that has performance shortfalls?
 - Which mechanisms have had delays in their draw down of funds, resulting in OPUs or in requests to over outlay?
 - Which mechanisms have unliquidated obligations? What are they related to and will be liquidated in COP19 or will they need to be included in the COP20 budget and outlays?
- Planned interventions and Implementing partner work plans

For each of the IP work plan elements below, teams should review the details about what partners planned to achieve against the COP strategy and results.

- Program narrative: Explains how the IP will comply with partner improvement plans and management directives and achieve the targets (categorized as service delivery and non-service delivery activities), above-site benchmarks, and SRE outputs in line with the approved COP/ROP19.
- Targets set against MER indicators.
- Human resources for health: Lists of IP staff categorized by cadre, program area, targeted beneficiary group (as reported in HRH MER indicators or another valid and relevant data source)
- Budget by program area, beneficiary, and cost category as well as budget narrative
- Commodities planned procurement
- Human Resources for Health (HRH):
 - Are HRH investments accelerating epidemic control? Are the facilities and community centres staffed with the right number and skill-mix of health workers to reach HIV targets? How is the PEPFAR program using data to optimize health workers to achieve program targets?

- Does adding additional health workers at sites result in improved site-level performance? For example: does adding ART providers at a site increase TX_NEW?
 - What is the role of community health workers across the HIV cascade? Are the CHWs implementing activities to improve retention, such as defaulter tracing and community ART dispensing?
 - Are PEPFAR-supported health workers supplemented adequately by the country government and other donors?
 - Is there a functioning information system or inventory to monitor the allocation, deployment, and productivity of health workers? Have the results from this system used to inform health workers optimization to epidemic control.
 - What is the role of peer monitoring, outreach and support and are they funded adequately?
 - How are country government and other donor-supported workers working with PEPFAR-supported staff at sites and contributing to HIV service delivery? Are PEPFAR-supported workers having an additive impact on workload?
- SID:
 - What were the major findings for each domain? Which elements represented particular sustainability strengths? Which elements were found to be vulnerabilities?
 - Among those SID elements identified as sustainability vulnerabilities, which do stakeholders regard as priorities? Based on the indicators that comprise these elements, what specific aspects of these elements require improvement/investment?
 - What are the priorities across partners? Are they aligned or in conflict? Do they complement each other?
 - Is the country government or any development partners already working to strengthen these priority elements? How do those efforts align with the specific vulnerabilities identified in the SID?
 - For priority elements not receiving support currently, which partner(s) (including both donors and government entities) are best placed to address these priorities and make the necessary investments? What is the plan forward for partner

investments based on priorities? Should the country team develop a multiyear strategy in collaboration with PEPFAR and GFATM?

- Are there particular priority elements that require PEPFAR investments in COP20, and why is PEPFAR uniquely qualified or positioned for achievement of this priority? (Note: It is not expected that PEPFAR would support all investment needs.)
- Resource Alignment and Funding Landscape:
 - Using the Resource Alignment tool, what is strategic alignment of investments across entities like PEPFAR and Global Fund?
 - Does the funds allocation match the program priorities and needs?
 - Are resources allocated duplicative?
 - Are there specific areas or types of funds with low absorptive capacities? If yes, what are the possible reasons? How can that be addressed?
 - Resource alignment, SID and MER -- to see if the systems investments are adequately targeted to address issues in the clinical cascade;
 - Resource Alignment and MER -- to assess possible duplication, gaps in funding and pockets of inefficiencies
 - Responsibility Matrix and MER -- to identify areas where agency/host government can prioritize resources based on competitive advantages
- Donor and Government responsibility:
 - The Responsibility Matrix (RM) serves as a baseline assessment of the functional responsibilities of the three major funding components of the HIV response: PEPFAR, the Global Fund, and Host Government.
 - Who is primarily responsible in elements that reflect lagging sustainability in the SID? Where is there a disconnect between financing and function? How should roles/responsibilities change to improve sustainability in this element?
 - Across the elements and dimensions of the RM, are stakeholder responsibilities complementary or fragmented towards achieving sustainability in the HIV response? How can stakeholder resources be better leveraged in priority elements? What are the ways to improve coordination?

- Above Site interventions: Efficient and effective above site investments continue to be an essential component of achieving PEPFAR goals, including identification and remediation of key barriers in the clinical cascade and shifting the national policies necessary to achieve epidemic control.
 - Are above site barriers and activities aligned to address barriers to epidemic control and improve site-level performance? How is the progress measured?
 - Teams should review expenditures and budgets against the Table 6 activities. Is the funding for above site investments aligned to the gaps identified? Are high priority gaps receiving sufficient funding? Low priority activities have should have declining funding or funding should be reallocated to higher priority activities.
 - What is the change in relevant MER indicators that can be attributed to respective Table 6 activities?
 - For activities that have achieved COP19 benchmarks, what is the rationale for continuing in COP20? How many additional years of support is needed?
 - For activities that have partially achieved COP19 benchmarks and continuing in COP20, what is the course correction?
 - For activities that are not initiated or have not achieved any of the COP19 benchmarks and continuing into COP20, what is the rationale for continuation?
 - Where relevant (especially for countries close to epidemic control), are investments in place to support systems for recency and case-based surveillance?
- Surveys, Research and Evaluation:
 - Are previously funded SREs providing data for program action to address known gaps and barriers in achieving epidemic control?
 - Are data from SREs disseminated and widely shared for use by stakeholders?
 - What evaluation activities are occurring in a given OU? (Note that you will only be able to see evaluations in the OU(s) associated with your DATIM account.)
 - What questions are being answered?
 - For these evaluations, what was the level of adherence to PEPFAR's publicly available Evaluation Standard of Practices?

7.3 Planning Step 3: Set Preliminary Budgets, Targets, and Above-Site Activities

By the end of Planning Step 3, PEPFAR teams and stakeholders should have consensus on:

- Balanced IM intervention-level budget for COP20 in the FAST
- Proposed IM by SNU-level targets for COP20 in the DataPack
- Proposed above-site, non-service delivery activities for COP20 in Table 6
- Proposed surveys, surveillance, research, and evaluation activities for COP20 in the SRE Tool

COP REQUIREMENT: OU teams are required to utilize the DataPack and related tools for target setting. Detailed guidance on target-setting with DataPack will be provided in the DataPack User's Guide.

COP REQUIREMENT: OU teams are required to utilize the FAST and FACTS Info for budget submission. Detailed guidance on budget entry and use of the FAST will be provided in the FAST User's Guide.

COP REQUIREMENT: OU teams are required to utilize the Excel tool for Table 6 and the SRE Tool. Detailed guidance on entry and use of Table 6 and the SRE Tool will be provided in the Table 6/SRE Tool User's Guide.

7.3.1 Set Preliminary Budget

In COP20, the Funding Allocation to Strategy Tool (FAST) budget allocation tool uses the PEPFAR Financial Classification structure for classifying the purpose, targeted beneficiary population, and what will be purchased with the PEPFAR funding. This classification is common across both PEPFAR program expenditures and budgeting, to be able to monitor expenditures against budget and improve planning and management of the PEPFAR investment.

