COP 21 Guidance Summary
April 2021

The OVC Task Force has prepared a summary of the COP 21 Guidance as a quick reference guide for program implementation in COP 21 which serves as a complement to the Priorities in OVC Programming document. This summary is meant for all OVC practitioners and while it is relevant to both clinical and OVC partners, it has an emphasis on community-based programming. The summary points in each category below were identified by the OVC Task Force Co-Chairs through a review of the PEPFAR 2021 Country and Regional Operational Plan (COP/ROP) Guidance for all PEPFAR Countries.

MER 2.5

- *MER 2.5 has been released for FY21. COP21/FY22 targets should be aligned with indicators and definitions per MER 2.5. This summary was prepared by the ACHIEVE project and shared with the Taskforce.*

Indicator	***Update***
OVC_SERV	● ***OVC_SERV has been restructured to distinguish between beneficiaries in the three OVC_SERV program models: OVC Comprehensive, DREAMS, and OVC Preventive***. ● *The OVC Comprehensive disaggregate is reported by program participation status, age/sex, Exited or Transferred, and* ***a new disaggregate to distinguish between OVC child beneficiaries aged 18-20 years and caregivers aged 18+.*** ● *The DREAMS and OVC Preventive disaggregates are reported by age/sex.* ● *The guiding narrative questions have changed* *Note: an individual is only reported once- under OVC comprehensive, DREAMS, or OVC preventive. If a beneficiary can be reported under more than one category, the default is the OVC comprehensive category. The guidance in the PIRS provides some scenarios to understand for how to report different beneficiaries.*

OVC_HIVSTAT	● *Only those beneficiaries reported under OVC Comprehensive program are to be reported under OVC_HIVSTAT and only the beneficiaries <18 in the Comprehensive program will be used as the Denominator for OVC_HIVSTAT and the Known Status Proxy.* ● *The narrative questions have been updated accordingly.*
AGYW_PREV	● *Clarifying language made throughout the reference sheet, including changing "AGYW" to "active DREAMS beneficiaries", updating the names of programs, and additional clarifications on data reporting.*
PrEP_NEW	● *The reporting frequency moves from semi-annually to quarterly in FY21. Added language in "How to Collect" section on screening for gender-based violence and intimate partner violence when determining PrEP eligibility*
PrEP_CURR	● *The reporting frequency moves from semi-annually to quarterly in FY21.*
GEND_GBV	● *The reporting frequency moves from annually to semi-annually in FY21.*
HRH_CURR	● *Starting in FY21, HRH_CURR will be retired. HRH Data will be collected via the HRH Inventory. Data collection through the HRH Inventory, along with more robust analysis and programmatic action, will allow PEPFAR to better capture the scope and nature of its staffing investments in order to optimize health worker utilization to advance epidemic control and inform sustainability planning once epidemic control is achieved. See Appendix G for additional information.*

Cross Cutting:

- Emphasis on leveraging differentiated service delivery (DSD) models - includes self-testing, mobile testing, etc. to make services more accessible to participants. Emphasis on DSD models accelerated in response to COVID and barriers to access for most vulnerable groups (e.g. clinic hours, stigma, transportation, etc.)

- Important considerations for all KP programs include: (1) partnering with community and civil society groups to improve the quality of existing KP programs and service delivery organizations; (2) mentoring and building capacity of nascent KP-led service delivery organizations; (3) reducing stigma and discrimination present in public and private HIV and other service settings; (4) addressing and preventing violence and various forms of abuse against key populations; (5) ensuring safe and accurate data collection and use to better inform programming through KP surveys and ongoing case-based surveillance; (6) promoting UICs and other means and tools to document key populations HIV and service-related outcomes ; and (7) ensuring strong coordination with other PEPFAR program areas, including DREAMS, OVC and pediatrics (page 413).

HIV Prevention:

- Prioritize adolescent girls with DREAMS HIV prevention interventions targeting sub-groups at highest risk of HIV infection in high HIV burden areas. Align HIV prevention interventions with DREAMS guidance.

- Emphasize risk avoidance among young adolescents (9-14) for primary prevention of sexual violence and HIV (i.e., preventing any form of coercive/forced/non-consensual sex and preventing early sexual debut).

- Deliver parenting using evidence-based curricula and focus on risk avoidance and protecting adolescents from violence and HIV infection.

- Ensure comprehensive post-rape/gender-based violence (GBV) care services for survivors of sexual violence, including access to post-exposure prophylaxis for HIV prevention.

- Use schools as a platform to deliver GBV and HIV prevention education and HIV response services to adolescents (including school-based prevention and ensuring interrupted treatment for school-going C/ALHIV)

- Engage boys/men in HIV prevention activities.

- Promote and support access to Voluntary Medical Male Circumcision (VMMC) among adolescent boys under 15.

Case finding:
**Note that these activities are led by clinical partners, and supported as possible by OVC partners.*

- Optimize Index Testing in collaboration with clinic partners to find the remaining HIV-positive children

- Improve case finding among children of key populations (KP), and work with KP and clinical partners to extend index testing for KPs to their children.

- Work with clinic partners as they prioritize rapid identification and treatment of infants with exposure to HIV during pregnancy, birth or the breastfeeding

- Support case-finding and treatment efforts with school-aged children and adolescents, while also improving early infant diagnosis and identification of 1-4 years old children

- Systematically and continuously assess and refer children and adolescents for HIV risk to HIV testing be sensitive to new risks that emerge in the child's life. Use a risk assessment tool as part of the case management process.