The COP20 budgeting approach is the same as for COP18-19. First, COP20 focuses on the intended program outputs and outcomes of the budget. A program is a set of activities that results in a common group of outputs or outcome. These programs are defined as either having a service delivery or non-

service delivery approach and are implemented at either the site or above site levels. Programs are targeted toward an intended beneficiary group. Interventions are the unique combination of program and beneficiary population. The PEPFAR Financial Classifications Reference Guide provides comprehensive definitions for PEPFAR program areas and beneficiaries that are used in both allocating budget and reporting expenditures.

Program budgeting questions:

- What is the purpose of this funding? What is being done with the funding?
 - Is that objective aligned to the overall strategy of moving toward epidemic control?
 - Are HIV services being provided by local partners and, if not, what are the plans to increase coverage by local partners?
- Is current investment achieving the intended objective?
 - Is this approach an appropriate intervention for the context, for the epidemic, and for the IM?
 - What are the opportunities to shift services to local partners?

Second, COP20 budgeting builds directly on what was executed in COP18 and planned in COP19. This practice of starting from the previous execution and budget is also known as *incremental budgeting* and focuses on what is incremental or different for the future.

Incremental budgeting looks at the following questions:

- What needs to go up? For example:
 - Rapid scale up or expansion to a new geographic area or population
 - Costs of providing HIV services among non-governmental, local partners given the lack of public support for HRH, lab, clinics, and other necessary resources to provide quality HIV services.
 - Macroeconomic issues such as inflation or nurse or doctor strikes
- What needs to go down? For example:
 - Initial start-up costs incurred in COP18 or planned for COP19 that do not need to be repeated in COP20
 - New, less expensive drug or a price drop on the laboratory reagent

- Shift of funding to achieve scale-up targets in a certain SNU
- Completion of a one-off investment or project
- Underperforming/overspending activities
- Which partners should be expanded, and which partners should be contracted?
 - Partners whose performance has not improved must be replaced or their activities decreased, with another partner brought in.
- What needs to be added? What must be deleted?
 - A new IM with specific consideration for increasing the role of local partners in providing services.
 - A new programmatic strategy or approach

PEPFAR country teams must work during this phase to draft an initial budget in the FAST to use as a starting point for budget adjustment and to identify strategic gaps that need to be closed to align to your country's strategic plan and planning envelope. The FAST is prepopulated with FY19/COP18 IM expenditure reporting and COP19 budgets by intervention and to facilitate the incremental changes for COP20. The entire budget should be represented in the FAST, including applied pipeline and new funding for all IMs across both bilateral and centrally funded initiatives. As in previous years, all outlays that are projected to be during the 12 months of COP20 should be included in the COP20 budgets as either new funding or applied pipeline. It is important to include any outstanding IM close-out costs that may need to be disbursed during COP20, even if it is not clear at this time if they will take place in COP20 or a future COP. Having these close-out costs accounted for in the budget ensures that budget levels are sufficient to meet obligations and outlays.

OU teams will use the FAST to draft initial budgets. Steps for using the FAST are outlined in the FAST User Guide on PEPFAR SharePoint.

Budgeting for commodity procurement

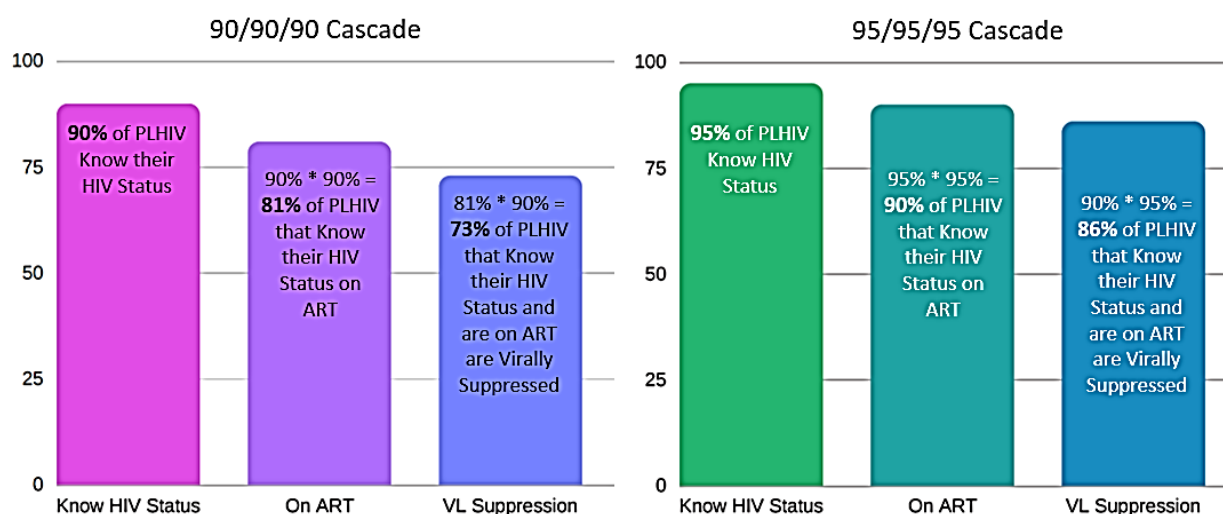
In addition to the overall budget represented by IM-level interventions, additional entry is required when commodities are procured. The commodity tab entry is similar to the process for COP17 and COP18 and is required for all IMs procuring commodities (i.e., ARVs, essential medicines, HIV rapid test kits, recency assays, condoms, VMMC kits and supplies, laboratory reagents or equipment).

Commodity procurement should be based on forecasting and supply chain planning for the OU and should take into consideration existing stock levels, guidance from PEPFAR as to preferred regimens, algorithms, or methods as applicable (see Sections [2.3.4](#), [7.3.4](#) and [8.5](#)), and procurement from other sources such as the host-country government and the Global Fund.

7.3.2 Setting Targets for Accelerated Epidemic Control in Priority Locations and Populations

Country teams should understand the initial SNU-level target outputs from the DataPack in advance of the January 2020 stakeholder strategic planning retreat. The purpose of the initial budget is to identify a starting point for the discussions at the strategic planning retreat. Initial targets should align with the budgets provided and should assist in identifying strategic gaps that need to be addressed to align the country's strategic plan and planning envelope, to get to 95/95/95 at country level. Additional level of ambitions over and above the current COP19 can be submitted as a country or as an agency.

Figure 7.3.2.1: Reaching 95/95/95 at the country level



Attained SNUs: Geographic areas that have achieved $\geq 90\%$ treatment coverage in both males and females within the following age bands: <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, and 50+. Getting to $>90\%$ treatment coverage by both males in females within the finer age bands at sub-national levels will ensure that the country gets to 95/95/95 overall.

Scale-up: Saturation and Aggressive Scale-Up SNUs: Geographic areas with the highest HIV prevalence nationally that have not yet achieved 90% treatment coverage, particularly among the population groups experiencing the greatest burden of disease.

- Scale-Up: Saturation SNUs receive intensive PEPFAR support with a target of reaching 90% of people at all ages, gender and risk groups, PLHIV on ART by 2020 and 2021.
- Scale-Up Aggressive SNUs receive intensive PEPFAR support with an overall goal of an increased rate of 'new on ART,' but are not expected to reach 90% of PLHIV by 2020 or 2021.

Sustained SNUs: Sustained SNUs receive a package of services provided by PEPFAR that are different in each country and include passive enrollment via HIV testing and counseling on request or as indicated by clinical symptomology, care and treatment services for PLHIV, and essential laboratory services for PLHIV. As the high-burden Scale-Up Districts are saturated, Sustained Districts will be aggressively scaled to reach 95/95/95 goals.

Central Support: In Central Support SNUs, site-specific activities have transitioned to government or other support. Central Support Districts will continue to receive PEPFAR national support for overarching activities, such as quality assurance and quality improvement (QA/QI) to ensure that patients continue to receive quality services.

As described above, the COP20 development process provides a platform for OUs to review progress toward the COP19 goals and reevaluate which sites or SNUs will be designated for saturation or aggressive scale-up in COP20 (Figure 7.3.3.2). Figure 7.3.3.3 shows the continuous nature of prioritization at the SNU level.

Figure 7.3.2.2: SNU prioritization for epidemic control COP19-20

Refreshing SNU Prioritization for Epidemic Control

COP 18 SNU Prioritization	Potential COP 19 SNU Prioritization
Attained	Attained (by default)
Scale-Up: Saturation	Attained (if >81% ART coverage is expected to be achieved among both adult and pediatric males <u>and</u> females living with HIV by APR 19) Scale-Up: Saturation (if ART coverage >81% is not expected to be reached for both adult and pediatric males and females living with HIV by APR 19)
Scale-Up: Aggressive	Scale-up: Saturation (if 81% target is achievable by APR 20) Scale-up: Aggressive (if 81% target is <u>not</u> achievable by APR 20)
Sustained	Scale-up: Saturation (if the SNU is prioritized based on PLHIV for the next tranche of scale-up, and a target of 81% is achievable by APR 20) Scale-up: Aggressive (if the SNU is prioritized based on PLHIV for the next tranche of scale-up, but a target of 81% is <u>not</u> achievable by APR 20) Sustained
Central Support	Central Support (by default) Sustained or Scale-Up (if a compelling case can be made to prioritize the SNU for scale-up or sustained support based on HIV burden)

Figure 7.3.2.3: Continuous nature of prioritization at the SNU level to reach epidemic control

SNU	COP	Prioritization	Results reported	Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall																				Overall TX Coverage				
				Treatment Coverage at APR by Age and Sex																								
				<1	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50+	F	M	F	M	F	M	F	M		F	M	F	M
SNU 1	COP 15	Scale-Up: Saturation	APR 16	45%	49%	55%	57%	65%	77%	63%	64%	77%	74%	80%	65%	62%	49%	60%	58%	77%	60%	81%	73%	80%	58%	77%	75%	65%
	COP 16	Scale-Up: Saturation	APR 17	66%	69%	71%	72%	75%	91%	81%	78%	83%	80%	91%	75%	77%	67%	78%	75%	91%	72%	93%	76%	91%	75%	94%	79%	81%
	COP 17	Scale-Up: Saturation	APR 18	81%	81%	83%	82%	82%	95%	85%	81%	87%	83%	95%	82%	90%	81%	89%	86%	95%	82%	96%	84%	95%	86%	95%	86%	86%
	COP 18	Attained	APR 19	83%	82%	85%	84%	85%	95%	87%	85%	92%	87%	95%	85%	92%	85%	90%	84%	95%	87%	97%	91%	95%	84%	96%	90%	92%
	COP 19	Attained	APR 20	86%	84%	85%	89%	83%	94%	88%	87%	94%	89%	95%	88%	95%	87%	89%	86%	95%	89%	97%	91%	95%	83%	94%	90%	92%
SNU 2	COP 15	Scale-Up: Aggressive	APR 16	27%	33%	47%	46%	73%	68%	35%	48%	58%	43%	55%	40%	68%	44%	67%	43%	70%	61%	66%	73%	77%	74%	57%	71%	47%
	COP 16	Scale-Up: Aggressive	APR 17	51%	60%	53%	59%	75%	77%	60%	48%	66%	51%	64%	42%	77%	50%	73%	45%	83%	66%	78%	75%	83%	80%	76%	89%	63%
	COP 17	Scale-Up: Saturation	APR 18	72%	71%	81%	77%	89%	88%	81%	63%	82%	79%	89%	65%	88%	77%	87%	81%	92%	77%	89%	89%	87%	83%	91%	93%	84%
	COP 18	Attained	APR 19	81%	82%	84%	82%	95%	91%	90%	83%	87%	85%	94%	82%	91%	83%	92%	85%	94%	82%	94%	95%	92%	87%	93%	95%	90%
	COP 19	Attained	APR 20	81%	82%	86%	82%	95%	92%	90%	84%	87%	86%	94%	83%	91%	84%	92%	85%	94%	82%	94%	95%	92%	87%	93%	95%	91%
SNU 3	COP 15	Sustained	APR 16	22%	26%	20%	21%	71%	39%	35%	37%	53%	25%	50%	39%	59%	36%	71%	49%	77%	55%	71%	60%	71%	68%	72%	68%	39%
	COP 16	Scale-Up: Aggressive	APR 17	30%	33%	25%	34%	81%	48%	40%	44%	51%	37%	54%	48%	61%	43%	81%	53%	83%	66%	73%	59%	81%	77%	74%	74%	50%
	COP 17	Scale-Up: Saturation	APR 18	45%	44%	38%	42%	84%	56%	46%	55%	56%	45%	70%	56%	66%	71%	84%	72%	88%	75%	91%	70%	84%	88%	81%	76%	63%
	COP 18	Scale-Up: Saturation	APR 19	61%	70%	66%	59%	91%	79%	71%	67%	79%	71%	84%	79%	80%	84%	91%	89%	94%	77%	92%	76%	91%	91%	83%	80%	82%
	COP 18	Attained	APR 19	81%	82%	83%	81%	93%	82%	81%	83%	85%	81%	85%	83%	91%	94%	93%	91%	95%	81%	95%	82%	91%	91%	85%	83%	90%
SNU 4	COP 15	Sustained	APR 16	39%	41%	60%	44%	60%	49%	56%	37%	60%	40%	65%	32%	82%	26%	50%	35%	57%	50%	74%	63%	74%	63%	70%	55%	45%
	COP 16	Sustained	APR 17	40%	44%	61%	47%	59%	53%	59%	40%	64%	44%	70%	41%	84%	31%	63%	37%	61%	55%	74%	66%	74%	66%	72%	47%	50%
	COP 17	Scale-Up: Aggressive	APR 18	49%	53%	70%	55%	70%	72%	62%	50%	71%	60%	81%	49%	86%	45%	66%	44%	70%	63%	77%	72%	77%	72%	75%	66%	62%
	COP 18	Scale-Up: Saturation	APR 19	67%	60%	75%	61%	76%	89%	83%	59%	83%	70%	93%	72%	93%	62%	72%	59%	83%	71%	86%	79%	86%	79%	90%	73%	81%
	COP 19	Scale-Up: Saturation	APR 20	67%	63%	79%	70%	75%	90%	88%	65%	89%	75%	93%	79%	94%	65%	75%	64%	85%	74%	89%	81%	87%	82%	94%	80%	85%
SNU 5	COP 15	Central Support	APR 16	N/A: no target required																				55%				
	COP 16	Central Support	APR 17	N/A: no target required																				58%				
	COP 17	Central Support	APR 18	N/A: no target required																				59%				
	COP 18	Central Support	APR 19	N/A: no target required																				61%				
	COP 19	Central Support	APR 20	N/A: no target required																				72%				

In this example, SNU 1 was prioritized in COP15 to get 90% ART coverage (saturation) by APR 17. The SNU did not reach saturation of 90% coverage at the SNU level by APR 17. The SNU then remains at scale-up saturation until it graduates into the next prioritization tier which is attained. In this example, you will see that SNU 1 will be designated as attained in COP18 with targets that will move the SNU to 90/90/90 by five-year age band to reach 95/95/95 overall by APR 19. In COP19, SNU 1 then remains at attained. In COP20, new ART targets should be allocated to SNUs 3, and 4. SNU 2 has also already reached attained. SNU 3 has reached saturation but should accelerate treatment among age bands that have not yet reached saturation. SNU 4 will continue a path toward reaching saturation at the SNU level, although reaching attained will be may not be feasible by APR 21.