- Support effective demand creation and male engagement for HIV testing, continuity of and uninterrupted treatment.

ART Adherence and Continuity of Treatment:

- Increase ART adherence among HIV-positive adolescents through community-based approaches such as peer groups and buddy systems, and address health facility transport issues for adolescents.

- Decrease stigma, discrimination, and violence against children/adolescents living with HIV (C/ALHIV) from teachers and students in school and support a safe environment for adherence for C/ALHIV.

- Deploy individual behavior approaches (e.g., behavior science, behavior change, psychology, nudges/primes/habits) to promote ART adherence among adolescents.

- Support age-appropriate disclosure of HIV status to children and adolescents to improve ART adherence and wellbeing.

- Support ALHIV's transition to adult care and treatment services by developing their HIV self-care skills.

- Coordinate with health facilities to identify and enroll children and adolescents on ART, to ensure access to the comprehensive socio-economic package of services offered by OVC programs.

Reducing Stigma

- Stigma reduces access to and use of essential health services, and undermines efforts toward effective responses to HIV/AIDS.

- PEPFAR programs broadly (including in OVC) should aim to increase access to, and uptake of, HIV prevention, treatment, and care services for all people living with HIV/AIDS and affected by HIV/AIDS; especially adolescents and young women, and key populations (e.g., men who have sex with men, transgender people, sex workers, people who inject drugs, and people in prisons and other closed settings) (p. 66-67).

- OVC partners should participate in broader PEPFAR working groups to develop a plan, timeline, and resource allocations to measure, document, and mitigate stigma, discrimination, and violence.

- OVC partners will be expected to participate in non-descrimination trainings held for implementing partners (p. 69).

Viral Load Monitoring and Viral Suppression

- Support uptake of services, eliminate barriers, and promote adherence for C/ALHIV

- Clinic partners will lead efforts to deliver test results directly to patients or alert them through SMS of the readiness of their results, coordinate with clinic partners to ensure proper orientation, training and coordination for tracking viral load monitoring, track and report viral load suppression results, and document reasons and mitigation strategies to address non suppression.

- Support clients to follow up with clinics on VLT results to expedite action on non-suppression.

- Coordinate closely with peer educators and clinic-based counselors to sensitize and educate caregivers and children around the importance of routine VL testing, understanding results, and clinical management. Effective family-based, high quality treatment literacy efforts are essential for closing pediatric VLS.

GBV Prevention and Post Violence Care (COP 21)

- A *strengthened continuum of response between GBV prevention and clinical post-violence response services* should be integrated into the HIV cascade at key points, including HIV prevention interventions, HIV testing (particularly index testing, recency testing, and partner notification), HIV care and treatment, PMTCT, ANC, and OVC services.

- Sexual violence places children on a trajectory of negative health outcomes.

- All active DREAMS beneficiaries aged 10-14 years should receive primary prevention of HIV and sexual violence as part of their primary package.

- Routine enquiry (also referred to as the IPV risk assessment) should always be conducted with index testing and partner notification, counseling and initiation of PrEP, and eligibility screening for DREAMS and OVC programs.

DREAMS

- During COP21, all 15 DREAMS countries should follow the updated DREAMS Guidance, implement evidence-based/informed curricula with fidelity, continue to utilize layering, and create strong referral networks

- Use evidence-based risk and vulnerability factors for enrollment into DREAMS: Multiple Sexual Partners; Sexually Transmitted Infection (STI); No or Inconsistent Condom Use; Transactional Sex; Experiences of Violence; Out of School/Never Schooled; Alcohol Use; Orphanhood

- Refer AGYW ages 10-20 in OVC programs needing intensive HIV prevention support to DREAMS / DREAMS-like services, use Risk and Vulnerability Assessment

- Programming using DREAMS and OVC funds should be closely coordinated in order to maximize AGYW-focused prevention activities in all DREAMS SNUs for AGYW 10-17 and young women 18-20 finishing secondary school

- Identify and engage out-of-school AGYW along with other vulnerable AGYW such as AGYW living with disabilities

- HTS and STI settings: all AGYW who are 10-24 years-old should be screened for DREAMS eligibility

- ANC and FP settings: all AGYW who are 10-17 years old should be linked to DREAMS and those 18-24 years old should be screened for DREAMS eligibility.

- Strengthening economic interventions continues to be a priority to decrease AGYW's reliance on transactional sex and strengthening AGYW's self-efficacy and decision-making power in relationships
    - 10-14 year old AGYW should receive financial literacy as part of the primary package;
    - 15-19 year old AGYW should receive basic economic strengthening including financial literacy with savings group as a secondary package if they are earning income

- Approved curricula: Families Matter! Program (FMP); Parenting for Lifelong Health (also known as Sinovuyo); Coaching Boys Into Men (CBIM); IMPower (also known as No Means No Worldwide)

- Five promising practices: Co-locating DREAMS programs and services; Transporting AGYW who participate in safe space activities, as a group, to receive needed clinical services; Ensuring facility partners providing services to vulnerable AGYW actively refer to DREAMS community services; Bringing clinical services to community programming (e.g., Safe Spaces) on a regular basis; and Formalizing MOUs between DREAMS partners to ensure effective linkages and referrals

Note: Statements expressed in this document do not necessarily represent the views of all OVC Task Force co-chairs or constituent organizations or U.S. government inter-agency representatives.