In COP21, the next districts should be identified for saturation by APR 2022. SNUs that were identified as scale-up: aggressive in previous COP cycles should be revisited to see which ones can become saturated by APR 2021 or APR 2022.

Process for Prioritizing Locations and Populations for COP20

As a first step in reviewing the prioritization for locations and populations, teams should gather the following key data elements and potential data sources as outlined in Figure 7.3.3.4, and the analysis already conducted in Step 2 above. This is to ensure 95/95/95 by age and sex, and a clear understanding of who we are missing to achieve these goals, as highlighted in earlier steps as well.

Figure 7.3.2.4: Key data elements and potential sources

Key Data Elements and Potential Sources	
Data element(s)	Potential Sources
<ul style="list-style-type: none"> • Total population • HIV prevalence and trends • Total number of PLHIV • ART coverage by age, sex, and SNU • Coverage of prevention services • Estimated key and priority populations within high prevalence SNUs • HTS and PMTCT yield and ART volume 	<ul style="list-style-type: none"> • Ministry of Health surveillance • Estimates from UNAIDS Spectrum and Subnational Estimates of HIV Prevalence Report • Surveillance studies supported by PEPFAR • Central Statistics Agency • U.S. Bureau of Census • PEPFAR program data • MOH program data

Multiple data sources and a number of contextual factors must be considered when PEPFAR teams review the geographic and priority populations prioritization for COP20. **The goal of this prioritization**

exercise and corresponding analysis is to continue to optimize resource allocation for maximum epidemiological impact.

Once the data elements described above have been assembled, the teams should rank SNUs as follows:

1. Sort SNUs by the total number of PLHIV from largest to smallest using latest estimates (i.e. where are the top 80-90% of PLHIV?)
2. Calculate the percentage of total (national) PLHIV in each SNU
3. Calculate the cumulative burden by SNU by summing and recording the percent of total PLHIV for each SNU entry.
4. Sort SNUs largest to smallest by current ART coverage as of APR 18. ART coverage should be represented as a percentage for each SNU. Unmet need should be calculated using total PLHIV as the denominator. Unmet need will be auto-calculated within the DataPack.
5. Sort SNUs again by largest to smallest by positive yield based on PEPFAR PMTCT and HTS data; calculate estimated PLHIV based on PEPFAR program data and compare the ranking of SNUs to the ranking in steps 1 and 4 above

Country teams should calculate the **net new patients** required to achieve at least 90% ART coverage for PLHIV (by age/sex) by SNU by end of APR 2021. In determining these targets, PEPFAR teams should adjust for scale-rate, mortality, and changes in program to retain individuals on treatment.

Each country context will be different and one method or standard selection criteria should not be applied across the board; however, there are key considerations PEPFAR teams should consider when prioritizing SNUs:

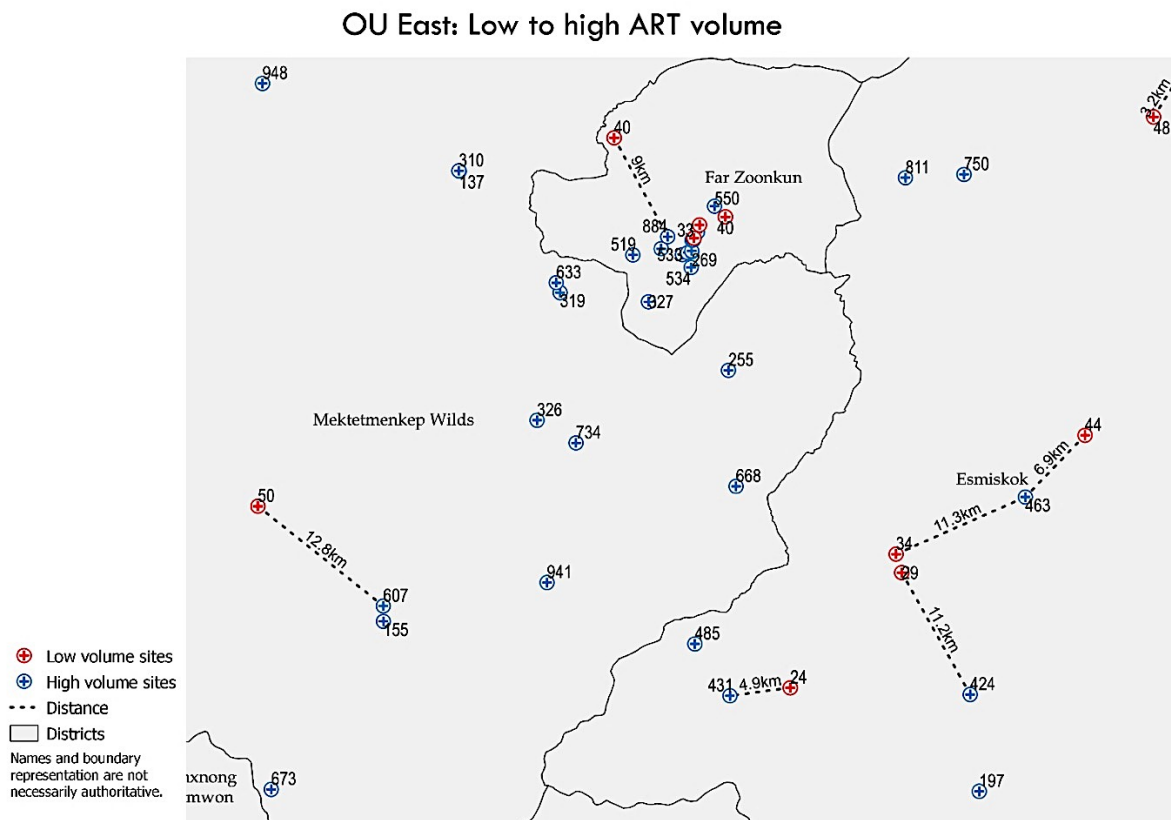
1. Prioritize **across** SNUs to give precedence to high disease burden geographic areas nationally and to the highest performing partners and districts. Funding and targets should move to those areas that are successful and can do more and funding should be constricted in low performing areas until performance improves.

Because the distribution of HIV within a population is driven by factors that cause it to be non-random, it is important to examine the epidemiologic data across geographic areas. A ranking of SNUs based on HIV prevalence, together with consideration of the population size, will enable country teams to identify highest priority areas for the

provision of evidence-based combination prevention services (HTS, PMTCT, ART, VMMC, condoms, and other targeted prevention for key and priority populations).

2. Prioritize **within** high-prevalence SNU to focus resources on the highest prevalence areas, highest volume facilities, and highest prevalence population groups at the local level, with the highest performing SNU. Identify sites with lower retention and volume of clients that can be consolidated to high quality sites should begin immediately with the shifting of resources and targets.

Figure 7.3.2.5: Example map illustrating SNU with potential to consolidate sites based on volume



3. Once high-burden SNU are identified, further analysis within those bounded areas may be needed to refine the geographic targeting, as new infections may not be distributed randomly or evenly throughout the SNU. Furthermore, teams are urged to focus not just on localized “hotspots” within SNU, but to utilize the available data to identify the population groups shouldering the greatest burden of disease within those bounded areas. Data analyses should clarify whether key population groups (e.g., MSM, PWID, SW) or other population groups, such as 15-24 year-old girls and women, account for

the largest attributable fraction of new infections and teams should target prevention and treatment resources accordingly. Other sources of data (e.g., program, ANC surveillance) may help to inform resource optimization in the absence of population-based epidemiologic estimates.

Finally, if a hotspot area within a lower-prevalence, sustained SNU meets criteria for a micro-epidemic with a high volume of new infections, the SNU in which it is located should be categorized as a scale-up SNU but only the hotspot area(s) within the SNU receive scale-up targets. In these cases, the number of PLHIV in the hotspot is needed to estimate current and target coverage levels. Teams should explain the need for a unique focus on these micro-epidemics and detail plans to achieve 90% ART coverage and accelerated coverage of combination prevention in the hotspot(s) within the SNU.

4. Ensure that gaps in treatment coverage are understood by age/sex to ensure SNUs will high rates of LTFU or low treatment program growth (and high PLHIV burden) are appropriately prioritized.
5. Ensure that gaps in quality of client centered services is understood to ensure SNUs and populations with high unmet are appropriately prioritized.
6. Ensure that **indigenous partners** without host government support are funded accordingly
7. Strive for **attained status and saturation** within prioritized SNUs

To reach 95/95/95 at the country level, PEPFAR teams are urged to design programs using available population size estimates and set complementary prevention and treatment targets necessary to saturate geographic areas and key or priority population groups. Saturation is defined as achieving 90% coverage of prevention or treatment services in those population groups within SNUs needing them.

Finally, if ART coverage has exceeded saturation in an SNU (defined as >90%ART coverage among both males and females of all ages living with HIV), that SNU should be designated as **attained** (and the relevant programs within that SNU). The aim then is to achieve saturation levels of ALL core interventions relevant to the populations within the SNU to curb HIV transmission and improve health outcomes for PLHIV. Even after achieving attained or saturation status, the SNU should remain a priority SNU and continue to scale other core interventions, as resources permit and as dictated by epidemiologic need.

In setting targets to accelerate epidemic control and in completing the relevant section in the SDS, team should keep several factors in mind:

1. Targets for epidemic control are distinct and mutually exclusive of expected volume to sustain support in other locations and populations.

In Section 4 of the SDS, PEPFAR teams will present targets across all scale-up areas in the standard tables. In many OUs, we expect PEPFAR resources dedicated to scale-up to shift to scale-up areas and interventions; however, PEPFAR teams will need to budget for continued support to existing ART and PMTCT patients and OVC beneficiaries in other locations and programs.

2. Target timeframe should be framed by goals beyond implementation in COP20.

Strategic planning requires PEPFAR teams to think beyond the implementation year associated with COP20 (FY21). In this COP, the DataPack will support calculating two-year strategic targets (e.g., APR 20120 and APR 2021), however teams are *not* expected to submit site-level targets.

In COP15, for ART coverage specifically, teams were requested to select priority locations and populations in which coverage of 81 percent is possible by the end of FY17 and then FY18 and FY19. Since areas have already been identified for saturation in FY20, in COP20 teams should identify the areas for saturation by FY 2021. This timeframe is intended to provide a near-term goal post for PEPFAR teams to guide decisions as they set targets to accelerate ART coverage in priority areas.

3. Program costs and trade-offs should be taken into account when setting targets for priority locations and populations.

In determining targets for ART, combination prevention activities, and OVC, teams should review and use COP18 expenditures against budget, as well as the information on what interventions were funded and what was purchased (objects of expenditure). If available, costing data may be used as well. The financial data should be used to allocate resources within the available funding envelope and entered in the FAST. Teams should also keep in mind that achieving targets in one technical program (e.g., the treatment cascade) has an impact on funding available to achieve targets in another technical area (e.g., prevention through VMMC). There is no specific guidance applicable to all PEPFAR OUs on the most appropriate percentage of funds to allocate to combination prevention and support activities; however, teams are expected to meet legislated budget code earmarks (see [Section 5.9.1](#));

consider any central funding that may be available to assist with achieving targets in specific technical areas, and consider the type and magnitude of support provided by the host country government and other stakeholders. The goal is to achieve epidemic control in prioritized geographic areas and populations as quickly possible. The mix of combination prevention interventions will vary by epidemiological context; teams should use any data available to optimize these allocations.

In addition to setting targets for current on ART and ART enrollment (newly initiated) by SNU, PEPFAR teams should determine how they will meet the enrollment target proposed by entry stream for ART. At minimum, 4 entry streams should be considered:

1. Initiate ART for all previously diagnosed and clinical care patients living with HIV infection

One very efficient way to increase enrollment for ART programs is to initiate clinical care of patients living with HIV on ART, as is consistent with WHO treatment recommendations. This population should have been already initiated on treatment in the previous COP cycles in most countries, but any remaining previously diagnosed patients should be immediately initiated on ART.

2. TB-HIV patients not on ART

Teams should initiate ART in TB patients diagnosed with HIV. PEPFAR teams should estimate how many individuals currently receiving TB treatment and prophylaxis at TB sites will receive HIV testing and be linked effectively to ART sites as newly initiating ART patients.

3. HIV-positive pregnant women and HIV-exposed infants

HIV-positive pregnant women receiving care through PMTCT sites will initiate or continue ART over the period. Teams should estimate the number of women newly initiated on ART through PMTCT programs as a key entry stream for new on ART enrollment targets. Early infant diagnosis (EID) of HIV-exposed infants is another important opportunity for case finding and pediatric ART initiation.

4. Other priority and key populations

Improve linkage to ART services for PLHIV diagnosed through existing HTS programs. Strategic testing of high-yield populations through PITC, *index client testing*, and index-based testing are also important opportunities for case finding, linkage, and ART initiation. PEPFAR teams should be able to describe with data how many newly initiating ART

patients can be expected from each of the entry streams above and determine PMTCT and HTS testing targets accordingly.

Setting Targets for VMMC in Priority Locations and Populations

Geographic areas and only age groups (15+) with higher levels of unmet need should be prioritized within the overall strategy, i.e., between SNUs of equivalent HIV burden, the SNU with lower circumcision prevalence should be prioritized (similar for age bands). SNU prioritization should use PHIA or other recent nationally representative survey data of MC coverage as its primary basis, where available.

Setting Targets for Prevention Interventions in Priority Locations and Populations

Once teams have identified key and priority populations in the selected SNUs, they should develop best-possible estimates of population size. Teams should then develop a basic package of interventions for each population based on existing guidance, and analysis from Step 2, and set coverage targets for each population based on an evidence-based hypothesis about the levels of coverage necessary to achieve population-wide reductions in incidence. Key and priority populations should align with HTS, as appropriate.

For DREAMS SNUs, DREAMS services for adolescent girls and young women (AGYW), their families, and their communities should be taken into consideration for all target-setting, including HTS_TST, PP_PREV, KP_PREV, PREP_NEW, and PREP_CURR. Countries should strive to provide at least the primary package of interventions to 90% of active DREAMS recipients for each DREAMS age band (10-14, 15-19, and 20-24).

Setting Targets for OVC

Based on a comparison of current PEPFAR OVC coverage and estimates of the OVC population and inputs such as situational analyses, PEPFAR teams use the analysis from Steps 1 and 2 to select locations and populations for program focus; and using the definitions provided in the indicator reference sheets, set targets for OVC_SERV in the DataPack. Teams should provide a brief description of the data sources used and assumptions made. All households with HIV and with children need a full OVC assessment and all new clients need a full assessment.

While setting OVC targets, teams should focus on providing a comprehensive package of prevention and treatment services and supports to OVC ages 0-17 years, with particular focus on adolescent girls in high HIV burden areas, 9-14 year-old girls and boys in regard to primary

prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support. Adolescent girls should be prioritized as they bear a disproportionate risk for HIV acquisition compared to their male peers. In DREAMS SNUs, DREAMS and OVC teams and implementing partners should co-plan and set targets together to maximize efficiencies and ensure that the needs of the most vulnerable adolescent girls are met. Likewise, OVC teams should work with pediatric, PMTCT, and KP colleagues to ensure coordinated planning that results in greater support to children.

7.3.4 Client-Centered Supply Chain Plans

To conduct accurate and complete forecasting, teams should include considerations patient months, buffer stock, expiry, warehousing and distribution chain, lead time for delivery to country and delivery to point of service, stock-outs, and influence on the ART supply chain. Additionally, country teams should confirm whether their country or region is eligible for subsidized procurement of ARVs for PrEP to potentially reduce procurement costs. Teams should consult commodities experts at HQ for any technical assistance needed with commodity forecasting, confirming whether their country is eligible for subsidized ARV procurement, or any other PrEP commodities-related questions.

Countries should complete the NVP-based formulation tab within the supply planning tool. Teams will not be able to place anticipated orders for these formulation as PEPFAR does not support the use of these ARVs and PEPFAR will not procure these formulations. This information will only capture the amount of stock on-hand that countries currently have. Each country with an excess stock on-hand must annotate within the FAST their disposal/destruction plan and budget required. Note: Programs must have transitioned all infants and children off NVP-based regimens to LPV/r or DTG-based regimens by the end of COP19.

PEPFAR recommends that the on-going TLD access transition plans should be fully implemented prior to COP20 and deviations will need to be fully explained in the SDS. Decisions around all ARVs required for each country be led by the country government with input from the USG team, donors such as Global Fund, implementing partners, and other local stakeholders that address policy, regulatory and operational issues of transition. These should address the total volume of TLD, LPV/r pellets and granules to be purchased by all stakeholders and be fully quantitated as well as source of funds (not just that procured by PEPFAR) and include these additional planning factors:

- Timing of anticipated country-led adoption of TLD, including estimates for stock build-up deliveries and timing of when first patients will be started on TLD
- Explicit description of plans for patients on second-line therapy, pregnant and breast-feeding women and patients with TB
- Explicit description of all pediatric meds and source of funding
- Assessment and documentation of viral load capacity, with a plan to prioritize patients who are transitioning/or have transitioned

Updating the commodities planning tool and the FAST Commodities Tab E will now be required on a semiannual basis. A submission of an OPU may be required to address any budgeting increases for commodity procurement or reallocation of excess funds within the commodities budget. The revised commodities supply planning tool, FAST commodities tab and an OPU submission will be required at the beginning of the FY Q3 period.

Country teams should continue to update national guidelines (to include TLD and optimized regimens for women and children living with HIV), ensure that the 18-month ARV supply plans are comprehensive and include the following:

- TLD transition should be complete
- Product registration
- Stakeholder engagement
- Quantification and forecasting
- Descriptions of facility level implementation, monitoring, and uptake
- Draw down plan for legacy TLE600, TLE400, or TEE600 to achieve zero wastage
- Budgeting for the replacement of NVP-based formulations and destruction of these ARVs.

7.3.5 PEPFAR-funded Surveys, Surveillance, Research, and Evaluation Activities

PEPFAR funds SRE activities to understand and address countries' epidemics; translate efficacious interventions tested in controlled environments to real-world contexts where resources are more limited; and provide the evidence basis for decision-making and public health action. In COP20, S/GAC S/GAC will lead a preliminary review process of all proposed surveys-surveillance, research, and evaluations (SRE) during the COP20 Strategic Planning

Meeting and will provide a final review during the COP20 Approval Meeting (see [Section 8.4](#), figure 8.4.1). All current, partially, or fully COP- and TOM-funded surveys-surveillance, research, and evaluations must be submitted in the COP. All proposed COP elements must be approved by S/GAC prior to planning or funding, as with all COP20 activities. As of the COP19 cycle, there are no longer centrally funded SRE activities with the exception of Population-Based HIV Impact Assessments (PHIAs). Research activities funded in COPs prior to COP17 that have not been executed will be canceled and monies reprogrammed.

Proposal and reporting of SRE activities follow the same requirements. All proposed, newly commencing, ongoing, completed, not implemented, and discontinued SRE activities must be recorded within the SRE Tool prior to COP20 Meetings. Additionally, all ongoing and proposed SRE activities that will be utilizing COP20 funding must also be recorded within Table 6 prior to the COP20 Meetings. Prior to COP20 Meetings, Table 6 of all such activities must be disseminated to in-country CSOs and CSO COP20 Meeting participants.

7.3.5.1 Prioritize Activities in Table 6

Under PEPFAR 3.0, accelerating progress toward epidemic control and ensuring that the program's achievements and gains are consolidated and sustained remains major areas of focus. Thus, sustainability remains a key dimension of PEPFAR's business model. Ensuring sustained epidemic control means that PEPFAR teams, in-country stakeholders (e.g., government and civil society), and multilateral partners (e.g., UNAIDS, Global Fund) must align their investments to efficiently remove barriers to epidemic control. With better coordination and accelerated impact with a focus on sustainability, PEPFAR can influence technical gains in country, and foster greater accountability, transparency, and use of evidence to accelerate progress toward epidemic control.

In COP20, efficient and effective systems investments continue to be an essential component of achieving PEPFAR's goals, including identification and remediation of key gaps in the clinical cascade and shifting the national policies necessary to achieve countries' 90/90/90 targets. Above site investments may also be needed to address gaps in achieving Minimum Program Requirements, see [Section 2.2](#). As part of COP20 SDS, field teams should describe their strategy for attaining a steady state where PEPFAR's efforts to support and strengthen health systems lead to sustainable epidemic control. A steady state is when the host country health systems function effectively and efficiently with minimal donor support. Activities in Table 6 should be designed with the goal of reaching the steady state and the yearly benchmarks

should show a clear pathway to monitor progress. To formulate the strategy, field teams should aggregate health systems investments using PEPFAR expenditure data for the Above-Site Programs (ASP) as available in PEPFAR Panorama over the last 5 years and describe achievements to date. The strategy toward a steady state should describe the rationale for continued investments in health systems and demonstrate the impact of these investments toward achieving sustainable epidemic control.

Complete the following before filling out your Table 6, based on your above analysis in Step 2.

- Determine the current programmatic needs and gaps that remain related to non-service delivery investments implemented above-site that are necessary to address program and system priorities and improve performance/achieve targeted outcomes using a variety of available data sources, including SID, MER, SIMS, and other sources.
- Define needs based on strategic priorities vis-a-vis epidemic control priorities (95/95/95), systems gaps, and minimum requirements for PEPFAR programs
- Focus on gaps
 - SID 2019 – Does SID 2019 highlight any gaps in sustainability that require above-site, non-service delivery investments?
 - MER – Do program results indicate gaps in performance that require above-site investments?
 - SIMS – Do SIMS assessment results indicate gaps in quality that require above-site investments?
 - Other sources – Are there other sources (e.g., Global Fund Key Performance Indicators, other third-party or contextual indicators relevant to key aspects of the enabling environment affecting sustainability) that indicate gaps in above-site, non-service delivery investments?
- Are above site barriers and activities aligned to address barriers to epidemic control and improve site-level performance? How is the progress measured?
- Teams should review expenditures and budgets against the Table 6 activities. Is the funding for above site investments aligned to the gaps identified? Are high priority gaps receiving sufficient funding? Low priority activities have should have declining funding or funding should be reallocated to higher priority activities.
- What is the change in relevant MER indicators that can be attributed to respective Table 6 activities?

- For activities that have achieved COP19 benchmarks, what is the rationale for continuing in COP20? How many additional years of support is needed?
- For activities that have partially achieved COP19 benchmarks and continuing in COP20, what is the course correction?
- For activities that are not initiated or have not achieved any of the COP19 benchmarks and continuing into COP20, what is the rationale for continuation?

7.3.5.2 Review and Revise Resource Alignment Tool

Resource Alignment and Funding Landscape:

The Resource Alignment collaboration between PEPFAR and the Global Fund has enabled efforts to better align resources, avoid duplication, drive efficiency, and improve the cost analysis and resource estimations of HIV treatment and prevention programming.

- Pre-populated country profiles available to country teams are intended to facilitate a collaborative planning process, inform guided discussions around strategic alignment of investments across entities, get a fuller understanding of the HIV funding landscape, and assist completion of the “Investment Profile” section of their strategic direction summary (SDS).
- While PEPFAR and Global Fund financial data are harmonized and validated through the resource alignment collaboration, domestic data, however, are less available and need to be verified during the COP20 planning process. Domestic budget data for 2018-2020 sourced from the Global Fund grant submission funding landscape tables are available via the country profiles for the host country team to verify and update where necessary prior to COP20 finalization and submission. If data is available on planned host country 2021 HIV investments (budgets), this should also be included.
- Additionally, though domestic HIV expenditure data form a critical part of the overall picture, these data are not readily available. Any additional information that can be gathered in consultation with host country teams during the COP20 planning process will enhance the overall understanding of the funding landscape, including estimation of resource needs going forward.
- Examining actual expenditures against planned investments by specific program areas will help identify areas of low absorptive capacities, investigate possible causes, and develop strategies to address it. Triangulating resource alignment data with national

program results, MER, Table 6, SID, and responsibility matrix will provide a better understanding of total funding against results; whether investments are adequately targeted to address issues along the clinical cascade; assess possible gaps in funding and pockets of inefficiencies; identify areas where agency/host country government can prioritize resources based on competitive advantages.

7.4 Planning Step 4: Interrogate, Adjust, Examine, and Align Notional Budgets and Country devised Targets with the Strategic Direction

The purpose of this step is to interrogate, adjust, examine, and ultimately align the initial budget, systems investments, and targets with the strategic direction for the OU, as reached by consensus during PEPFAR team and stakeholder discussions. This alignment must also consider supply chain planning and forecasting for the OU, for all key HIV commodities, even if the procurement is not using PEPFAR funding.

Aligning the budgets and targets with the strategic direction from the completion of Step 2 is an iterative process beginning in mid-January and finalized in April. The overarching questions country teams must consider are:

- Will the planned strategic objectives (interventions) and their budgets result in planned targets? OUs must show how this will be different than FY20 and what improvements are being done in FY21.
- Did planned budgets and targets shift based on partner performance?
- Are the planned targets, activities, and budgets in line with the identified strategic direction?
- Will the planned activities address barriers to achieving epidemic control?
- Is most of the work (defined by interventions) in the budget going toward the strategic direction from Step 2 or is there planned work that does not seem to correspond to the current strategic direction?
- Does the budget make the best use of available funds to pursue the OU's strategic plan?

With the budget, above-site and systems investment and targets in place, a qualitative analysis of the types of strategic objectives and solutions that were deemed appropriate for the country

may identify gaps. If certain elements of the strategic approach are underfunded in the budget, teams must examine where funds can be redirected. If existing interventions correspond to an outdated strategic approach, funds must be redirected to objectives that align with COP20 strategic objectives. Teams must quantify the total funding in the budget that align with identified interventions and understand whether budget reflects overall strategic approach.

By the end of Planning Step 4, teams should have:

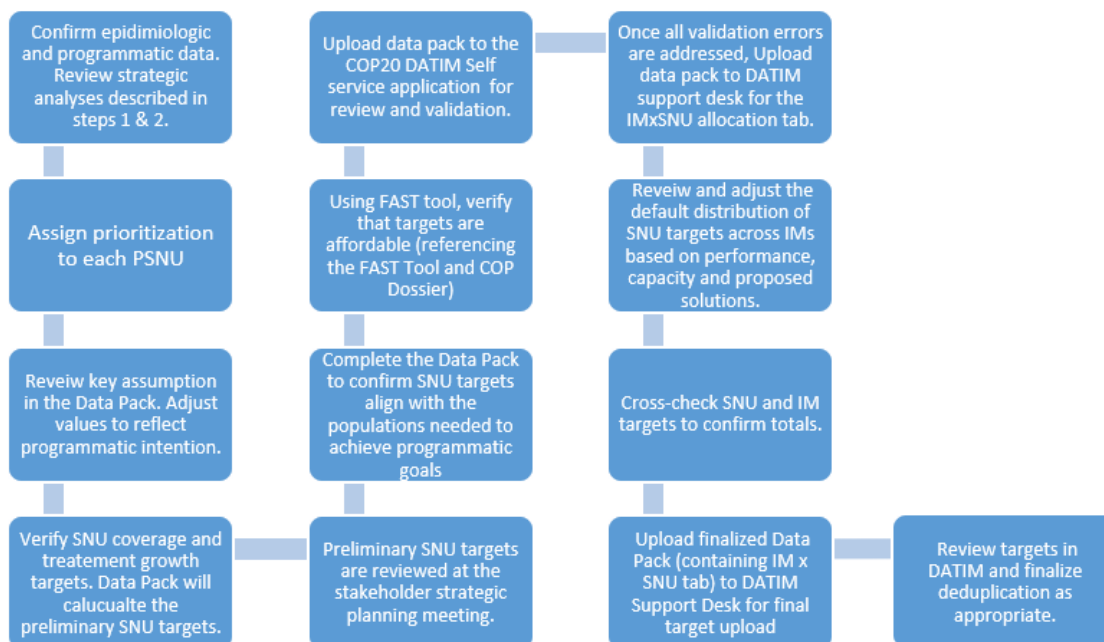
- Preliminary budgets and targets that are aligned with the proposed strategic plan
- A balanced, completed FAST budget that meets earmarks
- A completed DataPack
- A completed supply chain planning tool
- A completed Table 6 and SRE Tool
- All documentation required for the COP20 Meeting

The outcome of this incremental budgeting, targeting, and strategic alignment process will be updated to reflect targets and a budget that align with the COP20 strategic direction for the OU.

7.4.1 Recommended Process for Establishing and Entering Targets

A flowchart for PEPFAR’s process for establishing and entering targets is below.

Figure 7.4.1.1: PEPFAR’s process for establishing and entering targets



Implementing mechanism targets are produced in the DataPack. See DataPack User's Guide for detailed instructions. Where more than one partner may reach the same individuals at a given site, country teams should take the opportunity to rationalize partners for increased efficiency.

7.4.2 Supply Chain Data Availability, Visibility, and Use

PEPFAR and countries are facing new realities in the planning, managing and monitoring of supply chains globally. Given the size and scope of the supply chain program and the commodities budget, PEPFAR expects more granular-level reporting of commodities data in pursuit of PEPFAR's 90/90/90 goals to ensure effective use of funding for commodities procurement. This includes new MER indicators starting in FY20. Facility level partners will be asked to report on the quantities of ARVs dispensed as well as the quantity of stock available on the shelf at the end of the reporting period.

Countries are tasked to improve the management of HIV product inventory, optimize the global TLD transition, country-specific multi-month dispensing (MMD) implementation, and facilitate a triangulation between clinical and stock level data at site level to ensure that national programs fully optimize cost effective ARV regimens. In order to achieve this goal, it is necessary to increase PEPFAR's visibility into the availability of HIV commodities across all levels (and stakeholders) of the supply chain (i.e., central, regional [sub-national], and site [facility] level), hence the new MER metrics. Additionally, visibility should be extended to current orders and forecast for when deliveries of ARVs will arrive in-country, across all donors (PEPFAR, Global Fund, etc.) and procurement by the host-country government.

Countries will meet the supply chain data visibility goal through the use of several tools:

- The Procurement Planning & Monitoring Report (PPMR-HIV) will capture data input by MOH or a designated Partner(s) in each country for central and sub-national level stock and anticipated shipment data.
- The site-level data will be captured through an existing eLMIS or by a designated facility staff member or a PEPFAR Partner already providing oversight at the facility in a standardized data collection tool: SC-FACT (Supply Chain – Facility-level AIDS Commodity Tracking).
- Commodity forecasts as they exist either in excel, PipeLine or another software.

- MER metrics on stock available at the end of the reporting period (SC_CURR) and ARVs dispensed during the reporting period (SC_ARVDISP).
- USAID will expand coordination efforts with the Global Fund (GF) to include GF commodities orders and shipment data to improve visibility and predictions of in-country stock levels.

There are currently 18 out of 23 PEPFAR supported countries reporting into the PPMR-HIV for national and sub-national levels. Each country team must allot time and resources to do monthly monitoring of data collection and analysis for use in programmatic decision-making.

Countries that are not currently reporting need to follow the several steps to begin the data collection process:

- Contact your HIV supply chain country backstop to start the process and for first contact with the PPMR-HIV Administrator
- Work with the PPMR-HIV Administrator to identify the country data sources for the commodity data (e.g., eLMIS, PipeLine, WMS) and the data owners.
- Share the PPMR-HIV Data Use Agreement with the data owners, obtaining consent from data owners where necessary
- Determine list of reporting locations (central, sub-national, facility)
- Develop list of products to be reported
- Begin data collection

Prior to the COP20 Meetings, countries should understand their current commodity data collection status. After understanding the country data collection status, activities and corresponding budgets must be included in COP20 plans to initiate and continue commodity data collection as soon as possible with data collection at the national/sub-national level an immediate need and data collection at the facility level as a primary objective. Where possible, countries should proceed with discussions on formal data usage agreements now with country stakeholders including MOH officials and other donors to understand if any additional activities will be necessary to ease country concerns over data use and secure data storage that are an underlying foundation of this initiative.

While the need for data collection is immediate, plans should consider that the desired longer-term results are sustainable order and inventory management data collection mechanisms that make use of best practices in data management and data standardization. The following principles should be considered in planning for data collection in the medium and long-term:

- Promote sustainable data collection through implementation and maintenance of eLMIS solutions.
- Promote end-to-end visibility using global standards such as GS1 Healthcare standards for product names and labels. Work with local regulatory authorities to adopt the GS1 healthcare standard.
- Promote master data management. Most immediately, incorporate harmonization and regular updates of Master Product Lists and Master Facility Lists. The lists should also be harmonized with global programs (PEPFAR's Master Facility list and the MOH Master Facility List) to ensure consistency between the lists.
- Promote data quality through data usage not only by USG and Partner staff, but by MOH and facility staff as well.
- Reach out to USAID/W backstops as often as needed to help guide the adoption and usage of supply chain data standards.

Commodity data collection plans should be prepared and submitted at the COP20 Meeting and should include budget considerations.

7.5 Planning Step 5: Finalize SNU and IM Targets and Budgets

The FAST and DataPack must be completed and balanced to the planning level at the start of the COP20 Meeting.

Step 5 is to complete the COP20 Meeting with agreement on:

- IM level targets by PSNU
- IM level systems investments
- IM level budgets by intervention

No changes to IM by SNU targets, IM level systems investments and IM level budgets by strategic objectives should take place after the COP20 Planning Meetings.

As in COP19, S/GAC will import COP matrix IM-level budget fields (new funding source, applied pipeline amounts, new funding by budget code, new funding by cross-cutting attribute) at the end of the COP20 Planning Meeting.

7.6 Planning Step 6: Finalize and Submit COP

To finalize COP20, country teams must finalize the budget, targets, SDS, and all supplemental materials in advance of the COP 20 approval meetings.

To complete the COP submission:

- Confirm the final budget in FACTS Info following COP approval and sign-off. Further information on FACTS Info entry is provided in [Section 8](#) of this guidance and the FACTS Info User Guide
- Final FAST tool with budget balanced to planning levels, required applied pipeline, and mandatory earmarks
- Submit age and sex disaggregated targets by IM in DATIM
- Submit the SDS and supplemental documents

7.6.1 Develop Annual Work Plans and Targets

Keeping to the COP20 Meeting agreements (budgets by intervention and targets by IM by PSNU), implementing partners are asked to establish and submit detailed annual financial and activity work plans and targets. These work plans should correspond to the following items:

- OU strategic plan as articulated in the COP20 SDS
- Approved FAST
- Approved Table 6 / SRE Tool
- Approved targets in DATIM
- Agency contracts and cooperative agreements